COMPREHENSIVE GENDER IDENTITY POLICY USA

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1. PURPOSE

The purpose of this policy is to: 1. establish expectations for how schools can best support students with gender dysphoria, who are gender-questioning, who are gender non-conforming, or identify as transgender, 2. establishes expectations to ensure parents are informed about their child's gender-related concerns and participate in any decisions about how best to support their child in school; and 3. to set expectations of the school as a whole on how to responsibly respond to situations in which a child requests gender related accommodations.

2. DEFINITIONS

Gender Dysphoria – For the purposes of this policy, we define gender dysphoria as the distress that accompanies the persistent desire to become the opposite sex (or another non-traditional gender). The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) requires that this distress lasts for at least six months in order to receive a formal diagnosis of gender dysphoria.

2.1. CHILD ONSET GENDER DYSPHORIA

This is, historically, the most common type with 75% of transgender males and 72% of transgender females first experiencing gender-related distress by the age of 7; and over 80% of both males and females reporting that experiencing this distress was one of their earliest childhood memories.[1] Research has shown that for the vast majority (70-98%, depending on the study and severity of dysphoria) of children with child-onset gender dysphoria, their dysphoria resolves naturally during puberty or early adulthood.[2-4] This presentation is highly correlated with later homosexuality or bisexuality.[3]

2.2. LATE ONSET GENDER DYSPHORIA

This presents in adolescents and adults and is related to transvestic disorders with autogynephilia. This is seen almost exclusively in non-homosexual, and men who were gender conforming as children.[5-7]

2.3. GENDER DYSPHORIA ASSOCIATED WITH DISORDERS OF SEXUAL DEVELOPMENT

This presents in people who have rare intersex conditions (prevalence 0.018%} where chromosomal sex does not match biological sex characteristics.[8] Not all people with disorders of sexual development have gender dysphoria, but a small percentage do. A recent systematic review and meta-analysis found a 15% prevalence rate of gender dysphoria in those with a disorder of sexual development.[9]

2.4. RAPID ONSET GENDER DYSPHORIA (ROGD)

This term describes the relatively recent phenomenon, typically but not always involving adolescent females, who suddenly develop an interest in transitioning despite no history of childhood gender dysphoria. There is often a history of gender expression that aligns with their biological sex. Dr Lisa Littman, a physician and researcher with expertise in public health, coined the term rapid-onset gender dysphoria in her seminal paper after surveying parents of trans-identified adolescents who described that the onset of their children's gender dysphoria occurred in the context of belonging to a peer group where one, multiple, or even all of a child's friend group became gender dysphoric and transgender-identified during the same timeframe; and an increased use of social media/internet prior to disclosure of a transgender identity. This is not currently a clinically accepted diagnosis, and the idea of rapid onset gender dysphoria spreading as a social contagion is an area of active research and debate.[10-11]

2.5. GAMETES

Gametes are mature reproductive cells. There are two types of human gametes: sperm, which are produced by males, and eggs, which are produced by females.[12]

2.6. BIOLOGICAL SEX

A person's biological sex is nearly always discernible by the gametes they produce or have the potential to produce. A person who produces sperm is male. A person who produces eggs is female. Prior to puberty humans do not produce

gametes, so biological sex is determined at birth by the presence of male or female anatomy due to the very high probability that the vast majority will eventually produce the gametes corresponding to their anatomy seen at birth. There are exceptions to this general rule for intersex children, which is described below. A person's biological sex does not change if their reproductive organs are not functional, are removed, or they choose not to procreate. Biological sex as determined by gametes is binary; there are no gametes "in between" sperm and eggs. There are only two types.[13]

2.7. CHROMOSOMES

A structure found inside the nucleus of a cell that is made up of proteins and DNA organized into genes. Human body cells (somatic) contain 23 pairs of chromosomes, one set from each parent. Our gametes, however, have only one set of chromosomes. All eggs have an X chromosome. Each sperm carries either an X or Y chromosome. When an egg is fertilized (zygote) the egg's X chromosome is combined with either an X or Y chromosome from the sperm, resulting in somatic cells that are either XY (male) or XX (female). People with intersex conditions sometimes have a different set of sex chromosomes.[14]

2.8. INTERSEX

An umbrella term for the >40 different conditions where sexual development does not rigidly adhere to the typical male or female pathway, including, for example, Klinefelter Syndrome, Androgen Insensitivity Syndrome, and Congenital Adrenal Hyperplasia. These are rare conditions seen in approximately 0.018% of the population, where a person who has reproductive or sexual anatomy that would be considered atypical because it doesn't fit the standard appearance of male or female, such as someone who has both a vulva and testicular tissue.[8] A person who is intersex will typically only produce a single type of gamete or be infertile.

2.9. GENDER IDENTITY

A theoretical concept introduced in the 1960's[15] where a person's internal sense of their own gender can include being female, male, and more recently another gender, or no gender.[16] One's gender identity can be the same or different than their biological sex. It is believed that gender identity is less established in

younger children, and typically becomes stable after a child undergoes puberty, though some adults experience gender fluidity throughout their lifetime.[17] The general process of identity formation typically happens during adolescence and early adulthood. At the moment, there is ongoing debate about how many gender identities there are, with some people believing there are only two, others saying as many as 112, and others saying there are as many gender identities as there are people in the world.[18] Some people do not have an internal sense of a gender identity and therefore, do not ascribe to this notion for themselves.[19]

2.10. GENDER FLUID

Gender fluidity refers to change over time in a person's gender expression or gender identity, or both.

2.11. GENDER EXPRESSION

The way a person represents or expresses gender to others, often through behavior, clothing, hairstyles, activities, voice, or mannerisms.

