University of Denver
Digital Commons @ DU

Graduate School of Professional Psychology: Doctoral Papers and Masters Projects
Graduate School of Professional Psychology

5-30-2016

Transgender Awareness Within State Hospitals: Addressing Gaps in Training

Rose Ruoxi Yang

Follow this and additional works at: https://digitalcommons.du.edu/capstone_masters

Part of the Health Psychology Commons

Recommended Citation

Yang, Rose Ruoxi, "Transgender Awareness Within State Hospitals: Addressing Gaps in Training" (2016). *Graduate School of Professional Psychology: Doctoral Papers and Masters Projects*. 204.
https://digitalcommons.du.edu/capstone_masters/204

This Capstone is brought to you for free and open access by the Graduate School of Professional Psychology at Digital Commons @ DU. It has been accepted for inclusion in Graduate School of Professional Psychology: Doctoral Papers and Masters Projects by an authorized administrator of Digital Commons @ DU. For more information, please contact jennifer.cox@du.edu,dig-commons@du.edu.

TRANSGENDER AWARENESS WITHIN STATE HOSPITALS: ADDRESSING GAPS IN TRAINING

A DOCTORAL PAPER PRESENTED TO
THE GRADUATE SCHOOL OF PROFESSIONAL PSYCHOLOGY
UNIVERSITY OF DENVER

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE
DOCTOR OF PSYCHOLOGY

BY: ROSE RUOXI YANG, M.A.
MAY 30, 2016

Table of Contents

Title Page……………………………………………………………………………1

Table of Contents………………………………………………………………………2

Abstract…………………………………………………………………………………4

Introduction……………………………………………………………………………5

Terminology……………………………………………………………………………6

Literature Review (Part I)

Discrimination & Stigma……………………………………………………………8

Microaggressions……………………………………………………………………9

Hate Crimes…………………………………………………………………………11

The Double Minority Status………………………………………………………12

Healthcare……………………………………………………………………………13

Transgender & the Workplace……………………………………………………14

Civil Legislation……………………………………………………………………15

The Need for Transgender Awareness Training (Part II)

Current Training for Professional: Limitations and Challenges………………16

The State of State Hospitals………………………………………………………19

Outcomes of Diversity Training…………………………………………………21

Present Paper…………………………………………………………………………22

Limitations……………………………………………………………………………23

Future Directions……………………………………………………………………24

Conclusion……………………………………………………………………………24

Index…………………………………………………………………………………26

References 30

Appendix 41

Abstract

Individuals in the transgender ("trans") community continue to face stigmatization, discrimination, and violence in the United States (Benson, 2013; Bradford, Reisner, Honnold, & Xavier, 2013; Lombardi, Wilchins, Priesing, & Malouf, 2001; Shipherd, Green, & Abramovitz, 2010;). They remain underserved in many domains, including housing, healthcare, and employment (Bradford et al., 2013). This paper focuses on the need for trans-specific training within the U.S. state hospital system. Although many institutions, including state hospitals, are implementing diversity initiatives to increase the sensitivity of their employees to a broad range of identity statuses, transgender-affirmative trainings are often nonexistent or inadequate; trans-specific issues may fall under the broad umbrella of LGBT (lesbian, gay, bisexual, and transgender) awareness, and conflation of sexual identity and gender identity is prominent (Corliss, Shankle, & Moyer, 2007). This paper supports the development and implementation of transgender-specific training to foster discussion, create more supportive environments, and lay the foundation for a culture of inclusion within U.S. state hospitals. Part I examines the unique needs of and challenges facing members of the transgender community. Part II addresses specific needs and gaps in current state hospital training. An Index outlining common terminology follows this manuscript. Finally, the accompanying Appendix includes a proposed training manual that could be adapted by state hospitals as a supplement to current training protocols. It is intended for general use within the hospital, and would be appropriate for staff from all specialties. The manual provides basic information related to serving members of the trans community, and is intended as an introductory guide or refresher for mental health practitioners across a wide variety of domains.

Introduction

There is an estimated 0.00017% to 1.333% individuals per 100,000 people worldwide who identify as transgender or gender non-conforming (Meier & Labuski, 2013). Due to the difficulty in collecting demographic information of this population, the estimate varies widely across studies and countries. Individuals in this transgender ("trans") community are uniquely targeted and face stigmatization, discrimination, and violence (Benson, 2013; Bradford et al., 2013; Lombardi et al., 2001; Shipherd et al., 2010;). Although transgender-awareness and sensitivity trainings may be important for understanding these dynamics and promoting inclusion in state hospitals and other settings, organizations differ greatly in the degree to which (if at all) they prioritize such trainings. In addition, there is a paucity of research focusing specifically on transgender-specific trainings and their efficacy. Much of the literature focuses broadly on training related to LGB awareness and what may be extrapolated to address the needs of transgender individuals. Although manuals and training guidelines focused on transgender issues exist, hospitals may not seek out these guidelines and incorporate them into existing training models, meaning that issues related to gender identity and expression (as distinct from sexual orientation) may be overlooked. This paper details the rationale for a proposed transgender-specific training designed to decrease confusion, increase understanding, and promote a safer and more inclusive state hospital environment. A brief overview of terminology is included below, followed by a summary of the literature related to the ongoing discrimination and challenges faced by members of the transgender community; the needs for trans-affirmative training in state hospital settings is then examined, and a proposed trans-specific training model is included in the Appendix.

Terminology

Language can be of paramount importance in addressing trans-specific diversity training. Improper usage of terms can result in confusion and frustration, alienating the transgender community. A brief overview of terminology is provided. Please refer to the Index for a more comprehensive list of terms.

Gender is the social and cultural construct of being male or female ("Definition of Terms," n.d.). It includes the attitudes, feelings, and behaviors a given culture associates with biological sex ("Definition of Terms," n.d.). However, it is not the same as biological sex, since gender is a socially constructed entity that varies from culture to culture. An individual whose self-identity conforms with the gender that corresponds to their biological sex is *cisgender* ("Definition of Terms," n.d.). When one's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex, this is considered *gender non-conformity* (Coleman et al., 2011). *Transgender* is the term used to describe individuals whose biological sex does not match their gender identity ("Glossary of Terms," n.d.). These individuals may experience *gender dysphoria*, discomfort or distress that is caused by a discrepancy between a person's gender identity and that individual's sex assigned at birth (Coleman et al., 2011). Even though a transgender person may identify as other than heterosexual, the term does not connote sexual preference. Although the term, "transgendered" is used in the literature, it is viewed by some as inaccurate, misleading, or offensive (Gay & Lesbian Alliance Against Defamation).

Transmen and *transwomen* are included under the term, "transgender." Although this terminology does not necessarily do an injustice to transwomen and transmen, it does suggest the experiences of both are similar. However, this is not the case. Currently, there are more documented males who experience gender incongruence than females (DeCuypere et al., 2007).

Reasons for this are only speculative. In a study conducted by Mandal and Jakubowski, transwomen were found to be more stereotypically feminine than their cisgender counterparts (Mandal & Jakubowski, 2015). Additionally, when compared with cisgender women, transwomen rated themselves as lower in attractiveness compared to their romantic partners (Mandal & Jakubowski, 2015). Post-operative Male to Female (MTF) individuals reported higher levels of perfectionism, which is notable given the lower incidence of anorexia and bulimia than among their cisgender counterparts (Khoosal, Langham, Palmer, Terry, & Minajagi, 2009). Transwomen's post-transition exposes them to cultural beliefs regarding bodily weakness, constraint, and submission verses beliefs they may have held most of their lives regarding male strength, entitlement, and power (Yavorsky & Sayer, 2013). Transwomen reported being more fearful of victimization in public spaces after transitioning, especially with the possibility of rape (Yavrosky & Sayer, 2013).

Transmen often follow a different trajectory. Transmen were found to experience more verbal harassment from kindergarten to twelfth grade, whereas transwomen experienced more instances of physical assault (Grant et al., 2011). Transmen indicated that, as they transitioned, they no longer felt the same fears, such as feeling afraid of walking alone at night (Abelson, 2014). Whereas transmen were previously characterized as "masculine" lesbians prior to transition, their expression of masculinity post-transition disclaimed the negative aspects of traditional masculinity (Rubin, 2003). Henry Rubin hypothesized the stereotypical manifestations of traditional masculinity exhibited by lesbians prior to transition stemmed from individuals attempting to overcompensate for their female identities. Yet, in recent years, the transition of FTM has been found to be a more fluid and individualized process, with some

individuals embracing traditionally masculine gender norms and others transcending binary categories and instead identifying with a third category (Rubin, 2003).

Literature Review

Discrimination and Stigma

Transgender individuals experience discrimination in health care, employment, and housing (Clements-Nolle et al., 2006; Kenagy, 2005; Lombardi et al., 2001). Individuals who become aware of their transgender identity at a younger age tend to experience more discrimination than those who develop the awareness later in life. (Bradford et al., 2013; Lombardi et al., 2001). Lombardi et al. (2001) found that over half of respondents reported having experienced some sort of harassment or violence related to their transgender identity. Economic discrimination was the strongest predictor of victimization; the authors noted that individuals rendered homeless due to their transgender identity may turn to illegal activities as a way of survival, thus increasing the likelihood of encountering violence. In addition, those who have experienced violence as a result of their gender identity may experience a second wave of "legal" victimization by others, including statements of blame placed on the victim (Lombardi et al., 2001).

Clements-Nolle, Marx, & Katz (2006) hypothesized that the discrimination encountered by transgender individuals may be stronger and more intense than that based on sexual orientation, possibly because transitioning may be phenotypically more obvious and less accepted in society than sexual preference (Clements-Nolle et al., 2006). The ability of the individual to "pass" as male or female in society depends in part on biological phenotypic characteristics before transition and how "feminine" or "masculine" the individual presents after transition (Clements-Nolle et al., 2006). In terms of mental health services, trans people may

seek services for a variety of reasons, some related to transition and some not. However, many trans individuals report feeling misunderstood or not heard by their clinicians, and may disengage from or leave therapy as a result (Benson, 2013).

