

# Best Practices for Teachers and Providers Working with Gender-Variant Youth

Kathryn Kemp Chociej

## 2013



Transgender youth are at increased risk for low self-esteem, depression, suicide, substance abuse, school problems, family rejection and discord, running away, homelessness, and prostitution. It is important for social workers to understand the barriers transgender individuals face when accessing healthcare, to provide context for the clinical experience, and because mental health care providers play a significant gatekeeping role for this population. According to Section 6.04 of the NASW Social Work Cultural Standards, social workers should promote conditions that encourage respect for diversity, and social workers should promote policies and practices that demonstrate respect for difference, and promote policies that safeguard the rights of and confirm equity and social justice for all people. It is in this context that this cross-systems training for teachers, medical providers, and mental health providers was created - to support and affirm gender-variant youth and their families, through increased system capacity for gender-variant youth, increased environmental cues that demonstrate safe space for gender-variant related services; and reducing barriers to accessing health care services through education to 1) better meet patient's needs and 2) improve their health care experience.

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**Written for Gender Diversity**

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Capstone

Best Practices for Teachers and Providers: A Cross Systems Training to Support Gender-Variant Youth

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T SOCW 533 B

Advanced Integrative Practice II

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Thank you to all the researchers, activists, community organizers, and policy makers who came before me and have been and continue to make great strides in this movement. I honor you with this work.

## Dedication

### Transcript of a conversation with my child:

**Me:** Autumn, I really love you. I am so lucky to get to be your mommy.

**Autumn:** Who said you are lucky?

**Me:** Pretty much anyone who meets you – your teachers, your doctors, your friends’ parents...

**Autumn (reaching for my hand):** You need to tell all the parents how lucky they are.

**Me:** Okay.

**Autumn (holding my hand tightly):** And you need to show them how to love and hold their children, like you love and hold me.

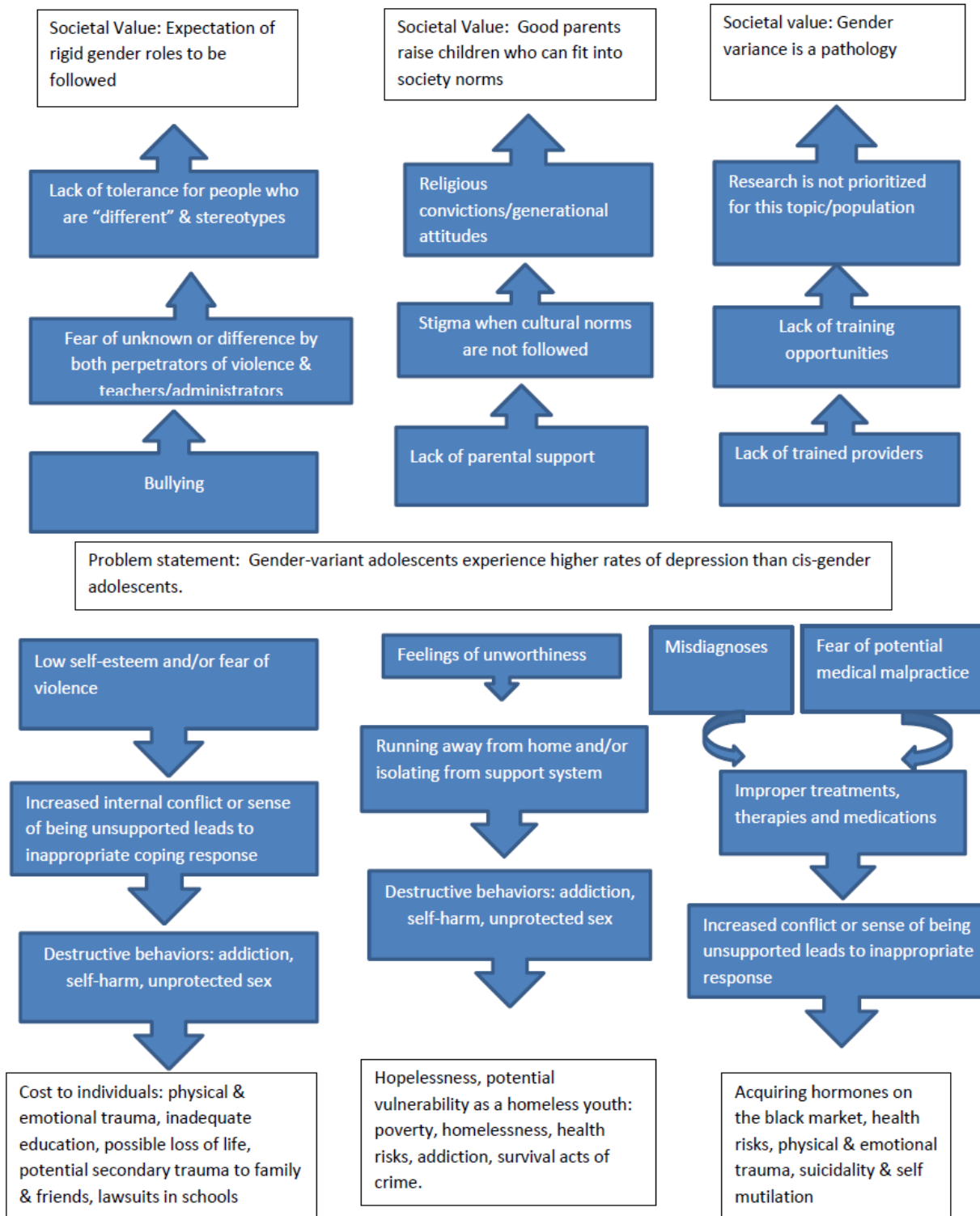
**Me:** I will. I promise.

This project was created as a commitment to this promise and is dedicated to all children, everywhere.

And, this project is dedicated to my partner, Matthew Chociej, and our exceptional child, Autumn. You both inspire me to be a better person and do good works in the world. Thank you for supporting and joining me on this journey. I love you.

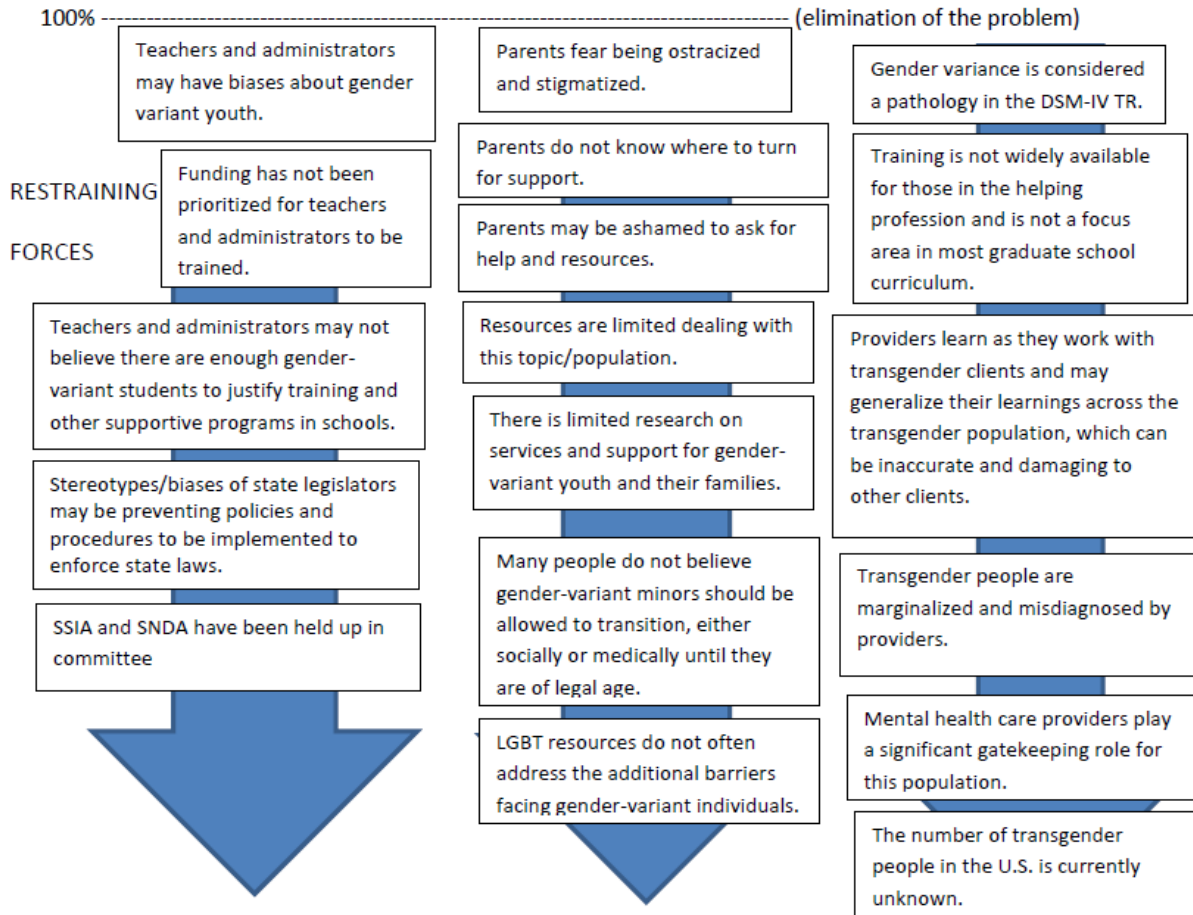
## Intervention Planning Process

## Problem Map

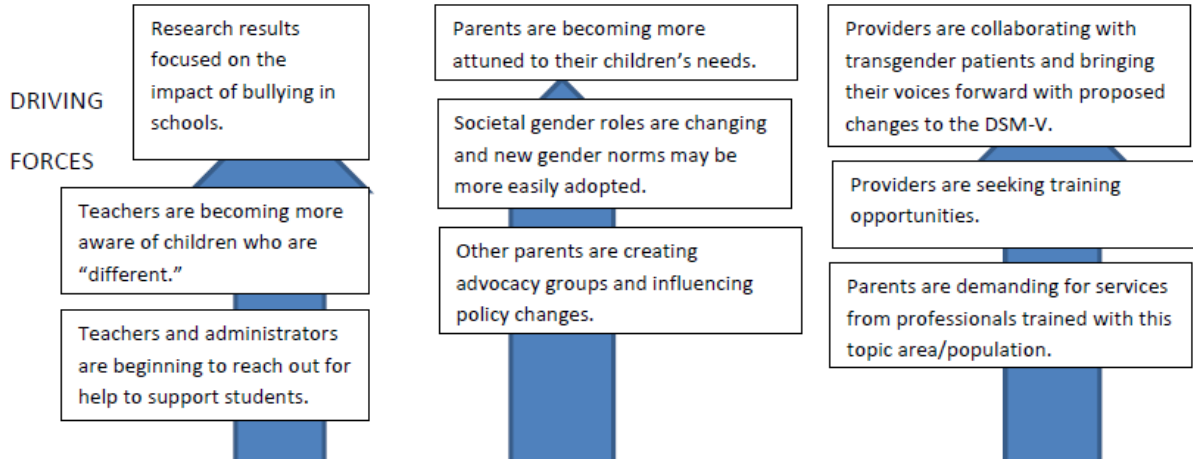


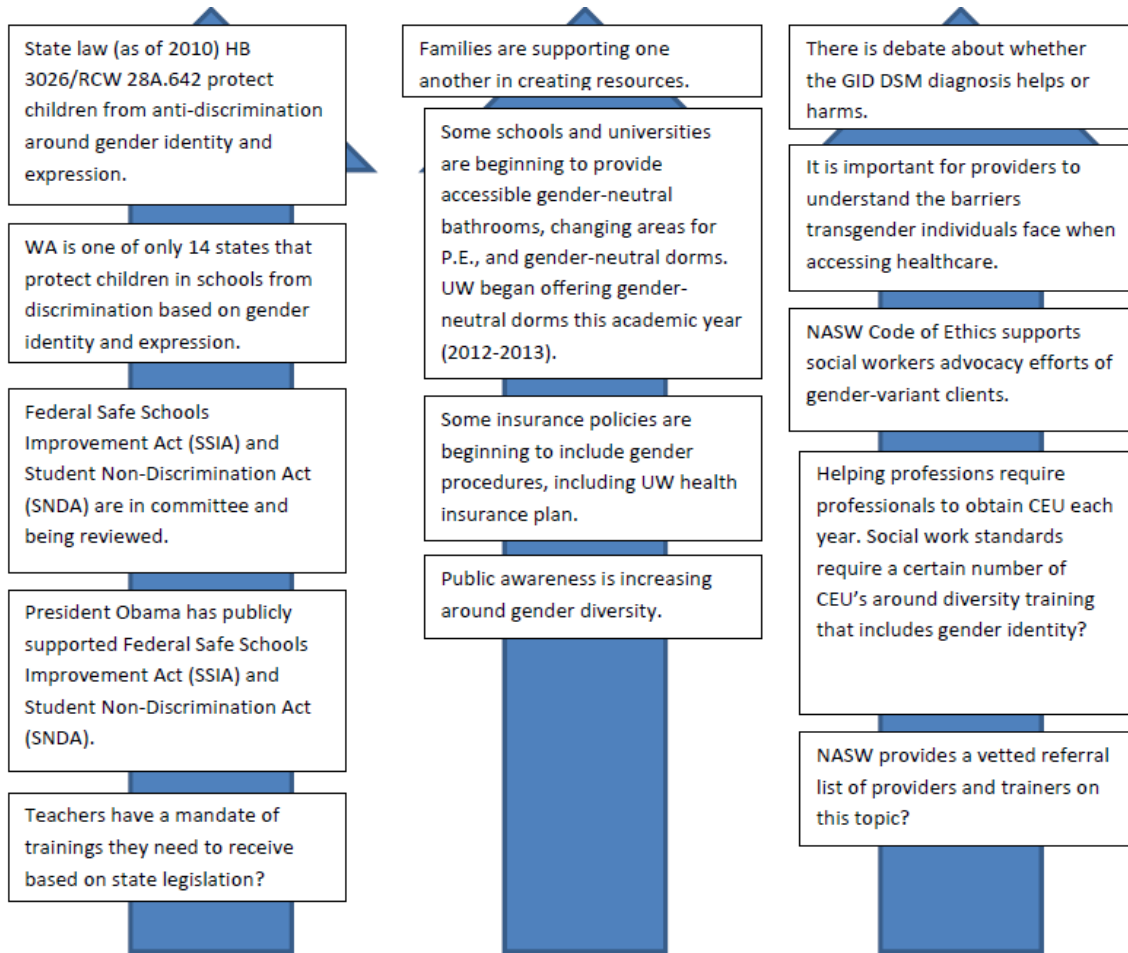
Force Field Analysis

Force Field Analysis



Goal Statement: Teachers, parents and providers know how to reduce the prevalence of suicide of gender-variant adolescents.





0% \_\_\_\_\_ 100% no improvement to problem intensity

## Literature Review

Western society endorses certain gender roles as being appropriate, and expectations begin even before birth. Gender identity is the subjective sense of gender one feels one is. If one's internal gender does not match their natal sex, one is said to have gender dysphoria also referred to as gender identity disorder (GID) (Seil, 2003).

Gender non-conformity is attributed to decreased coping and resilience and social rejection, which places youth at a higher risk for suicidal symptoms (Fitzpatrick, Euton, Jones & Schmidt, 2005). Youth Suicide Prevention Program (2012) reports one in eight adolescents may have depression; and transgender and gender non-conforming youth experience even higher rates. Some typical risk factors for youth include: 1) biological: puberty, gender nonconformity; 2) sociological: peer pressure, family conflict, abuse and bullying; 3) psychological: black and white thinking, poor distress tolerance and coping skills; and 4) existential: hopelessness, and failure to see their situation or acceptance in society improving. Some typical protective factors include supportive friends, peers, adults, teachers, providers, and access to a safe space.

The history of treating gender-variant individuals has been somewhat controversial. The diagnosis of Gender Identity Disorder (GID) in the Diagnostic and Statistical Manual of Mental Disorders (DSM) has been the subject of stigmatization. Some providers have expressed that the DSM acts as a "mechanism of social control" that does not distinguish between mental disorders and socially non-conforming behavior, which may in itself be psychologically sound (Kamens, 2011, p 38). The GID diagnosis is required for insurance coverage of hormonal therapy and gender reassignment procedures. Many who seek treatment view it as a trade-off between stigma and insurance reimbursement. So where the GID diagnosis facilitates payment and access to basic therapies and mental health care of gender-variant individuals, these individuals may experience social stigma, alterations of insurance coverage, and mistreatment by providers in accessing care (Kamens, 2011). In addition, many feel that the distress the

gender variant individual experiences is primarily a result of a conflict between the individual's gender identity or expression and society's normative gender expectations (Bockting, 2009).