2.12. GENDER CONSTANCY

The endpoint in the developmental process in which a child understands that biological sex is fixed, and that clothing and other contextual factors do not change one's biological sex.[20] Research indicates that more stable schema of sex begins at age 5, with sex constancy being achieved by the age of 7 for most children.[21] Sex constancy delays have been observed in children with gender dysphoria[22] and autism spectrum disorder.[23]

2.13. CISGENDER

An adjective describing a person whose gender identity or expression is the same as that traditionally associated with their biological sex. Some people find this an offensive term.

2.14. TRANSGENDER

An adjective describing a person whose gender identity or expression is different from that traditionally associated with their biological sex. A person who is transgender may or may not have gender dysphoria.

2.15. TRANSITION

The process in which a person goes from living and identifying as one gender to living and identifying as another. Transition is a process that is different for everyone, and it may or may not involve social, legal, or physical changes. There is no one step or set of steps that an individual must undergo to have their gender identity affirmed and respected. Social and physical transition are considered major therapeutic and medical interventions that require parental involvement and professional oversight by clinicians responsible for the individual's treatment plan.

2.16. DESIST

The process of reversing a social transition (e.g., by reverting to an earlier name) and reidentifying as their *birth-assigned sex*, thus individuals who were once seeking medical transition are no longer doing so.

2.17. DETRANSITION

The process of seeking to change a person's gender presentation back to his or her biological sex, by terminating the use of hormones and/or puberty blockers, often seeking to reverse earlier medical transition. This process typically involves significant social, legal, and/or physical changes and often requires medical professional and therapeutic support.

2.18. SOCIAL TRANSITION

The process in which a person takes on a new name, changes their appearance (hairstyle, clothing, makeup, and other non-medical changes) and uses preferred pronouns (such as opposite sex pronouns or non-binary pronouns such as "they"). Schools may participate in a child's social transition, for example by using preferred names and pronouns and/or allowing the student to use different facilities. This is a powerful psychosocial intervention that requires considerable therapeutic support.

2.19. COMORBIDITY

A medical term that refers to having more than one mental or physical condition at the same time, which in some cases may be related to each other. A person

who has diabetes may also have depression, for example, and it's possible that their diabetes may or may not play a role in their depression.

2.20. PRIMARY SEX CHARACTERISTICS

These are features that are typically present at birth that indicate a person's biological sex, such as a penis or vagina. These are clearly formed in the vast majority of cases, with the rare exception of people with intersex characteristics.

2.21. SECONDARY SEX CHARACTERISTICS

These are features of males and females that develop during puberty, such as facial hair for males and breasts for women, and pubic hair for both sexes.

2.22. TANNER STAGES

These stages, also known as sexual maturity ratings, describe the physical changes occurring during puberty. There are five stages, starting with stage 1, which typically begins after age 8 in females and after age 9 in males, with stage 5 beginning around age 15 for both biological sexes.[24]

2.23. PUBERTY BLOCKERS

These are drugs taken to suppress puberty. They may be given starting at Tanner stage 2 or beyond. Under the "gender affirmation" model, it is thought that such suppression would give a child time to consider their gender identity before developing secondary sex characteristics. However, 98% of children who take puberty blockers move on to cross sex hormones and it is considered by many as the first step of a medical transition.[25]

2.24. CROSS-SEX HORMONES

These are synthetic estrogen or testosterone prescribed by physicians to people who suffer from gender dysphoria and want to develop the secondary sex characteristics associated with the opposite sex to their biological sex.

2.25. MEDICAL TRANSITION

A process in which a person takes cross-sex hormones to masculinize or feminize their body, and/or undergoes surgical procedures to appear more

masculine or feminine by removing tissue/organs, and/or constructing facsimiles of opposite sex organs.

2.26. GENDER AFFIRMATIVE THERAPY

A therapeutic or medical treatment afforded an individual based on their gender identity. For children it is sometimes called "early transitioning." This approach to therapy is considered child-led, where adults affirm the child's internal sense of identity, and therapists act as facilitators to support the child's choice to identify as a gender different from their biological sex. Social transition is often offered in this approach. This may or may not be followed by a medical transition. This is a new model of treatment that has been used for the last ten years with the adoption of World Professional Association of Transgender Health (WPATH) Standards of Care (SOC), 7th edition, however it has gained traction quickly and is widespread in the U.S. Several European countries have moved away from childhood self-diagnosis and social and medical transition and now require extensive psychological evaluation before considering social or medical transitions.[26-28]

2.27. PSYCHOTHERAPEUTIC APPROACH

This approach offers conventional psychotherapy and allows children to explore their gender while being open to the possibility that they may grow comfortable in their biological sex. Approaches called "wait and see", "watchful waiting", "developmental" or "gender exploratory therapy" fall under this umbrella. The approach of the psychotherapist may depend on their training—some are psychoanalytical, others are cognitive behavioral therapists while more still are person-centered therapists. No matter what their training, psychotherapy offers a neutral, open-ended approach with a professional clinician seeking to understand factors relevant to the child's development, including trauma, psychopathy, neurodevelopmental conditions, and other life factors that may be causing a child to see transition as a preferred path. The child may or may not eventually decide to socially transition and/or medically transition. This approach seeks to destigmatize both gender dysphoria and transgenderism, and supports cisgender, transgender, homosexual, heterosexual and asexual identities as valid outcomes. It does not steer a child toward any particular outcome. This approach to mental distress has been used and refined for over

a century. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) recently published a position statement acknowledging the growing numbers of gender dysphoria youth. The College advocates for a developmental approach, considering personal and family history, comorbidities, and the context in which the dysphoria emerged.[29]

2.28. CONVERSION THERAPY

An outdated and barbaric practice that was offered decades ago but thankfully no accrediting body in the world recommends conversion therapy any longer. Ethical therapists will never try to convert an individual and we also strongly condemn this practice.

