

Safe Schools for Transgender and Gender Diverse Students

The National Association of School Psychologists (NASP) supports efforts to ensure that schools are safe and inclusive learning environments for all students, family members, and school staff, including those who are transgender or gender diverse. NASP respects a person's right to express gender identity, and the right to modify gender expression when necessary for individual well-being. In addition, NASP supports all students' right to explore and question their gender identity. NASP is committed to a policy of nondiscrimination and the promotion of equal opportunity, fairness, justice, and respect for all persons (NASP, 2012).

NASP acknowledges that neither having a transgender identity nor being perceived as gender diverse is a disorder, and that efforts to change a person's gender identity are ineffective, harmful, and discriminatory. NASP works to ensure that settings in which school psychologists work are safe and welcoming and provide equal opportunity to all persons regardless of actual or perceived characteristics, including gender, gender identity, gender expression, sexual orientation, and any other personal identity or distinguishing characteristics (NASP, 2010). A glossary of terms may be found at the end of the statement.

NEEDS OF TRANSGENDER STUDENTS

In many communities, it is dangerous to be gender nonconforming or to be known as transgender. Many children, youth, and adults blend with their chosen gender, and are safe to the extent that their transgender status is hidden. Data concerning school-age transgender youth are limited, but what data are available suggest that more action by school officials is needed to ensure schools are settings in which students can thrive.

Because transgender youth are so hidden, it would be easy to believe that these students are extremely rare. It is extremely difficult to estimate the prevalence of transgender students in school (Meier & Labuski, 2013). One of the few large districts to gather data is San Francisco. In 2011, 0.5% of San Francisco high school students self-identified as transgender on the annual Youth Risk Behavioral Survey (Timothy Kordic, personal communication, December 20, 2013). The prevalence of self-identified transgender adults has been estimated as 0.3% of the U.S. general population (Gates, 2011).

The experiences that transgender students have at school appear to have effects on their well-being as adults. Toomey, Ryan, Diaz, Card, and Russell (2010) showed that while gender nonconformity alone had no direct effect on these outcomes, the *victimization* experienced at school associated with gender nonconformity had a lasting impact and put these children at risk for negative mental health outcomes in adulthood. Harassment and assault lead to anxiety about school, leading to missing days of school. Nearly half (46%) of transgender students reported missing at least one school day in the previous month because they felt unsafe (Greytak, Kosciw, & Diaz, 2009).

Research suggests that gender diverse children are at higher risk of physical, emotional, and sexual abuse and are at higher risk of posttraumatic stress disorder (PTSD) in adulthood, with about a third of the higher risk of PTSD accounted for by being abused as a child (Roberts, Rosario, Corliss, Koenen, & Austin, 2012). Coming out to family members often results in physical assault and expulsion from the family home (Ray, 2006). In one study, more than half of transgender youth reported initial parental reaction to coming out as negative or very negative (Grossman, D'Augelli, & Frank, 2011). Young adults who experience low family acceptance of identity are more likely to be at risk for depressive symptoms, substance use, and suicidal ideation and attempts (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). In addition to longitudinal outcome risks, transgender youth face immediate challenges during their school-age years. Transgender youth are often desperate to transition. However, even if they have medical insurance, the healthcare procedures necessary to transition are explicitly excluded from most health insurance plans. Psychotherapy for gender dysphoria is often excluded. Transgender youth may take hormones obtained on the street or through the internet without medical supervision, and take excessive doses. They may seek silicone injections at “pumping parties,” resulting in severe disfigurement or death.

Despite these challenges, many transgender youth are resilient, and there are a number of factors that may help them guard against the worst outcomes. Resilience in children and youth appears to depend on personal characteristics like being outgoing, resourceful, and having a positive self-concept. In addition, social relationships, such as having an emotional bond with at least one adult over a period of time, and having a supportive community are associated with resilience (Werner, 1995). Specifically for transgender and gender diverse children, attention has been focused on *family acceptance* and *school acceptance*. LGBT youth from families rated high in acceptance (e.g., they discuss their child’s gender identity or sexual orientation openly, integrate their child’s LGBT friends into family activities, express appreciation for their child’s clothing choices even if the clothing was gender nonconforming) reported better self-esteem, better health, lower levels of depression, lower rates of substance abuse, lower rates of suicide attempts, and lower rates of risky sexual behavior (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). These findings suggest that similar acceptance in school environments is recommended.