In one sense, a diagnosis is a benefit in that the diagnosis allows a person diagnosed with GID under the narrowly defined binary roles of gender (male or female) to access medical care to further their transition (Ehrbar & Gorton, 2011). On the other hand, a transgender person is essentially forced to request a diagnosis of a disorder in order to be eligible for care (Ehrbar, 2010), thus further perpetuating systemic oppression. For those not seeking transition, who may identify as gender fluid, the issue can be even further complicated (Nuttbrock, Rosenblum and Blumenstein, 2002). The inability to measure the actual population size of transgender people in the U.S. is a constant theme in the available literature (Wester, McDonough, White, Vogel & Taylor, 2010), as is a lack of awareness and training of social work staff (Gallegos, White, O'Brien, Pecora & Thomas, 2011) and a bias toward transgender persons by social workers (Logie et al., 2007; Gallegos, et al., 2011; Mallon, 2006).

GID diagnoses appeared for the first time in the DSM-III (APA, 1980) and contained two diagnoses Gender Identity Disorder of Childhood (GIDC) and Transsexualism, which were to be used for children and adolescents/adults, respectively. In DSMIII- R (APA, 1987), a second diagnosis was added for use with adolescents and adults: Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT). For DSM-IV (APA, 1994), the Subcommittee on Gender Identity Disorders made two recommendations: 1) the GIDAANT diagnosis was "sunsetting," since its validity as a subtype of GID was arguable; 2) the DSM-III and DSM-III-R diagnoses of GIDC and Transsexualism were collapsed into one overarching diagnosis, Gender Identity Disorder, with separate criteria sets for children versus adolescents and adults that reflected age-related, developmental differences in clinical presentation (Zucker, 2005). The beliefs of whether GID should remain in the DSM fall under three categories: 1) advocates who believe gender nonconformity is not a mental illness and who want GID removed from the DSM and reclassified as a medical condition in the ICD; 2) those who believe GID is a mental illness, or may feel ambivalent about its status, but want to reform GID in the DSM to better help

transgender people; and 3) those who view GID or gender dysphoria as a mental illness but want to reform the diagnosis to aid transgender people (Sennott, 2011). Those holding the view of wanting the GID removed from the DSM include the National Association of Social Workers (NASW) National Committee on Lesbian, Gay, Bisexual, and Transgender Issues (NCLGBTI), which holds the position that Gender Identity Disorder, Gender Incongruence, Gender Dysphoria, Transvestic Fetishism and, Transvestic Disorder should not be considered as mental health diagnosis and therefore should be eliminated from the DSM (NASW, 2012). Individuals with gender dysphoria may need gender reassignment services, such as puberty suspension therapies in order to alleviate their distress and find comfort with their gender identity and role in society (Bockting, 2009). The World Professional Association for Transgender Health (WPATH) states in its 2001 sixth version of Standards of Care, “hormones are often medically necessary for successful living in the new gender; in persons diagnosed with transsexualism or profound GID, sex reassignment surgery, along with hormone therapy and real-life experience, is a treatment that has proven to be effective. Such a therapeutic regimen, when prescribed or recommended by qualified practitioners, is medically indicated and medically necessary. Sex reassignment is not "experimental," "investigational," "elective," "cosmetic," or optional in any meaningful sense. It constitutes very effective and appropriate treatment for transsexualism or profound GID.”

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Information Report

## Introduction

Western society endorses certain gender roles as being appropriate, and expectations begin even before birth. Gender identity is the subjective sense of gender one feels one is. If one's internal gender does not match their natal sex, one is said to have gender dysphoria (Seil, 2003). While adolescents in general are a high-risk group for suicidal ideation and self-harm, with suicide being the third cause of death for young adults ages 15-24 (Fitzpatrick, Euton, Jones & Schmidt, 2005), there is increasing evidence that transgender youth are at increased risk for low self-esteem, depression, suicide, substance abuse, school problems, family rejection and discord (Fitzpatrick, Euton, Jones & Schmidt, 2005), running away, homelessness, and prostitution (Kreiss & Patterson, 1997).

### Statistics, Risk and Protective Factors

To date, no general survey of the U.S. population has attempted to measure transgender identity. However, 1 in 30,000 assigned males and 1 in 100,000 assigned females are estimated to seek gender reassignment surgery at some point in their lifetime (Haas, et al., 2011). Gender non-conformity is attributed to decreased coping and resilience and social rejection, which places youth at a higher risk for suicidal symptoms (Fitzpatrick, Euton, Jones & Schmidt, 2005). In fact, gender-nonconforming youth are at elevated risk levels for experiencing victimization and negative psychosocial adjustment. The shame felt by gender-nonconforming adolescents may be compounded by the reactions from their peers and family. Peer reactions to gender nonconforming behavior are often negative, ranging from verbal questioning of another's biological sex to physical abuse (Ryan, Russell, Huebner, Diaz & Sanchez, 2010) Adding to this, transgender youth have reported parental rejection to be a particular stressor (Haas, et al., 2011). Some families choose never to complete or even begin to understand the child's identity and the youth may be rejected outright by the family (Kreiss & Patterson, 1997).

“It took me three and one-half years to wrap my head around my son's gender and come to a place of acceptance. Now I realize his body is in his way. He cannot comfortably move forward in life without at least top surgery” (Key informant 7, personal communication, November 9, 2012).

Other risk factors are attributed to lack of training among service providers. “How troubling when providers do not support and affirm our children. It makes things so much worse for them. We had one misdiagnosis after another from each doctor we went to, as my son became more and more unresponsive. Providers need to be educated and trained to support these youth.” (Key informant 7, personal communication, November 9, 2012).

Some protective factors for these youth, as described by Youth Suicide Prevention Program in Seattle include: unconditional support of a child’s identity, access to safe health care, ensuring that the child’s school is safe and welcoming, ensuring service providers are well trained and sensitive to transgender issues, and that service agencies implement explicit policies that prohibit all forms of discrimination (Youth Suicide Prevention Program, 2012).

Additional protective factors include supporting a child’s transition at a younger age at home and at school (Key informant 4, personal communication, November 1, 2012; Key informant 1, personal communication, October 26, 2012; Key informant 6, personal communication, October 30, 2012). By the time children enter school at the age of five, they react approvingly or disapprovingly of each other, because stereotypic expectations of their assigned gender have already been imprinted on them (Grossman, D’Augelli, Howell & Hubbard, 2005). Pressures continue to increase when gender non-conforming children enter puberty and have difficulty integrating a changing body with an internal gender identity that does not match (Grossman, D’Augelli, Howell & Hubbard, 2005). The two age groups that are associated with the most self-harm, distress and suicidality are five to seven year-olds who are being forced to fit into social gender roles that aren’t true to who they are, and self-harm and suicidality for kids entering puberty, whose bodies are betraying them (Key informant 6, personal communication, October 30, 2012). Zucker (2005) explains these age effects pertaining to the role of peer ostracism. It has been noted for some time that children with GID experience significant difficulties within the peer group.

“Every time a child is marginalized, it messes them up – trans or not. But when you are marginalized at home, at school, on the playground, or in the media for who you know yourself to be, then it places a

ticking time bomb inside your soul and it is only a matter of time before it goes off” (Key informant 1, personal communication, October 26, 2012).

### **The Historical and Current Understanding of the Topic**

The diagnosis of Gender Identity Disorder (GID) in the Diagnostic and Statistical Manual of Mental Disorders (DSM) has been the subject of stigmatization. Some providers have expressed that the DSM acts as a “mechanism of social control” that does not distinguish between mental disorders and socially non-conforming behavior, which may in itself be psychologically sound (Kamens, 2011, p 38). The GID diagnosis is required for insurance coverage of hormonal therapy and gender reassignment procedures. Many who seek treatment view it as a trade-off between stigma and insurance reimbursement. So where the GID diagnosis facilitates payment and access to basic therapies and mental health care of gender-variant individuals, these individuals may experience social stigma, alterations of insurance coverage, and mistreatment by providers in accessing care (Kamens, 2011). In addition, many feel that the distress the gender variant individual experiences is primarily a result of a conflict between the individual’s gender identity or expression and society’s normative gender expectations (Bockting, 2009).

GID diagnoses appeared for the first time in the DSM-III (APA, 1980) and contained two diagnoses Gender Identity Disorder of Childhood (GIDC) and Transsexualism, which were to be used for children and adolescents/adults, respectively. In DSMIII- R (APA, 1987), a second diagnosis was added for use with adolescents and adults: Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT). For DSM-IV (APA, 1994), the Subcommittee on Gender Identity Disorders made two recommendations: 1) the GIDAANT diagnosis was “sunsetting,” since its validity as a subtype of GID was arguable; 2) the DSM-III and DSM-III-R diagnoses of GIDC and Transsexualism were collapsed into one overarching diagnosis, Gender Identity Disorder, with separate criteria sets for children versus adolescents and adults that reflected age-related, developmental differences in clinical presentation (Zucker, 2005).

The beliefs of whether GID should remain in the DSM fall under three categories: 1) advocates who believe gender nonconformity is not a mental illness and who want GID removed from the DSM and reclassified as a medical condition in the ICD; 2) those who believe GID is a mental illness, or may feel ambivalent about its status, but want to reform GID in the DSM to better help transgender people; and 3) those who view GID or gender dysphoria as a mental illness but want to reform the diagnosis to aid transgender people (Sennott, 2011). Those holding the view of wanting the GID removed from the DSM include the National Association of Social Workers (NASW) National Committee on Lesbian, Gay, Bisexual, and Transgender Issues (NCLGBTI), which holds the position that Gender Identity Disorder, Gender Incongruence, Gender Dysphoria, Transvestic Fetishism and, Transvestic Disorder should not be considered as mental health diagnosis and therefore should be eliminated from the DSM (NASW, 2012).

Regarding children and adolescents who are gender variant, there is a greater risk for misdiagnosis of Oppositional Defiant Disorder, Attention Deficit Disorder, and Asperger's, as reported anecdotally by families attending support groups. Youth may be exhibiting symptoms that are similar to these disorders as a result of high anxiety levels and fixation of interests or hobbies as a way to cope (Bradley & Zucker, 1997). Adolescents referred for gender identity concerns also displayed significant behavioral difficulties such as anger, aggression, isolation, and depression, as reported by their mothers (Bradley & Zucker, 1997). In one parent support group this writer attended, a parent shared recent research about complex brain trauma. She explained that on-going stress and anxiety from living in the wrong gender can lead to complex brain trauma. Once gender issues are addressed, many parents shared that other symptoms go away. Some parents hypothesized that when the cortisol goes away, it gives the brain an opportunity to heal itself and other symptoms then retreat as well. These parents' insights are consistent with research published by Child Welfare Information Gateway (2009), which states that if a child lives in a threatening, chaotic world, the child's brain may be hyperalert for danger because their survival may depend on it. When children are exposed to chronic, traumatic stress, their brains sensitize the pathways for the fear response, resulting in a number of biological reactions, including a persistent

state of fear. Gender-variant children and adolescents receive perpetual messages in society that there is something wrong with them, and they live with a constant fear of people finding out their secret. For adolescents with symptoms of chronic stress, which may include changes in attention, impulse control, sleep, and fine motor control, it is understandable how they may be misdiagnosed as ODD or ADD. The research further explains that chronic activation of certain parts of the brain involved in the fear response can “wear out” other parts of the brain such as the hippocampus, which is involved in cognition and memory. This may cause excess production of cortisol—a hormone that may damage or destroy neurons in critical brain areas.

Professional services for children with GID are provided primarily by pediatric endocrinologists and urologists, and very few centers have mental health staff that are trained for and/or experienced in dealing with gender identity variants in such children (Meyer-Bahlburg, 2009). For providers who have adequate training, GID can be looked at as an end-point of a continuum of cross-gender identification and it is possible that there are now more individuals who identify within this broader spectrum of cross-gender identity (Zucker & Lawrence, 2009). Children with GID seem to have more trouble with basic cognitive concepts concerning their gender than do other children (Zucker, 2005) “It is the marked disjunction between somatic sex and psychological gender that causes their distress and motivates such individuals to seek out treatment” (Zucker, 2005). It is therefore important that efforts continue to assist individuals with GID to affirm their whole selves and develop skills to be comfortable with their families and peers (Bradley & Zucker, 1997). Individuals with gender dysphoria may need gender reassignment services, such as puberty suspension therapies in order to alleviate their distress and find comfort with their gender identity and role in society (Bockting, 2009). In support of this assertion, the World Professional Association for Transgender Health (WPATH) states in its 2001 sixth version of Standards of Care, “hormones are often medically necessary for successful living in the new gender; in persons diagnosed with transsexualism or profound GID, sex reassignment surgery, along with hormone therapy and real-life experience, is a treatment that has proven to be effective. Such a therapeutic regimen, when

prescribed or recommended by qualified practitioners, is medically indicated and medically necessary. Sex reassignment is not "experimental," "investigational," "elective," "cosmetic," or optional in any meaningful sense. It constitutes very effective and appropriate treatment for transsexualism or profound GID.”

### **Impacts of Economics, Difference and/or Diversity**

Gender variance seems to have been historically tolerated among the upper classes, but exterminated among the working classes (Key informant 2, personal communication, October 26, 2012). In addition, those with access to resources are the same class of individuals who have access to treatment and care (Key informant 5, personal communication, October 30, 2012). “Just as many feminists proposed that the overthrow of capitalism was a necessary condition for women’s emancipation from patriarchy, so does the liberation of all those who failed to adhere to social conventions around gender presentation require a revolution of the socioeconomic system” (Johnson, 2010, p 666). This implies the need for change of institutional systems to ensure access for all individuals in need of care (Key informant 5, personal communication, October 30, 2012).

In fact, multiple research studies conducted in the United States have found that access to higher income and health insurance are positively associated with adolescent health care (Vingilis, Wade & Seeley, 2007). Case in point, this writer has heard stories from families in support group who either 1) have doctors who are knowledgeable and supportive of gender-variant youth and are both aware and willing to code therapies to insurance under codes that will not refer to transgender-related care, which would disrupt the ability to continue providing care; or 2) do not want to risk the insurance company finding out and are utilizing a generous financial assistance fund through a local area hospital and are paying on average \$1,500 per month for puberty blockers. All of these families participating in the support group have high income, extensive education, and most are White. With the lack of prioritized funding to research and training for providers, it would seem that youth who do not come from homes with such resources would be lacking access to similar treatments and supportive services.

This writer believes the same to hold true for young adults who want to move on to cross-hormone therapy either following puberty blockers, having skipped medical stage Tanner 2, which refers to the onset of puberty and the development of sex characteristics, or those young adults who missed or lacked the opportunity to pursue blockers. While it is less costly to purchase cross-hormones, both out-of-pocket, and through insurance than pubertal suspension therapies, for those without access to resources, or adequately trained providers in community care centers, these trans adults might be tempted to commit survival crimes in order to purchase hormones through the black market or through online prescriptions services in other countries spending between \$25 to \$200 per month. This writer has heard stories from parents of gender-variant youth who have spoken of their child's distress when the child's body begins to betray them. Some parents have expressed the wish to allow their children develop with "peer concordance," meaning that they want their kids to be able to develop along with their peers, through a combination of puberty blockers and cross hormones. For those who are able to find providers willing to prescribe blockers and cross hormones to youth (generally between 15 and 17 years old), some parents get a prescription from a local endocrinologist, which they send to pharmacies in Canada, and have the medicines shipped back to the U.S. to cut down on the monthly expense.

Many trans male youth wear what are referred to as "packies," which are foam sewn into male underwear. One parent shared with this writer that when her affirmed son stated he was male, the mother told her son he could remove everything from his room that made him feel unhappy. The first thing he threw into the garbage was female panties and his first purchase was male briefs. This story is common among youth attending support group. They describe the "packies" as giving them confidence to live in their own skin, as it presently is.

For affirmed males, top-surgery becomes a focus of concern as the youth's breasts may be hindering their ability to assimilate in society as male. Many affirmed males bind their chests until they are able to afford top-surgery; and for some, binding results in significant health issues, such as a collapsed lung. Some affirmed males plan for bottom surgery, while others are content with the removal

of breast tissue. In the United States, one can expect to pay between \$1,500 and \$8,500 for chest surgery, depending on the surgeon's fee, cost of the surgical facility, the cost of the anesthesiologist, and other miscellaneous expenses (tissue pathology tests, aftercare visits, travel and hotel stay, etc.). Gender reconstruction-related surgeries are typically not covered by insurance companies in the U.S., so these costs must often be paid out of pocket by the patient. Some patients may be able to seek out lower surgical fees by traveling abroad for surgery (travel and lodging expenses must also be factored in to the final budget). There are skilled surgeons in a number of countries, and can be found by using resources such as [www.transbucket.com](http://www.transbucket.com).

Bottom surgery for an affirmed male might include either hysterectomy and/or oophorectomy. The cost of hysterectomy/oophorectomy can vary, but in general costs between \$7,000 and \$20,000 in the United States (including surgery fees and related hospital/staff fees). Because there is usually a hospital stay after the procedure; and since hospitals charge by the day, this will affect the overall price depending on the duration of the stay. Hysterectomy is one of the few surgeries that trans men may be able to have covered by insurance, if the procedure is shown to be health-related.