Gender Identity Disorder (GID) was listed as a mental health disorder in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994), but was removed from the fifth edition (American Psychiatric Association, 2013), which now includes a listing for Gender Dysphoria. Although a diagnosis of GID may have helped professionals understand the emotional, mental, and physical implications of an individual's gender identity not aligning with biological sex at birth, the diagnosis may have also served to stigmatize and alienate transgender or gender variant patients. Furthermore, the diagnosis confused gender dysphoria with gender nonconformity, as the criteria for GID did not clearly differentiate between the two (Benson, 2013). The criteria were also narrow and did not fully encompass the entire spectrum of transgender and gender nonconforming identities (Hanssmann, Morrison, & Russian, 2008). Gender Dysphoria, in contrast, focuses on the incongruence between biological sex and secondary sex characteristics, therefore making it clearer and easier to make a diagnosis. The wording of Gender Dysphoria removes some of the stigma associated with "disorder," making it a more acceptable diagnosis for individuals whose assigned gender is incongruent with their experienced gender.

Microaggressions

Transgender individuals are more likely than their cisgender counterparts to encounter physical threats or harassment, undergo denial of body privacy, experience familial microaggressions, and endure systemic and environmental microaggressions (Nadal, Skolnik, &

Wong, 2012). Nadal, Skolnik, and Wong separated microaggressions against LGBT people into the following nine themes:

	Theme	Example
1.	Transphobic or incorrectly gendered terminology	Usage of words such as shemale, heshe, faggot, dyke
2.	Assumption of the universality of experience	Assuming all transgender individuals identify as gay
3.	Endorsement of heteronormative or gender conforming culture/behavior	A teacher or parent forcing a child to dress in accordance to her birth sex
4.	Exoticization microaggressions when LGBT individuals are dehuamanized	Someone characterizing LGBT people as being "comedic relief"
5.	Displaying contempt for LGBT individuals when LGBT people are treated with disrespect and condemnation	Heterosexual individuals leering or glaring at same sex couples or transgender individuals
6.	Denying that heterosexism and homophobia exist	A close family member accusing a LGBT person of being overly sensitive or paranoid
7.	Heterosexual individuals oversexualize or characterize LGBT individuals as sexually deviant	Making the assumption that all transgender women are sex workers
8.	Heterosexual individuals deny their own heterosexist and transgender biases and prejudices	Someone making a comment about being able to joke about transgender individuals because they have a transgender friend.
9.	Physical threat or harassment towards LGBT individuals	A transgender woman is verbally threatened that she will be physically hurt if she continues to dress like a woman

Nadal, Davidoff, Davis, and Wong (2014) found that trans individuals who experience microaggressions often have emotional, cognitive, and behavioral reactions. Emotional reactions can include hopelessness, distress, exhaustion, and invalidation, and individuals may choose to

react behaviorally by direct confrontation, passive coping, or indirect confrontation (Nadal, Davidoff, Davis, & Wong, 2014). Genderqueer and androgynous individuals may experience microaggressions related to the binary division of gender (Chang & Chung, 2015). Individuals transitioning may experience varied microaggressions depending on whether they are pre-operation, in-transition, or post-operation. For example, pre-operation individuals may experience more isolation and castigation from family members, whereas in-transition individuals are more likely to experience open hostility and insults from others (Chang & Chung, 2015). This may be because individuals in-transition have a higher degree of visible incongruence between biological sex and identified gender.

Hate Crimes

Trans people are at a higher risk for experiencing hate crimes. A hate crime is defined by the Federal Bureau of Investigation as a crime that is motivated by biases based on race, religion, sexual orientation, ethnicity/national origin, and disability (Federal Bureau of Investigation, n.d.). In 2009, the Matthew Shepherd and James Byrd, Jr., Hate Crimes Prevention Act was ratified. This Act provided protection for LGBT populations who have been targeted and mandated longer sentences for individuals found guilty of a hate crime against members of the LGBT community (Hein & Scharer, 2013). This was the first federal hate crimes law that provided specific protections and consequences for members of the LGBT community. State hate crime laws vary widely in terms of who is protected and what protections are available. For example, any crime may qualify as a hate crime in some states, while only crimes involving harassment and assault may qualify in other states (Jacobs & Potter, 1998). Some state statutes include sexual orientation as a protected identity status, but fewer include gender identity (Hein & Scharer, 2013). This potentially leaves transgender individuals vulnerable under the law.

Trans people who have experienced a hate crime often suffer psychological consequences such as anger, depression, stress, anxiety, and fear of harm, to name just a few (Hein & Scharer, 2013). If the hate crime involves sexual assault, the psychological consequences can be particularly devastating and lasting. Rivers, McPherson, and Hughes describe three major consequences for LGBT individuals who experience a hate crime: it eliminates the sense of invulnerability, lowers self-esteem, and destroys the idea that the world is rational and fair (Rivers, McPherson, & Hughes, 2010).

The Double Minority Status

Every individual has multiple identities, some of which may assume differing levels of importance across contexts throughout the lifespan. Erich, Tittsworth, Meier, and Lerman (2010) have noted that trans people of color report feeling discriminated against in various domains based on different and intersecting aspects of their identities. The minority stress model suggests that stress associated with stigma, prejudice, and discrimination will increase rates of psychological distress in the transgender population (Bockting et al., 2013). Transgender individuals routinely face marginalization; combined with other issues such as poverty, racism, lack of housing, violence, unstable employment, and damaging experiences with medical providers, these challenges all contribute to increased rates of stress and mental health concerns (Lurie, 2005). Enduring challenges may lead to depression and suicidality (Mayock, Bryan, Carr, & Kitching, 2009).

If two minority statuses such as transgender identity and non-White ethnicity are introduced, the resulting picture becomes more complex. Fewer studies have been conducted on transgender individuals of color, yet studies focused on LGBT populations have indicated LGBT individuals of color report experiencing more discrimination both within the LGBT community

and outside of it than their White LGBT counterparts (Erich, Tittsworth, Meir, & Lerman, 2010). A 2006 study found evidence of racial discrimination in LGBT communities, with 82% percent of Asian American LGBT respondents indicating they had experienced racism from White LGBT community members (Magpantay, 2006).

As the importance afforded to a particular aspect of identity fluctuates over time, so may feelings of discrimination based on each domain be fluid, as well. For example, in the early 20s an individual may feel more discriminated against in the employment arena based on racial identity, but feel more discriminated against in the same domain based on gender identity or sexual orientation by the early 30s. Overall, Erich et al. (2010) found that trans individuals described discrimination based on their transgender status to be more aversive than discrimination based on their racial or ethnic identity (Erich et al., 2010).

Healthcare

Patients who are beginning transition, are in the process of transitioning, or have already transitioned may require access to masculinizing and feminizing hormones (Coleman et al., 2011). With the onset of endocrine therapy, various changes in the body will follow, such as development of breasts or deepening of the voice (Coleman et al., 2011; Dahl, Feldman, Goldberg, & Jaberi, 2006). Patients may or may not request gender-affirming surgery depending on how they would like to present and the degree of transition with which they feel comfortable. If gender-affirming surgery such as vaginoplasty or phalloplasty is undertaken, the individual will need follow up care in order to reduce complications and ensure satisfactory outcomes (Bowman & Goldberg, 2006). Although staff at hospitals may not need to understand the intricacies of the surgeries themselves, they do need to have an understanding of the long-term effects of hormone therapy and surgery. For example, MTF individuals on hormones may be at

an increased risk for deep vein thrombosis (formation of a blood clot in the veins), hypertension, or Type 2 Diabetes, whereas FTM individuals on hormones may be at an increased risk for cardiovascular disease, polycythemia (a condition in which there is an increased red blood cell count in the bloodstream), and destabilization of mood disorders that include manic symptoms (Coleman et al., 2011).

In the U.S., HIV/AIDS has had a devastating impact on vulnerable and marginalized populations, and some individuals continue to lack access to affordable care, resulting in quicker decline and deterioration. In a study conducted by Clements-Nolle, Marx, Guzman, and Katz (2001), 35% of MTF individuals had positive HIV results. In the same study, 2% of FTM individuals were infected with HIV. The large difference in prevalence between MTF and FTM populations may be associated with economic disadvantage and sexual orientation identification (Clements-Nolle, Marx, Guzman, & Katz, 2001). A review of HIV prevalence in 2008 found 28% of transgender persons were infected with HIV and 21% were infected with other sexually transmitted infections (Herbst et al., 2008). Although statistics vary across studies, staff, physicians, and nurses should be aware of prevalence rates and sensitive to the complicated psychological and physical implications for trans patients coping with a diagnosis of HIV or another sexually transmitted infection.

Transgender and the Workplace

Workplace discrimination is negatively related to job satisfaction, organizational commitment, and work related self-esteem (Ragins, Signh, & Cornwell, 2007). Furthermore, it is positively correlated with higher turnover rates. Taking into account the minority stress model, workplace discrimination against trans individuals also increases health problems and the likelihood of developing anxiety, depression, distress, and suicidal behavior (Bockting et al.,

2013). However, organizations that enact formal antidiscrimination policies may be effective at reducing discrimination against members of stigmatized groups (Madera & Hebl, 2013). In effect, these organizations are announcing their commitment to diversity, and such policies can be effective at influencing negative behavior in the workplace. The 2012 Equal Employment Opportunity Commission case *Macy v. Holder* established discrimination in the workplace based on transgender identity as a form of sex discrimination and a violation of Title VII of the Civil Rights Act of 1964. Yet, discrimination is still prevalent. In 2013, the United States Senate passed the Employment Non-Discrimination Act (ENDA) to "address the history and persistent, widespread pattern of discrimination … on the bases of sexual orientation and gender identity to private sector employers and local, State, and Federal Government Employers" (113th Congress, 2013-2014). However, ENDA has not yet successfully passed in the House of Representatives, which would effectively make the legislation law.

Transgender employees have reported experiencing negativity, discrimination, bullying, and harassment from supervisors, coworkers, and business partners (Levitt & Ippolito, 2014). Even though concealment of gender identity can help minimize external threats (and even internal ones. such as feelings of shame), long-term impacts of concealment can be mentally and emotionally debilitating (Levitt & Ippolito, 2014). On the reverse side of this, transgender employees reported relief upon realizing their coworkers were supportive of their transition, finding this support to be beneficial (Ruggs et al., 2015).

