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Incorporating Sexual and Gender Minority Patient Care Competencies: A Case Based Curriculum for Caring for Gender Diverse Youth

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Incorporating Sexual and Gender Minority Patient Care Competencies: A Case Based Curriculum for Caring for Gender Diverse Youth

SHORT TITLE: Gender Diversity in a Prepubertal Child

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ABSTRACT:

There is a gap in medical education training content specifically focused on the care of Sexual and Gender Minority (SGM) people and people with Differences in Sex Development (DSD). Inadequate training contributes to suboptimal health care access, utilization, and experiences among SGM-DSD people. Improving medical education training can be challenging as many clinician educators received sparse instruction themselves in these areas and there are limited teaching resources that expand beyond didactic instruction. In 2014 the Association of American Medical Colleges (AAMC) Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development published a landmark document identifying 30 specifiers of competence for best care practices and recommendations for curricular integration and assessment in medical education settings. Case Scenarios with key discussion points were included in the publication to illustrate clinical experiences encountered frequently when caring for SGM-DSD people. In this guide, we facilitate translation of this case scenario into educational curricula for application. Discussion points and experiential learning exercises can be narrowed or expanded to student learning level, time availability, and available institutional resources. Application of this guide does not require content expertise, as critical discussion content and background educational materials are included to support instruction with a minimum amount of advance preparation. The overall goal of this resource is to support the knowledge, attitude, and skill acquisition needed to provide competent care for gender diverse youth.

INSTRUCTOR'S GUIDE

Resource Components

- Case Scenario 1: Gender Diversity in a Prepubertal Child
- Teaching and Discussion Guide

Additional Resources Required

- None, however additional resources may be helpful depending on the chosen strategy for case implementation, as discussed below.

Educational Objectives*

Describe at least three medical disciplines that could be helpful to families with a child that is experiencing gender diversity or gender dysphoria.

1. Demonstrate at least five strategies for sensitively communicating with the child and parents about childhood development and potential identity outcomes for prepubescent children that experience gender diversity and gender dysphoria.
2. Outline a multimodal strategy to promote the psychological well-being of the child in this scenario, including naming at least three specific target areas where psychoeducation and sensitivity should be reinforced.
3. Describe the pros and cons of at least three clinical intervention strategies that might be applied to a gender diverse child and how they might differ from the recommended approach to a child with gender dysphoria.
4. Outline at least five practice and systems-based opportunities to enhance the health care experience for families and children who experience gender diversity or gender dysphoria.

Language Disclosure: Sexual and Gender Minorities (SGM) will be used throughout this document with the intention of it being an umbrella inclusive term. We recognize the importance of the use of various words and descriptors and want to be sure we do not contribute to erasure; therefore, we are using this wider umbrella term in hopes that all will feel included.

Purpose

Competency-based teaching resources are in high demand with the increasing push for curricula to be competency-based in order to provide quality care to all patients.[1,2] This is particularly true when training physicians to care for individuals who are lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, and others (LGBTQIA+) who constitute Sexual and Gender Minorities (SGM), as well as individuals with Differences in Sex Development (DSD); as the persistence of discrimination and health disparities suggests gaps in physician competence.[3-5] This resource aims to support the acquisition of competence in caring for children who are

* The activities presented in this teaching guide can be undertaken either in modular fashion (e.g., as one or two discussion points or as one experiential learning opportunity alone) or more comprehensively (e.g., as when the case serves as the focal point during several weeks Family Medicine or Pediatric clerkship). All learning objectives can be met if the chosen teaching activity encompasses all suggested discussion points and experiential learning opportunities; otherwise, learning objectives can be selected and/or adapted from the list to modular content and student learning level.

gender diverse using the specifiers of competence delineated by the Association of American Medical Colleges (AAMC) Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development.[6] Specifically, this resource addresses the following competencies:

Competency Domain	PCRS[a] Competency	LGBT/GNC/DSD Specifier[b]
Interprofessional Collaboration	Work with other health professionals to establish and maintain a climate of mutual respect, dignity, diversity, ethical integrity, and trust by:	● Valuing the importance of interprofessional communication and collaboration in providing culturally competent, patient-centered care and participating effectively as a member of an interdisciplinary health care team.[c]
Patient Care	Gather essential and accurate information about patients and their conditions through history taking, physical examination, and the use of laboratory data, imaging, and other tests by:	● Sensitively and effectively eliciting relevant information about sex anatomy, sex development, sexual behavior, sexual history, sexual orientation, sexual identity, and gender identity from all patients in a developmentally appropriate manner.
	Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment by:	● Describing the special health care needs and available options for quality care for transgender patients. ● Describing the special health care needs and available options for quality care for patients born with DSD.
	Counsel and educate patients and their families to empower them to participate in their care and enable shared decision making by:	● Assessing unique needs and tailoring the physical exam, counseling, and treatment recommendations to any of the individuals, taking into account any special needs, impairments, or disabilities.[c] ● Recognizing the unique health risks and challenges often encountered by individuals, as well as their resources, and tailoring health messages and counseling efforts to boost resilience and reduce high-risk behaviors.[c]

Knowledge for Practice	Apply established and emerging biophysical scientific principles fundamental to health care for patients and populations by:	● Defining and describing the differences among: sex and gender; gender expression and gender identity; gender discordance, gender-nonconformity, and gender dysphoria; and sexual orientation, sexual identity, and sexual behavior. ● Understanding and explaining how stages of physical and identity development across the lifespan affect the above-described populations and how health care needs and clinical practice are affected by these processes.
	Demonstrate an investigatory and analytic approach to clinical situations by:	● Recognizing the gaps in scientific knowledge (e.g., efficacy of various interventions for DSD in childhood; efficacy of various interventions for gender dysphoria in childhood) and identifying various harmful practices (e.g., historical practice of using reparative therapy to attempt to change sexual orientation; withholding hormone therapy from transgender individuals) that perpetuate the health disparities for patients in the population described above.[c]
Practice-Based Learning and Improvement	Locate, appraise, and assimilate evidence from scientific studies related to patients' health problems by:	● Identifying important clinical questions as they emerge in the context of caring and using technology to find evidence from scientific studies in the literature and/or existing clinical guidelines to inform clinical decision making and improve health outcomes.[c]
Interpersonal and Communication Skills	Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds by:	● Developing rapport with all individuals (patient, families, and/or members of the health care team) inclusive of others' gender identities, gender expressions, body types, sexual identities, or sexual orientations, to promote respectful and affirming interpersonal exchanges, including by staying current with evolving terminology. ● Recognizing and respecting sensitivity of certain clinical information pertaining to the care of the patient populations and involving the patient (or the guardian of a pediatric

		patient) in the decision of when and how to communicate such information to others.[c]
	Demonstrate insight and understanding about emotions and human responses to emotions that allow one to develop and manage interpersonal interactions by:	● Understanding that implicit (i.e., automatic or unconscious) bias and assumptions about sexuality, gender and sex anatomy may adversely affect verbal, nonverbal, and/or written communication strategies involved in patient care and engaging in effective corrective self-reflection processes to mitigate those effects. ● Identifying communication patterns in the health care setting that may adversely affect care of the described populations, and learning to effectively address those situations in order to protect patients from the harmful effects of implicit bias or acts of discrimination.
Professionalism	Demonstrate sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, race, religion, disabilities, and sexual orientation by:	● Recognizing and sensitively addressing all the patients' and families' healing traditions and beliefs, including health-related beliefs, and understanding how these might shape reactions to diverse forms of sexuality, sexual behavior, sexual orientation, gender identity, gender expression, and sex development.
	Demonstrate respect for patient privacy and autonomy by:	● Recognizing the unique aspects of confidentiality regarding gender, sex, and sexuality issues, especially for the patients described above, across the developmental spectrum, and by employing appropriate consent and assent practices.[c]
Systems-Based Practice	Advocate quality patient care and optimal patient care by:	● Explaining and demonstrating how to navigate the special legal and policy issues (e.g., insurance limitations [i.e., coverage for medications such as hormonal blockers, gender affirming surgery], lack of partner benefits, visitation and nondiscrimination policies, discrimination against children of same-sex parents, school bullying policies) encountered by the populations described above.[c]

	Coordinate patient care within the healthcare system relevant to one's clinical specialty by:	● Identifying and appropriately using special resources available to support the health of the individuals described above (e.g., target smoking cessation programs, substance use disorder treatment, and psychological support).[c] ● Identifying and partnering with community resources that provide support to the individuals described above (e.g., treatment centers, care providers, community activists, support groups, legal advocates) to help eliminate bias from health care and address community needs.[c]
	Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care by:	● Demonstrating the ability to perform an appropriate risk/benefit analysis for interventions where evidence-based practice is lacking, such as when assisting families with children born with some forms of DSD, families with prepubertal gender diverse children, or families with pubertal gender diverse adolescents.
[a] PCRS, Physician Competency Reference Set [b] Professional Competencies to Improve Health Care for People Who Are or May Be LGBT, Gender-Nonconforming, and/or Born With DSD [c] "individuals/patients/populations described above" refers to individuals/populations who are LGBT, Gender-Nonconforming, and/or Born with DSD		

6*Adapted from AAMC

Description of the Development Process

The paucity of content in undergraduate medical education addressing the health of SGM-DSD individuals is well described.[6] This lack of content is visible in preclinical years and even more so during clinical years.[7] Inadequate preparation is believed to contribute to the negative experiences – from microaggressions to overt bias – experienced by SGM-DSD individuals when accessing and receiving health care. Improving medical education in this realm is challenging for myriad reasons, including (1) determining what to teach, particularly when educators likely have received sparse instruction themselves and (2) limited teaching resources, particularly those that permit expansion of learning opportunities beyond didactic instruction.

The determination of what to teach (i.e., deliverable curricular content aimed at supporting the acquisition of competence) was challenged by a lack of definition regarding the key components that define competence in caring for SGM-DSD individuals. In November 2014, the Association of American Medical Colleges (AAMC) Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development (AXIS) published a landmark document titled *Implementing*

Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who Are LGBT, Gender diverse, or Born with DSD: A Resource for Medical Educators.[6] This publication identified 30 specifiers of competence, based on the Physician Competency Reference Set, that are necessary for the provision of care to these populations and presented recommendations to guide curricular integration, institutional climate change, and learner and program assessment in medical education settings.[2]

Case Scenarios were included in the publication to illustrate clinical experiences encountered frequently when caring for SGM-DSD people, highlight key questions when applying cases in competency-based curricula, and present experiential learning activities to support the acquisition of physician competence when caring for SGM-DSD individuals. The Case Scenario, *Gender Diversity*[*] *in a Prepubertal Child*, was written by Dr. Scott Leibowitz, a child and adolescent psychiatrist who works with gender diverse children at The Ohio State University Wexner Medical Center and edited by Dr. Alice Dreger.

General Suggestions for Using the Materials

While Case Scenario 1: Gender Diversity in a Prepubertal Child lists topics to discuss and potential experiential activities, this teaching guide expands these discussion points and activities to support the translation of this case scenario into educational curricula addressing the health of children who identify as gender diverse. Successful implementation entails identification of an apropos curricular location for content integration, selection, and preparation of instructor(s) and, if possible, assessment of competence.

This resource has been developed in a modular fashion to permit adaptation for application in a variety of settings and learning modalities: lecture-based case discussion, self-directed learning, problem-based learning, team-based learning, case-based learning, etc. While it is beyond the scope of this resource to discuss each potential application, creative use of the material to support active, higher-level learning is encouraged. Discussion points and experiential learning exercises can be narrowed or expanded as appropriate to student learning level, time availability and topics covered in the curricular, and available institutional resources. For example, in a curriculum with existing clinical skills activity, pieces of this case could be added providing students the opportunity to learn core content and receive feedback on their teaching skills. The case could be used as the focal point of a Pediatric clerkship, which would permit coverage of all the suggested discussion points and learning activities over a several week period.