For affirmed females, the most common surgeries are: breast augmentation; elective bilateral orchiectomy, the removal of both testicles through an incision in the scrotum, which reduces the male hormones in the body and allows the patient to reduce doses of prescribed hormones; a tracheal shave, which involves carving away cartilage from the Adam's apple to make it less prominent (if the trans adult was not taking blockers to delay the onset of puberty; and vaginoplasty, using skin and tissue from the penis to create a vagina, clitoris, clitoral hood and labia. Sexual reassignment surgery in the U.S. averages about \$25,000 and may include breast augmentation, vaginoplasty, three nights in a hospital and eight additional nights in the convalescence home. The same services may be found for about \$12,000 in Thailand. Gender confirming facial surgery, also called facial feminization surgery could range from \$2,500 to \$15,000, depending on the options selected. For additional procedure costs in Thailand, refer to Sava Perovic website. Before or after undergoing surgery, many patients work with voice and movement

coaches to help them adjust to living sexing the gender they were not previously socialized as. These coaches can cost \$30 an hour or more. Following surgery, it sometimes is necessary to consult a lawyer or pay fees in order to change the sex on official documents such as the birth certificate, driver's license and passport.

In the year before surgery for either transition, counseling can cost \$50 to \$200 per session, and letters from two therapists usually are needed for surgery; the total cost of the therapy and the letters can range from under \$1,000 to more than \$5,000 for that year. And hormone therapy could cost \$300 to \$2,400 for the year, depending on which hormones are prescribed. [TSRoadmap.com](http://TSRoadmap.com) is a site which offers a detailed financial worksheets and estimates on the all the costs of transition, and estimates that it is typical to spend a total of \$40,000 to \$50,000 for a mid-range transition, including surgery.

For patients not covered by health insurance, the typical cost of a sex reassignment surgery can range from about \$15,000 for just reconstruction of the genitals to about \$25,000 for operations on the genitals and chest to \$50,000 or more for procedures that include operations to make facial features more masculine or feminine. Prices typically depend on the techniques used -- different techniques often are recommended based on body type and patient preference.

Surgeons who perform sex reassignment surgery usually are gynecologists or plastic surgeons. There are only a handful of surgeons specializing in sex reassignment surgery in the United States, and many patients get referrals from other patients or transgender support groups.

Doctors typically follow the recommendations of the Harry Benjamin International Gender Dysphoria Association standards of care for gender identity disorders, which state that before undergoing sex reassignment surgery, an individual should: be 18, or the legal age of consent in their home country; have had one year of continuous hormone therapy, except for patients who cannot do so for medical reasons; one year of living successfully and continuously as a member of the other gender; psychotherapy during that year, if recommended by the patient's mental health professional; and have knowledge of the cost, risks, hospitalization requirements, necessary aftercare for the surgery; and know of competent surgeons

who can perform it. Most sex reassignment surgeries are major operations, and risks involved may include pain, swelling, serious complications from anesthesia that could include death, and the need to return for further surgery.

In total, the typical cost of a transition usually includes: expenses incurred in the year before surgery, during which hormone therapy, counseling and living full-time as the target sex are recommended; the cost of the surgery and follow-up care; and ongoing costs after the surgery, including hormone therapy for life and continued doctor visits.

### **Impact of Relevant Developmental Stages**

“As trans people, we all experience a degree of grief and loss. For those of us who transitioned as adults, we grieve not only the loss of our support systems – relationships, faith community, job, housing, etc., which dissipated as a result of our transition – but also the grief and loss over what might have been. What I mean by this is what might have been had we been supported in our youth to express who we are and live as our true selves. We may also grieve over never having been able to be true to our assigned sex at birth, or to fit in with the rest of society” (Key informant 3, personal communication, October 28, 2012).

Erik Erikson’s theory on psychosocial development describes the ages 4 to 5 as “Initiative versus Guilt” and emphasizes the social context (connectedness) of the child and the evolving psychosocial skills that lay the foundation for later stages. “The major socializing context of children in this stage of psychosexual/psychosocial development is the family, as both parents and siblings are significant figures who can contribute to the socialization of the child. It would appear that the extent to which the family emphasizes sex differences and gender roles in the child's expression of initiative could have a significant impact on gender identity and personality” (Franz, & White, 1985). Erik Erikson’s theory further describes adolescence as a period of developmental concern with “Identity versus Identity Confusion” and depicts adolescence as a struggle to develop a personal identity through their interaction with others.

Erikson believed puberty provides a crisis for adolescents seeking to form a personal identity, with a healthy establishment of identity leading to a successful resolution of this crisis (Glimps, 2005).

How a child is supported at home and at school may impact how successful they are in meeting these developmental milestones. “I think there are variables to how a person responds to their gender expression in all their developmental stages depending on how loving and supportive their environment is. If a child is allowed self-discovery and gender expression without all the confines of social mores, religious dogma and family values then I believe a child can develop their gender identity in a healthy way, a way in which they feel complete as a person” (Key informant 1, personal communication, October 26, 2012)

“If a youth needs to feel a sense of industry before they are able to grapple with identity, this may explain why a high percentage of trans kids stop going to school” (Key informant 2, personal communication, October 26, 2012). It is important to understand how the adolescent is adapting and what support systems they have in place (Herbert, 2011). It should be noted that adolescence is a critical time during which health care providers can intervene before medical and mental health issues and inappropriate coping behaviors become largely established (Vingilis, Wade & Seeley (2007). Utilization factors} “It seems from what I learn of others experiences that anytime the diagnosis and any form of treatment is made later as in teenage or adult years, the person has a sense that they have missed out on certain developmental stages in life” (Key informant 7, personal communication, November 9, 2012)

### **Cultural, Systemic and Global Influences as it Applies to Target Population**

“(Growing up) in the Hawaiian culture, it was acceptable to be a Mahu and almost every family had a family member that identified this way. Women who were identified as more masculine were identified as *tita* which means *sistah* or *sister*. They were gender variant as well. It was okay to be a masculine woman dressing masculine but identifying as female. This person would take on the more stereotypical male role in a relationship with another woman if there was a relationship” (Key informant 1, personal communication, October 26, 2012)

This varies greatly from culture in the contiguous United States. “There is very little normalization of transgender status portrayed in media. We parents are continuously seeking out information and find encouragement with each new discovery. We, trans individuals, and their allies are to be found often educating others” (Key informant 7, personal communication, November 9, 2012)

Even among professionals, an attitude of intolerance seems to permeate among mental health professions, which demonstrates a need for staff training and explicit policies around anti-discrimination practices. “Some professions change rapidly but some professionals will never change. There are a lot of anti-trans attitudes among school psychologists. They tend to be more conservative, so you have to become part of their community” (Key informant 2, personal communication, October 26, 2012).

So much of cultural expectations are defined around religious norms, as well. “We have faced a lot of religious rejection in our own family. We were shunned from our own faith community when my son transitioned. Some communities are accepting and welcoming, and I hope those who are continue to influence others” (Key informant 7, personal communication, November 9, 2012).

### **Discussion of the NASW Ethical Practice Guidelines and Other Professional Guidelines**

According to Section 6.04 of the NASW Social Work Cultural Standards, social workers should strive to increase opportunity for all people, with special regard for vulnerable, disadvantaged, oppressed, and exploited people and groups. Social workers should promote conditions that encourage respect for diversity, and social workers should promote policies and practices that demonstrate respect for difference, and promote policies that safeguard the rights of and confirm equity and social justice for all people. There is a note within the guidelines that gender identity and gender expression is included within these guidelines.

Regarding other professions with therapeutic practice guidelines, such as the APA, there appears to be a longer stretch to go with implementation of published guidelines. “If we go the social justice route, the APA has a code of ethics. As a psychologist, we need to receive six hours of ethics training to update our certification. This sounds good in theory, but in practice is a different experience. I went to a

counselor who said to me, ‘We don’t have treatment for people like you’” (Key informant 2, personal communication, October 26, 2012).

### **Identification and Discussion of the Relevant Theoretical Frameworks**

Two theoretical frameworks will be discussed in reference to providing affirmative therapies for this population. First, it may be beneficial to acknowledge the intersecting oppressions that shape the lived experiences of those assigned female at birth and those who do not identify with their gender assignment. “There is an intrinsic link between the century-long oppression of women’s mental well-being within the psycho-medical-industrial complex and the pathologization of gender non-conformity through the psychiatric classification and treatment of GID” (Sennott, 2011, p 94). The principles of the trans feminist therapeutic approach is based on the understanding that we develop our own gender identities based on what feels genuine and comfortable to us as we live and relate to others within social constructs (Sennott, 2011). This approach combines feminist thought and social justice frameworks with principles of allyship (Sennott, 2011) to provide gender affirming practice for those who are gender non-conforming and their support systems.

The second approach can further inform our understanding of intersectional oppressed identities. Transgender theory integrates this “embodiment with the self and socially constructed aspects of identity through the lived experiences of those with intersecting identities” (Nagoshi & Brzuzy, 2010, p 431). This approach would consider both the embodied experiences and social oppressions that are associated with having multiple social identities, as well as the narratives of lived experiences through which individuals understand and negotiate their identities (Nagoshi & Brzuzy, 2010).

### **Research Interventions**

“We absolutely must support our kiddos, which means supporting and educating their parents, teachers, and medical and mental health providers. We must do this to save lives” (Key informant 4, personal communication, November 1, 2012).

Many LGBTQ youth face or fear parent rejection because of their identity (Poteat, Mereish, DiGiovanni & Koenig, 2011). Family acceptance in adolescence is associated with young adult positive health outcomes and is protective for negative health outcomes. The lasting influence of accepting family comments, attitudes, behaviors, and interactions related to the adolescent's LGBT identity clearly applies to personal emotional and physical states (Ryan, Russell, Huebner, Diaz, Sanchez, 2010). The Family Acceptance Project is an example of how parents and family members are being used as a source to build resilience in LGBTQ youth (Key informant 2, personal communication, October 26, 2012).

Self-help organizations can be another source of support to adolescents and families in distress. They can provide a complementary form of help to the professional as they can become much more involved in practical help and can reduce the sense of isolation that these families often experience (Ceglie, 2009).

Children may also need to be supported in their social transition in an earlier age (Key informant 4, personal communication, November 1, 2012). There is reasonable evidence that untreated gender dysphoria in adolescents is a relatively stable trait. Although some gender-dysphoric adolescents who present for clinical assessment do not necessarily desire hormonal treatment and/or Sexual Reassignment Surgery (SRS), the majority do (Zucker, Bradley, Owen-Anderson, Singh, Blanchard & Bain, 2011).

Regarding medical interventions of children, there are medically reversible interventions that are available to support a child in transition before their bodies betray them in puberty (Key informant 6, personal communication, October 30, 2012). These medical interventions could include pubertal suspension prior to cross-hormone therapy. These pubertal suspension therapies buy the youth time to process and accept what gender they are most comfortable in. Cross-hormonal interventions are an often-sought option for transgender individuals seeking to medically transition to an authentic gender, typically after the age of 16. (Colton, Fitzgerald, Pardo & Babcock, 2011).

“It is absolutely critical that we address this social problem as a systems issue. We must engage providers in health care, education, criminal justice, and so on and so forth to understand the barriers we face on a daily basis” (Key informant 3, personal communication, October 28, 2012).

## Opposing Views

The question of whether GID should be thought of as a mental health diagnosis has been and continues to be controversial. Arguments for retention of a GID diagnosis should be understood as arguments in favor of having some version of GID continue to exist as a diagnostic category, rather than arguments in favor of the specific version of GID currently in the *DSMIV- TR* (Ehrbar, 2010).

Children diagnosed with GID may have a developmental delay in establishing gender constancy. Researchers speculate that this delay may occur because of a parent who does not help the child label gender correctly or correct “inappropriate” behaviors. Or, these children may have achieved an understanding of gender as flexible. Much of the attention to GID children comes from parents intolerant of gender variance, not from the children themselves, as is the case with most childhood psychological problems. It has been noted repeatedly in the literature that almost all referrals of GID youth to gender treatment centers come from parents and other adults, such as teachers, who are not comfortable with their gender expressive behaviors (Hill, Rozanski, Carfagnini & Willoughby, 2006).

Some medical interventions, such as puberty delay, are also controversial and many times are not covered treatments by insurance plans. In addition, some question the effectiveness of the treatment. While behavioral problems and depression have been documented to improve following pubertal suspension, anxiety, anger and gender dysphoria may remain (Hewitt, Paul, Kasiannan, Grover, Warne & Newman, 2012).

### **Discussion of What Can be Done on the Micro, Mezzo or Macro Levels to Resolve in Whole or in Part the Identified Needs Statement**

Transgender individuals’ needs include: basic acceptance of having a self-determined gender identity, finding a voice, gaining access to medical care, establishing fundamental civil protections, and maintaining and building families (Israel, 2005). The following are ideas at the micro, mezzo, and macro levels that seek to resolve the issue of gender variant youth suicide.

### **Micro Level Discussion of Needs**

Support for gender-variant individuals and their families are essential. Outreach and direct support of gender variant youth and their families should be a priority (Key informant 7, personal communication, November 9, 2012). Parent education is necessary for parents to pass through stages of acceptance in their ability to support their child.

Training for professionals and providers who work with adolescents around this issue is another need identified in serving this population effectively (Key informant 6, personal communication, October 30, 2012). There appears to be a scarcity of therapists who are skilled enough to work with gender variant children, adolescents, and their parents (Key informant 3, personal communication, October 28, 2012). This need for training encompasses medical providers as well (Key informant 5, personal communication, October 30, 2012).

A systematic level of training is needed for student peers within the classroom and on school grounds, from preschool through college. Providers should be required to go through trainings on this topic when they are in school, particularly mental health, social work, endocrinology and nursing (Key informant 1, personal communication, October 26, 2012). Research also suggests that the presence of a GSA in middle school and high school can serve as a protective factor for LGBTQ adolescents. The presence of a GSA is associated with reduced suicide risk for sexual minority youths (Toomey, Ryan, Diaz & Russell, 2011).

Creating a safe zone is a means of support for students who are LGBTQ. This can consist of a teacher or counselor with training concerning issues related to these students. Teacher preparation programs and in-service training should emphasize the importance of avoiding anti-biased language, particularly concerning students who are LGBTQ. Using a curricular focus, schools can assist children in becoming more comfortable with diversity in all its human forms. GLSEN proposes the use of early intervention to facilitate acceptance of sexual diversity by targeting elementary school students (Glimps, 2005).

### **Mezzo Level Discussion of Needs**

Verbiage needs to be developed for anti-discrimination policies across systems to address explicitly gender identity and expression. “We need policy statements by school districts publicized. Section 504 states school administrators can’t deny access to opportunities based on a disability. We need a similar expression about accepting transgender and cis-gender students” (Key informant 2, personal communication, October 26, 2012). To further define these terms, cis-gender refers to people whose birth sex is consistent with the gender identity and expression considered appropriate in society (Israel, 2011).

Continued advocacy around efforts to remove the GID diagnosis from the DSM will help, over time, to remove the idea that gender variance is a pathology." Pathologization is assured with the diagnosis being offered of GID which is only recently being slated for change in the upcoming DSM. But this pathologization continues with medical guidelines suggesting that only a therapist must determine that one is sufficiently sound to make the decision to move forward with a physical or medical gender transition. (This) assumes that one cannot know themselves to be who they are and that this is because GID still represents to them a state of pathology” (Key informant 7, personal communication, November 9, 2012).

### **Macro Level Discussion of Needs**

We need to increase exposure and convey the problem of youth suicide in a way that engages the general public. Children are particularly vulnerable to the hurt caused by discrimination and prejudice and we have lost many young people over the years to suicide (Penn, 2010).

Cross-systems interventions are necessary to address gender variant youth suicide as a social problem (Key informant 3, personal communication, October 28, 2012). Part of this effort would address an expanded presence within existing systems. (Key informant 5, personal communication, October 30, 2012).

To help change societal beliefs and attitudes, laws need to be revisited so they ensure insurance coverage for help with social and medical transition, including therapy, hormones and related surgeries

(Key informant 7, personal communication, November 9, 2012; Key informant 5, personal communication, October 30, 2012)

Since religious values guide much of our cultural norms, outreach and recruitment from supportive faith-based organizations could potentially help educate and raise awareness and support for gender variant youth.

Finally, we need more trans role models to change society's acceptance. "The most successful role models are the most invisible." We need capacity building with professions, professional conferences and trainings (Key informant 2, personal communication, October 26, 2012).