CONSIDERATIONS FOR PARENTS, PHYSICIANS, AND SCHOOLS

To adequately support their child’s growth, parents must allow their child’s personality to unfold while simultaneously protecting them from harm (Ehrensaft, 2011). Families go through a developmental process in accepting a transgender or gender diverse child. Much depends on a parent’s beliefs and understanding of child development and of gender. Some children have unexpected gender behavior at an early age, which persists in spite of parent attempts to divert the child to gender conforming behavior. Parents may be embarrassed or ashamed of their child’s behavior, depending on conformity pressures coming from extended family members, neighbors, clergy, daycare providers, and others. Parents may fear the future for their child, as well as their own future as they are judged by other adults. The parent who is the same sex as the child may question his or her own effectiveness as a role model. Children and youth are more likely to have successful outcomes if parents work to create safe and supportive spaces for their child within the home, require others to respect their child, and express love for their child (Brill & Pepper, 2008).

The World Professional Association for Transgender Health (WPATH) *Standards of Care* for the psychiatric, psychological, medical, and surgical management of gender transition note that “Treatment aimed at trying to change a person’s gender identity and expression to become more congruent with sex

assigned at birth has been attempted in the past without success. Such treatment is no longer considered ethical” (Coleman, et al., 2011, p. 175).

Some students arrive at kindergarten already living in their asserted gender, while others express a desire to make a gender transition later in elementary or in secondary school. The majority of gender diverse children under age 9 who assert that they are a different gender than assigned at birth do not persist in asserting that gender in adolescence and early adulthood. By comparison, the majority of youth age 11 and older asserting a gender different than assigned at birth persist in that identity throughout adolescence and adulthood (Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011). For children under age 9, only reversible social transitions are recommended (e.g., clothing, hair styles, activity preferences). For children age 11 or older, other treatments may be appropriate. A reversible medical treatment involving the administration of a gonadotropin-releasing hormone agonist (GnRH) in early puberty can put puberty on hold for several years, allowing the child time to mature and be ready for permanent changes. After puberty, youth can make more informed decisions regarding long-term treatment (Delemarre-van de Waal & Cohen-Kettenis, 2006; Spack et al., 2012).

Educational persistence of transgender and gender diverse students may depend on their sense of safety and belonging in the school environment. Title IX of the Education Amendment Act of 1972 prohibits harassment of students on the basis of gender expression. Schools have a duty to ensure that gender diverse and transgender students are included in all school infrastructure. For example, providing gender-neutral bathroom options and avoiding the use of gender segregation in practices such as school uniforms, school dances, and extracurricular activities are structural ways to provide safer school environments (Toomey et al., 2010). The presence of a Gay–Straight Alliance (GSA) in school can lead to greater feelings of safety and of belonging, better attendance, and lower rates of harassment. (Toomey, Ryan, Diaz, & Russell, 2011).

Comprehensive antiharassment policies that include protections for transgender and gender diverse students are helpful for all students. Adult intervention is helpful when homophobic or transphobic statements are heard (Case & Meier, 2014). Written policies and procedures addressing the needs of transgender and gender diverse students are helpful for staff and administrators and all students and families (e.g., Gay, Lesbian, and Straight Education Network/National Center for Transgender Equality, 2011; Massachusetts DOESE, 2012).

ROLE OF THE SCHOOL PSYCHOLOGIST

The school psychologist should be in tune with the needs of students and staff, and can provide evidence-based information about transgender issues. The school psychologist should be welcoming and supportive of transgender and gender diverse staff and parents, and he or she should be able to foster a climate of acceptance and security for all (Case & Meier, 2014). A student’s transgender status or history must be kept confidential and within the student’s control. In all cases school psychologists must be sensitive to the needs and welfare of all individuals at their school sites, including transgender and gender diverse students and staff. School psychologists must advocate for the civil rights of all students, including those who are transgender or gender diverse. This can be accomplished by:

- Advocating for gender neutral spaces and helping establish safe zones for transgender students
- Seeking additional training or supervision as needed regarding issues affecting transgender and gender diverse people