For suggestions on how to integrate similar case scenarios into existing medical education curricula, please refer to *Chapter 4-Integrating Competencies into Medical School Curricula to Improve Care for People Who Are or May Be LGBT, Gender Diverse, and/or born with DSD* of the AAMC Resource.[6]

Facilitating instruction using this case does not require content expertise; critical discussion content is included in the teaching guide so that an undifferentiated faculty member will be able to teach the material with a minimum amount of advance preparation. Furthermore, the teaching

[*] The original title of the case included the word non-conformity and the title has been updated by changing gender nonconformity to gender diversity.

guide includes select references and other educational resources to direct faculty and student teachers toward background material to enhance content expertise and support teaching in advance of implementation. Facilitating instruction of this case requires (1) the belief that the presented content is important for physicians to learn, (2) willingness to examine one's own inherent biases and how these biases may influence teaching the content, and (3) understanding of the specifiers of competence published in this resource.

Assessment of learner competence is a critical aspect of implementation, as the goal of this resource is to support the acquisition of knowledge, attitudes, and skills needed to provide competent care for gender diverse patients; however, the chosen assessment will depend on the teaching strategy employed. The proposed learning activities—for example, those employing standardized patients or involving peer feedback—will require significant preparatory time, development of robust feedback mechanisms, and creation of spaces in which learners feel comfortable sharing their experiences. Specific instructions on these details are beyond the scope of this teaching guide: we refer interested faculty to some of the well designed and executed curricular tools available in MedEdPORTAL Publications.[8-11] We also suggest that parts of this case could be used as the framework for the development of a history taking or physical examination OSCE, thereby serving as a tool to assess learner competence in caring for gender diverse children. For suggestions on how to assess learning uptake, please see *Chapter 6-How to Assess Learners and Evaluate the Impact of Curricular and Climate Initiatives* in the AAMC Resource.[6]

Resources are listed in each section and designed to provide supplemental information for that topic. References can be found at the end of the document and includes citations.

Limitations and Future Improvements

No formal assessment of competence was performed. This lack of data collection thus prevents the evaluation of competence, and future efforts should focus on applying this case in settings where assessment of the aforementioned specifiers of competence can be achieved.

SCENARIO 1: Gender Diversity in a Prepubertal Child
AUTHOR: Scott Leibowitz, M.D.

Jonny is a seven-year-old child who was born with anatomy consistent with the male sex. Ever since he could talk and express an interest in activities, his parents recall him preferring hobbies that were stereotypically feminine. For example, from a young age he preferred playing with dolls and taking dresses from his two older sisters' closets to wear. As he turned five years old, he would only play with female peers and threw tantrums every time his parents tried getting him to play soccer outside with the other boys. At that age, there were several instances when he seemed sad and when asked why, he would answer, "I wish I could be a girl" or "I just like the name Julia much better." This led to some disagreements between his mother and father over the best way to address his behaviors. His mother would wonder whether he might grow up to be transgender and she started buying him dolls and dresses, which made him very happy. His father, on the other hand, would try bringing Jonny to baseball games and would make statements to him such as, "Boys don't wear dresses." Now, at seven, Jonny insists on wearing his hair long, has only female friends, and continues to wear dresses in the comfort of his own home. Despite the fact that he wears stereotypically "boy clothes" at school, he still gets bullied by the boys and is often excluded from play with the girls.

Jonny's mother brings him in for a well-child visit with you, his pediatrician. Although his mother reports that Jonny has not made a statement that he wishes to be a girl in some time, he appears happy and comfortable wearing his favorite purple dress and playing with the dolls in the waiting room. As the mother and child are called back to the examination room, one of the nurses inadvertently refers to Jonny as "she" when telling Jonny's mother how adorable Jonny is. During the appointment, the mother shares several of her concerns with you and asks the following questions:

- "What is going to happen to Jonny?"
- "Is he transgender or gay?"
- "Is he simply a boy who likes 'girl things'?"
- "How can I best support him?"

When you ask Jonny about his friends in school, he quickly changes the subject to his favorite movie, Cinderella, and talks about his crush on the Prince. On physical exam, Jonny has Tanner I male genitals with no apparent abnormalities and displays no discomfort during the exam. At the end of the appointment, his mother asks if you could provide a note to excuse Jonny from gym: "He really doesn't like gym and tends to be teased for not being as athletic as the other boys." In response to this discussion, Jonny says, "I know I'm a boy, but sometimes I just wish I was a girl because I really like doing 'girl things.'" The mother says in front of him, "I keep telling him that it's okay if he wants to be a girl. I've seen plenty of documentaries on TV about boys who become girls."

At that point, you politely interrupt and ask to meet with the mother alone—pulling her into a separate room—where she begins to cry and says that she and her husband are at odds over how to best support Jonny. She notes that her husband "thinks this is all a phase." She recalls that her own brother was stereotypically feminine as a child, "...but he grew up to be gay and not

transgender, so I'm just really, really confused." You offer counseling on how to best support Jonny by educating her on the lack of scientific data regarding the predictability of trajectories of gender diverse children and help her understand how to advocate for Jonny in the school setting and elsewhere. You also encourage her to support Jonny's strengths and to minimize her use of language that creates shame or presumes future outcomes, and you assess whether a referral to a behavioral health provider (who is affirming and familiar with gender issues) is necessary.

DISCUSSION POINTS:

1. Describe the difference between sex and gender, gender identity and gender expression, and gender diverse and gender dysphoria.
2. How can you relate to prepubertal children as they express differing attitudes about their gender and sexuality given typical prepubertal development?
3. Discuss psychosexual development and which potential identity outcomes may exist for a prepubertal gender diverse child and/or child with gender dysphoria. Discuss ways to distinguish children who are exclusively gender diverse from those who are experiencing gender dysphoria.
4. Employ methods of sensitive clinical interviewing in working with diverse families. Identify language for families to use with their children that is open-ended and lacks assumptions.
5. Describe logistical interventions in practice (e.g., ways for office staff to avoid being presumptuous about gender identity) that could be used to enhance comfort in patient interactions in the office between staff and families when a child's appearance differs from the listed assigned sex in the medical record.
6. Discuss comorbidities that may lead to vulnerability in prepubertal gender diverse and/or gender dysphoric children.
7. Outline a multimodal strategy to promote the well-being of the child in this scenario, including naming specific target areas where patient/family-centered education and sensitivity to gender diversity should be reinforced.

EDUCATIONAL RESOURCES

Adelson, S. L. (2012). Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry, 51*(9), 957-974. doi:10.1016/j.jaac.2012.07.004

Malpas, J. (2011). Between Pink and Blue: A Multi-Dimensional Family Approach to Gender Nonconforming Children and their Families. *Family Process, 50*(4), 453-470. doi:10.1111/j.1545-5300.2011.01371.x

Pleak, R. R. (1999). Ethical issues in diagnosing and treating gender-dysphoric children and adolescents. In M. Rottnek (Ed.), Sissies & tomboys: Gender nonconformity & homosexual childhood, 34–51. New York: New York University Press.

Roberts, A. L., Rosario, M., Corliss, H. L., Koenen, K. C., & Austin, S. B. (2012). Childhood Gender Nonconformity: A Risk Indicator for Childhood Abuse and Posttraumatic Stress in Youth. *Pediatrics, 129*(3), 410-417. doi:10.1542/peds.2011-1804

World Professional Association for Transgender Health. (2022). Standards of Care for the Health of transgender and gender diverse people (8th ed.,). *International Journal of Transgender Health*, *23*(sup1), S1-S259.

Steensma, T. D., Mcguire, J. K., Kreukels, B. P., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors Associated With Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study. *Journal of the American Academy of Child & Adolescent Psychiatry, 52*(6), 582-590. doi:10.1016/j.jaac.2013.03.016

Wallien, M. S., Swaab, H., & Cohen-Kettenis, P. T. (2007). Psychiatric Comorbidity Among Children With Gender Identity Disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 46*(10), 1307-1314. doi:10.1097/chi.0b013e3181373848

TEACHING & DISCUSSION GUIDE:

This guide addresses both potential discussion points and activities to enhance the learning opportunities from Case Scenario 1. Each discussion point consists of (1) questions to promote discussion, (2) suggested discussion content, (3) summary learning points, and (4) references for learners and facilitators (located at the end of the document in "references"). Each activity consists of (1) suggested format, (2) suggested learning content, (3) summary learning points, and (4) educational resources for learners and facilitators.

To facilitate discussions and activities, we recommend the following definitions for key terminology.[6] Note that the terms and language used in this document are current at the time of its submission. Always check for the most up-to-date terms and language and adjust accordingly:

- Bisexual: usually refers to a person who has a sexual attraction to both males and females.
- Cisgender: usually refers to a person whose gender identity aligns with the gender label given at birth (i.e., the term refers to people who are not transgender).
- Female-to-Male (FtM): usually refers to a transgender person who was identified as female at birth but who identifies as a male in terms of his gender identity.
- Gay: usually refers to a person who identifies his or her primary romantic feelings, sexual attractions, and/or arousal patterns as being toward someone of the same gender.
- Gender: psychological, behavioral, and cultural characteristics that are believed to be associated with maleness and femaleness.
- Gender Expression: mannerisms, personal traits, clothing choices, etc., that serve to communicate a person's identity as they relate to a particular societal gender role.
- Gender Identity: an individual's personal and subjective inner sense of self as belonging to a particular gender (e.g., being a boy/man, girl/woman, genderqueer, transmasculine spectrum, transfeminine spectrum).
- Gender Diverse: a person who does not conform to prevailing gendered behaviors or roles within a specific society. People who are gender diverse may not take part in

activities conventionally thought to be associated with their assigned gender. For example, a gender diverse male child might wish to dress in girls' clothing and to play exclusively with girls.

- Gender Role: the role a person plays or is expected to play socially in terms of gender within a specific society, conventionally referred to along a masculine-feminine spectrum.
- Genderqueer: an umbrella category for people whose gender identities are something other than male or female. People who are genderqueer may identify as: having an overlap or indefinite lines among gender identity and sexual and romantic orientation; being two or more genders; being without a gender; or moving between genders or having a fluid gender identity.
- Heterosexual: literally "other sex" or "different sex," usually used as an adjective to refer to relations between a man and a woman. Although "heterosexual" was also historically used as a noun to refer to a straight person, that use has now fallen out of favor.
- Lesbian: usually refers to a female person who identifies her primary romantic feelings, sexual attractions, and/or arousal patterns as being toward a person of the same gender or sex.
- Male-to-Female (MtF): usually refers to a transgender person who was identified as male at birth but who identifies as a female in terms of her gender identity.
- Sex: the aggregate of an individual's biological traits (genotypic and phenotypic) as those traits map to male/female differentiation and the male-female anatomical and physiological spectrum (see also "natal sex" or "sex assigned at birth").
- Sexual Orientation: an individual's inclination to feel sexual attraction or arousal to a particular body type or identity. Relatively common forms of sexual orientation include heterosexuality (opposite-sex or opposite-gender attraction), homosexuality (same-sex or same-gender attraction), or bisexuality (attraction to people who are the opposite sex or gender along with attraction to people who are the same sex or gender).
- Straight: usually refers to a person who identifies her or his primary romantic feelings, sexual attractions, and/or arousal patterns as being toward a person of the opposite gender or sex.
- Transgender: individuals who have gender identities that do not align with the gender labels they were assigned at birth.

RECOMMENDED DISCUSSION POINTS:

1. Describe the difference between sex and gender, gender identity and gender expression, and gender diverse and gender dysphoria.