### **Results and Challenges**

Many trans youth are kicked out of their home, are pushed out or drop out of school, and many have survival sex for housing, get arrested, then have a criminal record, which leads to a downward spiral of chemical dependency, selling, and more arrests. "We need preparation for barriers we face as trans individuals, and yet our safety depends on us remaining invisible" (Key informant 2, personal communication, October 26, 2012).

Gender variant individuals attempt to remain invisible for their own safety, particularly as it is difficult to find therapists trained to work with gender-variant individuals. The lack of training can be attributed to the lack of data, which can be attributed to the lack of value we place on this topic or, generally speaking, of these people in our society. "Finding therapists who are skilled enough to work with children, adolescents, and their parents – even more rare" (Key informant 3, personal communication, October 28, 2012; Key informant 7, personal communication, November 9, 2012).

For those gender variant individuals willing to seek assistance, access to treatments is dependent upon class, race, and other socioeconomic factors. For all youth to have access to the same services, insurance coverage needs to be available for help with social and medical transition, including therapy, hormones and related surgeries. (Key informant 1, personal communication, October 26, 2012; Key informant 2,

personal communication, October 26, 2012; Key informant 7, personal communication, November 9, 2012).

In addition to accessing medical systems, legal systems are also a barrier for many families lacking resources. Additionally, there is no parity across states regarding requirements for changing gender markers on legal identity documents. There needs to be a simplification of process for change of ID across agencies, removing the requirement for SRS in order to obtain new gender marker. Evidence of surgery should not be needed to substantiate one's gender identity. (Key informant 1, personal communication, October 26, 2012; Key informant 7, personal communication, November 9, 2012; Key informant 2, personal communication, October 26, 2012 )

Finally, the greatest challenge is that discrimination of this population continues to be considered acceptable in our society. Even though employers such as the City of Seattle and Seattle Public Schools have added gender identity to discrimination statements regarding employment and harassment, many of the policies developed are perceived as something to hide behind, but not worthy of fully implementing and enforcing (Key informant 2, personal communication, October 26, 2012). Legislation needs to be strengthened to protect this population, and that requires time and funding. (Key informant 5, personal communication, October 30, 2012; Key informant 7, personal communication, November 9, 2012).

Introduction to Intervention

## Intervention Introduction

### **Target population**

Transgender youth are at increased risk for low self-esteem, depression, suicide, substance abuse, school problems, family rejection and discord, running away, homelessness, and prostitution.

### **Needs statement**

There is an overwhelming need for cross-systems training for teachers, medical providers, and mental health providers, to support and affirm gender-variant youth and their families, through increased system capacity for gender-variant youth, increased environmental cues that demonstrate safe space for gender-variant related services; and reducing barriers to accessing health care services through education to 1) better meet patient's needs and 2) improve their health care experience.

### **NASW Guidelines**

By the very fact that transgender people are marginalized and oppressed in U.S. society, they should be a population of concern to social workers (Burdge, 2007; Kohli, Kohli, Huber & Faul, 2010). It is therefore critical for social workers to have an accurate understanding of gender and strong practice skills which are in alignment with National Association of Social Workers (NASW) values and ethics. In addition, it is important for social workers to understand the barriers transgender individuals face when accessing healthcare, to provide context for the clinical experience, and because mental health care providers play a significant gatekeeping role for this population (Hanssmann, Morrison & Russian, 2008).

According to Section 6.04 of the NASW Social Work Cultural Standards, social workers should strive to increase opportunity for all people, with special regard for vulnerable, disadvantaged, oppressed, and exploited people and groups. Social workers should promote conditions that encourage respect for diversity, and social workers should promote policies and practices that demonstrate respect for difference, and promote policies that safeguard the rights of and confirm equity and social justice for all people. There is a note within the guidelines that gender identity and gender expression is included within these guidelines.

## **Theoretical framework**

Two theoretical frameworks will be discussed in reference to providing affirmative therapies for this population. First, it may be beneficial to acknowledge the intersecting oppressions that shape the lived experiences of those assigned female at birth and those who do not identify with their gender assignment. “There is an intrinsic link between the century-long oppression of women’s mental well-being within the psycho-medical-industrial complex and the pathologization of gender non-conformity through the psychiatric classification and treatment of GID” (Sennott, 2011, p 94). The principles of the trans feminist therapeutic approach is based on the understanding that we develop our own gender identities based on what feels genuine and comfortable to us as we live and relate to others within social constructs (Sennott, 2011). This approach combines feminist thought and social justice frameworks with principles of allyship (Sennott, 2011) to provide gender affirming practice for those who are gender non-conforming and their support systems.

The second approach can further inform our understanding of intersectional oppressed identities. Transgender theory integrates this “embodiment with the self and socially constructed aspects of identity through the lived experiences of those with intersecting identities” (Nagoshi & Brzuzy, 2010, p 431). This approach would consider both the embodied experiences and social oppressions that are associated with having multiple social identities, as well as the narratives of lived experiences through which individuals understand and negotiate their identities (Nagoshi & Brzuzy, 2010).

To apply these theories in practical terms, qualitative and quantitative research has shown us that providers have only a slight willingness or receptivity to treating transgender people, and their knowledge base about the needs of transgender patients is limited or non-existent. Because most providers are unwilling to step outside their knowledge base, they simply decline to treat trans patients altogether. Even worse, because transgender people often experience hostility and rejection when seeking health care, they may choose the dangerous behavior of securing no medical care whatsoever. The impact on

the trans and gender-variant populations of poor access to health care can easily mean the difference between life and death.

### **Intervention Type**

This cross systems intervention is comprised of a three-hour comprehensive training curriculum that provides a basic overview of the needs of gender-variant youth in three modules for 1) teachers to create safe spaces in school settings; 2) medical providers to offer prescriptive options for gender-variant youth and reduce common misdiagnoses; and 3) mental health providers to be better prepared to support gender-variant youth, and recommend other affirmative therapies and gatekeeping practices which positively advocates for potential medical interventions.

Training modules will be provided for delivery on-line and in-person: 1) curriculum and corresponding handouts provided to Aidan Key for unlimited use with Gender Diversity as an expansion to current training curricula in a) a webinar format to present PowerPoint training modules to teachers and providers who pre-register through Gender Diversity or Gender Odyssey and b) in-person presentations in schools, organizations, clinics and agencies to increase their knowledge and create more inclusive environments, help teachers better understand gender diverse student populations and decrease incidents of bullying; help medical providers and mental health therapists to increase their professional competency; and collaborate with community partners to develop best practices for gender-segregated spaces such as bathrooms, locker rooms, camp accommodations, etc.; 2) through outreach efforts to local GSAs and youth-led organizations by offering downloadable training modules to present as part of their speaker's bureau activities; and 3) downloadable training modules offered on a master DVD to Gay Lesbian Straight Education Network (GLSEN) – Washington State to distribute to GSA's state-wide.

### **Changes Intended as a Result of Intervention Implementation**

This intervention is a cross-systems training for teachers, medical providers and mental health providers to support gender-variant youth and their families. As a result of completing this training, teachers and providers will have an understanding of how to support gender-variant youth and their

families, resulting in stronger relationships and social supports, improved access to healthcare, and increased resilience for gender-variant youth.

Improved services to gender-variant youth and reduced barriers to receiving health care services, will support gender-variant youth and their families. Through additional training and exposure, teachers and providers can become much more involved in practical help and can reduce the sense of isolation that these youth and families often experience. In addition, the training modules will be provided to GSAs in schools and local LGBTQ youth outreach agencies, for LGBTQ youth who are active speaker's bureau participants to go out into the community with tools to educate and support their gender-variant youth peers. It is the combination of peer support and more informed and teachers and providers changing systems that will lead to stronger relationships and social supports, improved access to healthcare, and increased resilience for gender-variant youth.

With adequate training, medical and mental health providers experience a positive, pivotal shift in thinking that allows them not only to provide better care to transgender patients, but also to become very proactive in furthering their own education and the awareness of those that work in their practices or clinics to improve their cultural sensitivity in treating patients from gender minority communities. This shift in thinking extends to LGBTQ medical providers: many providers who are part of *sexual* minority communities often have “blind spots” when treating people of *gender* minority communities, erroneously assuming that health issues and considerations are the same. This project is also designed to reach as many transgender and gender non-conforming youth as possible by connecting with youth-based organizations as well as the organizations, agencies and providers that work with both mainstream and LGBTQ youth.

The simple goal of creating and distributing this training content is to educate teachers and providers, make more entities aware of available resources and get more youth (and their families, if possible) participating in supportive programs. An integral part of this training program is to have teens take on leadership and service responsibilities for two reasons. The first reason is to involve LGBTQ

teens in creating the programming and environment that best suits them and their peers. Second, many LGBTQ teens are isolated in their school communities. As they attempt to live authentically, they may experience many hardships from a society that is ill-prepared for them. Involvement in their own self-empowerment, through these leadership activities, is crucial to keeping these children alive. There is no doubt in our minds that our work saves lives. A seemingly simple task of sending teens out to educate and inform the communities of which they are a part gives them a tangible way to evoke change in their own lives and provides an important role in engaging with the bigger picture. While the populations we serve (gender-variant youth) are considered the fringe of the fringe, it is imperative to make extra efforts to reach those who are even further marginalized – trans people of color, our younger community members, and those with disabilities.



Workshop Curriculum

## Teacher Module

**Learning Objectives:** Teachers will gain an understanding of gender identity and expression, learn about and how to support implementation of anti-discrimination laws enacted in the state of Washington; and will gain resources and tools to create safe spaces in school settings for gender-variant youth and support Gay-Straight Alliances in schools.

### Materials needed:

- Web-based registration form
- Webinar technology
- Post-training survey tool

### Outline

- 1) Introductions and Check-ins (5 minutes)
  - a) Log-on of training participants
  - b) Check-in question: What do you hope to learn and/or gain from this workshop?
  - c) Participants type in what part of the state they work in and what age youth they typically work with
- 2) Overview of Training (5 minutes)
  - a) Participants will have pre-registered for workshop
  - b) Explain goals of training module
    - i) Gain an understanding of gender identity and expression,
    - ii) Learn about and how to support implementation of anti-discrimination laws enacted in the state of Washington;
    - iii) Gain resources and tools to create safe spaces in school settings for gender-variant youth
    - iv) Support Gay-Straight Alliances in schools

- (1) Gay-Straight Alliances (GSAs) are student-led, school-based clubs that aim to provide a safe environment in the school context for lesbian, gay, bisexual, and transgender (LGBT) students, as well as their straight allies (Toomey, Ryan, Diaz & Russell, 2011).
  - v) Understand how to support and affirm youth, and decrease isolation youth experiences at school
- 3) Develop Group Norms (5 minutes)
    - a) Create expectations for how participants and facilitators may communicate with one another and what is necessary to create a safe and welcoming learning environment.
  - 4) Details of Training (25-30 minutes)
    - a) Definition of terms and introduction of social norms and values
      - i) Genderbread Person
      - ii) “The discrimination in society toward children who do not behave or look the way we expect them to look and behave according to their gender can be even more extreme than anti-gay discrimination” (Baker, 2002).
      - iii) Explanation of genderqueer, how it differs from other terms, and unique challenges for youth
      - iv) “GID can be conceptualized as an end-point of a continuum of cross-gender identification and it is conceivable that there are now more individuals who identify within this broader spectrum of cross-gender identity” (Zucker & Lawrence, 2009).
    - b) Statistics: Gender non-conformity is attributed to decreased coping and resilience and social rejection, which places youth at a higher risk for suicidal symptoms. While adolescents in general are a high-risk group for suicidal ideation and self-harm, with suicide being the third cause of death for young adults ages 15-24, there is increasing evidence that transgender youth are at increased risk for low self-esteem, depression, suicide, substance abuse, school problems, family rejection and discord running away, homelessness, and prostitution.
      - a) Risks and protective factors:

- i) “Young people who do not conform to heteronormative societal values are at risk for victimization during adolescence” (Russell, Ryan, Toomey, Diaz & Sanchez, 2011).
- ii) “The more young people present as gender non-conforming, the more likely they will be victimized or abused at school” (Russell, Ryan, Toomey, Diaz & Sanchez, 2011).
- iii) Gender-nonconforming youth are at elevated risk levels for experiencing victimization and negative psychosocial adjustment. The shame felt by gender-nonconforming adolescents may be compounded by the reactions from their peers and family. Peer reactions to gender nonconforming behavior are often negative, ranging from verbal questioning of another’s biological sex to physical abuse. Additional risk factors are attributed to lack of training among service providers.
- iv) Emotional distress, isolation, internalized homophobia/transphobia, depression, substance abuse, suicide, violence/victimization, family conflict, school performance, sexually transmitted diseases and/or pregnancy or other health risk behaviors (Elze, 2007; Kitts, 2010).
- v) “Teenagers who believe they alone are responsible for family conflicts may feel overwhelmed by the constant stress and may perceive suicide as the best solution for everyone” (Kanel, 2012, p. 85)
- vi) There is an increased risk of suicidal thinking and attempts during the coming-out process (Kanel, 2012).
- vii) Protective factors include unconditional support of a child’s identity, access to safe health care, ensuring that the child’s school is safe and welcoming, ensuring service providers are well trained and sensitive to transgender issues, and that service agencies implement explicit policies that prohibit all forms of discrimination; and supporting a child’s transition at a younger age at home and at school.
  - (1) For adolescents, this could include pubertal suspension, to be discussed more later in the presentation

- (a) Suspension of the youth’s biological puberty reduces their preoccupation with it, and affords the adolescent greater opportunity to explore their longer-term gender identity options in a more reflective and less pressured way (Zucker, Bradley, Anderson, Blanchard & Bain, 2011).
  - (b) “In post-modern Western culture, it has been claimed that more and more individuals are rejecting the traditional binary of male versus female, suggestive of greater evidence of normative gender fluidity” (Singh, Peterson-Badali, Johnson, Bradley, Kibblewhite, Owen-Anderson, Deogracias & Zucker, 2010).
- viii) Resilience, positive and supportive family relationships, stable intellectual functioning, self-confidence, high self-esteem, a socially appealing disposition/personality and social competence, a supportive and validating faith, special talent (e.g., athletic or musical skills) and/or educational achievement, sustainable hope, and supportive school and other peer relationships.
- ix) “Most social service providers, schools, and families are ill-equipped to help transgender youth and many remain hidden to be accepted” (Grossman, D’Augelli, Howell & Hubbard, 2005).
- x) Family support is associated with greater self-acceptance, which contributes to fewer mental health problems (Elze, 2007).
- (1) Promoting family involvement can be affected by a few different factors, including emotional responses as they learn to adjust and accept their child’s status (Spencer, 2005):
- (a) Stage 1: shocked and dejected, may experience grief and fear
  - (b) Stage 2: confused, deny their child’s status, reject their child, or avoid dealing with the issue by looking for other explanations

- (c) Stage 3: anger, self-pity, disappointment, guilt and a sense of powerlessness that may be expressed as rage or withdrawal
  - (d) Stage 4: begin to understand and accept their child's status and impact on the family
  - (e) Stage 5: families may accept, love, and appreciate their child unconditionally
  - (f) Stage 6: families may begin to focus on living on the benefits accrued, on the future, and on working with others to teach and provide support services for their child
- xi) Youth Empowerment programs and events -provides a sense of community to fight against isolation
  - xii) School protective factors: welcoming environment, obvious safe zone/peer-based support programs (Like GSAs), all staff is trained, curricula is inclusive of LGBTQ issues and people, staff are representative, information is accurate and easy to access, forms are inclusive, there is an appropriate response to bullying and harassment, heterosexist and homophobic and transphobic remarks are not condoned, there are positive reactions to youth coming out, teachers and staff identify themselves as LGBTQ-friendly, there are LGBTQ inclusive policies.
  - xiii) The presence of a GSA was associated with greater levels of school safety, fewer reports of missing school due to fear, and greater awareness of a safe adult in the school context. A few studies have documented that the presence of a GSA is associated with reduced suicide risk for sexual minority youths (Toomey, Ryan, Diaz & Russell, 2011).
  - xiv) Stop harassment of students by enforcing anti-discrimination policies
  - xv) Normalize through the use of language
  - xvi) Train all staff, especially the school nurse and librarians; and incorporate acceptance messages into other subjects such as English, Science
  - xvii) Seek out resources
- (1) Gender Diversity trainings in schools for both students and educators and administrators

- (2) Trans Youth & Family Allies trainings for educators and administrators
  - (3) Welcoming Schools trainings in schools for both students and educators
  - (4) Safe Schools Coalition
  - (5) Gay Lesbian Straight Educators Network (GLSEN)
- b) Relevant developmental stages
- i) The two age groups that are associated with the most self-harm, distress and suicidality are five to seven year-olds who are being forced to fit into social gender roles that aren't true to who they are, and self-harm and suicidality for kids entering puberty, whose bodies are betraying them.
  - ii) The internalization of homophobic and heterosexist messages begins very early—often before LGBTQ youth fully realize their sexual orientation and gender identity.
  - iii) LGBTQ youth who disclose their sexual/gender identity to their parents are at risk for parental rejection, withdrawal of financial support, authoritative restrictions of their social lives, forced counseling, and even violence and removal from the home.
  - iv) Some youth may withdraw from their families as a way of coping (Green, 1994), whereas others may cope with the stress of keeping their secret by indulging in self-destructive behaviors, such as substance abuse, risky sexual behaviors, running away, self-harm such as cutting, or attempting suicide (Gonsiorek, 1988; Proctor & Groze, 1994; Savin-Williams, 1994).
  - v) How a child is supported at home and at school may impact how successful they are in meeting this developmental milestone.
  - vi) Children diagnosed with GID may have a developmental delay in establishing gender constancy. Researchers speculate that this delay may occur because of a parent who does not help the child label gender correctly or correct “inappropriate” behaviors. Or, these children may have achieved an understanding of gender as flexible. Much of the attention to GID

children comes from parents intolerant of gender variance, not from the children themselves, as is the case with most childhood psychological problems. It has been noted repeatedly in the literature that almost all referrals of GID youth to gender treatment centers come from parents and other adults, such as teachers, who are not comfortable with their gender expressive behaviors.

vii) “The passage through puberty, peer group acceptance, and the establishment of a personal identity are all developmental tasks of the adolescent years. For the youth who is lesbian, gay, bisexual, or transgender, self-acceptance and identity formation in the face of a heterosexist society are difficult tasks associated with many risks to physical, emotional, and social health” (Kreiss & Patterson, 1997).

c) Interventions

i) A systematic level of training is needed for student peers within the classroom and on school grounds, from preschool through college.