- Modeling acceptance and respect
- Providing staff training to increase awareness regarding transgender issues in the schools
- Responding to bullying, intimidation, and other harassment, whether perpetrated by students or staff
- Minimizing bias by using phrasing and pronouns that are not gender specific and by avoiding gender stereotypes
- Providing counseling and attending to the social–emotional needs of transgender and gender diverse students in school
- Acquiring and providing information on community agencies that provide services and supports to the transgender community
- Supporting or contributing to research regarding best practices for integrating transgender and gender diverse students in school

Gender diverse and transgender students might be referred to a school psychologist due to school victimization or bullying, suicidal ideation or attempts, nonsuicidal self-injury, sexual orientation instead of gender issues, social anxiety, and/or autism spectrum symptoms. School psychologists should be aware of resources for these children and their families. Transgender and gender diverse students may benefit from learning healthy coping skills and building resilience, but interventions for associated social–emotional problems should not attempt to enforce gender stereotypical behavior.

NASP's *Principles for Professional Ethics* (NASP, 2010) include provisions that pertain to gender diverse and transgender individuals, including the following:

- *Standard I.2.6:* School psychologists respect the right of privacy of students, parents, and colleagues with regard to sexual orientation, gender identity, or transgender status. They do not share information about the sexual orientation, gender identity, or transgender status of a student (including minors), parent, or school employee with anyone without that individual's permission.
- *Standard II.1.2:* Practitioners are obligated to pursue knowledge and understanding of the diverse cultural, linguistic, and experiential backgrounds of students, families, and other clients. When knowledge and understanding of diversity characteristics are essential to ensure competent assessment, intervention, or consultation, school psychologists have or obtain the training or supervision necessary to provide effective services, or they make appropriate referrals.
- *Principle I.3:* In their words and actions, school psychologists promote fairness and justice. They use their expertise to cultivate school climates that are safe and welcoming to all persons regardless of actual or perceived characteristics, including race, ethnicity, color, religion, ancestry, national origin, immigration status, socioeconomic status, primary language, gender, sexual orientation, gender identity, gender expression, disability, or any other distinguishing characteristic.

School psychologists should encourage schools to develop and implement policies and procedures to prevent harassment of gender diverse and transgender students in order to promote safe schools for all students. School psychologists can provide education about gender expression and LGBT issues to teachers, administrators, students, and staff (Toomey et al., 2010). School psychologists should encourage the formation of support or social groups for gender diverse and transgender students (Goodenow, Szalacha, & Westheimer, 2006; Toomey et al., 2010). School psychologists can work with teachers and administrators to serve as mentors for these students. Being accepted by even just one coach, teacher, or administrator can serve as a protective factor against negative psychosocial outcomes for these youth.

GLOSSARY

Language is evolving rapidly. Some terms that were considered acceptable in the past may be offensive in the present. Some previously offensive terms have been reclaimed by newer generations. We have attempted to use currently acceptable terms in this glossary. A glossary that is frequently updated is the *Media Reference Guide* available online from the Gay and Lesbian Alliance Against Defamation (GLAAD, 2010).