2.29. WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH (WPATH)

An international professional and lobbying organization working to further the understanding and treatment of gender dysphoria and those identifying as transgender.[30]

3. POLICY STATEMENT

This policy is intended to provide parents of children experiencing gender dysphoria with both information and options for working with the school to support their child at school. The underlying principles of this policy are as follows:

- Transparency – The parents of a child experiencing gender dysphoria, or who expresses concerns about their gender shall be informed when school staff become aware of the child's gender-related distress.
- Medical/Psychological Evidence and Ethics – Gender dysphoria can present in different ways, at different ages, and with different causes. The school will not pursue a "one size fits all" approach in which any child presenting with gender distress is automatically socially transitioned. The school will work within an ethical framework in which students are matched with a therapeutic approach that is appropriate for their particular presentation and age based on the best available scientific research. Such decisions will be undertaken in collaboration with parents, and where appropriate with other area experts.

- Supportive Neutrality – Schools can best respect their students' search for meaning and personal identity by creating space for uncertainty and exploration and remaining supportively neutral as to outcome or direction. The school considers variations in student interests and expression as normal and natural, not as signs that a student is necessarily transgender. The school will provide the same provisions for students seeking transition and detransition.
- Informed Consent – Parents shall have the right to play a determinate role in defining the school's approach to their child's needs. They have a right to be informed about their options prior to granting consent to the approach the school uses to support their child at school, subject to the conditions and limitations of parental rights outlined in section 5.
- Non-Stigmatization – The school shall offer a non-judgmental environment for students with gender dysphoria, making every effort to de-stigmatize it, show acceptance and comfort in dealing with gender issues, and create a safe environment for students.
- Privacy – The school shall not disclose a child's gender dysphoria to anyone other than the school staff who reasonably need to know to support the child, and to the child's parents or guardians.

4. GENDER DYSPHORIA INFORMATION PACK

The school counselling department should produce an information pack for parents that explains gender dysphoria and treatment options based on the best available scientific evidence in layperson's terms. This pack should be reviewed at least once annually to ensure it reflects the best available research. This pack should be freely available in printed form and made available to all parents who request it and be available to the general public on the school website.

5. PARENTAL RIGHTS AND THE SCHOOLS' RIGHTS

The school recognizes and respects that parents know their child's history and may have different interpretations than that of clinicians, the school respects the parents' beliefs and value systems, and the school recognizes that parents and educators may receive different recommendations from mental and medical health professionals that

may lead them to choose different approaches to support their child in school. The school shall support parents' right to choose affirmative therapy, conventional psychotherapy, or another approach as recommended by the child's mental health provider and/or medical doctor. At a parent's/guardian's request and with their written approval, the school may implement another approach when a child is participating in a clinical trial studying this approach. The school reserves the right to refuse to implement approaches that attempt to steer a child toward a particular gender identity through disciplinary or coercive means. In general, it is inappropriate for the school to act against parents' wishes unless the school has serious concerns about parents' fitness to support their child's wellbeing, which has been adjudicated via formal channels, such as Child Protective Services.

6. SCIENTIFIC FINDINGS, HISTORY, AND DEBATES

At the time of writing, the scientific understanding of gender dysphoria, especially adolescent-onset gender dysphoria, is not settled. The school recognizes that this information may change and will update this section as scientific research continues to emerge.

6.1. PREVALENCE

From 2017-2022, the number of youth who identify as transgender in the United States has doubled, with youth between the ages of 13-17 identifying at a rate of 1.4%, all adults identifying at a rate of 0.5%, and adults aged 65 or older identifying at a rate of 0.3%.[31] Historically, gender dysphoria was found in 0.01% of the United States population (mostly boys), and prior to 2012 there was little to no scientific literature about girls aged 11 to 21 having ever developed gender dysphoria.[10,32] Currently most gender dysphoric youth are female at a ratio of approximately 2:1.[33-35] There is currently no consensus regarding the cause for the recent rapid rise in gender dysphoria, or why females are now experiencing it at a much higher rate than males. These phenomena have been observed in other western countries as well.[36] Some have proposed that greater social acceptance has enabled more people to self-identify and regard this as a healthy development, while others have proposed that normal bodily discomfort accompanying puberty and identity development or other undiagnosed clinical conditions (such as personality disorders, autism) are leading impressionable

children to be influenced by peers, the internet, and pro-transition activists to inaccurately conclude they are transgender. Some have also theorized that the phenomenon is medically mediated; that is the medical and therapeutic community's response and validation of gender dysphoria and trans-identification with treatment itself, may mediate the rapid increase.[37] The relative contributions of each of these proposed causes, or the existence of other possible causes is not well understood or agreed upon.

6.2. PERSISTENCE AND DESISTANCE

Across all 12 long-term studies ever done on gender dysphoria, nearly 70% of children desist by the end of puberty, with a range of desistance from 61-98%.[38-41,3] Even children who are severe in their gender dysphoria can experience desistance.[13] While most children's gender dysphoria resolves during puberty, some children experience increased feelings of dysphoria as they undergo puberty.[39] Currently there is no accurate method to detect who will persist or who will desist.