Civil Legislation

Although, as discussed, federal legislation provides a measure of broad protection in the criminal arena, civil protections and policies differ widely on the state level. For example, California has laws in place that prohibit discrimination based on sexual orientation and gender

identity, whereas Wisconsin's statutory prohibition covers only sexual orientation (Gill, 2015). Various states have laws providing protection against discrimination in housing, public accommodations and facilities, educational settings, securing credit, health insurance, and Medicaid (Gill, 2015). Although some state laws are in place, federal policies may still be lacking. For example, no federal laws are in place to protect adoptive or foster families who have LGBT members. Families may be discriminated against by public child welfare agencies, thus making it difficult for them to foster or adopt a child (Gill, 2015). At the end of 2015, some states prohibited bans on insurance exclusions for transgender healthcare, including California, New York, and Oregon. Yet, Tennessee, Wyoming, and Iowa still permitted exclusions for transgender healthcare in the Medicaid system (Warbelow & Persad, 2016). The differences in policies amongst states illustrate the need for more uniform policies that afford trans individuals the same rights as their cisgender counterparts.

The Need for Transgender Awareness Training

There is a need for transgender sensitivity training in order to increase overall cultural competence, defined by Cross et al. (1989) as "a set of congruent behaviors, attitudes, and polices that come together in a system, agency, or among professionals that enable that system, agency, or those professionals to work effectively in cross-cultural situations." The goal of such training is to decrease the prevalence of microaggressions and lack of understanding of transgender dynamics while moving individuals toward the practice of inclusion.

Current Training for Professionals: Limitations and Challenges

Studies have been conducted on the needs of transgender youth (Grossman & D'Augelli, 2006; Yu, 2010), daily life experiences, geriatric populations, and prevalence of mental health issues and suicidality among transgender individuals (Leyva, Breshears, & Ringstad, 2014), as

well as what services are lacking and what providers can do to facilitate more supportive and inclusive settings (McCann & Sharek, 2015). This has not necessarily resulted in the development of more effective training models across populations and settings, however. The Standards of Care (Coleman et al., 2011) provided by the World Professional Association for Transgender Health (WPATH) and Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (APA, 2015) afford some guidance, but there is often not a direct way to measure the quality of the training received, thus making it difficult to ascertain how competent a clinician may be in a particular domain, even after exposure to training in this area. An additional complicating factor may be that clinicians rarely work alone in settings such as hospitals, making competency within treatment teams more difficult to assess and ascertain.

Clinical psychology programs may provide some training on LGBT issues (Pantalone, 2015), but the American Psychological Association (APA) Task Force on Gender Identity and Gender Variance found that less than 30% of psychologist and graduate student participants are familiar with transgender issues (APA TGFIGV, 2009). Over half of social workers indicated they received little or no training on transgender issues, although those with formal licensure and graduate training reported higher levels of knowledge and feelings of competency (Erich, Boutte-Queen, Donnelly, & Tittsworth, 2007).

Individuals such as physicians, nurses, case managers, and pharmacists often have limited knowledge regarding transgender issues and terminology, resulting in a noticeable paucity of staff who are knowledgeable, skilled, competent and comfortable with transgender clients (Carabez et al., 2015; Lurie, 2005; Nemoto, Operario, & Keatley, 2005). This may be because transgender health issues are rarely included in medical teaching, and medical professionals may

be poorly equipped to deal effectively with transgender-specific issues (Sequeira, Chakraborti, & Panunti, 2012).

In the arena of nursing, educators reported feeling ill prepared to effectively teach LGBT-based curricula to nursing staff (Sirota, 2013); although some nurses felt more competent and prepared to work with ethnically diverse patients, they reported lacking the knowledge base to work competently with LGBT populations (Carabez et al., 2015). Polly and Nicole (2011) authored guidelines for nursing staff that elucidate key issues such as terminology as well as the process and effects of transition. Similar to this, Lambda Legal, the Human Rights Campaign, and New York City Bar collaborated on a manual titled, "Creating Equal Access to Quality Health Care for Transgender Patients: Trasngender-Affirming Hospital Policies." This manual was intended to inform and educate providers within medical hospitals (Human Rights Campaign, n.d.). Although these resources are present, the frequency of utilization is unknown.

Front line staff may be hesitant to discuss certain issues related to health or lifestyle due to the fear of offending the patient (Lurie, 2005). They may refer transgender patients elsewhere with the assumption that other practitioners may be more knowledgeable and better able to treat the patient (Bauer et al., 2009). When it comes to referring a patient out, however, unique difficulties may arise. Lurie (2005) gives examples of caseworkers attempting to refer patients to residential substance abuse treatment facilities, but notes that staff at such facilities may not recognize individuals who identify as FTM or MTF and may decline to admit patients on the basis of their biological sex (Lurie, 2005).

Although there have been studies conducted on LGBT competency in counseling and clinical psychology graduate programs (Cochran & Robohm, 2015), fewer studies have been conducted on LGBT competencies in larger organizations such as state psychiatric hospitals. In

general, gender and sexuality are often confused, leading to frustration among members of the trans community and their allies (Mottet & Tanis, 2008); competencies in nursing and healthcare may be grouped under one "LGBT" umbrella, overlooking or neglecting important trans-specific issues (Keepnews, 2011). In addition, there is a dearth of literature regarding training needs and the intersection of ethnicity and transgender identity. Although studies have illustrated the complexities of transphobia, racism, privilege, and sexism (Crenshaw, 1991; Meyer, 2008), not all ethnicities are equally represented. Furthermore, no discussions in the literature address the unique issues associated with minority ethnic status and transgender identity within inpatient mental health settings.

In short, practitioners across disciplines may have little to no understanding regarding the impact of transphobia or the effect of normative gender stereotypes, nor do they necessarily understand that trans people may not always defer to the gender binary (i.e., the classification of people into only two genders; Benson, 2013). Clinicians who are unaware of or insensitive to trans issues may unintentionally turn away clients (Shipherd et al., 2010). Furthermore, a lack of skillful and appropriate responsiveness is a catalyst for misdiagnosis, lack of engagement and retention, and poor clinical outcomes (Cheung & Snowden, 1990). The current state of knowledge of clinicians and medical staff is woefully inadequate. This is concerning, given that many of these professionals work in inpatient settings such as state or private psychiatric hospitals, and suggests a need for more comprehensive training approaches.

The State of State Hospitals

Why might state hospital settings be especially vulnerable to the dangers of overlooking trans-specific awareness training? From its ignoble beginnings in "lunatics asylums" through the legal reforms of the 1960s and the deinstitutionalization movement of the 1980s, the state

hospital system has come to represent both a place for treatment and a place rife with bureaucratic tensions (Osborn, 2009). State hospitals are often under attack for failure to provide adequate services for their patients. Inadequate staffing, medication shortage, attempted suicides, assaults, sexual harassment, and staff negligence are just some of the criticisms state hospitals have faced in the past (Bachrach, 1996). Added to this, hospitals still vary greatly in their milieus, treatment offerings, and competence of their personnel. Another critical issue is the lack of patient beds or adequate outpatient services. From 1955 to 2005, the number of public psychiatric beds in the United States decreased by 95% (Torrey, Entsminger, Geller, Stanley, & Jaffe, 2008). Because of limited hospital capacity, waitlists are increasingly used to help regulate admissions for patients. The shortage of hospital beds and service providers represents an ongoing challenge for hospital administrators. States and counties have taken diverse approaches in financing and management of hospitals, resulting in striking geographic variations in terms of psychiatric bed capacity and the roles states systems play in mental health service provision (La et al., 2014). There has been an increase in episodes of aggression, seclusion, restraint, medication errors, and worker injuries within state hospitals in the last decade (Hanrahan, 2008; Serper et al., 2005).

The reality of burnout poses a considerable challenge for hospital officials. Not only do mental health workers within hospitals sometimes experience emotional exhaustion, but psychiatric nurses—who represent the largest professional group of individuals who provide direct care to psychiatric patients (Hanrahan, Aiken, McClaine, & Hanlon, 2010)—often do, as well. Optimal patient care is highly dependent on the organizational support of nurses. However, there is a serious shortage of psychiatric nurses in state hospital facilities, which increases the workload and stress for the individuals present (Hanrahan, 2009).

This, combined with other factors such as systemic stressors and acutely ill patients, increases the likelihood of insensitivity within the state hospital setting. Psychiatric nurses often receive little orientation or continuing education when entering the hospital, decreasing their likelihood of being exposed to LGBT issues or culturally competent care (Farrell & Dares, 1999).

Although it is important to assess the prevalence of burnout among psychiatric nursing staff, it should also be noted burnout occurs among mental health workers, including psychologists and social workers (Morse, Salyers, Rollins, Monroe-DeVita, M., & Pfahler, 2012). Burnout has social, emotional and physical consequences for the individuals experiencing it, including increased depression, anxiety, and impaired memory. Added to this, burnout has organizational effects, including reduced commitment to an organization, negative attitudes towards patients, and high turnover rates (Morse et al., 2012). Given this, burnout within state hospitals can very overtly affect the relationship between providers and patients. If sensitivity training and strategies to reduce burnout are not introduced, the likelihood of strained relationships between staff and patients is higher, preventing the establishment of a sensitive and inclusive environment.

Outcomes of Diversity Training

Instead of viewing diversity as a barrier, organizations (including state hospitals) now have the opportunity to recognize the value of inclusion and its usefulness in enhancing organizational outcomes (Kalinoski et al., 2013). Diversity training is primarily used to facilitate the integration of minority groups into the workforce and to promote the use of skills, knowledge, and motivation to encourage staff to productively work alongside one another (Pendry, Driscoll, & Field, 2007). At worst, training may not change preexisting ideas about

diversity or impact the organization in any way. Yet, at best, it has a positive effect on attitudes toward others. Although there may not be implicit attitude change initially, explicit changes still serve to promote workplace sensitivity, decrease turnover, enhance relationships, and increase productivity (Bendick, Egan, & Lofhjelm, 2001). A study of a transgender cultural competency training showed participants had a small but clinically significant increase in self assessed knowledge, particularly in the domain of terminology (Hanssmann et al., 2008). Positive outcomes of diversity training are also associated with the motivation of the organization and trainer. If a trainer presents as nonchalant and ambivalent about diversity, the impact will likely be less potent than if a trainer appears motivated and passionate about the issues presented (Kulik & Roberson, 2008b). Effects of diversity training may also be enhanced by an individual's sense of self-efficacy or confidence that what they are learning can be transferred to the work setting (Combs & Luthans, 2007). Although numerous other variables that may moderate effects of diversity training, research has found training to be beneficial overall (Kalinoski et al., 2013).