Competencies Addressed:

Competency Domain	PCRS[a] Competency	LGBT/GNC/DSD Specifier[b]

Knowledge for Practice	Apply established and emerging biophysical scientific principles fundamental to health care for patients and populations by:	● Defining and describing the differences among sex and gender; gender expression and gender identity; gender discordance, gender-nonconformity, and gender dysphoria; and sexual orientation, sexual identity, and sexual behavior.
[a] PCRS, Physician Competency Reference Set [b] Professional Competencies to Improve Health Care for People Who Are or May Be LGBT, Gender-Nonconforming, and/or Born With DSD		

6*Adapted from AAMC

Questions to Explore and Promote Discussion:

- How do biological sex and gender differ? Why is it important to make these terminology distinctions in a health care context?
- In what ways does gender dysphoria look different diagnostically in a child than in an adult? How are gender discordance and/or gender diversity related to gender dysphoria? Is evidence of discordance and/or nonconformity always diagnostically meaningful?

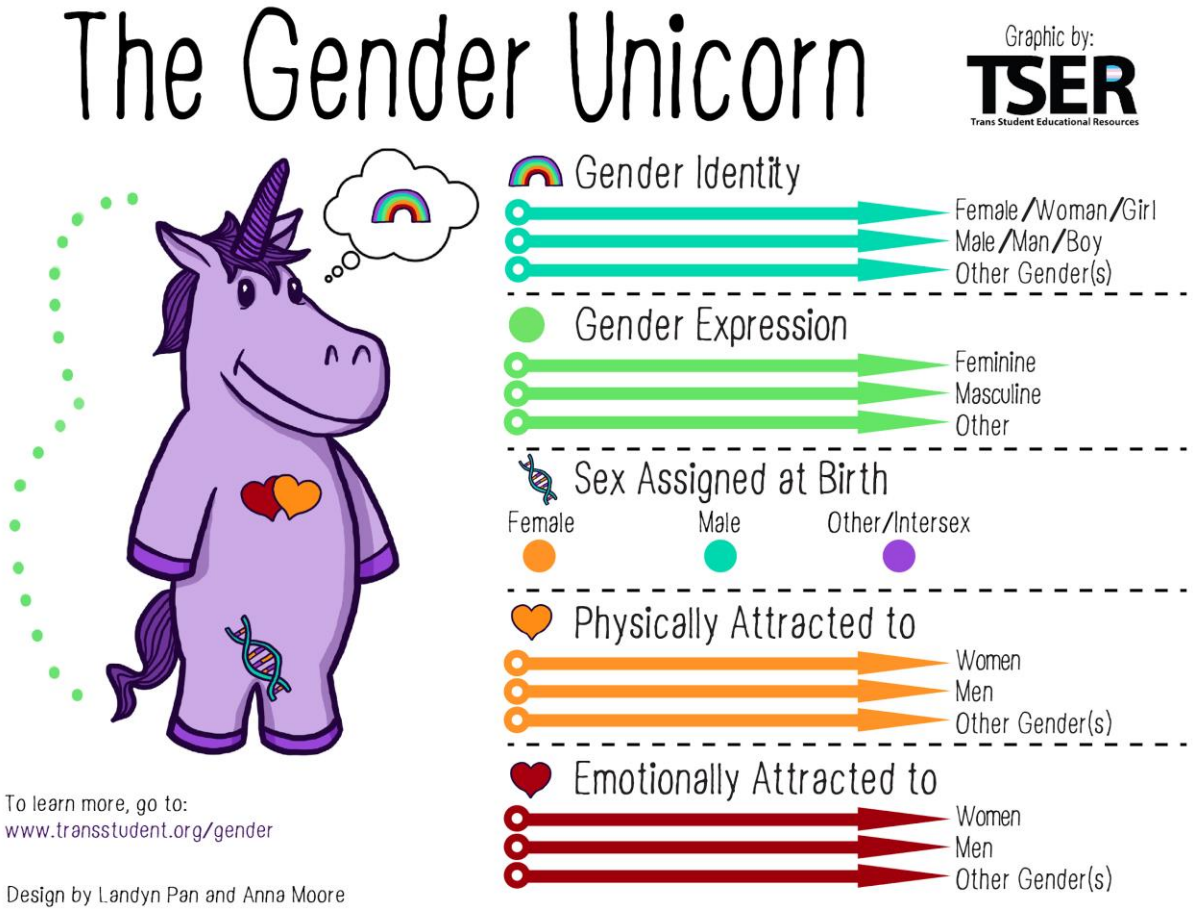
Suggested Discussion Content:

There are frequently misunderstandings in clinical environments about terminology related to sex and gender:

- Sex and Gender
  - Sex refers to an individual's biological traits (genotypic and phenotypic) as those traits map to male/female differentiation and the male-female anatomical and physiological spectrum. Sex is sometimes referred to as "natal sex" or "sex assigned at birth."
  - Gender is the psychological, behavioral, and cultural characteristics that are believed to be associated with maleness and femaleness.

- Gender Identity and Gender Expression
  - Gender Identity is an individual's personal and subjective inner sense of self as belonging to a particular gender (e.g., being a boy/man, girl/woman, genderqueer, transmasculine spectrum, transfeminine spectrum).
  - Gender Expression is defined as mannerisms, personal traits, clothing choices, etc., that serve to communicate a person's identity as they relate to a particular societal gender role.

- The Gender Unicorn chart is widely used and is very helpful for making clear distinctions among these categories. We recommend this be shared with students as part of the curriculum.[12]



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Gender Identity is how individuals know or feel themselves to be male, female, somewhere in between, or neither, regarding perceived and socialized gender assumptions in society. It is an internal knowledge or feeling of certain aspects of masculinity and femininity that feel right and true to that person's authentic self. Children have an experience of gender, identity, expression, and roles as young as two years old. A child's knowledge of their own identity and their need to express this identity (internally and externally) continues over time.

Definitions for gender discordance, gender diverse and gender dysphoria are provided below. It is important to consider that the latter requires a set for meeting clinical criteria (see DSM-V criteria), while the former two may or may not be clinically significant behavior. Not all ways in which children are gender diverse or gender discordant will meet the clinical definition of gender dysphoria. Many expressions of these behaviors and expressions can be part of typical childhood development.

- Gender Discordance, Gender diversity, and Gender Dysphoria[6]

- Gender Discordance is defined as a discrepancy between anatomical sex and gender identity. For example, transgender individuals have a gender identity that is discordant with their anatomical sex.
- Gender Diversity refers to a person who does not conform to prevailing gendered behaviors or roles within a specific society. People who are gender diverse may not take part in activities conventionally thought to be associated with their assigned gender. For example, a gender diverse male child might wish to dress in girls' clothing and to play exclusively with girls.
- Gender Dysphoria refers to an individual's strong, persistent feelings of identification with the opposite gender and discomfort with one's assigned sex that results in significant distress or impairment. Children and adults do have slightly different criteria according to the DSM-V for gender dysphoria. Criteria for children is based more on observational preferences while adult criteria are derived more on experienced internal desires. For instance, children experiencing gender dysphoria often have a strong preference for toys, playmates or make-believe play or dress in clothing typical of the alternative gender from one's assigned gender. Adults experiencing gender dysphoria have a strong desire to be of the other gender or have characteristics or be treated as the alternative gender from one's assigned gender. The following link provides the standard criteria for gender dysphoria: https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria

- Sexual Orientation, Sexual Identity, and Sexual Behavior[6]
  - Sexual Orientation can be defined as an individual's inclination to feel sexual attraction or arousal to a particular body type or identity. Relatively common forms of sexual orientation include heterosexuality (opposite-sex or opposite-gender attraction), homosexuality (same-sex or same-gender attraction), or bisexuality (attraction to people who are the opposite sex or gender along with attraction to people who are the same sex or gender). Sexual orientation is made up of attractions, identity, behaviors, and the gender of sexual partners. In prepubertal children these feelings may exist at different times in the context of their developmental framework. Grade school-aged children may develop crushes or have romantic feelings toward other children and people. Middle and high school students may become more interested in exploring these attractions and interests socially with peers or individually in a romantic or dating setting. As children approach puberty and adolescence, sexuality (i.e., attraction, interests, orientation, and behaviors) becomes relevant to the life tasks of developing relationships, fostering intimacy, and creating family. Sexual exploration, experimentation, and discovery are part of the normal process of adolescent development.
  - Sexual Identity is defined as how one thinks of oneself in terms of to whom one is romantically or sexually attracted. For many individuals, sexual identity "matches" with their sexual orientation, but for others sexual orientation does not align with their sexual identity.
  - Sexual Behavior is any activity—solitary, between two persons, or in a group—that induces sexual arousal. Sexual behavior can also be referred to as sexual activity.

Summary Learning Points:

The language describing sexual and gender identities changes. Terminology used to describe oneself or others can be related to many factors including age, cultural background, interaction with individuals having diverse sexual and gender identities, and in the case of providers, clinical training, and expertise in these areas. There is significant conflation in society (including among healthcare professionals) of the sexual orientation and gender aspects of identity. It is critical for patients and their families to feel understood and that their personal language around identity be solicited. Hospital systems also need to consider medical record data collection that moves beyond the binary. Such practices demonstrate cultural sensitivity and serve to better understand and care for patients. Not all children or adults who demonstrate gender diverse behaviors will have gender dysphoria, which makes understanding the clinical diagnostic criteria and differences between them for children and adults an essential part of working with these populations. Prior to puberty, children experiment with cross-gender play and expression. Cross-gender interests and expression in the prepubertal years are neither necessarily nor predictably associated with adolescent or adult transgender identity or sexual orientation.

Language and terminology influence the clinical experience of patients and can become a barrier to care. For example:

- Health care services often reinforce gender binaries (e.g., electronic health records).
- There is a limited number of knowledgeable and sensitive providers.
- There may be a lack of understanding by providers due to the need to keep up with evolving language to describe identity.

A recommended practice is to elicit patients' language that describes their sexual orientation and gender identity using open ended questions, ideally at the initial visit, both electronically and in person. It is recommended that all electronic medical records have a structured recording of an individual's sexual orientation and gender identity.[13]

Educational Resources:

Keener, E. (2015). The Complexity of Gender: It Is All That and More….In sum, It Is Complicated. *Sex Roles, 73*(11-12), 481-489. doi:10.1007/s11199-015-0542-5

Steensma, T. D., & Cohen-Kettenis, P. T. (2015). More Than Two Developmental Pathways in Children with Gender Dysphoria? *Journal of the American Academy of Child & Adolescent Psychiatry, 54*(2), 147-148. doi:10.1016/j.jaac.2014.10.016

2. How can you relate to prepubertal children as they express differing attitudes about their gender and sexuality given typical prepubertal development?

Competencies Addressed:

Competency Domain	PCRS[a] Competency	LGBT/GNC/DSD Specifier[b]

Patient Care	Gather essential and accurate information about patients and their conditions through history taking, physical examination, and the use of laboratory data, imaging, and other tests by:	● Sensitively and effectively eliciting relevant information about sex anatomy, sex development, sexual behavior, sexual history, sexual orientation, sexual identity, and gender identity from all patients in a developmentally appropriate manner. ● Performing a complete and accurate physical exam with sensitivity to issues specific to the individuals described above at stages across the lifespan.[c]
Knowledge for Practice	Apply established and emerging biophysical scientific principles fundamental to health care for patients and populations by:	● Understanding and explaining how stages of physical and identity development across the lifespan affect the above-described populations and how health care needs and clinical practice are affected by these processes.[c]
[a] PCRS, Physician Competency Reference Set [b] Professional Competencies to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming, and/or Born With DSD [c] "individuals/patients/populations described above" refers to individuals/populations who are LGBT, Gender Nonconforming, and/or Born With DSD		

6*Adapted from AAMC

Questions to Explore and Promote Discussion:

1. How does any child come to understand gender from typical cognitive development?
2. How does any child come to understand gender from typical social development?
3. How does a child develop a category for what is male or female?
4. How would knowledge of typical development inform a patient encounter with a prepubertal youth?