6.3. IDENTITY OUTCOMES

For those with childhood-onset gender dysphoria, in 2.5%-20% of cases their gender dysphoria is the initial manifestation of transgenderism and they will ultimately identify as transgender as adults.[42] After undergoing puberty, for 61-98% of these children, their gender dysphoria will resolve, with most identifying as homosexual or bisexual.[3,43,44] No long-term data is available for the newer cohort characterized as rapid onset gender dysphoria, for whom gender dysphoria emerged post puberty.

6.4. BIOLOGICAL SEX VS. GENDER SPECTRUM

Historically, science has accepted that there are only two biological, dichotomous sexes as determined by reproductive organs designed to produce one of two gametes. Some scientists have proposed a taxonomy that presents sex as a spectrum, based on various intersex conditions.[45] This interpretation has been adopted in government policy in Switzerland.[46] Critics, however, regard sex being on a spectrum as simply defining a range of atypical sexual anatomy and do not believe it establishes the existence of a third or more biological genders. With regard to gender identity, there is some evidence suggesting that

the brains of people with a transgender identity have shifts in the dimorphic parts of their brains that are more consistent with their gender identity rather than their biological sex. It has been suggested that this may be related to in utero testosterone levels.[13,47] Given that these same brain correlates have been found for homosexuals, and that none of the studies on the brains of transgender individuals controlled for sexual orientation, it is highly likely that this shift reflects homosexuality not gender identity.[48-50] Other confounding factors in various studies such as neuroplasticity due to living as the opposite gender (in post mortem studies) and changes due to cross sex hormone use are also not controlled for.[51] Twin studies show that only 28% of twin pairs will have both twins develop a transgender identity, suggesting that genetic influence exists but is not determinative of identity outcomes.[47]

6.5. TERMINOLOGY AND IDENTITY

With regard to terminology, newer terms such as "agender", "genderqueer", "non-binary", "pangender", "quadgender", "gender-neutral", "genderfree", "netrois", "demigirl", "demiboy", "feminine-of-center", "masculine-of-center", "girlflux", "boyflux", "paragirl", "paraboy", "librefeminine", "libremasculine", "FTX", "MTX", and "genderfluid", are just a few examples of ways in which some people describe their gender identity. Most parents are familiar with a limited set of descriptions, such as "girly girl", "manly man", "effeminate" (which some consider offensive), "transsexual" (usually considered an outdated term) or "tomboy". With these newer, more highly differentiated labels only recently being added to the vocabulary of gender identity, scientists have not yet conducted studies to determine if these identities correspond to finer-grained differences in the brain, genetics, or other biological structures or processes. Even if such evidence is not discovered, this doesn't mean that using either the older or newer terminology to describe one's own internal personal experience is invalid. Additionally, there is a well-documented overlap of 30% between masculine and feminine traits in both sexes, and whether or not a person conceptualizes themselves as transgender is subject to cultural and environmental factors.[52] It is also important to recognize that some children ruminate a lot about their gender identity in fine-grained detail (such as wondering if they are a demiboy or masculine-of-center), and that excessive focus on one's self seldom improves mental health outcomes.[53]

6.6. CONSIDERING COMORBIDITY

In the studies done in The Netherlands under the "Dutch protocol", gender questioning youth were screened for comorbidities prior to undergoing medical treatment, and they were strongly discouraged from socially transitioning prior to treatment. This stands in contrast to the current affirmative-only approach that allows for socially transitioning without proper screening. Adolescents with gender dysphoria are more likely than the general population to experience mental health issues, with 40-45% presenting with clinically significant psychopathology, as compared to roughly 20% of the general population.[39,54] There are multiple documented cases of individuals who socially and medically transitioned in order to relieve their gender dysphoria, but came to understand that their dysphoria was caused by other mental health issues.[11,32,55] One study found that 61% of patients presenting with gender dysphoria have another psychiatric condition, and in 75% of these patients, gender dysphoria was a symptom of another mental illness.[56] An internationally recognized expert who was instrumental in defining gender dysphoria for the DSM-5 and helped write WPATH's SOC 7th edition has stated that just because a person is fixated on gender as a source of their problems doesn't mean that transitioning will alleviate their distress. This scholar, who has sometimes advised his patients to transition, recommends that clinicians examine the entire person rather than immediately accepting someone's self-diagnosis of being transgender.[32] It is notable that WPATH's SOC 8th edition does not require a diagnosis or assessment, stating that "health care professionals should not make it mandatory for transgender and gender diverse people to undergo psychotherapy prior to the initiation of gender-affirming treatment."[57]

6.7. SUICIDE RISK

Suicide risk is often mentioned in discussing the mental health of those identifying as transgender, and is often used to justify the affirmation model. One of the most cited statistics, based on the National Transgender Discrimination Survey (NTDS) of adults, reported that as many as 41% of transgender adults have attempted suicide in their lifetime.[58] Similar increased risk of suicidality via surveys has been found in transgender youth.[59] While these and other statistics of suicidality are most concerning, they must be considered with caution. It has been pointed out, for example, that many studies of

suicidality in this population may not be accurate population estimates because they rely on samples of convenience. Further, such surveys are not able to discern whether the suicidality can be attributed to gender dysphoria or other mental health comorbidities common in this population.[13] Comorbidities are important to consider as these, too, are associated with increased risk of suicidality.[27, 60] A recent study using a large data set of youth seeking treatment at the Gender Identity Development Services at the Tavistock and Portman Foundation, found that the rate of completed suicide was 0.03%, 5.5 times greater than the suicide rate of adolescents of similar age.[61] Suicide risk, therefore, requires judicious consideration.