Present Paper

As the current state of the literature makes clear, transgender-specific research and advocacy has been gaining momentum as LGBT issues become more prominent in American culture; equally apparent, however, is the shortage of effective training protocols grounded in best practices for meeting the needs for transgender patients. The proposed Training Manual included in the Appendix represents a first step toward the creation of a transgender-affirmative model designed to meet the unique challenges of training providers in state hospital settings. The user-friendly edition is formatted to increase readability and comprehension, retain interest, and be informative. Content is specifically tailored to suit employees within state hospital systems.

Although the protocol is designed primarily for professionals with limited clinical knowledge regarding transgender populations, it may also serve as a useful refresher for more experienced practitioners. Readers should keep in mind this is not a finalized version—hospitals can and are encouraged to tailor the manual to meet their individualized training needs.

Limitations

This paper provides an overview of current gaps in trans-specific training, and a rationale for the training protocol proposed for use in state hospital settings. However, the scope is by no means comprehensive. In particular, there is less emphasis placed on transmen and transwomen, transgender individuals of color, the intersection of age and gender identity, and individuals who identify as third gender. Because of its primary function as a pragmatic, easy-to-understand tool, the sample training protocol is not designed to be all-inclusive or content-heavy. Thus, one important limitation of the manual is it does not afford a deeper understanding of transgender issues. Topics of great potential import to patients (e.g., discussion of initial transition, hormone letters, and name change) are overlooked or covered only superficially. The process of transition and subsequent changes were excluded from the manual in an effort to reach the broadest audience possible within the hospital setting. Given this, the material covered is not exhaustive. Furthermore, this paper and appendix are designed for use in state hospitals, not other institutions. Therefore, some material is specific to hospitals and may not generalize to other settings. Finally, systemic barriers such as minimal funding and cultural factors within state hospitals were not addressed in this paper, yet can influence the implementation of diversity training in profound ways.

Future Directions

It is difficult to overstate the need for research in this area, including regarding the efficacy of training protocols such as the one proposed here. In particular, it would be useful to develop a body of empirically-validated and evidence-based best practices for trans-specific training in state hospital settings, as no such research appears to exist at the present time. Linking training to markers of competency, and, ultimately, to patient satisfaction and outcomes will be both useful and necessary in developing and improving manuals such as the one proposed here.

Finally, on a practical level, awareness training represents only one of many components to providing an inclusive and affirming environment for trans patients. Hospitals wishing to implement this or a similar training protocol will find that their work is just beginning. In order to effectively support transgender patients and staff in state hospitals, written policies will need to be established. For example, it will be important to develop written policies addressing the availability of items such as makeup and intimates for individuals undergoing transition or post-transition. Other policies may include the pronouns used to address transgender patients and staff, as well as the protection of privacy in rooms and bathrooms. Although it would be beyond the scope of this paper to delineate specific policies for any given institution, care should be taken to incorporate current best practices and to remain true to the principles of inclusivity and cultural competence in crafting these incredibly impactful guidelines.

Conclusion

Although trainings focused on LGBT issues have become more popularized, transgender-affirming trainings are still needed. Members of the transgender community live in a unique context and face numerous challenges, including trans-specific discrimination, stigmatization, and violence. In state hospitals, broad "diversity" trainings too often fail to adequately prepare

clinicians and medical providers for the needs of their trans patients. The resulting lack of awareness, sensitivity, and competency may negatively impact treatment utilization and outcomes for members of the transgender community, potentially leading to further mistrust of systems of care and increased marginalization for members of an already vulnerable community.

Because transgender individuals face identity-specific stressors in areas such as healthcare discrimination, microaggressions, and employment discrimination, it is crucial for all providers to have some understanding of these dynamics. This not only fosters compassion and empathy for members of the community, but also helps health professionals move toward taking on roles as allies and advocates for their patients. Transgender-specific training and continuing education is crucial in establishing a work environment that champions social justice and condemns prejudice and discrimination.

Index

Androgynous – a person appearing and/or identifying as neither man nor woman, presenting a gender either mixed or neutral (Definition of Terms)

Bias – prejudice; an inclination or preference (Definition of Terms).

Bigender – A person whose gender identity is a combination of a man and a woman (Definition of Terms).

Cisgender – an individual whose gender identity conforms to their biological sex (Definition of Terms). Also referred to as "gender-straight" or "gender-normative."

Cisnormativity - the expectation that all people experience their mental and physical sexes as being aligned and denies the existence of trans people in cultural knowledge (Baur et al., 2009).

Coming Out – to recognize one's sexual orientation, gender identity, or sex identity, and to be open with self and others (Definition of Terms).

Cross Dresser – Someone who wears clothes associated with another gender part of the time. This term has replaced the term "transvestite," which is considered offensive. Just because someone participates in cross dressing, does not mean they are transgender (Definition of Terms).

Discrimination – the act of showing partiality or prejudice (Definition of Terms).

Drag – the act of dressing in gendered clothing and adopting gendered behaviors as part of a performance, most often clothing and behaviors not typically associated with one's gender identity (Definition of Terms).

Female to Male (FTM) – phrase used to delineated individuals who are born biologically female and express or feel their gender in more masculine ways (Glossary of Terms).

Gender – social and cultural construct of being male or female. One's gender identity may or may not match one's biological sex (Definition of Terms).

Genderism - the belief or assumption there are two, and only two genders (Definition of Terms).

Gender diverse – A person who by nature or by choice does not conform to gender based expectations of society. This phrase is preferable to "gender variant" because it does not imply a standard normativity (Definition of Terms).

Gender dysphoria - discomfort or distress that is caused by a discrepancy between a person's gender identity and that individual's sex assigned at birth (Coleman et al., 2011).

Gender expression – the way in which a person expresses their gender identity through clothing, behavior, posture, and mannerisms (Definition of Terms).

Gender fluid – a person whose gender identification and presentation shifts (Definition of Terms).

Gender Identity Disorder – diagnosis used in the Diagnostic and Statistical Manual of Disorders – IV (DSM-IV) to describe a person who experiences significant distress related to lack of identification with one's sex or gender (American Psychiatric Association, 1994).

Gender nonconformity - the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Coleman et al., 2011).

Genderqueer – a person whose gender identity is neither man nor woman, is between or beyond genders, or is a combination of genders (Definition of Terms).

Hate crime – a crime motivated by the actual or perceived race, color, religion, national origin, ethnicity, gender, disability, or sexual orientation of any person (Definition of Terms).

Intersex – set of medical conditions that feature congenital anomaly of the reproductive and sexual system. They are born with a combination of male and female features, or features not considered the "standard" for males or females (Definition of Terms).

Male to Female (MTF) – phrase used to delineate individuals who are born biologically male and express or feel their gender in more feminine ways (Glossary of Terms).

Microaggressions - subtle forms of discrimination in which brief, daily, behavioral, verbal, or environmental injustices can occur (Sue et al., 2007). These include microassaults (explicit derogation characterized by verbal or nonverbal attacks), microinsults (communications that degrade a person's identity), and microinvalidations (communications that deny the psychological thoughts, feelings, and reality of a person).

Pangender – A person whose gender identity is comprised of all or many gender expressions (Definition of Terms).

Pre-op – a trans-identified person who has not received sexual reassignment surgery (Definition of Terms).

Post-op – a trans-identified person who has received sexual reassignment surgery/sex confirmation surgery (Definition of Terms).

Queer – An umbrella term used to refer to all LGBTQ people. It is also used as a complex term to explain a complex set of sexual behaviors and desires (Definition of Terms).

Sexual orientation – a term describing a person's attraction to members of the same sex and/or different sex, usually described as lesbian, gay, bisexual, heterosexual, or asexual (Transgender Terminology, 2015).

Stereotype – an exaggerated, oversimplified belief about an entire group of people without regard for individual differences (Definition of Terms).

Stigmatize – to describe or regard something (such as a group of people) in a way that shows strong disapproval (Merriam-Webster).

Transgender – an individual whose biological sex does not match their gender identity (Glossary of Terms).

Transgenderist – an individual who disidentifies with their birth gender and instead identifies with a third gender (Thomas, 2002).

Transition – a multi step process as transgender people align their anatomy with their sex identity and/or gender expression with gender identity (Definition of Terms).

Transphobia is emotional repulsion, hatred, discrimination, and aggressions directed at people who are gender non-conforming and those whose gender and sex are unclear (Hill & Willoughby, 2005).

Transmen – individuals who are born biologically female and express or feel their gender in more masculine ways (Definition of Terms).

Transwoman – individuals who are born biologically male and express or feel their gender in more feminine ways (Definition of Terms).

Two-Spirit – Native American persons who have attributes of both men and women, have distinct gender and social roles in their tribes, and are often involved with mystical rituals (Transgender Terminology, 2015).

References

113th Congress (2013-2014). *Employment non-discrimination act of 2013*. Retrieved from https://www.congress.gov/bill/113th-congress/senate-bill/815.

Abelson, M. J. (2014). Dangerous privilege: Trans men, masculinities, and changing perceptions of safety. *Sociological Forum, 29*(3), 549-570.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington: DC. American Psychiatric Association.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington: DC. American Psychiatric Association.

American Psychological Association (2015). *Guidelines for psychological practice with transgender and gender nonconforming people*. American Psychologist, *70*(9), 832-864.

American Psychological Association Task Force on Gender Identity and Gender Variance. (2009). *Report of the task force on gender identity and gender variance*. Washington, DC: Author.

Bachrach, L. L. (1996). The state of the state mental hospital at the turn of the century. *New Directions for Mental Health Services*, *84*, 7-24.

Bauer, G. R., Hammond, R., Travers, R., Kaay, M., Hohenadel, K. M., & Boyce, M. (2009). 'I don't think this is theoretical; this is our lives:' How erasure impacts health care for transgender people. *Journal of the Association of Nurses in AIDS Care*, *20*(5), 348-361.

Bendick, M., Egan, M. L., & Lofhjelm, S. (2001). Workforce diversity training: From anti-discrimination compliance to organizational development. *Human Resource Planning, 24*(2), 10-25.

Benson, K. E. (2013). Seeking support: Transgender client experiences with mental health services. *Journal of Feminist Family Therapy, 25*(1), 17-40.

Bockting, W. O., Miner, M. H., Swinburne-Romine, R., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience in an online sample of the U.S. transgender population. *American Journal of Public Health, 103*, 943-951.