- **Asserted Gender.** The gender a person declares to be, verbally, nonverbally, covertly, or overtly. A transgender person's gender is usually affirmed insistently, consistently, and persistently over years. In transgender people, there is a difference between birth-assigned gender and affirmed gender. In *cisgender* people, affirmed gender aligns with birth-assigned gender. Depending on ecological safety, gender affirmation may be nonverbal and covert, or it may be a verbal declaration ("coming out") in a safe place.
- **Cisgender.** A person whose sex assigned at birth matches current gender identity. The opposite of *transgender*. "Nontransgender" is sometimes used, but implies that being transgender is not a normal variant of human difference.
- **Gender.** *Gender* implies the psychological, behavioral, social, and cultural aspects of being male or female (VandenBos, 2007). Gender refers to the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for boys and men or for girls and women (APA, 2011). While sex is a biological construct, gender is a social construct. As most people's sex and gender align, the two terms are sometimes used interchangeably.
- **Gender Assignment.** *Gender assignment* is the classification of an infant at birth as either male or female (VandenBos, 2007); this assignment of a legal gender (sex) to a child triggers a variety of social events and developmental tasks related to gender role.
- **Gender Constancy.** *Gender constancy* is a child's emerging sense of the permanence of being a boy or a girl (VandenBos, 2007), an understanding that occurs in stages but is mostly complete by age 7. School entry presents greater pressure to conform to gender expectations. At this age, some children with a gender identity incongruent with their birth-assigned sex may experience distress if they are not permitted to express and be witnessed as their gender. At clinically significant levels, this is called *gender dysphoria* (VandenBos, 2007).
- **Gender Dysphoria.** Discontent with the physical or social aspects of one's own sex (VandenBos, 2007). The degree of distress can vary from mild to severe, and can be life long, although not all transgender people experience gender dysphoria. The child with gender dysphoria may demonstrate symptoms of depression, anxiety, self-harm, or oppositionality (APA, 2013).
- **Gender Diverse.** Someone is *gender diverse* if his or her *gender expression* does not match what is culturally expected for the sex assigned at birth (Gender Equity Resource Center, n.d.). Individuals may dress or act in ways that others believe are not feminine enough or not masculine enough. Gender expression has become one aspect of diversity in human resource practice and in civil rights law, including nondiscrimination laws. Gender diverse implies that all humans express gender, and that no gender expression is inherently better than another. Gender diverse is an alternative term for *gender nonconformity*, which implies that gender diverse people are violating rules for gender expression; it is also an alternative for *gender variant*, which implies difference from a norm. Other respectful terms for gender diversity include *gender creative* and *gender expansive*.
- **Gender Expression.** *Gender expression* refers to how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice, or body characteristics

(NCTE, May 2009). Gender expression is visible, while gender identity is not. Being gender diverse means having an unexpected gender expression; being transgender means having an unexpected gender identity. Some transgender people do not appear gender diverse. Some people with diverse gender expression are happy with their sex assigned at birth and have no desire or intention to transition genders.

- **Gender Identity.** *Gender identity* is a person's internal sense of being male, female, both, or neither (APA 2011). This sense of maleness or femaleness typically develops from a combination of biological and psychic influences (VandenBos, 2007). Shortly after children begin to speak, most are able to state whether they are a boy or a girl, and this identity is stable and resistant to change. Gender identity typically forms between 2 and 5 years of age. For most people, gender identity is consistent with sex assigned at birth.
- **Genderqueer.** A person who defies or does not accept stereotypical gender roles and may choose to live outside expected gender norms may self-identify as *genderqueer*. (Center for Excellence in Transgender Health, April, 2011). Genderqueer people may or may not avail themselves of hormonal or surgical treatments.
- **Sex.** The term sex refers to a person's biological characteristics, including chromosomes, hormones, and anatomy (VandenBos, 2007).
- **Sexual Orientation.** A person's gender identity is distinct from sexual orientation. *Sexual orientation* refers to an enduring pattern of emotional, romantic, and/or sexual attractions to men, women, both sexes, transgender people, no one, or all genders (APA, 2008; VandenBos, 2007). A transgender adult may be attracted to women, to men, to both women and men (bisexual), to no one (asexual), and/or to other transgender people. One's sexual orientation identity label is typically derived from gender identity, and not birth assigned sex. For example, a female-to-male transgender man who is primarily attracted to other men is likely to self-identify as gay. A male-to-female transgender woman who is primarily attracted to men is likely to identify as straight. Transgender people are more likely to also identify as LGBTQ than cisgender people.
- **Trans.** shorthand term for a variety of transgender identities. Also, trans people or transpeople (Center for Excellence in Transgender Health, April 2011). Because there are a variety of disputes about the terms *transgender* and *transsexual*, *trans* is seen as a more widely accepted and respectful term than transgender. There are other terms which are more universally perceived as offensive, such as "tranny." See the GLAAD *Media Reference Guide* (2010) for terms that are universally offensive.
- **Transgender.** *Transgender* refers to having a gender identity that differs from culturally determined gender roles and biological sex (VandenBos, 2007). It is an umbrella term which includes diverse identities and includes persons identifying as female-to-male, male-to-female, two-spirit, genderqueer, and other terms (APA, 2011). The transgender umbrella includes those assigned female at birth who are or who wish to be living as men (*transgender men*), and those assigned male at birth who are or who wish to be living as women (*transgender women*). Many transgender people appear indistinguishable from *cisgender* people. They may or may not desire body modifications to express their asserted gender. Body modifications may be temporary (e.g., shaving, changing hair style, binding, using hormone blockers) or permanent (e.g., hormones, electrolysis, surgeries; APA, 2011). Medical assistance can help transgender people live more comfortable lives as they may be better able to blend in as their affirmed gender. Transgender women typically identify as *women*, and transgender men typically identify as *men*.
- **Transition.** The process of changing gender expression from that of one gender to another is called *transition* (APA, 2011). *Social transition* may include changes in clothing, grooming, pronouns, names, and identity documents. Children, adolescents, and adults may undergo social transition at