(1) The City of Seattle and Seattle Public Schools have added gender identity to discrimination statements regarding employment and harassment, but there isn’t much training offered.

ii) Research suggests that the presence of a GSA in middle school and high school can serve as a protective factor for LGBTQ adolescents. The presence of a GSA is associated with reduced suicide risk for sexual minority youths.

(1) Creating a safe zone is a means of support for students who are LGBTQ. This can consist of a teacher or counselor with training concerning issues related to these students.

Teacher preparation programs and in-service training should emphasize the importance of avoiding anti-biased language, particularly concerning students who are LGBTQ. Using a curricular focus, schools can assist children in becoming more comfortable with diversity

in all its human forms. GLSEN proposes the use of early intervention to facilitate acceptance of sexual diversity by targeting elementary school students.

(a) Gender neutral bathrooms are another visual cue for transgender youth that this is a safe zone

(b) Support students in dressing and expressing consistent with their internalized identity

iii) Legal issues in schools

(1) Anti-discrimination laws – note that even the laws confuse sexual orientation with gender identity

(a) **Anti-Bullying** — In 2002 the Washington state Legislature [passed](#) an anti-bullying law requiring schools to adopt an anti-bullying policy covering all the protected classes in Washington’s hate crimes law, including sexual orientation.

(i) 2007 the anti-bullying law was [expanded](#) to prohibit cyber-bullying

(ii) In 2009 the definition of sexual orientation was [amended](#) to include gender identity and expression.

(iii) The legislature commissioned a report to study the effectiveness of the state’s anti-bullying law. The 2008 [Report](#) found that bullying in Washington Schools had not diminished.

(iv) The legislature responded in 2010 by unanimously passing [HB 2801](#), “an act relating to anti-harassment strategies in public schools”.

(v) Among its [provisions](#), the new law requires that school districts’ anti-harassment policies and procedures meet minimum standards and be made available to the public.

(vi) In 2010, the legislature passed [HB 3026](#), giving the Superintendent authority to investigate allegations of [all kinds of discrimination](#) and to enforce laws when violations occur.

(vii) We have taken the opportunity to show all of our students – including students of color and gay, lesbian, bisexual and transgender students – that we will not tolerate any kind of discrimination in our schools.

(viii) We need policy statements by school districts better publicized. While these laws passed 2-3 years ago, many school district board members are unfamiliar with the laws and have taken no steps to implement appropriate policies or procedures

(b) **Compliance with Civil Rights Laws** — Washington schools are some of the nation’s most diverse, yet discrimination has remained a persistent problem.

(i) Under previous law, the Superintendent of Public Instruction had broad authority to investigate *only* sex discrimination in school districts.

(ii) Verbiage needs to be developed for anti-discrimination policies across systems to address explicitly gender identity and expression. “We need policy statements by school districts publicized. Section 504 states school administrators can’t deny access to opportunities based on a disability. There is a need for a similar expression about accepting transgender and cis-gender students.

(c) Office of Superintendent of Public Instruction (OSPI)

(i) OSPI Bullying Policy – review document

(ii) OSPI Bullying Procedures – review document

(iii) OSPI Guidelines - Prohibiting Discrimination in Washington Public Schools (February 2012), pp 28-31.

**1. What terms are commonly used to describe gender identity or gender expression?**

a. Individuals use a number of words to describe their gendered experiences. Some people may refer to themselves as trans, transsexual,

transgender, male-to-female (MTF), female-to-male (FTM), two-spirit, and a variety of other terms. Terminology can differ based on region, language, race, ethnicity, age, culture, and many other factors. Some common terms are defined below.

- i. *Gender identity* is a person's deeply felt internal sense of being male or female, regardless of their sex assigned at birth.
  - ii. *Gender expression* is the manner in which a person represents or expresses gender to others, often through behavior, clothing, hairstyles, activities, voice, or mannerisms.
  - iii. *Transgender* is a general term used to describe a person whose gender identity or expression is different from that traditionally associated with the person's sex assigned at birth.
  - iv. *Transitioning* is the process in which a person changes their gender expression to better reflect their gender identity.
  - v. *Gender nonconforming* is a term for people whose gender expression differs from stereotypical expectations about how they should look or act based on the sex they were assigned at birth. This includes people who identify outside traditional gender categories or identify as both genders.
- b. **Example 1:** Alexis was assigned female at birth, but she identifies as gender nonconforming. Alexis prefers to express herself like a tomboy - she enjoys playing sports with boys in her class, and she prefers that her friends call her Alex. While Alex currently uses female pronouns, she is questioning her gender identity and is considering transitioning to a male

role. Currently, Alex is consistently presenting as female at school, but that will change if she decides to transition.

- c. **Example 2:** Although Casey attended kindergarten and first grade as a boy, about midway through first grade, she and her family decided that Casey would transition and begin presenting as a girl. Casey prefers to dress in stereotypically feminine attire such as dresses and skirts.

Although she is growing her hair out, it is still in a rather short, typically boyish haircut. Casey, her parents, and school administrators have asked her friends and teachers to use female pronouns to address her. Casey is consistently presenting as female at school.

**2. Should transgender and gender nonconforming students have the right to express their gender identity in school?**

- d. Yes. Washington state law prohibits discrimination in public schools based on gender expression and identity (RCW 28A.642.010). Students must be permitted to dress according to the gender in which they consistently identify and should be addressed and treated using the name and pronouns of their choice (i.e., “he” and “him” or “she” and “her”). School districts are encouraged to adopt gender-neutral dress codes that do not restrict a student’s clothing choices on the basis of gender. Dress codes should be based on educationally relevant considerations, apply consistently to all students, include consistent discipline for violations, and make reasonable accommodations when the situation requires an exception.

**3. How should school districts address a student’s name and sex on official records?**

e. School districts maintain permanent student records that include a student's legal name and legal gender. To the extent that the school district is not legally required to use a student's legal name and gender on school records or documents, the district should use the name and gender by which the student identifies. School IDs, for example, are not legal documents and should use the student's preferred name. The school district should change a student's official record to reflect a change in the student's legal name or gender upon receipt of documentation that such change has been made pursuant to a court order or through amendment of state- or federally-issued identification. In situations where school staff or administrators are required by law to use or report a student's legal name or gender, such as for standardized testing, school staff should adopt practices to avoid the inadvertent disclosure of such confidential information.

**4. Should schools inform staff, students, or parents about a student's transgender status?**

f. Information about a student's transgender status, legal name, or gender assigned at birth may constitute confidential medical or education information. Disclosing this information to other students, their parents, or other third parties may violate privacy laws, such as the federal Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 C.F.R. Part 99). School staff should not disclose information that may reveal a student's transgender status to others, including parents and other school staff, unless legally required to do so or unless the student has authorized such disclosure.

**5. Should a school district require proof of medical treatments as a prerequisite for respecting a student’s gender identity or expression?**

- g.** No. School districts should not require proof of medical treatments in order to respect a student’s gender identity or expression. If a school district has an objective basis that would justify questioning whether a student’s asserted gender identity is genuine, it may ask for information to show that the student’s gender identity or expression is sincerely held. No particular type of information (such as medical history information) should be specifically required.

**6. Should school districts allow transgender students to use the restroom of their choice?**

- h.** Yes. School districts should allow students to use the restroom that is consistent with their gender identity consistently asserted at school. Any student – transgender or not - who has a need or desire for increased privacy, regardless of the underlying reason, should be provided access to an alternative restroom (e.g., staff restroom, health office restroom). This allows students who may feel uncomfortable sharing the facility with the transgender student(s) the option to make use of a separate restroom and have their concerns addressed without stigmatizing any individual student. No student, however, should be required to use an alternative restroom because they are transgender or gender nonconforming.
- i.** If school administrators have legitimate concerns about the safety or privacy of students as related to a transgender student’s use of the restroom, school administrators should bring these concerns to the school

district compliance coordinator. Such privacy or safety issues should be immediate and reasonably foreseeable, not speculative. School administrators and/or compliance coordinator should meet with the student and/or parents to determine if there is a need for an alternative facility. Determination to provide an alternative facility for any student should be on a case-by-case basis.

**7. How should school districts address physical education and athletic participation by transgender students?**

- j. School districts should allow students the opportunity to participate in physical education and athletic activities in a manner that is consistent with their gender identity. For interscholastic athletics, should any questions arise as to whether a student's request to participate in a sex-segregated activity consistent with his or her gender identity is bona fide, a student may seek review of his or her eligibility for participation by working through the Gender Identity Participation procedure set forth by the Washington Interscholastic Athletic Association (WIAA), available at <http://www.wiaa.com/subcontent.aspx?SecID=350>.

**8. Should school districts allow a transgender student to use the locker room of their choice?**

- k. The use of locker rooms by transgender students should be assessed on a case-by-case basis, with the goals of maximizing the student's social integration and equal opportunity to participate in physical education classes and sports, ensuring the student's safety and comfort, and minimizing the stigmatization of the student. In most cases, transgender students should have access to the locker room that corresponds to their

gender identity consistently asserted at school. Any student who has a need or desire for increased privacy, regardless of the underlying reason, should be provided with a reasonable alternative changing area, such as the use of a private area (e.g., a nearby restroom stall with a door), or a separate changing schedule. Any alternative arrangement should be provided in a way that protects the student’s ability to keep his or her transgender status private. No student, however, should be required to use a locker room that conflicts with his or her gender identity.

1. **IV. Discriminatory Harassment - Are school districts required to adopt a Harassment, Intimidation, and Bullying policy and procedure?**

- i. Yes. Under RCW 28A.300.285, each school district is required to adopt the state’s model Harassment, Intimidation, and Bullying (HIB) policy and procedure, available at <http://www.k12.wa.us/safetycenter/BullyingHarassment/default.aspx>. While some student misconduct may fall under a school district’s HIB policy, the behavior may also trigger responsibilities under nondiscrimination laws. By limiting its response to the school district’s HIB policy, a school district may fail to properly consider whether student misconduct also results in discriminatory harassment. If harassment, intimidation, or bullying is based on any protected class, a school district must assess the behavior for civil rights implications.

**m. What is discriminatory harassment?**

- i. Harassment may be discrimination when it is:

- ii. Based on sex, race, creed, religion, color, national origin, sexual orientation, gender expression or identity, veteran or military status, disability, or the use of a trained dog guide or service animal;
- iii. Sufficiently serious to create a hostile environment; and
- iv. Encouraged, tolerated, ignored, or not adequately addressed by school employees.
- v. Harassing conduct may include verbal acts and name-calling, graphic and written statements, or other conduct that may be physically threatening, harmful or humiliating. Harassment does not have to include intent to harm, be directed at a specific target, or involve repeated incidents.

**n. When does discriminatory harassment create a hostile environment?**

- i. Discriminatory harassment creates a hostile environment when the conduct is sufficiently severe, pervasive, or persistent so as to interfere with or limit a student's ability to participate in or benefit from the services, activities, or opportunities offered by a school district. For example, a hostile environment may cause a student to experience emotional distress, physical illness, or declining grades and attendance.

**o. When is a school district responsible for addressing discriminatory harassment?**

- i. A school district is responsible for addressing discriminatory harassment about which it knows or reasonably should have known. In some situations, harassment may be in plain sight, widespread, or well-known to students and staff, such as harassment occurring in

hallways, during classes, during extracurricular activities, at recess or lunch, on a school bus, or through graffiti in public areas. In these cases, the obvious signs of the harassment are sufficient to put the school district on notice. In other situations, the school district may become aware of misconduct, triggering an investigation that could lead to the discovery of additional incidents that, taken together, may constitute a hostile environment.

**p. How should school districts respond to allegations of discriminatory harassment?**

- i. A school district must take prompt and appropriate action to investigate or otherwise determine what occurred. School districts that receive an allegation of discriminatory harassment may need to respond using the discrimination complaint and appeal procedures outlined in WAC 392-190-065, 392-190-070, and 392-190-075 (see page 62). If an investigation reveals that discriminatory harassment has occurred, the school district must take prompt and effective steps reasonably calculated to end the harassment, eliminate any hostile environment and its effects, and prevent the harassment from recurring. These duties are a school district's responsibility even if the misconduct is also covered by the school district's HIB policy, and regardless of whether a student has complained, asked the school district to take action, or identified the harassment as a form of discrimination.

**q. What are appropriate steps to end discriminatory harassment?**

- i. School and district administrators should look beyond simply disciplining the perpetrators. While disciplining the perpetrators is likely a necessary step, it often is insufficient. A school district's responsibility is to eliminate the hostile environment created by the harassment, address its effects, and take steps to ensure that harassment does not recur. Put differently, the unique effects of discriminatory harassment may demand a different response than would other types of bullying. Appropriate steps to end harassment may include separating the accused harasser and the target, providing counseling for the target and/or harasser, or taking disciplinary action against the harasser. These steps should not penalize the student who was harassed – for example, not requiring the target to change his or her class schedule.
- ii. In addition, depending on the extent of the harassment, the school district may also need to provide training or other interventions not only for the perpetrators, but also for the larger school community, to ensure that all students, their families, and school staff can recognize harassment if it recurs and know how to respond. A school district may also be required to provide additional services to the student who was harassed in order to address the effects of the harassment, particularly if the school initially delays in responding or responds inappropriately or inadequately to information about harassment. An effective response may include revising the procedures by which students, parents, and employees may report allegations of harassment (or wide dissemination of existing policies and

procedures), as well as wide distribution of the contact information for the school district's compliance coordinator.

**r. What steps should a school district take to stop future harassment and prevent retaliation?**

- i. A school district should take steps to stop further harassment and prevent any retaliation against the person who made the complaint (or was the subject of the harassment) or against those who provided information as witnesses. At a minimum, the school district's responsibilities include making sure that the harassed students and their families know how to report any subsequent problems, conducting follow-up inquiries to discover if there have been any new incidents or any instances of retaliation, and responding promptly and appropriately to address continuing or new problems.
- ii. Law falls under sexual orientation, although sexual orientation and gender identity are two separate aspects for a person's identity.

**2. EXAMPLE – SEXUAL ORIENTATION (AS MISLABELED BY STATE)**

- a. *Over the course of a school year, a gay high school student was called names (including anti-gay slurs and sexual comments), physically assaulted, threatened, and ridiculed because he did not conform to stereotypical notions of how teenage boys are expected to act and appear. As a result, the student missed school to avoid further harassment. The school did not recognize that the misconduct was discriminatory harassment. The school responded to complaints from the student by reprimanding the perpetrators consistent with its HIB policy.*

*The reprimands of the identified perpetrators stopped the harassment by those individuals. It did not, however, stop others from undertaking similar harassment of the student.*

- b. As noted in the example, the school failed to recognize the pattern of misconduct as a form of discriminatory harassment based on the student's sexual orientation and gender expression. It may be discriminatory if students are harassed for their sexual orientation, for not exhibiting what is perceived as a stereotypical characteristic for their sex, or for failing to conform to stereotypical notions of masculinity and femininity. In this example, the school had an obligation to take immediate and effective action to eliminate the hostile environment. By responding to individual incidents of misconduct on an ad hoc basis only, the school failed to confront and prevent a hostile environment from continuing. Had the school recognized the conduct as a form of discriminatory harassment, it could have employed the full range of sanctions (including progressive discipline) and remedies designed to eliminate the hostile environment. For example, this approach could have included a more comprehensive response to the situation that involved notice to the student's teachers so that they could ensure the student was not subjected to any further harassment, more aggressive monitoring by staff of the places where harassment occurred, increased training on the scope of the school's harassment and discrimination policies, notice to the target and harassers of available counseling services and resources, and educating the entire school community on civil rights and expectations of tolerance, specifically as they apply to gender

stereotypes. The school also should have taken steps to clearly communicate the message that the school does not tolerate harassment and will be responsive to any information about such conduct.