Suggested Discussion Content:

Gender development begins early and typically in stages.[14] For example, a two-year-old realizes that males look different from females, and males and females have different "parts." Around three years of age, most children are able to label themselves as a boy or girl.[14] In typically developing children, gender identity is stable and constant by four years of age.[15]

Young or prepubertal children may experience romantic feelings or attraction which can be explored in a developmentally appropriate way. It is critical that the provider follow the lead of the youth about language. Go where the child takes you. Listen and respond, rather than guide, enforce or force. Reinforce and remember that there is no one healthy gender outcome.[16]

Suggested questions parents or providers might ask children to further explore gender are below:

- "Do you feel more like a boy, like a girl, or neither or both or some way else?" (younger children)
- "How do you feel about your gender?" (adolescents/older children)
- "What name do you use?"
- "How do you like to play? Cut your hair? Dress?"
- "Do you think your name fits you?"
- "Do adults or other children ever pick on you for how you express being a boy or girl?"
- "Some of my patients wonder if they're more like a girl or boy inside, or something else entirely. What has it been like for you?"
- "Do you ever feel the people around you have it wrong about being a boy or a girl?"
- "If you had a crush on someone in your class or neighborhood who might that be?"
- "When you think about liking someone in a romantic way, does it matter if that person is a boy or girl?"

Please refer to the Educational Resource below for additional information.

Summary Learning Point:

It is typical to have gender fluidity in child development. Most children will play across typical gender roles some time in their development (e.g., a boy might play the role of the "mom" when playing house). Gender and sexuality develop in concert with social and cognitive development, all of which need to be considered simultaneously. Literature on gender diverse youth suggests that gender diverse youth have multiple possible trajectories.[17] Gender and sexual development are not straightforward and therefore assumptions should not be made about outcomes. As a provider, you can explore issues and questions about gender and sexuality with the youth, but this should be done in the same social and cognitive developmental context as you would for any youth.

Clinicians need not make any assumptions or judgements about what it means to like or have a crush on someone. This information provides a gateway into a useful conversation about what children think, feel, and mean when they refer to various social and personal relationships.

Educational Resource:

Levine, D. A., Braverman, P. K., Adelman, W. P., Breuner, C. C., Levine, D. A., Marcell, A. V., O'Brien, R. F. (2013). Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth. *Pediatrics, 132*(1), 198-203. doi:10.1542/peds.2013-1282

3. Discuss psychosexual development and what potential identity outcomes may exist for a prepubertal gender diverse child and/or child with gender dysphoria. Discuss ways to distinguish children who are exclusively gender diverse from those who are experiencing gender dysphoria.

Competencies Addressed:

Competency Domain	PCRS[a] Competency	LGBT/GNC/DSD Specifier[b]
Patient Care	Gather essential and accurate information about patients and their conditions through history taking, physical examination, and the use of laboratory data, imaging, and other tests by:	● Sensitively and effectively eliciting relevant information about sex anatomy, sex development, sexual behavior, sexual history, sexual orientation, sexual identity, and gender identity from all patients in a developmentally appropriate manner. ● Performing a complete and accurate physical exam with sensitivity to issues specific to the individuals described above at stages across the lifespan.[c]
Knowledge for Practice	Apply established and emerging biophysical scientific principles fundamental to health care for patients and populations by:	● Defining and describing the differences among: sex and gender; gender expression and gender identity; gender discordance, gender nonconformity, and gender dysphoria; and sexual orientation, sexual identity, and sexual behavior. ● Understanding and explaining how stages of physical and identity development across the lifespan affect the above-described populations and how health care needs and clinical practice are affected by these processes.[c]
Systems-Based Practice	Incorporate considerations of cost awareness and risk-benefit analysis inpatient and/or population-based care by:	● Demonstrating the ability to perform an appropriate risk/benefit analysis for interventions where evidence-based practice is lacking, such as when assisting families with children born with some forms of DSD, families with prepubertal gender diverse children, or families with pubertal gender diverse adolescents.

[a] PCRS, Physician Competency Reference Set
[b] Professional Competencies to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming, and/or Born With DSD
[c] "individuals/patients/populations described above" refers to individuals/populations who are LGBT, Gender Nonconforming, and/or Born With DSD

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Questions to Explore and Promote Discussion:

- How might a gender diverse child respond in a safe and accepting environment versus one that is unaccommodating and unaccepting?
- What role do primary care providers play in screening and counseling a family with a gender diverse child?

Suggested Discussion Content:

Gender can be thought of as a continuum. Gender development is still not well understood, but thought to be an interweaving of biology, development, and society. While typically gender identification is stable at age 4, gender play is common in prepubertal children, and gender variant behavior can extend for days, weeks, or even years.[18] More recent literature suggests a child's gender identity is not a choice and is determined by biologic underpinnings.[19] Gender variant behavior has been well described throughout history and cultures, and does not represent abnormal development.

Gender diverse is an umbrella term to describe youth whose assigned sex at birth does not match their expressed gender identity. Often, gender diverse youth express their gender more in line with their internal gender identity. Gender dysphoria is a term used to denote the distress of the incongruence between an assigned sex at birth and an individual's internal or expressed gender identity. Gender dysphoria has replaced the psychiatric diagnosis of gender identity disorder (GID) in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

The trajectory of gender diverse children can vary. Some gender variant children will persist in their gender identity throughout adolescence and identify as transgender.[17] Other gender diverse children will identify as genderqueer, a term used to describe individuals who do not identity primarily as male or female.[17] Many gender diverse children may identify as gay, lesbian, or bisexual adults.[17] Recent literature suggests that gender dysphoria present in adolescence is likely to continue.[20]

Gender diversity can be evident as early as two years of age. While there is no consistent developmental pathway for children who are gender diverse, it is important for providers to not dismiss this as "just as phase."[20] While research in this field is limited, current data suggest that the strongest predictor of persistence of gender dysphoria into adolescence and adulthood is the intensity of the gender dysphoria experienced as a youth.[20] It is important to recognize that puberty can often be a trigger for some gender diverse youth, and gender exploration or gender dysphoria may emerge during this time.[21] Other factors associated with persistence of gender dysphoria include more body dissatisfaction, and higher reports of a same-sex sexual orientation.[20]

Summary Learning Point:

Gender diversity can be part of a child's normal psychosexual development. While the factors associated with gender development are still being understood, children with gender dysphoria express distress from the incongruence in their affirmed gender and sex assigned at birth. It is essential for both primary care providers and mental health professionals to be familiar with normal psychosexual development and the possible trajectories of a gender diverse child to provide appropriate counseling and support for both patients and families.

Educational Resources:

Bonifacio, H. J., & Rosenthal, S. M. (2015). Gender Variance and Dysphoria in Children and Adolescents. *Pediatric Clinics of North America, 62*(4), 1001-1016. doi:10.1016/j.pcl.2015.04.013

Olson-Kennedy, J., Cohen-Kettenis, P. T., Kreukels, B. P., Meyer-Bahlburg, H. F., Garofalo, R., Meyer, W., & Rosenthal, S. M. (2016). Research priorities for gender nonconforming/transgender youth. *Current Opinion in Endocrinology & Diabetes and Obesity, 23*(2), 172-179. doi:10.1097/med.0000000000000236

Tishelman, A. C., Kaufman, R., Edwards-Leeper, L., Mandel, F. H., Shumer, D. E., & Spack, N. P. (2015). Serving transgender youth: Challenges, dilemmas, and clinical examples. *Professional Psychology: Research and Practice, 46*(1), 37. doi:10.1037/pro0000040

Steensma, T. D., Biemond, R., Boer, F. D., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry, 16*(4), 499-516. doi:10.1177/1359104510378303

Vance, S. R., Ehrensaft, D., & Rosenthal, S. M. (2014). Psychological and Medical Care of Gender Nonconforming Youth. *Pediatrics, 134*(6), 1184-1192. doi:10.1542/peds.2014-0772

4. Employ methods of sensitive clinical interviewing in working with diverse families. Identify language to help families use with their children that is open-ended and lacks assumptions.

Competencies Addressed:

Competency Domain	PCRS[a] Competency	LGBT/GNC/DSD Specifier[b]
Patient Care	Gather essential and accurate information about patients and their conditions through history taking, physical	● Sensitively and effectively eliciting relevant information about sex anatomy, sex development, sexual behavior, sexual history, sexual orientation, sexual identity, and gender identity from all patients in a developmentally appropriate manner. ● Performing a complete and accurate physical exam with sensitivity to issues specific to the

	examination, and the use of laboratory data, imaging, and other tests by:	individuals described above at stages across the lifespan.[c]
	Counsel and educate patients and their families to empower them to participate in their care and enable shared decision- making by:	● Assessing unique needs and tailoring the physical exam and counseling and treatment recommendations to any of the individuals described above, taking into account any special needs, impairments, or disabilities.[c] ● Recognizing the unique health risks and challenges often encountered by individuals described above, as well as their resources, and tailoring health messages and counseling efforts to boost resilience and reduce high-risk behaviors.[c]
Practice-Based Learning and Improvement	Identify strengths, deficiencies, and limits in one's knowledge and expertise by:	● Critically recognizing, assessing, and developing strategies to mitigate the inherent power imbalance between physician and patient or between physician and parent/guardian, and recognizing how this imbalance may negatively affect the clinical encounter and health care outcomes for the individuals described above.[c]
Interpersonal and Communication Skills	Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds by:	● Developing rapport with all individuals (patients, families, and/or members of the health care team) regardless of others' gender identities, gender expressions, body types, sexual identities, or sexual orientations, to promote respectful and affirming interpersonal exchanges, including by staying current with evolving terminology.
	Demonstrate insight and understanding about emotions and human responses to emotions that allow one to develop and manage interpersonal interactions by:	● Understanding that implicit (i.e., automatic or unconscious) bias and assumptions about sexuality, gender, and sex anatomy may adversely affect verbal, nonverbal, and/or written communication strategies involved in patient care, and engaging in effective corrective self-reflection processes to mitigate those effects. ● Identifying communication patterns in the health care setting that may adversely affect care of the described populations, and learning to effectively address those situations in order to protect patients from the harmful effects of implicit bias or acts of discrimination.

Professionalism:	Demonstrate sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, race, religion, disabilities, and sexual orientation by:	● Recognizing and sensitively addressing all the patients' and families' healing traditions and beliefs, including health-related beliefs, and understanding how these might shape reactions to diverse forms of sexuality, sexual behavior, sexual orientation, gender identity, gender expression, and sex development.
[a] PCRS, Physician Competency Reference Set [b] Professional Competencies to Improve Health Care for People Who Are or May Be LGBT, Gender-Nonconforming, and/or Born With DSD [c] "individuals/patients/populations described above" refers to individuals/populations who are LGBT, Gender-Nonconforming, and/or Born With DSD		

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Questions to Explore and Promote Discussion:

- What are social and cultural issues that might affect how a parent views and interacts with their child regarding gender expression, gender roles, and gender identity?
- What might be common concerns or questions parents have regarding a gender diverse child? How might these concerns inadvertently discourage a child's gender exploration?
- Why might children be reluctant to divulge their feelings in the presence of their parents, and parents reluctant to express their feelings in the presence of their child?
- What is gender affirming language? How can sensitive interviews employ gender affirming language as a model for the family?