Bowman, C., & Goldberg, J. M. (2006). Care of the patient undergoing sex reassignment surgery. *International Journal of Transgenderism, 9*(3/4), 135-165.

Bradford, J., Reisner, S. L., Honnold, J. A., & Xavier, J. (2013). Experiences of transgender-related discrimination and implications for health: Results from the Virginia transgender health initiative study. *American Journal of Public Health, 103*(10), 1820-1829.

Carabez, R., Pelligrini, M., Mankovitz, A., Eliason, M., Ciano, M., & Scott, M. (2015). "Never in all my years:" Nurses education about LGBT health. *Journal of Professional Nursing, 31*(4), 323-329.

Chang, T. K., & Chung, B. (2015). Transgender microaggressions: Complexity of the heterogeneity of transgender identities. *Journal of LGBT Issues in Counseling*, *9*(3), 217-234.

Cheung, F. K., & Snowden, L. R. (1990). Community mental health and ethnic minority populations. *Community Mental Health Journal, 26*, 277-291.

Clements-Nolle, K., Marx, R., Guzman, R., & Katz, M. (2001). HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. *American Journal of Public Health, 91*(6), 915-921.

Clements-Nolle, K., Marx, R., & Katz, M. (2006). Attempted suicide among transgender persons. *Journal of Homosexuality, 51*(3), 53-69.

Cochran, B. N., & Robohm, J. S. (2015). Integrating LGBT competencies into the multicultural curriculum of graduate psychology training programs: Expounding and expanding upon Hope and Chappell's choice points. [Commentary on "Extending Training in Multicultural Competencies to Include Individuals Identifying as Lesbian, Gay, or Bisexual: Key Choice Points for Psychology Training Programs," by D. A. Hope & C. L. Chappell]. *Clinical Psychology: Science and Practice, 22*(2), 119-126.

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., ... Zucker, K. (2011). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism, 13*(4), 165-232.

Combs, G. M. & Luthans, F. (2007). Diversity training: Analysis of the impact of self-efficacy. *Human Resource Development Quarterly, 18*(1), 91-120.

Corliss, H. L., Shankle, M. D., & Moyer, M. B. (2007). Research, curricula, and resources related to lesbian, bisexual, and transgender health in U.S. schools of public health. *American Journal of Public Health, 97*(6), 1023-1027.

Crenshaw, K. (1991). Mapping the margins: intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241-99.

Cross, T., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). *Towards a culturally competent system of care. Vol 1: A monograph of effective series for minority children who are severely emotionally disturbed.* Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Dahl, M., Feldman, J. L, Goldberg, J., & Jaberi, A. (2006). *Physical aspects of transgender endocrine therapy*. Vancouver, BC: Vancouver Coastal Health.

DeCuypere, G., Van Hemelrijck, M., Michel, A., Carael, B., Heylens, G., Rubens, R.,… Monstrey, S. (2007). Prevalence and demography of transsexualism in Belgium. *European Psychiatry, 22*(3), 137-141.

Definition of terms. (n.d.). Retrieved from http://geneq.berkeley.edu/lgbt_resources_defintion_of_terms

Farrell, G. A., & Dares, G. (1999). Nursing staff satisfaction on the mental health unit. *Australian and New Zealand Journal of Mental Health Nursing, 8*(2), 51-57.

Federal Bureau of Investigation. *Hate crimes – overview.* Retrieved from https://www.fbi.gov/about-us/investigate/civilrights/hate_crimes/overview

Erich, S., Boutte-Queen, N., Donnelly, S., & Tittsworth, J. (2007). Social work education: Implications for working with the transgender community. *The Journal of Baccalaureate Social Work, 12*(2), 42-52.

Erich, S., Tittsworth, J., Meier, S. L. C., & Lerman, T. (2010). Transsexuals of color: Perceptions of discrimination based on transsexual status and race/ethnicity status. *Journal of GLBT Family Studies, 6*, 294-314.

Gay & Lesbian Alliance Against Defamation. *GLAAD Media Reference Guide—Transgender Issues.* Retrieved from http://www.glaad.org/reference/transgender

Gill, A. M. (2015). *2014 State Equality Index.* Washington, DC: Human Rights Campaign Foundation.

Glossary of Terms. (n.d.). Retrieved from http://transwhat.org/glossary/#F

Grant, J. M., Mottet, L., Tanis, J. E., Harrison, J., Herman, J., & Keisling, M. (2011). *Injustice at every turn: A report of the national transgender discrimination survey.* National Center for Transgender Equality. Washington, DC.

Grossman, A. H., & D'Augelli, A. R. (2006). Transgender youth: Invisible and vulnerable. *Journal of Homosexuality, 51*(1), 111-128.

Hanrahan, N. P. (2008). Psychiatric nurse reports on the quality of inpatient psychiatric care in general hospitals. *Quality Management in Healthcare, 17*(3), 211-218.

Hanrahan, N. P. (2009). Analysis of the psychiatric mental health registered nurse workforce in the United States. *Journal of Psychosocial Nursing and Mental Health Services Research, 47*(5), 1-9.

Hanrahan, N. P., Aiken, L. H., McClaine, L., & Hanlon, A. L. (2010). Relationship between psychiatric nurse work environments and nurse burnout in acute care general hospitals. *Issues in Mental Health Nursing, 31*(3), 198-207.

Hanssmann, C., Morrison, D., & Russian, E. (2008). Talking, gawking, or getting it done: Provider trainings to increase cultural and clinical competence for transgender and gender-nonconforming patients and clients. *Sexuality Research & Social Policy*, 5(1), 5-23.

Hein, L. C., & Scharer, K. M. (2013). Who cares if it is a hate crime? Lesbian, gay, bisexual, and transgender hate crimes-mental health implications and interventions. *Perspectives in Psychiatric Care, 49*, 84-93.

Herbst, J. H., Jacobs, E. D., Finlayson, T. J., McKleroy, V. S., Neumann, M. S., & Crepaz, N. (2008). Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systemic review. *AIDS and Behavior, 12*, 1-17.

Hill, D. B., & Willoughby, B. L. (2005). The development and validation of the genderism and transphobia scale. *Sex Roles, 53*(7-8), 531-544.

Human Rights Campaign, Lambda Legal, & New York City Bar. (n.d.). *Creating equal access to quality health care for transgender patients: Transgender-affirming hospital policies.* Retrieved from http://www.lambdalegal.org/blog/20131105_transgender-affirming-hospital-policies

Jacobs, J. B., & Potter, K. (1998). *Hate crimes: Criminal law and identity politics*. New York, NY: Oxford University Press.

Kalinoski, Z. T., Steele-Johnson, D., Peyton, E. J., Leas, K. A., Steine, J., & Bowling, N. A. (2013). A meta-analytic evaluation of diversity training outcomes. *Journal of Organizational Behavior, 34*, 1076-1104.

Keepnews, D. M. (2011). LGBT health issues and nursing. Editorial. *Policy, Politics, & Nursing Practice, 12*(2), 71-72.

Kenagy, G. P. (2005). Transgender health: Findings from two needs assessment studies in Philadelphia. *Health & Social Work, 30*(1), 19-26.

Khoosal, D., Langham, C., Palmer, B., Terry, T., & Manjunath, M. (2009). Features of eating disorder among male-to-female transsexuals. *Sexual and Relationship Therapy, 24*(2). 217-229.

Kulik, C. T., & Roberson, L. (2008b). Diversity initiative effectiveness: What organizations can (and cannot) expect from diversity recruitment, diversity training, and formal mentoring programs. In A. Brief (Ed.), *Diversity At Work*: 265-317. London, UK: Cambridge Press.

La, E. H., Zhu, R., Lich, K. H., Ellis, A. R., Swartz, M. S., Kosorok, M. R., & Morrissey, J. P. (2015). The effects of state psychiatric hospital waitlist policies on length of stay and time to readmission. *Administration and Policy in Mental Health, 42*, 332-342.

Levitt, H. M., & Ippolito, M. R. (2014). Being transgender: Navigating minority stressors and developing authentic self-presentation. *Psychology of Women Quarterly, 38*, 46-64.

Leyva, V. L., Breshears, E. M., & Ringstad, R. (2014). Assessing the efficacy of LGBT cultural competency training for aging service providers in California's Central Valley. *Journal of Gerontological Social Work, 57*(2-4), 335-348.

Lombardi, E. L., Wilchins, R. A., Priesing, D., & Malouf, D. (2001). Gender violence: Transgender experiences with violence and discrimination. *Journal of Homosexuality, 42*(1), 89-101.

Lurie, S. (2005). Identifying training needs of health-care providers related to treatment and care of transgendered patients: A qualitative needs assessment conducted in New England. *International Journal of Transgenderism, 3*(2/3), 93-112.

Macy v. Holder, 126 E.E.O.C. (2012).

Madera, J. M., & Hebl, M. R. (2013). "Don't stigmatize": The ironic effects of equal opportunity guidelines in interviews. *Basic and Applied Social Psychology, 35*, 123-130.

Magpantay, G. D. (2006). The ambivalence of queer Asian Pacific Americans towards same-sex marriage. *Amerasia Journal, 32*(1), 109-119.

Mandal, E., & Jakubowski, T. (2015). Masculinity, femininity, self-appeal, strategies of self-presentation and styles of interpersonal functioning in transsexual women. *Archives of Psychiatry and Psychotherapy, 3*, 5-13.

Mayock, P., Bryan, A., Carr, N., & Kitching, K. (2009). Supporting LGBT lives: A study of the mental health and well being of lesbian, gay, bisexual, and transgender people. Dublin, Ireland: Gay and Lesbian Equality Network and BeLonG to Youth Services.

McCann, E., & Sharek, D. (2015). Mental health needs of people who identify as transgender: A review of the literature. *Archives of Psychiatric Nursing, 30*(2), 280-285.

Meier, S. C., & Labuski, C. M. (2013). The demographics of the transgenderpopulation. In A.L. Baumle (Ed.), *International handbook of the demography of sexuality* (pp. 289-327). New York, NY: Springer.

Meyer, D. (2008). Interpreting and experiencing anti-queer violence: Race, class, and gender diferences among LGBT hate crime victims. *Race, Gender & Class, 15*(3-4). 262-282.

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health and Mental Health Research, 39*(5), 341-352.

Mottet, L., & Tanis, J. (2008). *Opening the door to the inclusion of transgender people: The nine keys to making lesbian, gay, bissexual and transgender organizations fully transgender-inclusive*. New York, NY: National Gay and Lesbian Task Force Policy Institute and the National Center for Transgender Equality.