- d) Bullying prevention strategies and policies include (Spencer, 2005):
  - i) Conduct a survey to determine the nature and extent of bullying problems
  - ii) Establish school rules that prevent bullying, and enforce them
  - iii) Use a confidential message box to report incidents of bullying
  - iv) Hold meetings with students to discuss bullying incidents
  - v) Identify locations where bullying is likely to occur and increase supervision in those areas
  - vi) Model respectful behavior toward others
  - vii) Create a school environment that does not tolerate bullying and have students make “No Bullying Zone” posters
  - viii) Confront and discipline bullying quickly and firmly by addressing inappropriate behavior and using the situation to teach pro-social behaviors
  - ix) Address victims of bullying by being supportive
  - x) Refer bullies and their victims for counseling and other appropriate services
  - xi) Foster communication among and between teachers and families
  - xii) Help bullies develop empathy for others
- e) Incorporating diversity practices:
- f) Know your terms
- g) Address your biases
- h) Simple steps schools can take:
  - i) Include sexual orientation and gender identity in school administration policies
  - ii) Provide diversity training to students and faculty

- iii) Designate a liaison at each school in each school district to be available to LGBTQ students and to the committee
- iv) Designate a “safe zone” for LGBTQ students at each school
- i) Demonstrate your support with visual cues
  - i) Hang a rainbow flag
  - ii) Safe space signs or stickers
  - iii) Have books or magazines in your library pertaining to anti-oppression and LGBTQ issues
  - iv) Advocate for gender neutral bathrooms
  - v) Have a policy that everyone who comes into your office or classroom is asked what gender pronouns they prefer
  - vi) Request anti-oppression trainings for yourself and your colleagues
  - vii) If your school does not have a GSA, create one!
- 5) Closing (5 - 10 minutes)
  - a) Need statement: Transgender individuals’ needs include: basic acceptance of having a self-determined gender identity, finding a voice, gaining access to medical care, establishing fundamental civil protections, and maintaining and building families.
  - b) Make your action plan
    - i) What can I do to support gender-variant students?
    - ii) What can I do to educate students and school staff?
    - iii) What can I do to advocate for changes within the school?
    - iv) What further resources, information, or help do I need?
  - c) Resources
    - i) Dear Colleague Letter (October 26, 2010) - Harassment and Bullying (U.S. Department of Education): <http://www2.ed.gov/about/offices/list/ocr/letters/colleague-201010.html>
    - ii) OSPI Bullying Policy

- iii) OSPI Bullying Procedures
  - iv) OSPI Guidelines - Prohibiting Discrimination in Washington Public Schools (February 2012), pp 28-31.
  - v) Cis-gender privilege checklist
  - vi) List of LGBTQ youth centers
  - vii) List of transgender books [www.glsen.org/booklink](http://www.glsen.org/booklink)
  - viii) Support groups and advocacy organizations
  - ix) Safe Schools Coalition [www.safeschoolscoalition.org](http://www.safeschoolscoalition.org)
  - x) [www.glsen.org/educator](http://www.glsen.org/educator)
  - xi) Jump-start guide for GSAs [www.glsen.org/jumpstart](http://www.glsen.org/jumpstart)
  - xii) Educators Allies Network <http://edallies.ning.com>
  - xiii) WPATH Standards of Care
- 6) Survey Tool (5-10 minutes)
- (1) Subscribe to the Gender Odyssey mailing list to learn about training events, such as professional Day: <https://app.e2ma.net/app2/audience/signup/28753/17074/?v=a>
  - (2) Register for more in-depth training at Gender Odyssey's annual Professional Day: <http://www.genderdiversity.org/event-registration/?ee=2>

### **Challenges That May Arise**

Training participants may have been required to attend the training and have not confronted biases they may have regarding gender nonconformity.

Training participants may want to case manage during the training and will need to be guided to scheduling an individual appointment to discuss.

There is a lot of content to cover and the trainer may need to speed through some sections that may require more in-depth discussion and reflection.

This training may need to be expanded to a longer training period in order to better engage with training participants.

## Medical Provider Module

**Learning Objectives:** Medical providers will gain an understanding of gender identity and expression, better understand barriers gender-variant youth face when accessing healthcare services; and will be able to offer prescriptive options for gender-variant youth and reduce common misdiagnoses.

### Materials needed:

- Web-based registration form
- Webinar technology
- Post-training survey tool

### Outline

- 2) Introductions and Check-ins (5 minutes)
  - a) Log-on of training participants
  - b) Check-in question: What do you hope to learn and/or gain from this workshop?
  - c) Participants type in what part of the state they work in and what age youth they typically work with
- 3) Overview of Training (5 minutes)
  - a) Participants will have pre-registered for workshop
  - b) Explain goals of training module
    - i) Gain an understanding of gender identity and expression
    - ii) Better understand barriers gender-variant youth face when accessing healthcare services;
    - iii) Able to offer prescriptive options for gender-variant youth and reduce common misdiagnoses.
- 4) Develop Group Norms (5 minutes)
  - a) Create expectations for how participants and facilitators may communicate with one another and what is necessary to create a safe and welcoming learning environment.
- 5) Details of Training (25-30 minutes)
  - a) Definition of terms and introduction of social norms and values

- i) “It is absolutely critical that we address this social problem (of discrimination) as a systems issue. We must engage providers in health care, education, criminal justice, and so on and so forth to understand the barriers we face on a daily basis” – interview participant
- b) Statistics: Gender non-conformity is attributed to decreased coping and resilience and social rejection, which places youth at a higher risk for suicidal symptoms. While adolescents in general are a high-risk group for suicidal ideation and self-harm, with suicide being the third cause of death for young adults ages 15-24, there is increasing evidence that transgender youth are at increased risk for low self-esteem, depression, suicide, substance abuse, school problems, family rejection and discord running away, homelessness, and prostitution.
- c) Risks and protective factors:
  - i) Gender-nonconforming youth are at elevated risk levels for experiencing victimization and negative psychosocial adjustment. The shame felt by gender-nonconforming adolescents may be compounded by the reactions from their peers and family. Peer reactions to gender nonconforming behavior are often negative, ranging from verbal questioning of another’s biological sex to physical abuse. Additional risk factors are attributed to lack of training among service providers.
  - ii) Emotional distress, isolation, internalized homophobia/transphobia, depression, substance abuse, suicide, violence/victimization, family conflict, school performance, sexually transmitted diseases and/or pregnancy or other health risk behaviors (Elze, 2007; Kitts, 2010).
  - iii) “Teenagers who believe they alone are responsible for family conflicts may feel overwhelmed by the constant stress and may perceive suicide as the best solution for everyone” (Kanel, 2012, p. 85)
  - iv) There is an increased risk of suicidal thinking and attempts during the coming-out process (Kanel, 2012).

- v) Protective factors include unconditional support of a child's identity, access to safe health care, ensuring that the child's school is safe and welcoming, ensuring service providers are well trained and sensitive to transgender issues, and that service agencies implement explicit policies that prohibit all forms of discrimination; and supporting a child's transition at a younger age at home and at school.
  - vi) Resilience, positive and supportive family relationships, stable intellectual functioning, self-confidence, high self-esteem, a socially appealing disposition/personality and social competence, a supportive and validating faith, special talent (e.g., athletic or musical skills) and/or educational achievement, sustainable hope, and supportive school and other peer relationships.
  - vii) Family support is associated with greater self-acceptance, which contributes to fewer mental health problems (Elze, 2007).
  - viii) It is important to identify and use these protective factors as client strengths in social work practice with LGBTQ youth (Zubernis, Snyder & McCoy, 2011).
- d) Relevant developmental stages
- i) The two age groups that are associated with the most self-harm, distress and suicidality are five to seven year-olds who are being forced to fit into social gender roles that aren't true to who they are, and self-harm and suicidality for kids entering puberty, whose bodies are betraying them.
  - ii) The internalization of homophobic and heterosexist messages begins very early—often before transgender youth fully realize their gender identity.
  - iii) Transgender youth who disclose their gender identity to their parents are at risk for parental rejection, withdrawal of financial support, authoritative restrictions of their social lives, forced counseling, and even violence and removal from the home.

- iv) Some youth may withdraw from their families as a way of coping (Green, 1994), whereas others may cope with the stress of keeping their secret by indulging in self-destructive behaviors, such as substance abuse, risky sexual behaviors, running away, self-harm such as cutting, or attempting suicide (Gonsiorek, 1988; Proctor & Groze, 1994; Savin-Williams, 1994).
  - v) How a child is supported at home and at school may impact how successful they are in meeting this developmental milestone.
  - vi) Children diagnosed with GID may have a developmental delay in establishing gender constancy. Researchers speculate that this delay may occur because of a parent who does not help the child label gender correctly or correct “inappropriate” behaviors. Or, these children may have achieved an understanding of gender as flexible. Much of the attention to GID children comes from parents intolerant of gender variance, not from the children themselves, as is the case with most childhood psychological problems. It has been noted repeatedly in the literature that almost all referrals of GID youth to gender treatment centers come from parents and other adults, such as teachers, who are not comfortable with their gender expressive behaviors.
- e) Interventions
- i) AMA Policy
    - (1) In 2007, the Board of Trustees of the American Medical association (AMA) amended its policies to include language that would prohibit discrimination against and ensure “protection and equality relating to gender identity issues.”
    - (2) The AMA’s policy states “Physicians cannot refuse to care for patients based on gender identity.”
    - (3) The AMA also opposes the denial of health insurance on the basis of sexual orientation or gender identity.

(4) Doctors who do not comply can be admonished, censured, or even lose their licenses.

ii) WPATH Standards of Care

- (1) The World Professional Association for Transgender Health (WPATH) is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health.
- (2) The vision of WPATH is to bring together diverse professionals dedicated to developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transsexual, transgender, and gender nonconforming people in all cultural settings.
- (3) One of the main functions of WPATH is to promote the highest standards of health care for individuals through the articulation of *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People*.
- (4) The overall goal of the *SOC* is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments.
- (5) The *SOC* are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria – broadly defined as discomfort or distress that is caused

by a discrepancy between a person's gender identity and that person's sex assigned at birth.

iii) DSM – Sexual and Identity Disorder (APA, 2000)

(1) There are two components of Gender Identity Disorder (GID) which both must be present to make a diagnosis.

(a) There must be evidence of a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the other sex.

(b) This cross-gender identification must not merely be a desire for any perceived cultural advantages of being the other sex. There must also be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex.

(c) The diagnosis is not made if the individual has a concurrent physical intersex condition.

(d) To make the diagnosis, there must be evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning.

(2) Distress in individuals with GID is manifested differently across the life cycle.

(a) In young children, distress is manifested by the stated unhappiness about their assigned sex. Preoccupation with cross-gender wishes often interferes with ordinary activities.

(i) Children with GID may manifest coexisting Separation Anxiety Disorder, Generalized Anxiety Disorder, and symptoms of depression.

(ii) For clinically referred children, onset of cross-gender interests and activities is usually between ages 2 and 4 years. Typically children are referred around the time of school entry because of parental concern that what they regarded as a phase does not appear to be passing.

- (b) In older children, failure to develop age-appropriate same-sex peer relationships and skills often leads to isolation and distress, and some children may refuse to attend school because of teasing or pressure to dress in attire stereotypical of their assigned sex.
- (c) In adolescents and adults, preoccupation with cross-gender wishes often interferes with ordinary activities. Relationship difficulties are common, and functioning at school or at work may be impaired.
  - (i) Adolescents are particularly at risk for depression and suicidal ideation and suicide attempts.

(3) Diagnostic criteria code is based on age

- (a) 302.6 Gender Identity Disorder in Children
- (b) 302.85 Gender Identity Disorder in Adolescents or Adults

(4) 302.6 Gender Identity Disorder Not Otherwise Specified

- (a) Example: persistent preoccupation with castration or penectomy without a desire to acquire the sex characteristics of the other sex

(5) Criteria

- (a) Regarding the criteria for GID for adolescents and adults, the current criteria do not capture the whole spectrum of gender variant phenomena (Narrow & Cohen-Kettenis, 2010).

iv) Dutch Protocol

- (1) Since the mid-1990s, one model of therapeutic care, developed by Dutch clinicians and researchers, has been to initiate the biomedical aspects of sex reassignment in early – to mid-adolescence, rather than wait for the legal age of adulthood. After careful psychological evaluation, adolescents deemed appropriate for such treatment are prescribed hormonal medication to delay or suppress somatic puberty. If the gender

dysphoria persists, then cross-sex hormonal therapy is offered at the age of 16, and if the adolescent desires, surgical sex change procedures are then offered (Zucker, Bradley, Owen-Anderson, Singh, Blanchard & Bain, 2011).

- (2) The rationale for this treatment protocol includes the following:
  - (a) There is the assumption that for some adolescents with GID there is little systematic empirical evidence that psychological interventions can resolve the gender dysphoria
  - (b) The use of hormonal blockers can be helpful to the adolescent because it reduces the incongruence between the development of natal sex secondary physical characteristics (male: facial hair growth, hair growth on other parts of body, deepening of voice; female: breast development, menstruation) and the felt psychologic gender, thereby reducing stress
  - (c) Reduction of incongruence makes it easier for adolescents to present socially in the cross-gender identity/role, which is also helpful in reducing stress during the gender transition process
- (3) “A study in the Netherlands at a gender clinic found adolescents to be faring better than adults in measures of psychological health, largely attributed to the youth receiving gender role assistance by way of puberty suspension or hormone therapy, and implications the adolescents felt more supported and experienced less harm through stigmatization than adults” (Herbert, 2011).
- (4) Risk of misdiagnosis
  - (a) On quantitative gender assessment scales, children with GID are at risk for misdiagnosis.
  - (b) Professional services for GID children are provided primarily by pediatric endocrinologists and urologists, and very few centers have staff experienced with treating gender identity variants in children (Meyer-Bahlburg, 2009).

- (c) Inexperienced clinicians may mistake indications of gender dysphoria for delusions.

The vast majority of children and adolescents with gender dysphoria are not suffering from underlying severe psychiatric illness such as psychotic disorders (WPATH, 7<sup>th</sup> version)

- (d) It is more common for adolescents with gender dysphoria to have co-existing internalizing disorders such as anxiety and depression, and/or externalizing disorders such as oppositional defiant disorder (WPATH, 7<sup>th</sup> version)

- (e) There seems to be a higher prevalence of autistic spectrum disorders in clinically referred, gender dysphoric adolescents than in the general adolescent population (WPATH, 7<sup>th</sup> version).

- (f) Regarding children and adolescents who are gender variant, there is a greater risk for misdiagnosis of Oppositional Defiant Disorder, Attention Deficit Disorder, and Asperger's, as reported anecdotally by families attending support groups.

- (g) Youth may be exhibiting symptoms that are similar to these disorders as a result of high anxiety levels and fixation of interests or hobbies as a way to cope (Bradley & Zucker, 1997).

- (h) Adolescents referred for gender identity concerns also displayed significant behavioral difficulties such as anger, aggression, isolation, and depression, as reported by their mothers (Bradley & Zucker, 1997).

- (i) In one parent support group, a parent shared recent research about complex brain trauma. She explained that on-going stress and anxiety from living in the wrong gender can lead to complex brain trauma.

- (j) Once gender issues are addressed, many parents shared that other symptoms go away.

- (k) Some parents hypothesized that when the cortisol goes away, it gives the brain an opportunity to heal itself and other symptoms then retreat as well.
  - (l) These parents' insights are consistent with research published by Child Welfare Information Gateway (2009), which states that if a child lives in a threatening, chaotic world, the child's brain may be hyperalert for danger because their survival may depend on it.
  - (m) When children are exposed to chronic, traumatic stress, their brains sensitize the pathways for the fear response, resulting in a number of biological reactions, including a persistent state of fear.
  - (n) Gender-variant children and adolescents receive perpetual messages in society that there is something wrong with them, and they live with a constant fear of people finding out their secret.
  - (o) For adolescents with symptoms of chronic stress, which may include changes in attention, impulse control, sleep, and fine motor control, it is understandable how they may be misdiagnosed as ODD or ADD.
  - (p) The research further explains that chronic activation of certain parts of the brain involved in the fear response can "wear out" other parts of the brain such as the hippocampus, which is involved in cognition and memory. This may causes excess production of cortisol—a hormone that may damage or destroy neurons in critical brain areas.
- (5) Tanner stages
- (a) When the brain determines that it is time to start puberty, usually around age 11 in male bodied persons and 10 in female bodied persons, the pituitary gland releases 2 hormones called LH (leutinizing hormone) and FSH(follicle stimulating hormone).