Suggested Discussion Content:

Common concerns or questions from parents that may discourage a child's gender exploration:

- "Is there a cure? Is this just a phase? Is this just for attention?"
- "Is this a sign that they were abused? Is this a sign of sexual abuse?"
- "Does this mean they're gay?"
- "Can you make them normal?"
- "God made him/her a boy/girl, how can they become a girl/boy?"
- "What did I do wrong? I feel like I failed as a parent. This is going to be so difficult. I'm disappointed in my child."
- "What if we just ignored this 'behavior'? I'm afraid to do anything because I may harm my child."
- Addressing the child: "Well, are you a boy or girl?!"

Family support and parental acceptance is critical to the child's overall well-being. It is extremely important to recognize that parental rejection of a child's expressed gender can increase the risk of psychiatric comorbidities. The educational resources below stress the importance of parental acceptance and the potential negative outcomes associated with lack of support by a parent or significant adult.

During the clinical encounter, it is important for providers to remind parents of the importance of offering support to their children. Remind parents specifically to tell their child:

- "I love you, inclusive of the gender you find affirming."
- "I may not understand everything that is going on, but I love you and support you. We will figure this out together."
- "I'm going to make mistakes, but I want you to know that you can always talk to me and that I will support your decisions."

Providers should also seek to understand unique spiritual and cultural aspects of the family to provide context regarding these intersecting/conflicting values on the family's response to the patient. The Family Acceptance Project and others organizations such as the Substance Abuse and Mental Health Services Administration provide a comprehensive and evidence-based resource that may be useful for both providers and families in understanding issues related to spirituality and culture.[22-25] The Family Acceptance Project and others have offered some helpful perspectives for clinicians and families as to the role of a safe, loving home environment and the benefits that family love and support offer any gender diverse child. Applying this strategy in the clinical setting means that clinicians can help parents and families listen more carefully to the words, feelings, and behaviors that a child offers as they explore their gender and sexual identity. Clinicians can help parents and families make home a safe place for every child to explore various aspects of their gender and sexual development. Unconditional love and acceptance for the authentic self is critical to healthy self-esteem and continued long-term health outcomes for not just children, but adults as well.

A conversation with the parents and/or caregivers is critical to address parental concerns. Not all conversations between medical providers and parents need to include the child as the child can be particularly vulnerable during this time. In addition, much of the counseling between medical providers and parents currently focus on parental understanding, support, and providing resources. An example of a helpful resource that can be modified with a prepubertal child is Pediatric and Adolescent Gender Health Clinic Patient History Form from Children's Wisconsin.[26]

It is also important to teach and use language that is inclusive and to pose questions that are open-ended and lack assumptions. Such conversations between the medical provider and child may be best suited with the parents outside the room, as children may be more willing to discuss their feelings and thoughts. Children may fear guilt or sadness by disappointing a parent or may fear consequences by an unaccepting parent. Conversely, a parent might feel more comfortable discussing issues without the child present.

A conversation between medical provider and child may include a discussion entailing the following:

- "Do you feel more like a boy or girl?"
- "What does being a boy or being a girl mean?"
- "What name do you use?"
- "What pronouns do you use?"
- "Do you think your parents have any worries or concerns about you wanting to be a boy/girl or a person who feels you are somehow perhaps different?"
- "Is there anything that your parents can do to help you?"

When obtaining a medical history from a child who is gender diverse it is important to obtain a gender history, because everyone's experience is different and important. If a patient uses specific terms to define their gender it is important to have the patient define what those terms mean to them. When obtaining a patient's gender history, include questions similar to the following:[22]

- "What is your family's knowledge and understanding about your gender?"
- "Do you feel accepted by your family and safe at home?"
- "Do you feel safe at school?"
- "Do you feel a sense of acceptance and safety in your community?"
- Often patients will feel isolated, so it is necessary to ask about friend groups.
- Obtain a sexual history including number and gender of partners, use of protection, and forms of sexual activity.
- Obtain a social history including tobacco use, vaping, alcohol consumption, and recreational drug use.

A conversation between the parent and medical provider may include:

- "Tell me about how your child is doing."
    - "Are there behaviors that are of concern?"
    - "How would you feel about your child being gender diverse?"
    - "How does that fit within your family?"
    - "How does that fit within your community?"
    - "How do you think others around you in your school and community are responding to your child's gender identity?"
- "Do you have any worries or concerns about your child?"
- "What support do you receive, and which resources do you have access to for both you and your child?"

Students can practice and role play the above discussion material in several discussion formats:

- Have students develop scenarios in pairs regarding which discussions in front of a child could be potentially harmful and then report back to the larger group.
- Have students develop scenarios in pairs in which inclusive language lacking assumptions is used to interview the child.

- Students can also practice scenarios regarding counseling parents of a gender diverse child by addressing typical parental concerns.

Patient encounters can be stress-inducing for gender diverse children, especially when it comes to having a physical exam. Often children who are gender diverse do not feel comfortable with their bodies and do not like having their bodies exposed. It is important to explain all aspects of the exam before the exam begins. It is also important to only expose body parts when needed and to always re-drape when finished examining each body part. To make patients feel as comfortable as possible make sure exam rooms and bathrooms are gender neutral so patients feel comfortable changing into gowns. Asking patients their preferred words to reference their body parts supports a feeling of being more comfortable with the exam. Often patients use "top" or "chest" instead of "breasts" and they might use "bottom" or "down there" instead of penis and testicles. It is important to not assume names and to always ask so that your language mirrors theirs.[21]

Summary Learning Point:

Family acceptance of a child's gender identity is critical to his/her/their success as multiple studies have shown that parental rejection increases risk for psychiatric comorbidities, particularly suicide.[27] The words and language we use affect those around us, especially children. Children are eager to please their parents and may be reluctant to reveal their true feelings and beliefs to prevent disappointing those adults and caregivers around them. Using inclusive language and addressing the concerns of a child and their parents separately can facilitate better understanding without unwittingly causing undue worry, tension, and/or potential harm to the child.

Educational Resources:

Alpert, A., CichoskiKelly, E.,& Fox, A. (2017). What Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Patients Say Doctors Should Know and Do: A Qualitative Study. *Journal of Homosexuality, 64*(10), 1368-1389. doi:10.1080/00918369.2017.1321376

Gender Health Center. (2012, October 9). Gender History Questionnaire. Retrieved March 11, 2023, from http://www.thegenderhealthcenter.org/files/Gender_History.pdf

Grossman, A. H., & D'augelli, A. R. (2007). Transgender Youth and Life-Threatening Behaviors. *Suicide and Life-Threatening Behavior*, *37*(5), 527-537. doi:10.1521/suli.2007.37.5.527

Kane, R., Nicoll, A. E., Kahn, E., & Groves, S. (2014, March 11). Supporting and Caring for Our Latino LGBT Youth (Rep.). Retrieved March 11, 2023, from The Human Rights Campaign & The League of United Latin American Citizens website: http://hrc-assets.s3-website-us-east-1.amazonaws.com//files/assets/resources/LatinoYouthReport-FINAL.pdf

Katz-Wise, S. L., Rosario, M., & Tsappis, M. (2016). Lesbian, Gay, Bisexual, and Transgender Youth and Family Acceptance. *Pediatric Clinics of North America*, *63*(6), 1011-1025. doi:10.1016/j.pcl.2016.07.005

Ryan, C. (2009). Supportive Families, Healthy Children: Helping Families with Lesbian, Gay, Bisexual & Transgender Children (Rep.). Retrieved March 11, 2023, from San Francisco State University website: http://familyproject.sfsu.edu/family-education-booklet

Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family Acceptance in Adolescence and the Health of LGBT Young Adults. *Journal of Child and Adolescent Psychiatric Nursing*, *23*(4), 205-213. doi:10.1111/j.1744-6171.2010.00246.x

San Francisco State University. (2002). Welcome to the Family Acceptance Project. Retrieved March 11, 2023, from http://familyproject.sfsu.edu/

Substance Abuse and Mental Health Services Administration. (2014). A Practitioner's Resource Guide: Helping Families to Support Their LGBT Children (Rep. No. PEP14-LGBTKIDS). Retrieved March 11, 2023, from Substance Abuse and Mental Health Services Administration website: https://store.samhsa.gov/sites/default/files/d7/priv/pep14-lgbtkids.pdf

5. Describe logistical interventions in practice (e.g., ways for office staff to avoid being presumptuous about gender identity) that can be used to enhance comfort in patient interactions in the office between staff and families when a child's appearance differs from the listed assigned sex in the medical record.

Competences Addressed:

Competency Domain	PCRS[a] Competency	LGBT/GNC/DSD Specifier[b]
Practice-Based Learning and Improvement	Identify strengths, deficiencies, and limits in one's knowledge and expertise by:	● Critically recognizing, assessing, and developing strategies to mitigate the inherent power imbalance between physician and patient or between physician and parent/guardian, and recognizing how this imbalance may negatively affect the clinical encounter and health care outcomes for the individuals described above.[c]
	Demonstrate insight and understanding about emotions and human responses to emotions that allow one to develop and manage	● Understanding that implicit (i.e., automatic or unconscious) bias and assumptions about sexuality, gender, and sex anatomy may adversely affect verbal, nonverbal, and/or written communication strategies involved in patient care, and engaging in effective corrective self-reflection processes to mitigate those effects. ● Identifying communication patterns in the health care setting that may adversely affect care of the described populations, and learning to effectively address those

	interpersonal interactions by:	situations in order to protect patients from the harmful effects of implicit bias or acts of discrimination.
Interprofessional Collaboration	Work with other health professionals to establish and maintain a climate of mutual respect, dignity, diversity, ethical integrity, and trust by:	● Valuing the importance of interprofessional communication and collaboration in providing culturally competent, patient-centered care to the individual described above and participating effectively as a member of an interdisciplinary healthcare team.[c]
[a] PCRS, Physician Competency Reference Set [b] Professional Competencies to Improve Health Care for People Who Are or May Be LGBT, Gender-Nonconforming, and/or Born With DSD [c] "individuals/patients/populations described above" refers to individuals/populations who are LGBT, Gender-Nonconforming, and/or Born With DSD		

6*Adapted from AAMC

Questions to Explore and Promote Discussion:

- Within the context of a pediatric medical office, what presumptions might an office staff or medical provider team member make about a medical record listing a first name frequently associated with a male sex assigned at birth? How might this be a problem?
- In what ways can a provider's implicit biases about sexuality, gender, and sex anatomy adversely influence verbal and written communications with or about gender diverse children and their families? What steps could a provider take to develop awareness and manage/challenge implicit biases to avoid their harmful influence on patients?
- What practical recommendations would you make to a pediatric medical practice to reduce the potential harm of acting on assumptions?

Suggested Discussion Content:

A welcoming clinic environment is important for all individuals. An individual who is gender diverse or transgender may find the clinic unwelcoming, especially if they are referred to by an incorrect name or pronoun. To create a welcoming clinic environment, appropriate sign in sheets, which allow the individual to specify a name and pronoun and the inclusion of their name and sex on their insurance card, can help clinic staff and providers refer to the patient in their affirmed gender. If the name or gender is not stated, or if a mismatch between name and gender is noted, simply calling out the family name in a busy waiting room can avoid an embarrassing and anxiety-provoking moment for the individual, the family and staff members. For example, calling "Smith Family" can avoid an incorrect name identification for a transgender or gender diverse pediatric patient.[26, 28-30]

There are multiple best practices for creating a welcoming environment.[31] Attention should also be given to respecting the cultural background of the child and family and will require the practitioner to educate themselves by asking open-ended questions to ensure cultural sensitivity and respect.[31] The importance of training all staff members as well as providers on providing gender affirming care should not be underestimated. Every person in the clinical care process, from the front desk staff to the medical assistant, to the health care provider, has a duty to provide a supportive environment. It may also be helpful to provide brochures, posters or other informational materials in the waiting room that signify the gender affirming nature of the clinic. In addition, gender neutral bathrooms in the clinic can also increase the comfort of an individual.