Nadal, K. L., Davidoff, K. C., Davis, L. S., & Wong, Y. (2014). Emotional, behavioral, and cognitive reactions to microaggressions: Transgender perspectives. *Psychology of Sexual Orientation and Gender Diversity, 1*, 72-81.

Nadal, K. L., Skolnik, A., & Wong, Y. (2012). Interpersonal and systemic microaggressions toward transgender people: Implications for counseling. *Journal of LGBT Issues in Counseling, 6*(1), 55-82.

Nemoto, T., Operario, D., & Keatley, J. (2005). Health and social services for male-to-female transgender persons of color in San Francisco. *International Journal of Transgenderism, 8*(2-3), 5-19.

Osborn, L. A. (2009). From beauty to despair: The rise and fall of the American state mental hospital. *Psychiatric Quarterly, 80*, 219-231.

Pantalone, D. W. (2015). Improving the evidence base for LGBT cultural competence training for professional psychologists. [Commentary on "Quality LGBT Health Education: A Review of Key Reports and Webinars," by A. R. Matza, C. A. Sloan, & M. R. Kauth]. *Clinical Psychology: Science and Practice, 22*(2), 145-150.

Pendry, L. F., Driscoll, D. M., & Field, S. C. T. (2007). Diversity training: Putting theory into practice. *Journal of Occupational and Organizational Psychology, 80*, 27-50.

Polly, R., & Nicole, J. (2011). Understanding the transsexual patient: Culturally sensitive care in emergency nursing practice. *Advanced Emergency Nursing Journal, 33*(1), 55-64.

Ragins, B. R., Singh, R., & Cornwell, J. M. (2007). Making the invisible visible: fear and disclosure of sexual orientation at work. *Journal of Applied Psychology, 92*(4), 1103-18.

Rivers, I., McPherson, K. E., & Hughes, J. R. (2010). The role of social and professional support seeking in trauma recovery: lesbian, gay, and bisexual experiences of crime and fears for safety. *Psychology & Sexuality, 1*(2), 145-155.

Rubin, H. (2003). *Self-made men: Identity and embodiment among transsexual men*. Vanderbilt University Press.

Ruggs, E. N., Martinez, L. R., Hebl, M. R., & Law, C. L. (2015). Workplace "trans" actions: How organizations, coworkers, and individual openness influence perceived gender

identity discrimination. *Psychology of Sexual Orientation and Gender Diversity.* Retrieved from: http://dx.doi.org/10.1037/sgd0000112

Sequeira, G. M., Chakraborti, C., & Panunti, B. A. (2012). Integrating lesbian, gay, bisexual and transgender (LGBT) content into undergraduate medical school curricula: A qualitative study. *The Ochsner Journal, 12*(4), 279-282.

Serper, M. R., Goldberg, B. R., Herman, K. G., Richarme, D., Chou, J., Dill, C. A., & Cancro, R. (2005). *Comprehensive Psychiatry, 46*(2), 121-127.

Shipherd, J. C., Green, K. E., & Abramovitz, S. (2010). Transgender clients: Identifying and minimizing barriers to mental health treatment. *Journal of Gay & Lesbian Mental Health, 14*(2), 94-108.

Sirota, T. (2013). Attitudes among nurse educators towards homosexuality. *Journal of Nursing Education, 52*, 219-227.

Stigmatize. (n.d.). In Merriam-Webster's online dictionary (11th ed.) Retrieved from http://www.merriam-webster.com/dictionary/stigmatize

Sue, D. W., Capolidupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everday life: Implications for clinical practice. *American Psychologist, 62*, 271-286.

Thomas, B. (2002). *HDHHS STD Program in-service*. Houston, TX: Houston Department of Health and Human Services.

Torrey, E. F., Entsminger, K., Geller, J., Stanley, J., & Jaffe, D. J. (2008). *The shortage of public hospital beds for mentally ill persons*. Arlington, VA: Treatment Advocacy Center.

Transgender Terminology (2015). Retrieved from http://www.transequality.org/issues/resources/transgender-terminology.

Warbelow, S., & Persad, X. (2016). *2015 State Equality Index*. Washington, DC: Human Rights Campaign Foundation.

Yavorsky, J. E., & Sayer, L. (2013). "Doing fear": The influence of hetero-femininity on (trans)women's fears of victimization. *The Sociological Quarterly, 54*, 511-533.

Yu, V. (2010). Shelter and transitional housing for transgender youth. *Journal of Gay & Lesbian Mental Health, 14(*4), 340-345.

Appendix

Appendix Table of Contents 43

Introduction..44

Definitions and Terms..46

Terms to Avoid! 50

The Genderbread Person.. 51

What is Gender Dysphoria..53

Transgender Within the State Hospital.. 55

Respectful Interactions 57

How can you be an Ally.. .59

True or False?.. 61

Answer Key for True or False..63

Facts..65

Additional Resources.. 67

Let's Talk About Gender

An Introductory Manual

A brief discussion on transgender issues and its applicability to state hospital settings.

Table of Contents

Introduction .... Pg. 3

Definitions & Terms .... Pg. 5

Terms to Avoid! ....Pg. 9

The Genderbread Person ....Pg. 10

What is Gender Dysphoria...Pg. 12

Transgender Within the State Hospital ....Pg. 14

Respectful Interactions ....Pg. 16

How can you be an Ally...Pg. 18

True or False? ....Pg. 20

Answer Key for True or False ....Pg. 22

Facts..Pg. 24

Additional Resources...Pg. 26

Introduction

What is gender? Gender refers to the attitudes, feelings, and behaviors that a given culture associates with a person's biological sex.

If that's gender, what is sex? Sex refers to a person's biological status and is typically categorized as male, female, or intersex (combinations of characteristics that usually distinguish male from female). There are a number of indicators of biological sex, including sex chromosomes, gonads, internal reproductive organs, and external genitalia.

In society, we often confuse the two because we often see people's gender conforming to their biological sex.

The Gender Spectrum

In America, we often view gender as binary, consisting of only male and female, both of which are grounded in a person's anatomy. However, this would be inaccurate because gender and gender expression is on a spectrum, similar to that of sexuality. But how is it that we've come to understand gender as being binary? Influences such as culture, peer relationships, media, upbringing, schools, and religion have affected the way we have viewed gender. Although our society has made huge strides in breaking down stereotypes about gender, we still have ideas regarding what it means to be typically masculine and typically feminine. What would it be like if we pictured gender to be on a spectrum, to be fluid?

We all fall somewhere on this spectrum. However, all of us fit somewhere differently. It is important for us to appreciate individuality and self-identity.

So what does it mean to be transgender?

Although definitions vary about what it means to be transgender, most people describe transgender individuals as people who feel strongly their gender is not the same as their biological sex. Transgender people feel they were born the wrong gender; they may have biological characteristics of females, but feel strongly that they are male. Often, feelings of incongruence develop as children. However, some may not develop these feelings until adolescence or adulthood. Although some

people feel strongly they are male or female, still other transgender individuals identify as neither male or female, or they are somewhere on the spectrum of female to male.

Most transgender people will present in a way that matches their inner sense of gender. This often includes dress and behavior. For example, a male transitioning to female may start changing their wardrobe to be more traditionally female clothing. They may start shopping in the women's section of retail stores. Additionally, they may start adopting traditionally female characteristics, including body language and other mannerisms.

Transgender people may choose to undergo hormones or surgery in order to feel more congruent with their gender. For example, a female transitioning to male may start androgen hormone treatment in order to start developing male characteristics, such as facial hair and muscle tone. A male transitioning to female may opt to have sex reassignment surgery in order to have female genitalia. Trans people may change their names to reflect their identified gender, and identify with gender congruent pronouns (he, she, they, zee, etc.). These are just a few ways transgender people can reflect how they perceive themselves.

Definitions and Terms

There are many terms transgender people use to describe themselves. However, terminology changes over time and some people choose to identify with a term more than others. Therefore, it is always a good idea to provide the opportunity for trans people to tell you how they wish to be identified. Below is a list of terms that are commonly used.

Gender Identity – A person's internal sense of being a man, woman, both, or neither.

Gender Expression – The way an individual acts, dresses, speaks, and behaves in order to show their gender as masculine, feminine, both, or neither.

Biological Sex – The sex of an individual, determined by physiological characteristics at birth.

Transgender – An individual's gender identity does not match with their birth sex.

Transsexual – This is an older term that is sometimes no longer preferred. It is still preferred by some people who have permanently or wish to permanently change their bodies through medical interventions.

Transition – The time when a person starts living as the gender with which they identify rather than the gender they were assigned at birth, which often includes changing one's first name and dressing and grooming differently. Transition may or may not include medical and legal aspects, including taking hormones, having surgery, or changing identity documents to reflect one's gender identity.

Gender Non-Conforming – People who express their gender than what is culturally expected of them. Gender non-conforming individuals are not necessarily transgender, but instead choose to express themselves differently. For example, a woman may choose to dress in masculine clothing, but still identifies as female.

Female to Male (FTM)– Individuals who are born biologically female but choose to express their identity in more masculine ways.

Male to Female (MTF)– Individuals who are born biologically male but choose to express their identity in more feminine ways.

Genderqueer – This is a term used for individuals who identify as neither male nor female, or both female and male. This term is relatively new, and some use this term interchangeably with transgender.

Trans – an abbreviation for transgender

Sexual Orientation – used to identify romantic or sexual attraction to a specific gender. Sexual orientation and gender identity are separate and distinct parts of one's identity.

Gender Dysphoria – this refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that individual's sex assigned at birth.

Transphobia - emotional repulsion, hatred, discrimination, and aggressions directed at people who are gender non conforming and those whose gender and sex are unclear

Passing – being seen as the gender you are presenting as, instead of being transgender.

Sex Reassignment Surgery (SRS) – Doctor supervised surgical interventions. These interventions change one's body to better reflect the individual's gender identity. There are many types of surgery, and not just one type.

Transition – The time when a person starts living as the gender with which they identify rather than the gender they were assigned at birth, which often includes changing one's first name and dressing and grooming differently. Transition may or may not include medical and legal aspects, including taking hormones, having surgery, or changing identity documents to reflect one's gender identity.