- (b) With a rise in these two hormones, they both then affect the sex gland at hand by producing sex hormones: testes produce testosterone, and ovaries produce estrogen.
- (c) It is these sex hormones that cause the typical changes we see with puberty and they occur in a series of steps called Tanner Stages 1-5. Tanner Stage 1 is, generally speaking, the time from birth to the onset of puberty, at which point the child enters Tanner Stage 2.
- (d) In male-bodied persons:
  - (i) First, the LH and FSH cause increase in testicular size;
  - (ii) Which then results in an increase in testosterone production;
  - (iii) Testosterone causes increase in pubic hair and phallic size;
  - (iv) There is more acne;
  - (v) They get axillary (armpit) hair and facial hair;
  - (vi) Eventually they get a growth spurt and their voice changes;
  - (vii) When they are around 18 years of age, puberty is complete and growth stops
- (e) In female-bodied persons:
  - (i) Estrogen causes breast development first;
  - (ii) This progresses and the person then gets more curves, and fat deposits in the typical adult female places;
  - (iii) About 2 years after the start of breast development, menstrual periods start;
  - (iv) A female-bodied person does get pubic hair, axillary (armpit) hair and acne, but not from estrogen. These changes come from hormones that are produced from the adrenal glands, and happen independently of LH, FSH and estrogen.

(6) Delaying puberty (Dr. Karin Selva, TransActive, 2012)

[http://transactiveonline.org/community\\_education/TransActive%20HSC%20Testimony.pdf](http://transactiveonline.org/community_education/TransActive%20HSC%20Testimony.pdf)

- (a) What are puberty blockers and how do they work?
  - (i) These are agents (or medicines) that block (or as we say suppress) the release of LH and FSH from the pituitary gland.
  - (ii) This then stops testosterone from being released from the testes, and estrogen from being released from the ovaries.
  - (iii) Thus, they SUPPRESS PUBERTY.
  - (iv) Without exposure to the sex hormones, the body does not undergo the changes associated with them.
- (b) These agents (medicines) come in 2 forms:
  - (i) Leuprolide or Depot Lupron: This form of the medicine is an injectible that is given on either a monthly or every 3 month basis. It is injected into the muscle. Often the patient or family members are taught how to administer this shot at home.
  - (ii) Suprellin or Histrelin: This form is an implant. A very small device is implanted under the skin of one's upper arm, and it slowly releases the agent (medicine) over a period of one year. The unit must be replaced on a yearly basis by a surgeon, but this can be done under local anesthesia.
- (c) Why are they used and when are they prescribed?
  - (i) These agents (medicines) are used for many different reasons. In children they are used to treat precocious puberty, when puberty happens too early. They are given to a child until the child is older and mature enough to enter into puberty, and once these agents are stopped, puberty will start on its own.

(ii) These agents are also used to suppress endogenous sex hormone production in an adult individual who is undergoing cross-gender transition. By suppressing the individual's production of sex hormones, administering cross hormone therapy for transition is more effective.

(iii) In transgender youth, puberty blockers are used to suppress the endogenous pubertal changes that quite often worsen the individual's gender dysphoria. In addition, by not being exposed to one's own sex hormones, cross hormone therapy is even more effective at achieving the desired physical appearance in gender transition.

(7) Endocrine Society recommendations [www.endo-society.org](http://www.endo-society.org)

(a) We recommend that adolescents who fulfill eligibility and readiness criteria for gender reassignment initially undergo treatment to suppress pubertal development.

(b) We recommend that suppression of pubertal hormones start when girls and boys first exhibit physical changes of puberty (confirmed by pubertal levels of estradiol and testosterone, respectively), but no earlier than Tanner stages 2–3.

(c) We recommend that GnRH analogues be used to achieve suppression of pubertal hormones.

v) Cost considerations and insurance coverage

(1) The GID diagnosis is, to date, required for insurance coverage of hormonal therapy and sex reassignment procedures for transitioning individuals. Those who seek treatment often view it as a trade-off between stigma and insurance reimbursement. Because most insurance companies require DSM diagnoses for treatment coverage in general, the diagnoses of GID facilitates payment and thus access to basic care for gender-variant individuals. While many view GID diagnoses as a societal prejudice rather than a mental

disorder, there has been concern that without a specific disorder label to categorize behaviors, treatment-seeking individuals would be turned away. (Kamens, 2011).

- (2) Utilization of health care services is reduced in this population, with received barriers, including cost, fear of services in general, and fear of mental health stigma (Colton, Fitzgerald, Pardo & Babcock, 2011).
- (3) Puberty blockers are both medically necessary and expensive.
  - (a) Peggy Cohen-Kettenis of the *Free University of Amsterdam Medical Center* said:

"People are always afraid that it will be harmful for the children. But what they never take into account is that it is also harmful to *not* give them this treatment."
  - (b) Considerations
    - (i) While a child is being treated with GnRH inhibitors, they will not experience the cognitive development that comes naturally with the increase of hormonal activity in the body, which is simply a delay and not a permanent impact on development.
    - (ii) If a child is not treated with puberty blockers, the likelihood for future surgical interventions will increase.
  - (c) Typically, Depot-Lupron costs range from around \$700 (online) to \$800 (Portland area) to \$1,500 dollars a month elsewhere for the monthly preparation. The 3 month preparation is equivalent in price.
  - (d) The Histrelin implant is approximately \$15,000 total for the device and the cost of surgically implanting it.
  - (e) Also, labs need to be monitored while on these agents. A pre-treatment LH, FSH and testosterone or estradiol level is checked, as well as a post treatment level to assess the level of suppression.

(f) Some health insurance will cover them partially in cross-gender treatment, and some won't. As a result, the out of pocket cost of these agents can be quite substantial and out of reach for most youth and their families.

(4) ICD-9-CM Code for billing insurance for puberty blockers

(a) 259.1 Sexual development and puberty, precocious

(b) 259.8 is a billable medical code that can be used to specify a diagnosis on a reimbursement claim.

(c) Providers may also use nonspecific diagnostic and procedural codes to work around the issue related to hormonal imbalances or unwanted puberty changes.

vi) Cross-hormones

(1) Hormonal interventions are an often-sought option for transgender individuals seeking to medically transition to an authentic gender (Colton, Fitzgerald, Pardo & Babcock, 2011).

(2) Due to lack of insurance coverage, hormone replacement therapy (HRT) is more commonly accessed than surgery. Most individuals who desire to make a gender transition select hormonal regimens solely or as an initial step.

(3) The aim for HRT for transgender individuals is to diminish the secondary sex characteristics of the original sex (such as fat distribution) and to engender and/or enhance the secondary sex characteristics (hair growth, muscle), of the sex with which the individual identifies (Colton, Fitzgerald, Pardo & Babcock, 2011).

vii) Fertility considerations

(1) It should be noted that suppression of the natal sex hormones combined with cross-hormone therapy will alter reproductive capacity in patients, so sperm storage for genetic males and cryopreservation of eggs for genetic females might be presented as an option to maintain the possibility of having their own biologic offspring later in life.

- (2) Prepubertal or pubertal adolescents may not develop reproductive function in their natal sex due to blockers or cross gender hormones. There is currently no technique for preserving function from the gonads of these individuals (WPATH, 7<sup>th</sup> version).
- viii) Health care consent for minors
- (1) The Sylvia Rivera Law Project ([www.srlp.org](http://www.srlp.org)) states: “A parent, guardian, or the state can consent to health care for people under 18. Health care providers may treat young people for gender identity issues – including with hormones – if a parent, guardian, or foster care agency agrees.”
  - (2) Feminizing/masculinizing hormone therapy may lead to irreversible physical changes. Providers should document in the medical record that comprehensive information has been provided and understood about all relevant aspects of hormone therapy, including both possible benefits and risks and the impact on reproductive capacity. (WPATH, 7<sup>th</sup> version)
- ix) Surgeries
- (1) Individuals with gender dysphoria may need sex reassignment services in order to alleviate their distress and find comfort with their identity and role (Bockting, 2009).
  - (2) Gender affirmation treatment (GAT) are medical affirmation treatments that align physical sex with the transgender individuals’ identity and can take the form of surgical interventions and/or hormonal regimens (Colton, Fitzgerald, Pardo & Babcock, 2011).
- x) “Adolescents who have a persistent experience of incongruity between mind and body find puberty painful and unbearable. They are often at high risk of suicide attempts. A staged approach to management has been devised and this provides a containing framework for these unbearable states of mind. The approach involves four stages:
- (1) Stage 1: therapeutic exploration

- (2) Stage 2: For adolescents whose GID persists and becomes more distressing during adolescent development, stage two may be considered following careful assessment. This involves the use of hypothalamic blockers which suppresses the production of estrogen or testosterone and produces a state of biological neutrality. This intervention is reversible. A controversy exists about the timing of this intervention during pubertal development.
  - (3) Stage 3: includes partially reversible interventions such as hormonal treatment which masculinizes or feminizes the body. Current guidelines allow this intervention after the age of 16
  - (4) Stage 4: after the age of 18, stage four includes irreversible interventions, such as surgical procedures” (Ceglie, 2008).
- 6) Closing (5 - 10 minutes)
- a) Need statement: Transgender individuals’ needs include: basic acceptance of having a self-determined gender identity, finding a voice, gaining access to medical care, establishing fundamental civil protections, and maintaining and building families.
  - b) What you can do today to affirm gender variant youth in your practice (HRSA Care, 2011)  
[http://hab.hrsa.gov/newspublications/careactionnewsletter/hab\\_transgender\\_dec\\_careaction\\_pdf.pdf](http://hab.hrsa.gov/newspublications/careactionnewsletter/hab_transgender_dec_careaction_pdf.pdf)
- i) Steps like posting trans-friendly materials in provider waiting rooms and having single-occupancy bathrooms go a long way in making transpeople feel welcomed and comfortable in your clinic space.
  - ii) Electronic medical records (EMRs) sometimes do not have transgender-specific options. Some EMR systems may permit a change but retain a record of the change that can be seen without the need for the physician or patient to provide permission. Such systems leave transpatients vulnerable to exposure and discrimination.

- iii) A best practice would be to include preferred name in a chart alongside legal name, which is a trigger to other providers so they know what name to call the patient and helps avoid creating billing issues.
- iv) To demonstrate that a clinic is transgender friendly, it is important to have materials in the waiting room that are specific to this population.
- v) Have visual cues – such as posters
  - (1) [http://www.safeschoolscoalition.org/SafeZone\\_SafeSchoolsCoalition.pdf](http://www.safeschoolscoalition.org/SafeZone_SafeSchoolsCoalition.pdf)
- vi) Clinics should also post antidiscrimination policies and provide written hiring policies indicating the organization’s desire to employ qualified, diverse candidates.
- vii) Do research and find out which insurance codes your clinic can bill services through
- viii) Confidentiality concerns
  - (1) Mitigate patient worries around the confidentiality of client-level data and assure patients that any patient-specific information disclosed among medical staff is restricted to appropriately addressing their health needs.
  - (2) Providers should also create a nonjudgmental environment where patients feel comfortable discussing any risk-taking behaviors.
- ix) Using the correct pronoun
  - (1) Clinics should respect what gender a client says he or she is. If providers are in doubt, they should ask the patient politely and discreetly what his or her preference is. Use of gender-neutral language ensures inclusion of all transpersons and avoids inadvertently “outing” someone in public.
  - (2) Patients may wish to be labeled male or female according to their gender identity and expression, their legal status, or according to the way they are registered with their insurance carrier.

(3) Patients may wish to be referred to as female in one situation (e.g., in their record with the physician's office and in personal interactions with the physician and staff), but male in other situations (e.g., on forms related to their insurance coverage, lab work, etc.).

(4) This application of terminology could change at any time as individuals come to understand or evaluate their gender.

c) Resources

- i) AMA Policy
- ii) WPATH Standards of Care
- iii) WPATH Clarification on Medical Necessity
- iv) Injustice at Every Turn Executive Summary
- v) Sample doctor's letters
- vi) Cis-gender privilege checklist
- vii) LGBTQ Worksheet
- viii) Safe Zone poster
- ix) Book reference list for adults
- x) Book reference list for children
- xi) List of LGBTQ youth organizations, conferences, support groups
- xii) List of gender therapists in Washington state
- xiii) Gender Alliance of the South Sound Resource Guide
- xiv) Provider tool kit for adolescents

7) Survey Tool (5 - 10 minutes)

(1) Subscribe to the Gender Odyssey mailing list to learn about training events, such as professional Day: <https://app.e2ma.net/app2/audience/signup/28753/17074/?v=a>

(2) Register for more in-depth training at Gender Odyssey's annual Professional Day: <http://www.genderdiversity.org/event-registration/?ee=2>

### **Challenges That May Arise**

Training participants may not have confronted biases they may have regarding gender nonconformity.

Training participants may want to case manage during the training around billing codes or specific treatments plans, and will need to be guided to scheduling an individual appointment to discuss.

There is a lot of content to cover and the trainer may need to speed through some sections that may require more in-depth discussion and reflection.

This training may need to be expanded to a longer training period in order to better engage with training participants.

## **Mental Health Provider Module**

**Learning Objectives:** Mental health providers will gain an understanding of gender identity and expression, better understand barriers gender-variant youth face when accessing mental health services, be better prepared to support gender-variant youth; and recommend other affirmative therapies and gatekeeping practices which positively advocates for potential medical interventions.

### **Materials needed:**

- Web-based registration form
- Webinar technology
- Post-training survey tool

### **Outline**

- 1) Introductions and Check-ins (5 minutes)
  - a) Log-on of training participants
  - b) Check-in question: What do you hope to learn and/or gain from this workshop?
  - c) Participants type in what part of the state they work in and what age youth they typically work with
- 2) Overview of Training (5 minutes)
  - a) Participants will have pre-registered for workshop
  - b) Explain goals of training module
    - i) Gain an understanding of gender identity and expression
      - (1) “Rather than a binary concept, gender identity includes gradations of masculinity to femininity and maleness to femaleness, as well as identification as neither essentially male nor female” (Haas, Eliason, Mays, Mathy, Cochran, D’Augelli, Silverman & Clayton, 2011).
    - ii) Better understand barriers gender-variant youth face when accessing mental health services
    - iii) Be better prepared to support gender-variant youth; and

- iv) Recommend other affirmative therapies and gatekeeping practices which positively advocates for potential medical interventions.
- 3) Develop Group Norms (5 minutes)
- a) Create expectations for how participants and facilitators may communicate with one another and what is necessary to create a safe and welcoming learning environment.
- 4) Details of Training (25 – 30 minutes)
- a) Definition of terms and introduction of social norms and values
    - i) Transgender patients may present with gender dysphoria. For transgender care, humaneness and technical competence are particularly important. Transgender patients are among the most socially stigmatized of sexual minorities, facing discrimination in health care coverage and insensitivity from ill-informed health providers. (Bockting, Robinson, Benner & Scheltema, 2004).
    - ii) (<http://community.pflag.org/page.aspx?pid=702>) As counselors/therapists: Be open to learning the truth about transgender—that it is not a psychiatric disorder, but a physical issue that has not been understood until research, reported in recent years, identified the site of sex identity—which is the brain. This means that you will need to unlearn your own personal and professional socialization, which told you that the genitals define sex identity. They do not.
    - iii) Become aware of your own comfort levels. Some helpers just are not appropriate to work with the transgender community, just as some cannot work with excessively dependent people or with spousal abusers.
    - iv) Become aware of the WPATH Standards of Care established by the Harry Benjamin International Gender Dysphoria Association, Inc.
    - v) Become aware of the transgender community and of the resources available in that community.