6.8. ETHICAL DECISION MAKING

There are a number of areas that need to be considered to be able to make sound, ethical decisions for youth with gender dysphoria. Because social transition is a major psychological intervention, the ethical responsibilities of teachers and school administrators must be informed by the following considerations:

- Online Influencers: There are documented cases where adolescents were influenced by online transgender influencers to transition so they won't end up killing themselves.[32] The advice these influencers give included statements such as, "if you're asking the question 'Am I trans' the answer is probably yes" and "[Y]ou don't need to be a hundred percent sure you're trans to try hormones", both of which are inaccurate and unethical.[32] Some influencers coach children to answer clinician's questions with fabricated stories about their gender dysphoria in order to obtain puberty blockers or cross-sex hormones.[32] Some online influencers encourage children whose parents doubt the clinical appropriateness of transition to establish a "glitter family" of online contacts who "truly understand them" and who will support the child's choices.[32] Aaron Kimberly, who transitioned from female to male as a young adult and has an intersex condition, has also been outspoken in his opposition to current trends in transgender care, stating that students are "picking up a culture, not evidence-based clinical information".[62] Researchers have also found that social media platforms, that push content using algorithms based on viewing history, are associated with negative mental health outcomes for

adolescents, particularly adolescent girls.[63] It's important to note that none of this means that transgender identities in general should be regarded as invalid or suspect, only that parents and school staff need to be aware that in many cases children's interest in transitioning could be influenced by inaccurate information from social media or other sources.

- Therapists: The issue of informed consent in the context of youth gender transition has received considerable attention considering the low and very low-quality evidence in support of the affirmative care approach. Some affirming therapists sometimes tell parents that their choice is between "having a dead daughter or a live son" (for transgender males) or "having a dead son or a live daughter" (for transgender females). The ethics of such practices is questionable given the complex evidence around suicidality and co-morbidities. It is notable that under these conditions, consent to treatment is done under duress and cannot be considered informed. These professional debates have led mental health professionals to question affirmative practices without extensive psychotherapeutic assessment and support. The recommendations of the Interim CASS Review[27] and the Gender Exploratory Therapy Association specifically recommend traditional psychotherapy instead of affirmative-only therapy.[64]
- Schools: Aside from pregnancy and time-sensitive emergency situations, medical ethics for life-altering treatments for minors require that parents be aware of the child's condition and be provided with accurate and balanced information prior to obtaining informed consent to pursue treatment. Some school systems have made it their policy not to inform parents of their child's gender-related concerns and implement social transition without the knowledge or consent of parents. Litigation in such circumstances is emerging as school districts navigate these challenges.[65] Social transition is increasingly understood to be a major clinical intervention that should not be undertaken without the oversight of clinical professionals and parental consent/involvement.[27] Further, for young children, the literature on gender constancy should be consulted in considering social transition as the act of social transition may impede the development of sex constancy.[66] Schools engaging in social transition must be cognizant of the fact that they are embarking on a powerful psychosocial intervention they are not qualified to engage in.

The mental and physical health risks, informed consent and long-term implications of social transition require partnership and collaboration between families, treating clinicians and educators of any individual student with gender dysphoria.

- Gillick Competence: The issue of whether children can be "Gillick competent," a legal standard in the United Kingdom for minors to be able to consent to medical treatment without parental permission, has informed ethical debates in America.[67] After several rounds in the British courts both affirming and denying Gillick consent for puberty blockers, the courts ruled that children under 16 could not meet this standard. Additionally, the UK shut down its Tavistock NHS Foundation Trust gender clinic amid long waiting lists, inadequate data collection, and ethical concerns relating to staff feeling under pressure to only use the affirmative approach.[68]
- Internalized Homophobia: Sexual orientation conflicts, often associated with shame, are a central dynamic for many young people with gender dysphoria.[64] In some cases, transgender identification may be a strategy aimed at addressing issues described as manifestations of internalized homophobia.[11] A psychotherapeutic process can help illuminate whether transgender identification is an important developmental attainment or whether gender is being recruited to solve other difficulties. The Gender Exploratory Therapy Association provides a guide to clinicians for exploring this with clients.[64]
- Positive Medical Outcomes: Numerous transgender clinical experts and activists have expressed concerns about the current rush to medical transition in today's clinical practice.[69,70] However, in some cases medically transitioning is the most appropriate treatment for transgender adults.
- Bullying: Bullying is never acceptable for any reason, including for students who are gender-questioning or have a transgender identity. Schools must be cognizant of the fact that peer pressure can work in two directions—both influencing students to identify as transgender and also influencing them to not identify as transgender—and that staff should not underestimate this influence or assume it is always in one direction. Staff should also be aware that some students who socially transition desist and reidentify with their *birth-assigned sex*. These individuals are at

considerable risk of bullying. Studies have noted that *trans-identified children* are as likely to be perpetrators as they are to be targets of bullying.[71]

- Summary of Ethical Concerns: The questionable advice of internet influencers and peers, the positive reinforcement of "glitter families", and some schools covertly supporting transitioning, can create a situation in which children can become alienated from their families at a point in their life where they need even more support. Parents should be aware there are significant ethical and scientific questions regarding the quality of information parents and students are provided (or not provided), the lack of long-term scientific studies supporting social or medical transitioning, and minors' competence to make decisions about their own care.