For a more comprehensive list of terms, please visit:
GLADD Media Reference Guide at www.gladd.org/reference/transgender

National Center for Transgender Equality **at**
www.transequality.org/issues/resources/transgender-terminologyy

Gender Equity Resource Center of UC Berkeley **at**
Geneq.berkeley.edu/lgbt_resources_definition_of_terms

More About Terminology

Some people can find it daunting knowing how to address someone who is transgender, gender queer, or gender fluid. Oftentimes, it may be polite to ask the individual how they prefer to be addressed. Below is a list of commonly used pronouns.

Instead of saying he/she, some people prefer *sie* or *zie*. This is pronounced as "*see*" or "*zee.*"

Instead of saying him/her, some people prefer *hir* or *zir*. This is pronounced as "*here*" or "*zir* (like sir but with a z)."

Instead of saying his/hers, some people prefer *hirs* or *zirs*. This is pronounced "*heres*" or "*zirs* (like sirs but with a z)."

Instead of saying himself/herself, some people prefer *hirself* or *zirself*. This is pronounced "*here-self*" or "*zir-self* (like sir but with a z)."

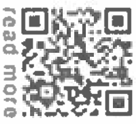
If it is unclear what pronouns the individual prefers, it is often acceptable to use the following: *they, them, themselves*, and *their*. However, some trans people prefer to be called he/she, whichever is congruent with their identified gender.

Terms to Avoid!

There are some terms that are offensive to transgender people. We are sometimes exposed to inaccurate terminology through the media or mainstream society. Below is a list of terms that should not be used:

1. He-She
2. She-Male
3. Shim
4. Tranny – Although this word is sometimes used inside the trans community, it may be considered offensive for outsiders to use this word to describe trans people.
5. Fag, or Faggot
6. Dyke, or Queer – Although some individuals within the LGBT community may use these terms to describe themselves or trans people, some may find these terms offensive.
7. It
8. "a" transgender – Transgender should be used as an adjective, not a noun. It is not appropriate to say "Liz is a transgender." Instead, "Liz is transgender" would be more appropriate.

The Genderbread Person



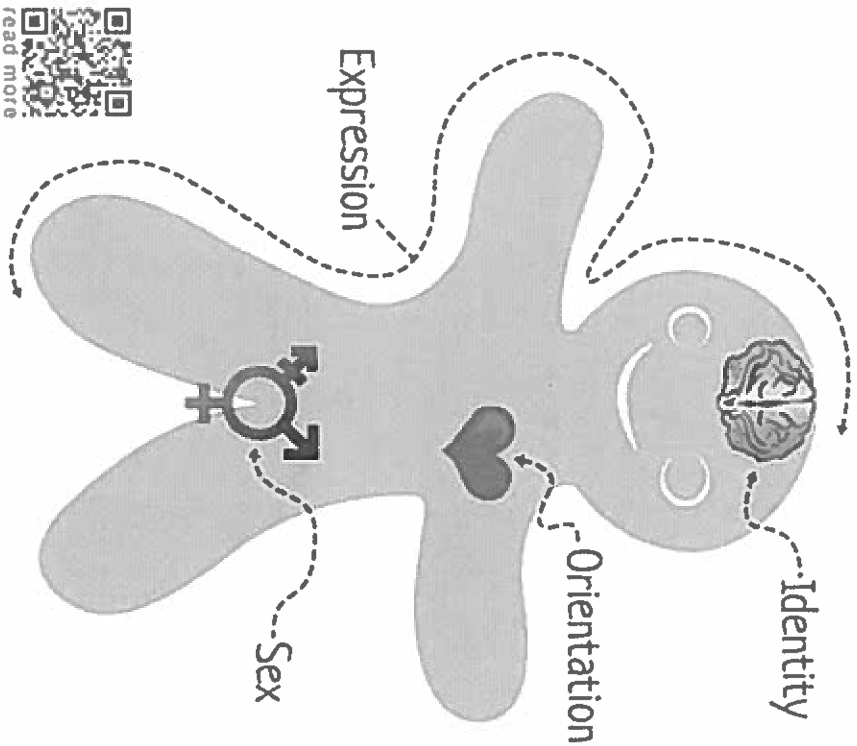


*Image used with permission from itspronouncedmetrosexual.com

What is the GenderBread person?

The GenderBread person is a visual depiction of gender identity, gender expression, biological sex, and sexual orientation (another version of the GenderBread person exists, but for the purposes of this training, we will be using the original version). All four identities are part of us, and may be related. Someone can be biologically male, indicate their gender identity as being male, but choose to express their gender through androgynous clothing. The same individual may identify as bisexual, which is separate from their gender identity. The following are a few more examples:

- Annie is biologically male but has transitioned to female. She identifies as a woman, and expresses her gender in feminine clothing. Annie considers herself to be a lesbian, because she is a woman who is attracted to other women.

- Leslie is a biological male who identifies as genderqueer. Leslie expresses themself in an androgynous fashion, choosing to dress and act in neither overtly feminine nor masculine ways. Leslie is attracted to women, and identifies as gynesexual (attraction to females, women, and/or femininity)

- Linda is a biological female who identifies as a woman. She expresses herself in a feminine way, including wearing feminine clothing and acting in feminine ways. She considers herself to be heterosexual because she is attracted to men.

The above are just some examples of how biological sex, gender identity, gender expression, and sexual orientation can intersect or diverge. However, there are many more ways the four can interact. For a more comprehensive understanding of the GenderBread person, visit *www.itspronouncedmetrosexual.com*.

What is Gender Dysphoria?

Historically, transgender people were considered to have a "disorder" because their gender identities were not congruent with their biological sex. It was listed in the Diagnostic and Statistical Manual of Mental Disorders – Fourth Version (DSM-IV) as Gender Identity Disorder. There was controversy over this diagnosis because it implied individuals who are transgender or wished to transition were "abnormal" or mentally ill. Thankfully, the DSM-IV was revamped and the Diagnostic and Statistical Manual of Mental Disorders – Fifth Version (DSM-V) has changed the diagnosis from Gender Identity Disorder to Gender Dysphoria. Gender dysphoria in the DSM-V is defined as: *A marked incongruence between one's experienced/expressed gender and assigned gender.*

Below are the criteria of Gender Dysphoria in Adolescents and Adults:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

Gender Dysphoria must cause significant distress or impairment in social, occupational, or other important areas of functioning. Furthermore, gender dysphoria presents differently in children. However, since the state hospital services primarily adults and adolescents, the criteria for Gender Dysphoria in adults and adolescents is more salient.

Individuals who meet the above criteria for Gender Dysphoria may indeed qualify for the diagnosis. However, if the individual is not distressed, they may not qualify for Gender Dsyphoria. Additionally, each individual is different, and should be treated as such. One individual's experience with Gender Dysphoria may be markedly different from another's experience.

References:
Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)
Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)

Transgender within the State Hospital

Transgender issues have become a subject of research in the past decade. We know more and more about the experiences of trans individuals, and the obstacles they face. From the research, we do know transgender people experience misunderstanding, rejection, and discrimination, all of which can affect their physical, mental, and spiritual well being. We may encounter individuals in the state hospital who identify as transgender, whether they be our patients or coworkers. If our goal is to serve our patients to the best of our ability and provide an inclusive work environment, then we should understand how to respectfully interact within the hospital.

Addressing Patients

It is sometimes difficult to know what gender an individual identifies with based on their name, appearance, or voice. When addressing patients or coworkers we don't know, we may accidentally address them by the wrong gender, causing discomfort and embarrassment. The individual may not know how to correct us without causing further shame or humiliation. Even when we know our patients and coworkers better, we may unintentionally say insensitive comments that cause discomfort and other negative feelings.

What we should refrain from saying	A better way to phrase
How may I help you, sir/ma'am?	How may I help you?
I'm going to call you by your name in your file.	What name should I address you by?
So what's your "real" name?	What is the name you go by?
He's here for his treatment update.	They are here for their treatment update.
So are you a man or a woman?	What gender, if any, do you identify with?

It is important to remember how patients are talked about with other staff. Avoid using inaccurate gender terms to describe the patient, and never refer to the patient as an "it."

Using Preferred Names

Members of the treatment team and other staff members often access patient information. Patients may not have legally changed their name, but prefer to go by the name that is congruent with their self-identified gender. Legal name change can be a lengthy process, and changes would need to be made on insurance records and other identity documents. Therefore, staff should be aware of the possible discrepancy. For example, John Smith may be in the process of transition and choose to go by Jenna Smith. It would be inappropriate and insensitive of staff to use the name, "John" instead of "Jenna" when in the milieu. Never ask patients what their "real" name is. Similarly, staff should use pronouns patients are comfortable with. If staff are initially uncertain what pronouns the patient goes by, they should ask the patient politely in a private area, away from other patients or bystanders. This will prevent embarrassment or "outing" the patient.

Staff members who identify as transgender may tell others their preferred name and pronouns. However, similarly, all staff should be respectful of the individual's identified gender and avoid using any derogatory terms, phrases, or inappropriate pronouns.

Apologizing

We all make mistakes, and this may happen when you are addressing a fellow coworker or patient. It is important to take responsibility for your mistake and apologize. Although you may feel less embarrassed if you ignore your mistake, it could be damaging to the relationship. If you say a wrong name or pronoun, an apology could go like: "I apologize for saying the wrong name. It was not my intention to be disrespectful."

Respectful Interactions

Avoid Asking Questions from Curiosity

Although it may be tempting to ask patients and coworkers about their gender identity and transition, it can sometimes be overwhelming or probing for the individual. Furthermore, questions can be uncomfortable, especially if the individual is still settling in to their gender identity. Ask yourself: Am I asking the question to be helpful, or is it to satisfy my own curiosity? If the question is relevant, remember to ask the question in a sensitive manner.

Do Not Joke or Gossip

Gossip and joking about transgender issues can be very damaging to the relationship. Even if the gossiping is away from the individual, it can be very hurtful and impact the individual in a negative way. If the gossip or jokes spread to other people, they may also think it is okay to do the same. Gossiping and joking does not promote inclusivity; rather, it creates an environment that is unsafe and intolerant.

Keep Each Other Accountable

In order to promote a tolerant and inclusive environment, it is important that all individuals are respectful to transgender staff and patients. Although it may feel uncomfortable to correct colleagues and coworkers if they are being disrespectful, doing so in a polite manner can actually improve the relationship, establish boundaries, and increase mutual respect.