To create an optimal inclusive environment, it is important to be aware of our implicit biases. According to Chapman et al., (2013), implicit bias, also referred to as unconscious bias or implicit social cognition, refers to a positive or negative mental attitude or stereotype that an individual holds at an unconscious level.[32] There is growing evidence that implicit bias in physician decision making makes a significant contribution to perpetuating health care disparities, and there have been numerous calls to address these biases in the training of future health care providers.[32] Implicit biases impact our behaviors and influence basic processes such as attention and memory, and they also direct judgment and action. Implicit biases are pervasive even in people with avowed commitments to impartiality such as health care professionals. As an example, one study found that despite reporting very little explicit bias, approximately two-thirds of clinicians were found to harbor implicit bias against African Americans and Latinos.[33] Because of this impact, often an undetected one, stereotyping may contribute to social problems.[34] Like all human beings, health care professionals are conditioned to react in unconscious ways to people who are in a small minority, and therefore "unknown," such as people who are transgender.[35-36]

There are evidence-based strategies for addressing such bias.[37]

1. Pursuing egalitarian goals; in this case, the healthcare professional identifies the desired goal and monitors their own behavior for egalitarian values and the unconscious stereotypes. Each time the person encounters the members of the group for whom the goal has been set, they view this as an opportunity to practice the egalitarian behavior goal. Over time, this process may become automatic.[37] For example, a healthcare professional has as their egalitarian goal to treat children who are gender diverse with respect, accurate, fair, unbiased, and skilled practice. Subsequently, when the healthcare professional encounters a gender diverse child, they mentally trigger their goal, and act accordingly. Over time, in individuals strongly committed to fair treatment, preconscious and automatic regulatory systems inhibit the expression of implicit bias.[38]

2. Identifying common identities; this strategy requires a provider to ask questions about their patient's interests and activities to identify and consider which characteristics they have in common. The theory is that the provider then views the patient with that shared perspective, which will in turn inhibit the stereotypes associated with bias.

3. Counter-stereotyping; this strategy requires a provider to ask questions about a patient to learn about their "personal attributes and behaviors." In doing so, the provider forms new, positive associations that counter the negative associations with the stereotype group.

4. Perspective taking; this strategy requires the provider to perform an exercise in which they will imagine themselves as the patient, including any difficult situations they may encounter, to develop empathy. In doing so, the theory suggests that negative stereotypes diminish.

Suggestions for addressing and understanding implicit bias in health care such as "consider gut reactions to specific individuals or groups as potential indicators of implicit bias, and consider how these reactions might affect your work" can be found in the publication *Unconscious (Implicit) Bias and Health Disparities: Where Do We Go from Here?*[37]

While electronic health care records (EHR) have benefited many aspects of medicine, many EHR systems do not allow both the sex assigned at birth and affirmed gender to be recorded. Additionally, affirmed names are often not recorded, and instead the name listed on the insurance card is recorded. Unfortunately, this sets up a mismatch between names and genders for the individual, which can lead to embarrassing moments in the clinic setting for all parties involved. Knowing the EHR systems and documenting "alerts" or other notifications in the chart may be a way of acknowledging the affirmed gender and name. In addition, modeling how to document the individual's affirmed name and pronoun in the individual's clinic note will also allow other providers within the network to follow suit with similar affirming language. Unfortunately, "messing up" an individual's name and/or pronoun does occur, even when no malice or disrespect is meant. Clinicians and staff are often fearful of mistakes and become paralyzed and unable to move on. It is important to teach providers and staff how to move on when these "mess ups" occur. Validate that "messing up" can happen. Teach staff and providers to apologize for the error and move on.

In addition to pronouns, intake forms should also include sexual orientation, gender, and sex assigned at birth. Not only is this best practice, but it is now a legal requirement. U.S. Department of Health and Human Services has included sexual orientation and gender identity data collection to its requirements for Electronic Health Records (EHRs) certified under the Meaningful Use Program.[39] The change took effect in 2018 after health care providers received training on how to collect sexual orientation and gender identity data. The new requirement is part of the Centers for Medicare and Medicaid Services' Meaningful Use program, which provides incentives to health care providers for making the switch from paper to electronic health records. Certified EHRs allow health care providers to securely record electronic patient records that can be accessed by other health care providers who also participate in the program. There are resources available to determine best practices around language.[28,29]

Developing an organizational policy to provide affirming care to all individuals inclusive of gender and sexual orientation is also highly recommended.

Summary Learning Point:

Creating a warm and welcoming clinic environment is important for all patients, inclusive of race, religion, sexual orientation, and gender. Every interaction matters in the medical setting, from greetings at the front office, to the care provided. Creating inclusive spaces can have a significant impact on patients, and training staff members to respectfully communicate with patients whose gender may not match the sex on their birth certificate promotes affirming health care. A clinician's own biases may impact patient care, and thus it is imperative that clinicians reflect on those biases and take steps to address them. This is challenging work that needs continual processing. The common goal is that all patients receive quality medical care in an environment which fosters respect and communication.

Educational Resources:

Alpert, A., CichoskiKelly, E.,& Fox, A. (2017, May 8). What Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Patients Say Doctors Should Know and Do: A Qualitative Study. *Journal of Homosexuality, 64*(10), 1368-1389. doi:10.1080/00918369.2017.1321376

Blair, I. V., Steiner, J. F., & Havranek, E. P. (2011). Unconscious (Implicit) Bias and Health Disparities: Where Do We Go from Here? The Permanente Journal, 15(2), 71-78. Retrieved March 11, 2023, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3140753/

Burke, S. E., Dovidio, J. F., Przedworski, J. M., Hardeman, R. R., Perry, S. P., Phelan, S. M., . . Ryn, M. V. (2015). Do Contact and Empathy Mitigate Bias Against Gay and Lesbian People Among Heterosexual First-Year Medical Students? A Report From the Medical Student CHANGE Study. *Academic Medicine, 90*(5), 645-651. doi:10.1097/acm.0000000000000661

Fallin-Bennett, K. (2015). Implicit Bias Against Sexual Minorities in Medicine. *Academic Medicine, 90*(5), 549-552. doi:10.1097/acm.0000000000000662

Margolies, L. (Producer), & Ross, K. (Director). (2015, March 12). Vanessa Goes to the Doctor. Retrieved March 11, 2023 from https://www.aamc.org/initiatives/diversity/451748/vanessagoestothedoctor.html

Marksamer, J., Spade, D., & Arkles, G. (2011). A Place of Respect: A Guide for Group Care Facilities Serving Transgender and Gender Nonconforming Youth (Rep.). Retrieved March 11, 2023 from San Francisco, CA: National Center for Lesbian Rights; New York, NY: Sylvia Rivera Law Project. website: http://www.nclrights.org/wp-content/uploads/2013/07/A_Place_Of_Respect.pdf

Moore, T. (2016, October 18). How Implicit Bias Affects the Health of Black Gay Men. Retrieved March 11, 2023 from http://www.advocate.com/commentary/2016/10/18/how-implicit-bias-affects-health-black-gay-men

Sabin, J. A., Riskind, R. G., & Nosek, B. A. (2015). Health Care Providers' Implicit and Explicit Attitudes Toward Lesbian Women and Gay Men. *American Journal of Public Health, 105*(9), 1831-1841. doi:10.2105/ajph.2015.302631

Stone, J., & Moskowitz, G. B. (2011). Non-conscious bias in medical decision making: what can be done to reduce it? *Medical Education, 45*(8), 768-776. doi:10.1111/j.1365-2923.2011.04026.x
Sukhera, J. I. (2018). Bias in the mirror: exploring implicit bias in health professions education. Datawyse/Universitaire Pers Maastricht. https://doi.org/10.26481/dis.20181129js

Transgender IAT. (2016). Trans Implicit Association Test. Retrieved March 11, 2023 from https://implicit.harvard.edu/implicit/selectatest.html

6. Discuss comorbidities that may lead to vulnerability in prepubertal gender diverse and/or gender dysphoric children.

Competencies Addressed:

Competency Domain	PCRS[a] Competency	LGBT/GNC/DSD Specifier[b]
Patient Care	Educate patients and their families to empower them to participate in their care and enable shared decision making by:	● Recognizing the unique health risks and challenges often encountered by individuals described above, as well as their resources, and tailoring health messages and counseling efforts to boost resilience and reduce high-risk behaviors.[c]
[a] PCRS, Physician Competency Reference Set [b] Professional Competencies to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming, and/or Born With DSD [c] "individuals/patients/populations described above" refers to individuals/populations who are LGBT, Gender Nonconforming, and/or Born With DSD		

6*Adapted from AAMC

Questions to explore and promote discussion:

- Are gender diverse and gender dysphoric youth at risk for mental health comorbidities? If so, which comorbidities are increased compared to their cisgender peers?
- What are protective factors against these comorbidities?
- What factors contribute to an increased risk of these comorbidities?

Suggested Discussion Content:

Gender dysphoric children are also at high risk of many psychiatric comorbidities including the following:[27,40]

- Anxiety
- Depression
- Suicidality
- Oppositional defiance
- Lower school performance

- School bullying
- Nonsuicidal self-injury
- Drug and alcohol abuse

Some studies suggest that the rates of depression and anxiety are 20-35%, or five times higher than their gender conforming counterparts.[40] School bullying is four times as high.[41] Transgender adolescents have five times the risk of suicide attempts.[27] These statistics are alarming. While there is no federal legislation regarding bullying, there are policy and legislative decisions at the state level.

Historically, several behavioral health approaches have been utilized when working with gender diverse children. An affirmative approach has the best physical and psychosocial outcomes. In an affirming approach, the goal is to help the child and their family decipher subjective gender experience and differentiate those with persistent transgender identity from those exploring gender diverse expression. Healthcare providers assist youth and families in learning about and engaging in gender affirming care, such as social and medical interventions. Children who are rejected by their families are at increased risk for the above comorbidities. Family acceptance and support during childhood is associated with positive self-esteem, high social support, positive mental health, less depressive symptoms, and greater life satisfaction.[22,23]

Summary Learning Points:

- Prepubertal children who are gender diverse and/or experience gender dysphoria are a vulnerable population at risk for numerous psychological comorbidities.
- Gender diverse and gender dysphoric children are also at a higher risk for school bullying, poor school performance, behavioral issues, and substance abuse.
- An affirming approach to gender diversity and gender dysphoria promotes acceptance and support. A supportive approach leads to better mental, behavioral and physical outcomes of all youth.

Educational Resources:

Hill, D. B., Menvielle, E., Sica, K. M., & Johnson, A. (2010). An Affirmative Intervention for Families With Gender Variant Children: Parental Ratings of Child Mental Health and Gender. *Journal of Sex & Marital Therapy, 36*(1), 6-23. doi:10.1080/00926230903375560

Spack, N. P., Edwards-Leeper, L., Feldman, H. A., Leibowitz, S., Mandel, F., Diamond, D. A., & Vance, S. R. (2012). Children and Adolescents With Gender Identity Disorder Referred to a Pediatric Medical Center. *Pediatrics, 129*(3), 418-425. doi:10.1542/peds.2011-0907

Toomey, R. B., Ryan, C., Diaz, R. M., Card, N. A., & Russell, S. T. (2010). Gender-nonconforming lesbian, gay, bisexual, and transgender youth: School victimization and young adult psychosocial adjustment. *Developmental Psychology, 46*(6), 1580-1589. doi:10.1037/a0020705

U.S. Department of Health and Human Services. (2012, March 08). Federal Laws. Retrieved March 11, 2023 from https://www.stopbullying.gov/laws/federal/

7. Outline a multimodal strategy to promote the well-being of the child in this scenario, including naming specific target areas where patient/family-centered education and sensitivity to gender diversity should be reinforced.