6.9. LEGAL STATUS

Schools must align with the laws of their state. To fall within the protection of the Equal Protection Clause, a protected personal attribute (such as biological sex) must be "immutable". Changeable attributes such as hair color are not protected. Transgender rights advocates usually claim gender identity is immutable, which would have the desired legal effect of falling within the Equal Protection Clause.[32] The fact that gender identity is known to be flexible in children[41], the existence of detransitioners and desisters[11,55,72], and the existence of adults who experience gender fluidity[55], calls into question whether gender identity is immutable. Whether or not gender identity is immutable, it is considered protected under Title VII of the Civil Rights Act of 1964, though this has been subject to multiple ongoing court challenges.[73]

6.10. CONSIDERATIONS FOR SOCIALLY TRANSITIONING

Some studies find that children who socially transition experience relief from gender dysphoria and a reduction in suicidal ideation.[74] Others have found that gender transition does little, if anything, to relieve gender dysphoria, suicidality and mental health comorbidities, or improve life-functioning.[75] Further, there is speculation that "gender affirming treatments" may be highly subject to the placebo effect[76], which is consistent with detransitioner accounts that they initially experienced euphoria, only to return to a dysphoric

state later.[55,72,77] Social transition is reversible in the sense that it involves temporary cosmetic and name changes, but the long term psychological effects of social transition and/or desisting are not known.[78,79] It is important to consider that social transition is likely to impede the natural resolution of gender dysphoria as it is associated with higher rates of persistence; some have argued it is iatrogenic leading to medical transition.[80-82] Further, once a child has made the transition public, reverting back maybe be embarrassing and cause considerable stress and anxiety, making hormonal and surgical interventions more likely.[13,80] In some cases children will want to change schools to assume their new identity or return to their old identity more easily. For biological females, socially transitioning can involve binding their breasts, which poses considerable risks such as back, shoulder, chest and abdominal pain, rib and spine changes, shortness of breath and light headedness, and skin infections.[83] Tucking (for males) lacks long term studies but studies suggests that this can impact fertility by causing cryptozoospermia and testicular torsion.[84,85] Schools affirming a student's gender identity or publicly celebrating a transgender student's courage are not neutral actions and can unintentionally influence students' identity formation.[81,86] There is currently no validated method to determine the likelihood of whether a person will or won't desist prior to socially transitioning.

6.11. CONSIDERATIONS FOR MEDICALLY TRANSITIONING

Puberty blockers, which are used "off label" for the treatment of gender dysphoria are commonly prescribed at Tanner Stage 2. Once thought of as a harmless "pause button", this is no longer the case. A recent study shows that in 98% of cases, children put on puberty blockers move onto cross sex hormones.[87] The long-term physical and psychological effects of taking puberty blockers and delaying puberty are not fully understood.[88] Taking puberty blockers will delay brain development that would normally occur during puberty, a time in which significant brain development occurs, potentially impacting cognitive development.[89] There is also evidence that puberty blockers may negatively impact bone density and cause bone and skeletal issues.[90] The impact of puberty blockers on sexual development and anorgasmia in adulthood is also of concern.[91] Some research has found an association between puberty blockers, depression and other psychological issues. Discussing an experimental trial of puberty blockers in the U.K., one

scholar wrote, "there was no statistically significant difference in psychosocial functioning between the group given blockers and the group given only psychological support. In addition, there is unpublished evidence that after a year on [puberty blockers] children reported greater self-harm, and that girls experienced more behavioral and emotional problems and expressed greater dissatisfaction with their body—so puberty blockers exacerbated gender dysphoria.[25] If a person has not undergone puberty before taking cross-sex hormones, they will be permanently infertile. For biological males, who have taken puberty blockers to halt puberty, medically transitioning to female via vaginoplasty may prove challenging since there may not be enough tissue available to perform the operation.[92] Cross-sex hormones result in irreversible secondary sex characteristics. Surgical procedures, including facial reconstruction, double mastectomy, breast construction, gonadectomy, and phalloplasty, involve risks in terms of undesirable health outcomes (infertility, infection, scarring, loss of sensation, and sepsis) and may result in less-than-desired cosmetic outcomes. Maintaining a cross sex appearance requires lifelong hormonal treatment, which carry risks including hypertension, vaginal atrophy, higher cancer risk, stroke, liver damage, and bone mineral loss.[93] Since the affirmation model is relatively new, long-term research is needed to understand the full effects. Some people who medically transition have regret and detransition, while others are satisfied with the result. Approximately 25-35% of transgender people pursue medical transitioning of some sort.[94] There is currently no validated method to determine the likelihood of whether a person will or won't desist prior to medically transitioning, or who may regret medically transitioning. In sum, there are serious risks associated with medically transitioning. Despite its risks, most experts agree that in some cases medically transitioning is the most appropriate treatment.

6.12. DETRANSITION EVIDENCE

There is currently limited data on the reasons people choose to detransition. One study found that trauma (including sexual trauma), difficulty accepting oneself as homosexual, dysphoria rooted in misogyny, peer influence, and social media and online communities influenced their development of a transgender identification and desire to transition. Some reported health concerns and found alternatives methods to deal with their dysphoria.

External factors such as a lack of support, financial concerns, and discrimination also occurred, but were much less common. This study found that only around 24% of people who detransition report their detransition to the doctor who facilitated their transition.[11] The rates of desistence and detransition have not been reliably established. One study of youth in the UK indicate that it may be as high 10.3% within 12 months of seeking treatment.[95] A study of adolescents and adults found that as many as 30% discontinue gender affirming hormonal treatment within 4 years.[96]

6.13. STANDARDS OF CARE

The use of puberty blockers and cross-sex hormones for gender transitioning is considered an off-label use and has not been evaluated by the U.S. Food and Drug Administration to determine long term outcomes. In terms of therapy, the traditional psychotherapeutic approach is the most consistent with scientific evidence and was regarded as the standard of care up until roughly 2010, when countries began adopting a gender affirmative approach.[13] The gender affirmative approach is not supported by long term studies.[2]

Currently, most American medical and psychological organizations have adopted the Standards of Care issued by WPATH, an organization that some professionals no longer consider credible. It is worth noting that despite its title, WPATH states the document aims to provide "clinical guidance", and is not standards of care,[57] since it does not meet the level of scientific rigor to qualify as a standards of care document. Genspect offers a different approach for the treatment of youth and young adults with gender distress and welcomes diversity of expression and self-acceptance free from medicalization.