Notice Similarities, Not Differences

Although we are all quicker to point out how other people are different from us, this does not mean we should treat others in a disrespectful manner. The same goes for transgender individuals. Speak with transgender patients as you would other patients, and keep eye contact. Remember, trans people are people just like you and I, and they deserve the same respect we all deserve.

Off Limits Questions

- **Do not ask about a person's surgical status or body parts.** This is a tricky one within hospital settings. It may be relevant to ask about someone's surgical status if they are a patient. Post surgery complications may make it necessary to bring up topics regarding hormone therapy and surgery. However, be judicious! If it is not necessary for you to know whether the individual has undergone surgery, don't ask. Transgender individuals may opt for or against surgery, depending on their preference. Having surgery does not make transgender people any less "trans."

- **Do not ask what an individual's name used to be.** This is particularly true if you are working with coworkers or supervisors who are transgender. If patients have had a legal name change and their documentation reflects this, do not ask what the patient's "old" name used to be. If patients have not had a legal name change and their documentation still has their previous name, use the name they indicated they preferred.

- **Do not ask when the individual became transgender.** Questions regarding this can be provocative, since individuals may have had a lifetime of questioning their gender. Others may have known their gender was incongruent with their biological sex at a young age. The experience for everyone is different, but this question begs the question of choice.

- **Do not ask how trans people have sex.** This might seem like an awkward "don't," but people are curious about this. But, just like how you wouldn't ask any other person how they have sex, don't ask trans people this. Just refrain.

How can you be an Ally?

The first question should be, what does it mean for you to be an ally? There are a lot of things allies are **not**, but that list can go on and on. Instead, here is a list of things allies **are**.

1. **Allies desire to learn.** Allies don't know everything about LGBT people, but they want to know more and understand.
2. **Allies address the obstacles.** Allies recognize there are potential barriers and difficulties with being an ally for LGBT people, and are willing to face those challenges.
3. **Allies show support differently.** When we think of support, many images pop up in our minds. Support comes in many different forms, whether public or personal. It could mean going to a Pride Fest and showing support openly, or it could mean encouraging and providing validation for a friend who is in the process of transition.
4. **Allies are different.** Allies come in many different forms. Let us be open minded and recognize allies may are diverse.

The following are some tips on how you can become an ally.

- **Become familiar with the terminology** – No, you don't need to understand or know all the terms (terminology is constantly evolving!), but understanding what terms are offensive and what terms are acceptable can be helpful. If you don't know the correct terminology, it may be appropriate to politely ask the individual. Especially when working with patients or coworkers, you wouldn't want to consistently address them wrong, right?
- **Think differently about gender** – Most people are raised with the notion, "Born a man, always a man." We are bombarded in society by ideas about gender and what it means to be a man or a woman. We make unconscious and conscious judgments about people all the time, often during our first impressions. In order to be an ally, we need to "rethink" gender and what gender means. Ask yourself about your own biases and assumptions, and then challenge them! Look around you and ask how and why you conceptualized gender the way you have.
- **Mistakes will happen** – Understand that as an ally, mistakes will undoubtedly occur! When mistakes do happen, apologize and ask for

guidance. What better way to learn than from our mistakes? Similarly, if someone who is transgender objects to what you said, keep an open mind and be willing to listen to what they have to say.

- **Be respectful** – Treat transgender people as you would other patients and coworkers. Be empathetic, and try to use gender neutral pronouns. If the patient or coworker asks you to address them in a way that is congruent with their identified gender, it would be respectful to do so.
- **Sometimes curiosity can be invasive** – It can be tempting as an ally to want to know everything in order to understand. But, sometimes others may find that uncomfortable or probing. Therefore, using an appropriate approach is important in fostering mutual respect and understanding.
  - Just because you want to know something, doesn't mean the individual is required to give you an answer. This is true in many circumstances, but is particularly salient when interacting with trans individuals. Obviously, when the question is of medical necessity or pertinent to treatment for a transgender patient, you may need an answer. Still, questions should be posed in a respectful manner.
  - Listen to what the individual has to say. This can't be emphasized enough. By listening, we can better understand each individual's experiences and keep us from generalizing.

True or False?

Let's test your knowledge regarding the transgender community.

1. Gender Identity refers to a person's biological sex. **T F**

2. Transitioning is the process some transgender people go through to begin living as the gender with which they identify. **T F**

3. FTM means an individual is transitioning or has transitioned from biological male to female. **T F**

4. An individual who comes out as transgender may risk rejection or denial from family members, friends, acquaintances, and strangers. **T F**

5. Gender is a social construct of society, whereas sex is an individual's biological physiology. **T F**

6. A transgender person must receive sex reassignment surgery in order to identify with their gender. **T F**

7. All state hospitals have policies regarding equal and humane treatment of transgender individuals. **T F**

8. Transgender people have a greater risk for suicide, depression, drug abuse, homelessness, and other debilitating mental health issues. **T F**

9. A man who wears women's clothing must be transgender. He must want to be a woman. **T F**

10. It is okay to refer to trans people as trannies, it, that, shemale, and shim. **T F**

11. Transgender is an umbrella term to refer to individuals who challenge gender norms and societal expectations of gender related behaviors. **T F**

12. All transgender people are homosexuals.
T F

13. Drag Queens are men who want to transition to women, and Drag Kings are women who want to transition to men. **T F**

14. All transgender people would like to be referred to as "them."
T F

15. All 50 states in the United States currently have laws protecting transgender people from being from being fired for being *who they are*. **T F**

16. Historically, transgender people have experienced discrimination in the United States.
T F

17. Hate crimes committed against transgender people have never occurred in the United States. **T F**

18. Because transgender is under the LGBT umbrella, it indicates trans individuals do not identify as heterosexual. **T F**

19. Most transgender people have HIV or AIDS.
T F

20. Almost all people in the United States know someone personally who is transgender.
T F

21. Transgender people are never denied access to health care.
T F

Answer Key for True or False?

1. Gender Identity refers to a person's biological sex.
T **F**

2. Transitioning is the process some transgender people go through to begin living as the gender with which they identify. **T** F

3. FTM means an individual is transitioning or has transitioned from biological male to female. T **F**

4. An individual who comes out as transgender may risk rejection or denial from family members, friends, acquaintances, and strangers. **T** F

5. Gender is a social construct of society, whereas sex is an individual's biological physiology. **T** F

6. A transgender person must receive sex reassignment surgery in order to identify with their gender. T **F**

7. All state hospitals have policies regarding equal and humane treatment of transgender individuals. T **F**

8. Transgender people have a greater risk for suicide, depression, drug abuse, homelessness, and other debilitating mental health issues. **T** F

9. A man who wears women's clothing must be transgender. He must want to be a woman. T **F**

10. It is okay to refer to trans people as trannies, it, that, shemale, and shim.
T **F**

11. Transgender is an umbrella term to refer to individuals who challenge gender norms and societal expectations of gender related behaviors. **T** F

12. All transgender people are homosexuals.

T F

13. Drag Queens are men who want to transition to women, and Drag Kings are women who want to transition to men. T F

14. All transgender people would like to be referred to as "them."

T F

15. All 50 states in the United States currently have laws protecting transgender people from being from being fired for being *who they are*. T F

16. Historically, transgender people have experienced discrimination in the United States.

T F

17. Hate crimes committed against transgender people have never occurred in the United States. T F

18. Because transgender is under the LGBT umbrella, it indicates trans individuals do not identify as heterosexual. T F

19. Most transgender people have HIV or AIDS.

T F

20. Almost all people in the United States know someone personally who is transgender.

T F

21. Transgender people are never denied access to health care.

T F

Facts about Transgender People

- According to a survey conducted in 2015 by Greenberg Quinlan Rosner Research, 22% of likely voters know somebody who transgender.
- There are approximately 700,000 transgender individuals in the United States. That is about 0.3% of the population and 3.5% of the LGBT population.
- There is still no comprehensive non-discrimination law that includes gender identity. As of 2014, only 18 states and the District of Columbia prohibit discrimination in employment and housing based on gender identity.
- At least 13 transgender women were murdered in 2014. They were murdered violently; the women were shot, stabbed, strangled, or burned.
- 22% of transgender people who have interacted with police experienced bias based harassment from the police. This percentage was even higher for transgender people of color.
- Transgender people can be rejected from military service if there is evidence of genital surgery.
- Transgender people can identify as gay, lesbian, heterosexual, bisexual, or another sexual identity. Gender identity is not the same as sexual identity.
- Transgender people may undergo various surgeries, not all of which are related to genitalia. For example, a transwoman may choose to undergo a tracheal shave (sometimes colloquially termed the Adam apple reduction), a surgery used to reduce the cartilage in the throat to make it appear more feminine.
- Transgender people may opt to partake in voice therapy, where they practice speaking in a way that is congruent with their identified gender.
- Although it is incorrect to assume transgender people all have HIV or AIDS, it is true that some transgender people do have HIV or AIDS and are unable to receive adequate medical treatment.

- In a survey conducted by the Human Rights Campaign in 2012, it was found 10% of LGBT youth identified as transgender or other gender. Additionally, youth wrote they identified as gender queer, gender fluid, or androgynous.

- Medicare provides for transgender related healthcare such as routine medically necessary care, hormone replacement therapy, and gender reassignment surgeries. Some Medicaid programs will cover for transition related care.

- Fortunately, many colleges in the United States now have gender neutral housing. Some of these include: Stanford University, University of California – Berkeley, Yale University, Brown University, Emory University, Rice University, Princeton University, Sarah Lawrence University, Cornell University, and many more.

*Facts obtained from:
thecenterforequality.org
thedcccenter.org
lexiecannes.com
thetaskforce.org
transgenderlaw.org
wpath.org
hrc.org

Additional Resources

The following are some additional general transgender resources.

- Human Rights Campaign at *ww.hrc.org*
- National Center for Transgender Equality at *www.transequality.org*
- Guide to Being a Trans Ally by PFLAG National at *www.pflag.org*
- Trans People of Color Coalition at *www.transpoc.org*
- Trans Youth Family Allies at *www.imatyfa.org*
- Gender Identity Project at NYC's The Center at *www.gaycenter.org*
- The National LGBT Health Education Center at *www.lgbthealtheducation.org*
- Center of Excellence for Transgender Health at *www.transhealth.ucsf.edu*
- World Professional Association for Transgender Health Standards of Care at *www.wpath.org*
- Transgender Law Center: Health Care Issues at *www.transgenderlawcenter.org/issues/health*