Competencies Addressed:

Competency Domain	PCRS[a] Competency	LGBT/GNC/DSD Specifier[b]
Patient Care	Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment by:	• Describing the special health care needs and available options for quality care for transgender patients and for patients born with DSD.
	Counsel and educate patients and their families to empower them to participate in their care and enable shared decision making by:	• Assessing unique needs and tailoring the physical exam, and counseling and treatment recommendations to any of the individuals described above, taking into account any special needs, impairments, or disabilities.[c] • Recognizing the unique health risks and challenges often encountered by individuals described above, as well as their resources, and tailoring health messages and counseling efforts to boost resilience and reduce high-risk behaviors.[c]
Interpersonal and Communication Skills	Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds by:	• Recognizing and respecting sensitivity of certain clinical information pertaining to the care of the patient populations described above, and involving the patient (or the guardian of a pediatric patient) in the decision of when and how to communicate such information to others.[c]
Systems-Based Practice	Coordinate patient care within the healthcare system relevant to one's clinical specialty by:	• Identifying and appropriately using special resources available to support the health of the individuals described above (e.g., target smoking cessation programs, substance abuse treatment, and psychological support).[c]

		● Identifying and partnering with community resources that provide support to the individuals described above (e.g., treatment centers, care providers, community activists, support groups, legal advocates) to help eliminate bias from health care and address community needs.[c]
Interprofessional Collaboration	Work with other health professionals to establish and maintain a climate of mutual respect, dignity, diversity, ethical integrity, and trust by:	● Valuing the importance of interprofessional communication and collaboration in providing culturally competent, patient-centered care to the individuals described above and participating effectively as a member of an interdisciplinary health care team.[c]
[a] PCRS, Physician Competency Reference Set [b] Professional Competencies to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming, and/or Born With DSD [c] "individuals/patients/populations described above" refers to individuals/populations who are LGBT, Gender Nonconforming, and/or Born With DSD		

6*Adapted from AAMC

Questions to Explore and Promote Discussion:

- In what ways can different medical or clinical specialties be helpful to families with gender diverse children?
- How can an interdisciplinary healthcare team be useful when outlining a strategy to promote the well-being of a gender diverse team?
- What are some of the benefits and challenges of clinical intervention?

Suggested Discussion Content:

Coordinated care among several medical disciplines can provide optimal care to gender diverse and gender dysphoric children. Since pediatricians and family practitioners are often the first point of contact for a gender diverse child and parents, these providers should be well equipped to provide guidance, support, and resources to families. These primary care providers often need to interact with other medical specialties and refer patients, parents and/or other family members to other medical disciplines when additional services are needed. Since family acceptance and a loving and nurturing home environment are essential to the overall well-being of the child, psychology, psychiatry, and social work can provide behavioral health services and counseling for patients and families. Furthermore, children who experience gender dysphoria may benefit from additional behavioral health services, as the distress a child experiences can influence their mental, emotional, and physical well-being. Children with gender dysphoria may also benefit from pubertal suppression.[42] Current guidelines recommend pubertal suppression, under the care of a pediatric endocrinologist, for children with gender dysphoria at the first sign of puberty, which is Tanner 2 (sexual maturity rating) for both females and males sex assigned at birth.[42]

While studies are not abundant on hormonal suppression for a gender diverse child, the literature does suggest a positive effect on both the physical and psychological functioning of the individual.[43] Research does suggest that children treated with hormonal suppression had significantly better psychosocial functioning after 1 year of pubertal suppression compared with those children who had received only psychological support.[44] One of the larger studies of 70 patients treated with GnRH agonist therapy noted improved psychological functioning and no patients opted to discontinue pubertal suppression; all eventually began gender affirming hormone treatment.[45]

Benefits of pubertal suppression with GnRH agonist therapy may include:[42]

- Reversible
- "Buys" time to continue to explore gender identity
- May improve suffering, including school performance and social development
- Physical benefits
    - Prevent need for mammoplasties
    - Prevent menarche/menses
    - Delayed epiphyseal closure
    - Preventing skeletal changes (i.e., development of Adam's apple)
    - Unwanted phallic growth and spontaneous erections
    - Prevent permanent male voice changes

Disadvantages of pubertal suppression with GnRH agonist therapy may include:[42]

- Uncertainty about definitive persistence of gender identity
- Delay of bone accrual/density
- Height might be influenced hormonally
- Psychological long- term effects relatively unknown

The following resource provides guidance for an interdisciplinary approach to health care for gender diverse children and their families.[46]

Multimodal/Interprofessional Strategy to Promote the Well-being of the Child:

Role	Responsible Team Member
Person who the team is designed to support	Child
Support the health and well-being of the child	Family
School Support	Provider referral to school support system which may include administrators, teachers, school counselors, school nurses, and social workers

Overall child health and coordination of specialties	Pediatrician or Primary care provider
Pubertal suppression	Pediatric endocrinologist
Child mental health and well-being	Mental health professionals (psychologist, psychiatrist, school counselor)
Family and/or child health and well-being	Community Support Group/Organization
Family and/or child health and well-being	National Support Group/Organization (e.g., GLMA, PFLAG, GLAAD, TAN, Trevor Project)
Consult with the team regarding future surgery needs (e.g., gender affirmation)	Surgeon
Consult with the team for future medical care (e.g., trans masculine Gynecology care)	Gynecologist

Summary Learning Point:

Children with gender dysphoria experience distress due to the incongruence between one's affirmed and one's assigned gender. While children who are gender diverse may also experience this distress, other medical disciplines, especially psychology, psychiatry, and social work, can provide counseling and guidance to children and their families. Pediatricians and primary care providers are often the first point of contact for families and are critical in providing support for patients and families and coordinating care with all the various medical specialties. Family acceptance and nurturing is vital to the overall health and well-being of any child.

Educational Resources:

CenterLink. (2017). Local, State, and National LGBT Organizations and Groups. Retrieved March 11, 2023, from https://www.lgbtcenters.org/LGBTCenters

Tishelman, A. C., Kaufman, R., Edwards-Leeper, L., Mandel, F. H., Shumer, D. E., & Spack, N. P. (2015). Serving transgender youth: Challenges, dilemmas, and clinical examples. *Professional Psychology: Research and Practice, 46*(1), 37-45. doi:10.1037/a0037490

Recommended Learning Activities

Learning Activity 1: Role play to demonstrate developmentally appropriate history for a gender diverse prepubertal child

Competencies Addressed:

Competency Domain	PCRS[a] Competency	LGBT/GNC/DSD Specifier[b]
Patient Care	Gather essential and accurate information about patients and their conditions through history-taking, physical examination, and the use of laboratory data, imaging, and other tests by:	● Sensitively and effectively eliciting relevant information about sex anatomy, sex development, sexual behavior, sexual history, sexual orientation, sexual identity, and gender identity from all patients in a developmentally appropriate manner. ● Performing a complete and accurate physical exam with sensitivity to issues specific to the gender diverse prepubertal child.
Knowledge for Practice	Apply established and emerging biophysical scientific principles fundamental to health care for patients and populations by:	● Understanding and explaining how stages of physical and identity development across the lifespan affect the above-described populations and how health care needs and clinical practice are affected by these processes.[c]
[a] PCRS, Physician Competency Reference Set [b] Professional Competencies to Improve Health care for People Who Are or May Be LGBT, Gender-Nonconforming, and/or Born With DSD [c] "individuals/patients/populations described above" refers to individuals/populations who are LGBT, Gender-Nonconforming, and/or Born With DSD		

6*Adapted from AAMC

Suggested Format:

Parent and gender diverse child "Sam" are at a well child visit. At the visit, the parent makes a comment about their child expressing concern about "Sam" wearing boy clothes. You, as the provider, take this opportunity to take a history of "Sam" using language and developmentally appropriate practices that are sensitive to gender diverse youth.

Suggested Content:

Explore how you would respond if the parent refused to leave the room, or if the parent is talking negatively about the child's gender while the child is present. Refer to interview questions under discussion point #2 to guide this role play scenario.

Summary Learning Point:

Assumptions should not be made about gender and sexual development. As a provider, you can explore issues and questions about gender and sexuality with the youth and this should be done in the same social and cognitive developmental context as you would for any youth.

Prepubertal children may experience romantic feelings or attraction which can be explored in a developmentally appropriate way. It is critical that the provider follow the lead of the youth about language. Go where the child takes you. Listen and respond, rather than guide, enforce or force. Reinforce and remember that there is no one healthy gender outcome. It is important to consider how to best involve other family members in such interviews. It is often most appropriate for parents to be interviewed separately from the child to facilitate accurate information and establish trust with the family and individual members. As part of this process, an initial discussion would include reviewing content that would remain private between the child and the provider and instances where disclosing information collaboratively to the parents may be clinically necessary or required by law.

Educational Resources:

Levine, D. A., Braverman, P. K., Adelman, W. P., Breuner, C. C., Levine, D. A., Marcell, A. V., O'Brien, R. F. (2013). Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth. Pediatrics, 132(1), 198-203. doi:10.1542/peds.2013-1282

Sherer, I., Baum, J., Ehrensaft, D., & Rosenthal, S. M. (2015). Affirming gender: Caring for gender-atypical children and adolescents. Contemporary Pediatrics, 32(1), 16.

Learning Activity 2: Reflection Prompts

Competencies Addressed:

Practice-Based Learning and Improvement	Locate, appraise, and assimilate evidence from scientific studies related to patients' health problems by:	● Identifying important clinical questions as they emerge in the context of caring for the individuals described above, and using technology to find evidence from scientific studies in the literature and/or existing clinical guidelines to inform clinical decision making and improve health outcomes.[c]

6*Adapted from AAMC

Suggested Format:

The following prompts are appropriate for either a written or verbal reflection. They may be used in a small group discussion, or one-on-one, or even for individual processing. It may also be used more than once to indicate learner understanding over time.

Suggested Content:

As a future doctor, reflect on and describe practices (may include physical exam, verbal and/or nonverbal communication behaviors) that you believe are important for working with gender diverse youth. Why did you choose these practices?

As with most areas of medicine, working with gender diverse youth is an evolving field. How might you stay current about the best practices for working with gender diverse youth and their families? How would you determine the trustworthiness of your resources?

Summary Learning Point:

Current research is limited in its ability to universally predict the persistence of gender identity of prepubertal children. Best practices continue to evolve, and it is incumbent upon providers to access and utilize appropriate evidenced-based resources and management guidelines provided by reputable professional organizations.

Educational Resource:

World Professional Association for Transgender Health. (2022). Standards of Care for the Health of transgender and gender diverse people (8th ed.,). *International Journal of Transgender Health*, *23*(sup1), S1-S259.