In 2006, the 6th edition of WPATH Standards of Care set standards for medically transitioning, including requiring patients to live in their gender identity for a year, and obtaining a referral from a psychologist before obtaining surgical interventions. In 2012, the 7th edition of the WPATH Standards of Care removed the one-year requirement and recommended psychotherapy prior to transition but no longer required it.[97]

The 8th edition of the WPATH Standards of Care removed any requirements to obtain a diagnosis of gender dysphoria, and no longer includes minimum age requirements for medical treatment with the exception of phalloplasty.[57] Notably, this latest edition also removed the chapter on ethics and added a chapter on eunuchs; those who "wish for a body that is compatible with their eunuch identity—a body that does not have fully functional male genitalia." Instead of "first, do no harm" WPATH now supports the idea that a healthy male may be castrated so his body aligns with his internally felt identity that he is a neuter. These changes in the Standards of Care have been criticized by medical professionals for not providing sufficient safeguards to ensure patients will be properly assessed to ensure they receive the appropriate treatments.[98] A petition has been started documenting the concerns shared by clinicians internationally.[99] (Beyond WPATH | WPATH has discredited itself). Those in favor of the standards argue that these changes eliminate "medical gatekeeping" that could prevent transgender people from getting the care they need.

7. PROCEDURES

The school staff shall take the following steps to support students experiencing gender dysphoria:

- School staff shall notify parents if a student states that they are transgender, questions their gender, or behaves in a manner consistent with the characteristics of gender dysphoria defined in Section 2. Staff are not expected to make a formal clinical diagnosis, only to inform parents if their child has gender-related concerns. Staff do not need to wait for six months to fulfil the DSM-TR-5 definition of gender dysphoria since a child's statements or behavior at school could mark the beginning of a six-month period in which this definition is fulfilled, and the intent of this policy is to keep parents informed as early as possible so they can decide how to best support their child.
- Being homosexual or having interests or personality traits that are not traditionally associated with a student's biological sex are not indications of gender dysphoria or being transgender and should not be reported as such.

- School staff shall meet in person with the child's parents to share their reasons for believing the child has gender identity concerns and shall share the Gender Dysphoria Information packet described in Section 4 that explains gender dysphoria in layperson's terms.
- The school and parents/guardians shall mutually agree on a plan to support the child, if needed. In the event of differences of opinion about the best approach, parents' approach will be determinant over the plan, subject to the conditions in Section 5. The plan shall be written with a copy provided to the parent(s) and a copy kept on file at the school.
- The school and parents will continue to keep each other informed as to the child's academic performance and mental health status. Either party may request additional meetings to adjust the plan at any time. Parents have the right to change or terminate the plan at any time, subject to the conditions in Section 5.

8. PARENT COMMUNICATION AND TRIANGULATION

The school recognizes that young people can use triangulation as a communicative strategy. Triangulation occurs when a third party (the school) is used either as a substitute for direct communication with the subject of the communication (in this case, the parents), or used as a messenger to carry the communication. In this case, it expresses implicit dissatisfaction with the parents. The goal of triangulation is to divide, which often happens through the use of exclusion or manipulation of a situation. The school staff need to be aware of triangulation and endeavor to avoid allowing triangulation to occur between the student, parents, and school body. The school shall not exclude parents from decisions or information exchange unless this takes place within a formal structure and involves social services. The school shall not act against the parents' will unless there are adjudicated concerns about the fitness of the parents involving formal proceedings with Child Protective Services.

9. STUDENT SAFETY AND SECRECY FROM FAMILIES

The school shall not encourage children to keep secrets from their families unless there is serious justification to do so. If there is good reason to believe that any student will

become unsafe if their parents are made aware of their gender dysphoria or transgender identity, the school shall immediately follow the appropriate protocol, including contacting Child Protective Services. Unless otherwise warranted, the school shall assume the family unit is a safe and nurturing place. If parents have previously shown themselves to be reasonable, loving and engaged, the school should collaborate as far as possible with the family, and nurture healthy communication between students and parents.

The school recognizes that, historically, schoolteachers may have kept a student's secret because of a fear of serious repercussions from their family. The school acknowledges that there is a significant difference between a conversation that is kept in confidence between a student, and an open secret kept by the school staff and entire school community. The latter can be humiliating for the parents and damaging for the family's wellbeing and ultimately the child. In some cases, families could end up being the last to know, even though the entire school community was fully aware of the child's social transition. The school should avoid creating these situations.

The school acknowledges that needlessly keeping secrets from parents can inadvertently cause divisions between the school body and the parents, and damage the parent-child relationship, leading to triangulation and even alienation. A child may end up changing clothing, names, and pronouns halfway between home and the school in order to live a "double life." The school is mindful of how distressing and potentially damaging this could be for everyone, including the child. The school shall help parents who feel distressed by their child's gender dysphoria by giving them information about family support groups. The school shall aim to uphold the integrity of the family unit to ensure the long term mental and physical health of the student.