- vi) Be prepared to provide supportive counseling to transgender persons, both individually and in transgender groups. You may also need to be ready to do family work, to be an advocate (job, school, community), and be able to work with medical persons and others.
- b) “It is absolutely critical that we address this social problem (of discrimination) as a systems issue. We must engage providers in health care, education, criminal justice, and so on and so forth to understand the barriers we face on a daily basis” – interview participant
- c) Statistics: Gender non-conformity is attributed to decreased coping and resilience and social rejection, which places youth at a higher risk for suicidal symptoms. While adolescents in general are a high-risk group for suicidal ideation and self-harm, with suicide being the third cause of death for young adults ages 15-24, there is increasing evidence that transgender youth are at increased risk for low self-esteem, depression, suicide, substance abuse, school problems, family rejection and discord running away, homelessness, and prostitution.
- a) Risks and protective factors:
  - i) Gender-nonconforming youth are at elevated risk levels for experiencing victimization and negative psychosocial adjustment. The shame felt by gender-nonconforming adolescents may be compounded by the reactions from their peers and family. Peer reactions to gender nonconforming behavior are often negative, ranging from verbal questioning of another’s biological sex to physical abuse. Additional risk factors are attributed to lack of training among service providers.
  - ii) Emotional distress, isolation, internalized homophobia/transphobia, depression, substance abuse, suicide, violence/victimization, family conflict, school performance, sexually transmitted diseases and/or pregnancy or other health risk behaviors (Elze, 2007; Kitts, 2010).
  - iii) “Teenagers who believe they alone are responsible for family conflicts may feel overwhelmed by the constant stress and may perceive suicide as the best solution for everyone” (Kanel, 2012, p. 85)

- iv) There is an increased risk of suicidal thinking and attempts during the coming-out process (Kanel, 2012).
  - v) Protective factors include unconditional support of a child's identity, access to safe health care, ensuring that the child's school is safe and welcoming, ensuring service providers are well trained and sensitive to transgender issues, and that service agencies implement explicit policies that prohibit all forms of discrimination; and supporting a child's transition at a younger age at home and at school.
  - vi) "There is no compelling reason to withhold treatment as the youth and their families are very troubled, and the prognosis of any treatment is extremely guarded after puberty. So, for those interested in converting the gender-variant child back to a traditionally gendered child, the current wisdom states that the earlier the diagnosis, the better the prognosis" (Hill, Rozanski, Carfagnini & Willoughby, 2006).
  - vii) Resilience, positive and supportive family relationships, stable intellectual functioning, self-confidence, high self-esteem, a socially appealing disposition/personality and social competence, a supportive and validating faith, special talent (e.g., athletic or musical skills) and/or educational achievement, sustainable hope, and supportive school and other peer relationships.
  - viii) Family support is associated with greater self-acceptance, which contributes to fewer mental health problems (Elze, 2007).
  - ix) Youth Empowerment programs and events - provide a sense of community to fight against isolation
  - x) It is important to identify and use these protective factors as client strengths in social work practice with transgender youth (Zubernis, Snyder & McCoy, 2011).
- b) Relevant developmental stages

- i) The two age groups that are associated with the most self-harm, distress and suicidality are five to seven year-olds who are being forced to fit into social gender roles that aren't true to who they are, and self-harm and suicidality for kids entering puberty, whose bodies are betraying them.
- ii) The internalization of homophobic and heterosexist messages begins very early—often before transgender youth fully realize their gender identity.
- iii) Transgender youth who disclose their gender identity to their parents are at risk for parental rejection, withdrawal of financial support, authoritative restrictions of their social lives, forced counseling, and even violence and removal from the home.
- iv) One of the challenges for clinicians in working with gender-variant youth is that parents want to know whether the child will persist or desist, so they can prepare themselves and it is difficult to predict. However, if GID is present in adolescence, it is likely to continue into adulthood (Herbert, 2011).
- v) Some youth may withdraw from their families as a way of coping (Green, 1994), whereas others may cope with the stress of keeping their secret by indulging in self-destructive behaviors, such as substance abuse, risky sexual behaviors, running away, self-harm such as cutting, or attempting suicide (Gonsiorek, 1988; Proctor & Groze, 1994; Savin-Williams, 1994). It is important for the clinician to understand how the adolescent is adapting and what support systems they have in place (Herbert, 2011).
- vi) How a child is supported at home and at school may impact how successful they are in meeting this developmental milestone.
- vii) Children diagnosed with GID may have a developmental delay in establishing gender constancy. Researchers speculate that this delay may occur because of a parent who does not help the child label gender correctly or correct “inappropriate” behaviors. Or, these children may have achieved an understanding of gender as flexible. Much of the attention to GID

children comes from parents intolerant of gender variance, not from the children themselves, as is the case with most childhood psychological problems. It has been noted repeatedly in the literature that almost all referrals of GID youth to gender treatment centers come from parents and other adults, such as teachers, who are not comfortable with their gender expressive behaviors.

viii) “The distress is not in the individual, but primarily a result of a conflict between the individual’s gender identity or expression and society’s normative gender expectations” (Bockting, 2009).

d) Interventions

i) WPATH Standards of Care

- (1) The World Professional Association for Transgender Health (WPATH) is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health.
- (2) The vision of WPATH is to bring together diverse professionals dedicated to developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transsexual, transgender, and gender nonconforming people in all cultural settings.
- (3) One of the main functions of WPATH is to promote the highest standards of health care for individuals through the articulation of *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People*.
- (4) The overall goal of the *SOC* is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This

assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments.

- (5) The *SOC* are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria – broadly defined as discomfort or distress that is caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth.
- ii) DSM – Sexual and Identity Disorder (APA, 2000)
    - (1) “The DSM does not account for the difference between distress or impairment that is inherent to the psychology of an individual and that which is a result of oppressive sociocultural structures. A GID diagnosis relies on stereotypes about men and masculinity and women and femininity” (Sennott, 2011).
    - (2) There are two components of Gender Identity Disorder (GID) which both must be present to make a diagnosis.
      - (a) There must be evidence of a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the other sex.
      - (b) This cross-gender identification must not merely be a desire for any perceived cultural advantages of being the other sex. There must also be evidence of persistent discomfort about one’s assigned sex or a sense of inappropriateness in the gender role of that sex.
      - (c) The diagnosis is not made if the individual has a concurrent physical intersex condition.

- (d) To make the diagnosis, there must be evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- (3) Distress in individuals with GID is manifested differently across the life cycle.
  - (a) In young children, distress is manifested by the stated unhappiness about their assigned sex. Preoccupation with cross-gender wishes often interferes with ordinary activities.
    - (i) Children with GID may manifest coexisting Separation Anxiety Disorder, Generalized Anxiety Disorder, and symptoms of depression.
    - (ii) For clinically referred children, onset of cross-gender interests and activities is usually between ages 2 and 4 years. Typically children are referred around the time of school entry because of parental concern that what they regarded as a phase does not appear to be passing.
  - (b) In older children, failure to develop age-appropriate same-sex peer relationships and skills often leads to isolation and distress, and some children may refuse to attend school because of teasing or pressure to dress in attire stereotypical of their assigned sex.
  - (c) In adolescents and adults, preoccupation with cross-gender wishes often interferes with ordinary activities. Relationship difficulties are common, and functioning at school or at work may be impaired.
    - (i) Adolescents are particularly at risk for depression and suicidal ideation and suicide attempts.
- (4) Diagnostic criteria code is based on age
  - (a) 302.6 Gender Identity Disorder in Children
  - (b) 302.85 Gender Identity Disorder in Adolescents or Adults
- (5) 302.6 Gender Identity Disorder Not Otherwise Specified

(a) Example: persistent preoccupation with castration or penectomy without a desire to acquire the sex characteristics of the other sex

(6) Criteria

(a) Regarding the criteria for GID for adolescents and adults, the current criteria do not capture the whole spectrum of gender variant phenomena (Narrow & Cohen-Kettenis, 2010).

iii) Dutch Protocol

(1) Since the mid-1990s, one model of therapeutic care, developed by Dutch clinicians and researchers, has been to initiate the biomedical aspects of sex reassignment in early – to mid-adolescence, rather than wait for the legal age of adulthood. After careful psychological evaluation, adolescents deemed appropriate for such treatment are prescribed hormonal medication to delay or suppress somatic puberty. If the gender dysphoria persists, then cross-sex hormonal therapy is offered at the age of 16, and if the adolescent desires, surgical sex change procedures are then offered (Zucker, Bradley, Owen-Anderson, Singh, Blanchard & Bain, 2011).

(2) The rationale for this treatment protocol includes the following:

(a) There is the assumption that for some adolescents with GID there is little systematic empirical evidence that psychological interventions can resolve the gender dysphoria

(b) The use of hormonal blockers can be helpful to the adolescent because it reduces the incongruence between the development of natal sex secondary physical characteristics (male: facial hair growth, hair growth on other parts of body, deepening of voice; female: breast development, menstruation) and the felt psychological gender, thereby reducing stress.

- (c) Reduction of incongruence makes it easier for adolescents to present socially in the cross-gender identity/role, which is also helpful in reducing stress during the gender transition process
- (3) “A study in the Netherlands at a gender clinic found adolescents to be faring better than adults in measures of psychological health, largely attributed to the youth receiving gender role assistance by way of puberty suspension or hormone therapy, and implications the adolescents felt more supported and experienced less harm through stigmatization than adults” (Herbert, 2011).
- (4) Clinical competence (Mallon, 2009)
  - (a) Clinicians who diagnose and treat transgender and gender variant adolescents should have training in adolescent psychiatry and/or clinical psychology and/or clinical social work and experience in diagnosing and treating typical issues related to adolescents, as well as specific expertise relating to transgender and gender variant identity development and gender identity concerns
  - (b) Therapists working with transgender adolescents must be accustomed to working with adolescents and be able to practice in a trans-affirming manner that includes the ability to discuss sensitive topics, including sexuality
  - (c) Regardless of the presenting issues, the clinician should be able to evaluate the impact of trans-specific issues on the adolescent’s overall health and well-being, and incorporate this into the overall care plan
  - (d) Clinicians should be aware of the gender diversity among the local transgender/gender variant adolescent population as part of the general sensitivity and awareness needed for any work with the transgender communities
- (5) Risk of misdiagnosis

- (a) On quantitative gender assessment scales, children with GID are at risk for misdiagnosis.
- (b) Professional services for GID children are provided primarily by pediatric endocrinologists and urologists, and very few centers have staff experienced with treating gender identity variants in children (Meyer-Bahlburg, 2009).
- (c) Inexperienced clinicians may mistake indications of gender dysphoria for delusions. The vast majority of children and adolescents with gender dysphoria are not suffering from underlying severe psychiatric illness such as psychotic disorders (WPATH, 7<sup>th</sup> version)
- (d) It is more common for adolescents with gender dysphoria to have co-existing internalizing disorders such as anxiety and depression, and/or externalizing disorders such as oppositional defiant disorder (WPATH, 7<sup>th</sup> version)
- (e) There seems to be a higher prevalence of autistic spectrum disorders in clinically referred, gender dysphoric adolescents than in the general adolescent population (WPATH, 7<sup>th</sup> version).
- (f) Regarding children and adolescents who are gender variant, there is a greater risk for misdiagnosis of Oppositional Defiant Disorder, Attention Deficit Disorder, and Asperger's, as reported anecdotally by families attending support groups.
- (g) Youth may be exhibiting symptoms that are similar to these disorders as a result of high anxiety levels and fixation of interests or hobbies as a way to cope (Bradley & Zucker, 1997).
- (h) Adolescents referred for gender identity concerns also displayed significant behavioral difficulties such as anger, aggression, isolation, and depression, as reported by their mothers (Bradley & Zucker, 1997).

- (i) In one parent support group, a parent shared recent research about complex brain trauma. She explained that on-going stress and anxiety from living in the wrong gender can lead to complex brain trauma.
- (j) Once gender issues are addressed, many parents shared that other symptoms go away.
- (k) Some parents hypothesized that when the cortisol goes away, it gives the brain an opportunity to heal itself and other symptoms then retreat as well.
- (l) These parents' insights are consistent with research published by Child Welfare Information Gateway (2009), which states that if a child lives in a threatening, chaotic world, the child's brain may be hyperalert for danger because their survival may depend on it.
- (m) When children are exposed to chronic, traumatic stress, their brains sensitize the pathways for the fear response, resulting in a number of biological reactions, including a persistent state of fear.
- (n) Gender-variant children and adolescents receive perpetual messages in society that there is something wrong with them, and they live with a constant fear of people finding out their secret.
- (o) For adolescents with symptoms of chronic stress, which may include changes in attention, impulse control, sleep, and fine motor control, it is understandable how they may be misdiagnosed as ODD or ADD.
- (p) The research further explains that chronic activation of certain parts of the brain involved in the fear response can "wear out" other parts of the brain such as the hippocampus, which is involved in cognition and memory. This may cause excess production of cortisol—a hormone that may damage or destroy neurons in critical brain areas.

- (6) Psychosocial interventions (Mallon, 2009)
  - (a) Psychosocial assessment should include evaluation of the transgender adolescent's home life, education/employment, eating, activities, drugs, sexuality, suicide/depression, and safety.
  - (b) When discussing sexuality, clinicians should engage in frank and explicit discussion about the actual practices an adolescent is engaged in, rather than making assumptions about the gender of partner(s) or sexual activities. The transgender adolescent should be asked about preferred terms for genitals to ensure that sexual health discussion is respectful of self-defined gender identity.
  - (c) For adolescents with intense frustration or distress about body image, in addition to a general screening tool for eating disorders, it may be appropriate to inquire about excessively tight breast binding, wrapping of the penis/testicles, and compulsive or excessive exercise. Intervention may explore transgender identity, transgender community involvement, and peer support.
  - (d) For adolescents undergoing gender transition, psychosocial issues that tend to be impacted over the course of gender transition or to change as part of general adolescent development (such as relationships, sexuality, infertility, disclosure of transgender identity and body image) need to be revisited periodically.
  - (e) Sexual health education should be offered as part of treatment.
  - (f) Family therapists or family counselors should try to help parents determine realistic demands and to work on the development of healthy boundaries and limits. In some cases, it may be appropriate to involve a second clinician in work with parents to avoid compromising the therapeutic alliance with the adolescent.
- (7) The GID diagnosis is, to date, required for insurance coverage of hormonal therapy and sex reassignment procedures for transitioning individuals. Those who seek treatment

often view it as a trade-off between stigma and insurance reimbursement. Because most insurance companies require DSM diagnoses for treatment coverage in general, the diagnoses of GID facilitates payment and thus access to basic care for gender-variant individuals. While many view GID diagnoses as a societal prejudice rather than a mental disorder, there has been concern that without a specific disorder label to categorize behaviors, treatment-seeking individuals would be turned away. (Kamens, 2011).

(8) Utilization of health care services is reduced in this population, with received barriers, including cost, fear of services in general, and fear of mental health stigma (Colton, Fitzgerald, Pardo & Babcock, 2011).

(9) Puberty blockers are both medically necessary and expensive.

(a) Peggy Cohen-Kettenis of the *Free University of Amsterdam Medical Center* said:

"People are always afraid that it will be harmful for the children. But what they never take into account is that it is also harmful to *not* give them this treatment."

iv) "Adolescents who have a persistent experience of incongruity between mind and body find puberty painful and unbearable. They are often at high risk of suicide attempts. A staged approach to management has been devised and this provides a containing framework for these unbearable states of mind. The approach involves four stages:

(1) Stage 1: therapeutic exploration

(2) Stage 2: For adolescents whose GID persists and becomes more distressing during adolescent development, stage two may be considered following careful assessment. This involves the use of hypothalamic blockers which suppresses the production of estrogen or testosterone and produces a state of biological neutrality. This intervention is reversible. A controversy exists about the timing of this intervention during pubertal development.

- (3) Stage 3: includes partially reversible interventions such as hormonal treatment which masculinizes or feminizes the body. Current guidelines allow this intervention after the age of 16
- (4) Stage 4: after the age of 18, stage four includes irreversible interventions, such as surgical procedures” (Ceglie, 2008).
- e) What you can do today to affirm gender variant youth in your practice (HRSA Care, 2011)  
[http://hab.hrsa.gov/newspublications/careactionnewsletter/hab\\_transgender\\_dec\\_careaction\\_pdf.pdf](http://hab.hrsa.gov/newspublications/careactionnewsletter/hab_transgender_dec_careaction_pdf.pdf)
- i) Post trans-friendly materials in waiting rooms
- ii) Offer single-occupancy or gender-neutral bathrooms
- iii) A best practice would be to include preferred name in a medical chart alongside legal name, which is a trigger to other staff in your clinic so they know what name to call the patient and helps avoid creating billing issues.
- iv) To demonstrate that a clinic is transgender friendly, it is important to have materials in the waiting room that are specific to this population.
- v) Have visual cues – such as posters
  - (1) [http://www.safeschoolscoalition.org/SafeZone\\_SafeSchoolsCoalition.pdf](http://www.safeschoolscoalition.org/SafeZone_SafeSchoolsCoalition.pdf)
- vi) Clinics should also post antidiscrimination policies and provide written hiring policies indicating the organization’s desire to employ qualified, diverse candidates.
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  - (4) This application of terminology could change at any time as individuals come to understand or evaluate their gender.
- f) Resources
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  - xii) List of gender therapists in Washington state
  - xiii) Gender Alliance of the South Sound Resource Guide
  - xiv) Provider tool kit for adolescents
- 5) Closing (5 – 10 minutes)
- a) Need statement: Transgender individuals’ needs include: basic acceptance of having a self-determined gender identity, finding a voice, gaining access to medical care, establishing fundamental civil protections, and maintaining and building families.
- 8) Survey Tool (5 - 10 minutes)
- (3) Subscribe to the Gender Odyssey mailing list to learn about training events, such as professional Day: <https://app.e2ma.net/app2/audience/signup/28753/17074/?v=a>
  - (4) Register for more in-depth training at Gender Odyssey’s annual Professional Day: <http://www.genderdiversity.org/event-registration/?ee=2>

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