Learning Activity 3: Implicit Bias Test

Competency Domain	PCRS[a] Competency	LGBT/GNC/DSD Specifier[b]
Patient Care:	Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment by:	● Describing the special health care needs and available options for quality care for transgender patients and for patients born with DSD.
	Counsel and educate patients and their families to empower them to participate in their care and enable shared decision making by:	● Assessing unique needs and tailoring the physical exam and counseling and treatment recommendations to any of the individuals described above, taking into account any special needs, impairments, or disabilities.[c] ● Recognizing the unique health risks and challenges often encountered by individuals described above, as well as their resources, and tailoring health messages and counseling efforts to boost resilience and reduce high-risk behaviors.[c]

Knowledge for Practice:	Demonstrate an investigatory and analytic approach to clinical situations by:	● Recognizing the gaps in scientific knowledge (e.g., efficacy of various interventions for DSD in childhood; efficacy of various interventions for gender dysphoria in childhood) and identifying various harmful practices (e.g., historical practice of using reparative therapy to attempt to change sexual orientation; withholding hormone therapy from transgender individuals) that perpetuate the health disparities for patients in the population described above.[c]
[a] PCRS, Physician Competency Reference Set [b] Professional Competencies to Improve Health Care for People Who Are or May Be LGBT, Gender-Nonconforming, and/or Born With DSD [c] "individuals/patients/populations described above" refers to individuals/populations who are LGBT, Gender-Nonconforming, and/or Born With DSD		

6*Adapted from AAMC

Suggested Format:

We have provided a link to The Implicit Association Test (IAT) that provides a measure of attitudes and beliefs and may uncover an implicit bias for which the test taker may not be aware. This test can be a learning activity that is especially useful for Objective #5. It may be paired with individual reflection prompts such as: Did the IAT uncover any biases that you were unaware of? How might you incorporate this information into your practice in medicine? What resources may provide strategies in this work? Please pay special attention to the guidelines for using the IAT because this work can be difficult to process for some learners.

Suggested Content:
https://implicit.harvard.edu/implicit/takeatest.html

Sukhera, J. I. (2018). Bias in the mirror: exploring implicit bias in health professions education. Datawyse/Universitaire Pers Maastricht. https://doi.org/10.26481/dis.20181129js

Summary Learning Point:

Creating spaces that promote affirming health care can have a significant impact on patients. It is important to train staff members to respectfully communicate with patients whose gender identity may not match their sex assigned at birth. A clinician's own implicit biases can impact patient care; thus, it is imperative that clinicians reflect on their biases and take steps to address them. This is challenging work that needs continual processing and action. The common goal is that all patients receive quality medical care, in an environment which fosters respect and communication.

Educational Resources:

Ratliff, K., Umansky, E., Bar-Anan, Y., Lai, C., Smith, C. T., Hawkins, C. B., & Greenwald, T. (2011). Project Implicit. Retrieved March 11, 2023 from https://implicit.harvard.edu/implicit/takeatest.html

Sabin, J. A., Riskind, R. G., & Nosek, B. A. (2015). Health Care Providers' Implicit and Explicit Attitudes Toward Lesbian Women and Gay Men. *American Journal of Public Health, 105*(9), 1831-1841. doi:10.2105/ajph.2015.302631

Stone, J., & Moskowitz, G. B. (2011). Non-conscious bias in medical decision making: what can be done to reduce it? *Medical Education, 45*(8), 768-776. doi:10.1111/j.1365-2923.2011.04026.x

Learning Activity 4: Small group activity to strategize interprofessional interactions for a child who is gender diverse.

Competencies Addressed:

Competency Domain	PCRS Competency	LGBT/GNC/DSD Specifier
Interpersonal and Communication Skills	Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds by:	● Recognizing and respecting sensitivity of certain clinical information pertaining to the care of the patient populations described above, and involving the patient (or the guardian of a pediatric patient) in the decision of when and how to communicate such information to others.
Systems-Based Practice	Coordinate patient care within the healthcare system relevant to one's clinical specialty by:	● Identifying and appropriately using special resources available to support the health of the individuals described above (e.g., target smoking cessation programs, substance abuse treatment, and psychological support). ● Identifying and partnering with community resources that provide support to the individuals described above (e.g., treatment centers, care providers, community activists, support groups, legal advocates) to help eliminate bias from health care and address community needs.
Interprofessional Collaboration	Work with other health professionals to establish and maintain a climate of mutual	● Valuing the importance of interprofessional communication and collaboration in providing culturally competent, patient-centered care to the

	respect, dignity, diversity, ethical integrity, and trust by:	individual described above and participating effectively as a member of an interdisciplinary health care team.

6*Adapted from AAMC

Suggested Format:

1. Students should be divided into groups of four to outline a strategy to promote the well-being of the child in this scenario utilizing the worksheet below.
2. Students will be asked to answer the worksheet questions which include what additional resources the parent and/or child would benefit from, including interprofessional resources.
3. A representative from each group will be asked to share their strategy with a larger group.
4. The larger group should give feedback on the individual group strategy.

Suggested Content:

Multimodal/Interprofessional Strategy to Promote the Well-being of the Child
1. What are some key issues the patient presents with in this scenario?
2. What are some of the barriers the patient faces?
3. List specific target areas where psychoeducation and sensitivity to gender issues should be reinforced.
4. What strategies would you suggest promoting the well-being of the child?
5. What specific additional resources should the parent and/or child be linked to, including resources outside of medicine?

6. Who are the team members and what roles are they responsible for?
Adapted with permission from: Leslie, K. F., Steinbock, S., Simpson, R., Jones, V. F., & Sawning, S. (2017). Interprofessional LGBT health equity education for early learners. *MedEdPORTAL*, *13*, 10551. https://doi.org/10.15766/mep_2374-8265.10551 [47]

Summary Learning Point:

This activity gives students an opportunity to take a holistic approach to patient care. It allows for the assessment of patient and family needs while recognizing that there may be barriers to care. It asks for a multidisciplinary approach which extends beyond health care (e.g., school, community) acknowledging that the physician is one of many providers. Understanding the unique roles and contributions of each interdisciplinary team member is very important, as is having a mechanism of communication within the team, child, and family (when appropriate).

Educational Resources:

CenterLink. (2017). Local, State, and National LGBT Organizations and Groups. Retrieved March 11, 2023, from https://www.lgbtcenters.org/LGBTCenters

National LGBT Health Education Center. (2020 Winter) Affirmative Services for Transgender and Gender Diverse People: Best Practices for Frontline Health Care Staff (Rep.). Retrieved March 11, 2023, from https://www.lgbtqiahealtheducation.org/publication/affirmative-services-for-transgender-and-gender-diverse-people-best-practices-for-frontline-health-care-staff/

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Resources Useful to All:

The Family Acceptance Project provides a comprehensive and evidence-based resource that may be useful for both providers and families in relation to spirituality and culture.
Family Acceptance Project:

- San Francisco State University. (2017, May 24). The Family Acceptance Project. Retrieved March 11, 2023, from http://familyproject.sfsu.edu/
- San Francisco State University. (2017, May 24). Family Education Booklet. Retrieved March 11, 2023, from http://familyproject.sfsu.edu/family-education-booklet
- San Francisco State University. (2017, May 24). Family Education LDS Booklet. Retrieved March 11, 2023, from http://familyproject.sfsu.edu/family-education-booklet

- Substance Abuse and Mental Health Services Administration. (2014). A Practitioner's Resource Guide: Helping Families to Support Their LGBT Children (Rep. No. PEP14-LGBTKIDS). Retrieved March 10, 2023, from Substance Abuse and Mental Health Services Administration website: https://store.samhsa.gov/product/A-Practitioner-s-Resource-Guide-Helping-Families-to-Support-Their-LGBT-Children/PEP14-LGBTKIDS

Pre/Post Assessment

The following pre/post assessment can be used to assess your learners. There are knowledge-based questions, as well as confidence and comfort questions. This is not a comprehensive list of questions to assess all of the content above but is provided to give instructors an example. The following link provides a resource for those who would like to expand their assessment of learners understanding and comfort with working with transgender youth. This can be used to supplement the survey (below) for these modules.
https://www.sciencedirect.com/science/article/pii/S1054139X16308734

The authors of this work are interested in the results of the following assessment to guide their future efforts. If you utilize the assessment, the authors invite you to share the results (de-identified) with them by emailing Eileen CichoskiKelly at:
Eileen.CichoskiKelly@med.Uvm.Edu

Knowledge:

1. In children with normal gender development, what age is gender identity considered to be stable and constant? {Discussion Points, 2,3}

A. 1-year-old
B. 2-years-old
C. 3-years-old
D. 4-years-old
E. 5-years-old

Answer: D

2. Which of the following is the strongest predictor that gender dysphoria will persist into adolescence? {Discussion Points, 3}

A. Intensity of gender dysphoria
B. Late childhood onset of gender dysphoria
C. Parental acceptance and affirmation
D. Same sex romantic attraction
E. Lack of mental health support

Answer: A

3. Children with gender dysphoria are at high risk of suicide ideation and suicidal behaviors. Which of the following is the strongest impact factor in reducing this risk? {Discussion Points, 4,6,7}

A. Higher socioeconomic status
B. Identify as white

C. Accepting friends
D. Supportive parents
E. Lack of anxiety and depression

Answer: D

4. Which of the following psychosocial comorbidities are children with gender dysphoria likely to endorse? {Discussion Points, 6,7}

A. Anxiety
B. Depression
C. Victim of bullying
D. Self-harm
E. All the above

Answer: E

5. Which of the following is an example of gender affirming care in the context of a medical office? {Discussion Points, 4,5,6}

A. Using a child's affirmed pronoun
B. Using the child's birth name when called from the waiting room
C. Using sex assigned at birth specific terminology when referring to anatomy, such as breast or penis
D. Providing literature in the office regarding conversion/reformative therapy
E. Keeping affirmed name and pronoun confidential so office staff are not privy to this information

Answer: A

6. An individual was assigned female sex at birth. They enjoy climbing trees, playing with toy trucks, wearing a pretend mustache, and building forts. They prefer to dress in jeans or shorts and like to wear their hair short. Which of the following best describes this individual? {Discussion Points, 1}

A. The individual is transgender
B. The individual is non-binary
C. The individual is gay
D. The individual has a masculine gender expression
E. The individual has a masculine gender identity

Answer: D

7. While long term studies are limited, current evidence-based medicine studies suggest that pubertal suppression in children with gender dysphoria has which of the following advantages? {Discussion Points, 7}

A. Irreversible
B. Inexpensive
C. Easy to administer orally
D. Accelerated epiphyseal closure
E. Prevents certain skeletal changes such as development of an Adam's apple

Answer: E

Confidence of knowledge:

8. Please rate your overall KNOWLEDGE level in caring for pediatric patients initially presenting with gender diversity using a scale of 1 to 5, with 1 being the least knowledgeable and 5 being the most knowledgeable, after completing this module.

A. 1
B. 2
C. 3
D. 4
E. 5

9. This module has improved my KNOWLEDGE base for how to care for pediatric patients presenting with gender diversity.

A. Strongly Disagree
B. Disagree
C. Neutral
D. Agree
E. Strongly Agree

Confidence/Comfort:

10. Please rate your overall CONFIDENCE level in your ability to care for pediatric patients initially presenting with gender diversity using a scale of 1 to 5, with 1 being the least confident and 5 being the most confident, after completing this module.

A. 1
B. 2
C. 3
D. 4
E. 5

11. This module has improved my COMFORT level in caring for pediatric patients presenting with gender diversity.

A. Strongly Disagree
B. Disagree
C. Neutral
D. Agree
E. Strongly Agree

Barriers:

12. Which of the following do you feel is the largest barrier when it comes to caring for pediatric patients presenting with gender diversity in a primary care setting?

A. Lack of medical education/training in caring for this patient population
B. Lack of exposure to this patient population
C. My own personal beliefs (spiritual, cultural, religious, etc.)
D. Time constraints in a primary care setting
E. Other_____

13. What other barriers, if any, have you encountered when caring for pediatric patients presenting with gender diversity? If you have not cared for pediatric patients presenting with gender diversity, what barriers do you foresee?

_____

Additional Training:

14. What other training have you completed regarding caring for pediatric patients with gender diversity?

A. Grand Rounds
B. Noon Conference
C. Medical school training
D. Other_____

Which training was the most helpful (including this module)?

_____