10. SOCIAL TRANSITION

The school acknowledges that social transition is a powerful psychosocial intervention that should not be pursued prior to a student obtaining a psychological evaluation from a qualified mental health professional, and that ongoing clinical assessment and support must be provided. It is important to recognize that schools agreeing to change a child's name and pronouns is not a neutral act to demonstrate respect or acceptance for the child's identity, but has an effect on the child's identity development. As such,

socially transitioning shall only be permitted with the written permission of the parents, in accordance with the following:

- Name Changes: The school recognizes that students often change their names and use nicknames during the process of identity exploration that occurs between the ages of roughly 12-25 years, and many teachers choose to use their students' preferred names. However, teachers and other school staff should acknowledge the responsibility of their position and be careful not to give an official imprimatur on any given name as doing so may inadvertently foreclose further exploration of a vulnerable student's identity or transient gender identity. Some gender non-conforming young people go through a series of different names, so staff should not concretize a current chosen name. The school shall retain students' official names on all official documents, and exercise caution with regard to teachers' use of students' new names. The school will not allow students to adopt new names against their parents' will, nor allow a student's new name to be interpreted as the official imprimatur of a student's gender identity, unless parents provide written approval to do so.
- Pronoun Changes: The school shall retain the use of biologically accurate pronouns when referring to students, unless the child's parents have specifically requested in writing that different pronouns be used.
- Desistance and detransition: The school acknowledges that the adoption of new name and pronoun can undermine a person's fluidity to re-adopt their birth name if they so choose, which often happens in cases of desistance and detransition.

11. MISGENDERING AND DEADNAMING

"Misgendering" is a term to describe the situation when someone refers to or addresses a person with language that inaccurately represents the person's inner sense of gender identity, as indicated by the individual's preferred pronouns. "Deadnaming" refers to when someone calls a person by a name they used to be known as but no longer wish to be identified as. The school recognizes that this can be perceived as harmful to an individual. There is, however, no quality evidence that supports this perception, nor is there evidence to demonstrate the impact of referring to a person with terms that do

not align with their biological sex is harmful. The best available evidence on social transition indicates that general peer and family support, not social transition, leads to better mental health.[73] The school recommends that the terms "misgendering" and "deadnaming" be de-emphasized. The school recognizes that some students with social communication difficulties will find it difficult to use the language that others might prefer when it comes to the social construct of gender identity. School staff shall not equate "misgendering" or "deadnaming" with violence or make other hyperbolic comparisons. Unless a wider pattern of bullying or other malicious behavior is taking place, "misgendering" and "deadnaming" should not be punishable.

12. BATHROOMS AND CHANGING AREAS

The school shall provide an option for additional single-occupancy toilets and single-occupancy changing rooms, so that vulnerable students can have privacy while accommodating students whose religious and cultural traditions prohibit sharing these spaces with students of a different biological sex. Single-sex spaces shall be maintained, and a third space shall be provided where single-occupancy toilets and changing rooms are available, allowing anyone who wishes to use a gender-neutral space to do so.

13. OVERNIGHT STAYS

To the extent possible, the school shall retain single-sex residential stays and dormitories, while offering a viable alternative option for students who may find staying overnight with students of the same sex difficult. If a school needs to allow mixed-sex dormitories or sleeping arrangements to comply with a child's written and parent-approved plan to support their child or legal mandate, a comprehensive and documented risk and impact assessment shall be performed to ensure that safeguarding is upheld for all students. The parents of all pupils need to be provided with this risk assessment, and consent for all participating pupils must be obtained prior to commencing the overnight stay.

14. BINDING AND TUCKING

The school shall make materials available to parents about the health consequences of binding and tucking, especially during sports activities, to enable families to discuss whether their child's concerns about appearance should override serious health concerns. Under no circumstances shall the school provide students with binders or other clothing or devices to allow students to change their physical appearance.

15. STEALTH TRANSITIONS

Some families seek help from the school to maintain the secret transition of a child. This is often known as "stealth transition," and may involve failing to disclose that a child is staying overnight with, or changing clothes alongside children of the opposite sex. In all situations, the consideration of the student body as a whole need to be balanced with the needs of the child seeking stealth transition. Full discussion with the child and family, with health professional input, should be sought, and a risk and impact assessment should be carried out before any decisions are made.

Schools shall prize openness and transparency wherever it is possible to do so. Vulnerable individuals should have access to extra counselling support so that they can live with honesty and integrity, liberated from the pressure to live a secret life. The school shall support these vulnerable students by nurturing a school community that is supportive of gender non-conforming behavior.

Psychologists and therapists often remind us that "we are only as sick as our secrets." The school shall encourage school administrators to focus on creating an environment of openness and transparency in staff dealings with students and parents and shall not compromise other members of the school community by keeping secrets inappropriately. The parents of all pupils in a school shall be provided with any risk assessment associated with the school facilitating a "stealth transition," along with all identifying information removed from the assessment to protect the students' privacy.

16. SPORTS PARTICIPATION

The school recognizes that there is usually little morphological difference between boys and girls before puberty, and they can often compete with one another safely and fairly. For older students, however, the school shall endeavor to maintain single sex sports, and shall create viable alternative options and activities for students who do not want to engage in single-sex sports. The school recognizes it is important that girls and young women have opportunities to compete safely and that competing against biological males can be demoralizing. If allowing mixed-sex sports is required to comply with a legal mandate, a full risk and impact assessment should be conducted and documented according to the relevant protocols, addressing the impact not just on the individual concerned but on the wider student population. The parents of all pupils shall be provided with this risk assessment (with student identifying information removed), and consent for all participating athletes must be obtained prior to participating in the sporting activity. Any injury or negative impact must be documented and used to inform and update risk assessments.

17. PROFESSIONAL DEVELOPMENT

The school staff shall be provided training to acquaint them with the symptoms of gender dysphoria and the scientific findings and history cited in Section 6. This training shall include materials from the following organizations at a minimum:

- Genspect
- Gender Exploratory Therapy Association

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