any time. *Medical transition* may include hormones and surgeries. Surgeries are only available after age 18, after at least one year of living persistently and consistently as the desired gender. Youth who have lived persistently in their preferred gender and who have reached Tanner Stage 2 for their birth sex (around age 12 for female-born youth and about 14 for male-born youth) may be eligible for medication that can suppress puberty until they reach age 16 or older when they may be eligible to be treated with hormones appropriate to their desired gender, saving much of the expense, pain, and cost of medical transition for adults.

REFERENCES

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th Edition). Arlington, VA: American Psychiatric Publishing.
- American Psychological Association. (2008). *Answers to your questions: For a better understanding of sexual orientation and homosexuality*. Washington, DC: Author. Retrieved from <http://www.apa.org/topics/orientation.pdf>
- American Psychological Association. (2011). *Answers to your questions about transgender people, gender identity, and gender expression*. Washington, DC: Author. Retrieved from <http://www.apa.org/topics/sexuality/transgender.pdf>
- Brill, S., & Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. San Francisco, CA: Cleis Press.
- Case, K., & Meier, C. (2014). Developing allies to transgender and gender-non-conforming youth: Training for counselors and educators. *Journal of LGBT Youth, 11*(1), 62–82. doi:10.1080/193653.2014.840764
- Center for Excellence in Transgender Health. (2011, April). *Primary care protocol for transgender patient care*. San Francisco, CA: University of California at San Francisco, Department of Family and Community Medicine. Retrieved from <http://www.transhealth.ucsf.edu/trans?page=protocol-terminology>
- Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., & Zucker, K. (2011). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, Version 7. *International Journal of Transgenderism, 13*, 165–232. doi:10.1080/15532739.2011.700873
- Delemarre-van de Waal, H. A., & Cohen-Kettenis, P. T. (2006). Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology, 155*, S131–S137. doi:10.1530/eje.1.02231
- Ehrensaft, D. (2011). *Gender born, gender made*. New York, NY: The Experiment.
- Gates, G. (2011, April). *How many people are lesbian, gay, bisexual, and transgender?* Los Angeles, CA: The Williams Institute, UCLA. Retrieved from <http://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-Many-People-LGBT-Apr-2011.pdf>
- Gender Equity Resource Center. (n.d.). Gender diverse. *Definition of terms*. Berkeley, CA: University of California at Berkeley. Retrieved from http://geneq.berkeley.edu/lgbt_resources_definiton_of_terms#genderdiverse
- GLAAD. (2001). *Media Reference Guide, 8th Edition*. Gay and Lesbian Alliance Against Defamation. Retrieved from <http://www.glaad.org/files/MediaReferenceGuide2010.pdf>

- GLSEN/NCTE. (2011). *Model district policy for transgender and gender nonconforming students*. New York, NY: Gay, Lesbian and Straight Educators Network/National Center for Transgender Equality. Retrieved from http://www.glsen.org/binary-data/GLSEN_ATTACHMENTS/file/000/001/1977-1.pdf
- Goodenow, C., Szalacha, L. A., & Westheimer, K. (2006). School support groups, other school factors, and the safety of sexual minority adolescents. *Psychology in the Schools, 43*, 573–589. doi:10.1002/pits.20173
- Grant, J. M., Mottet, L. A., Tanis, J., Harrison, J., Herman, J. I., & Keisling, M. (2011). *Injustice at every turn: A report of the national transgender discrimination survey*. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force. Retrieved from http://www.thetaskforce.org/reports_and_research/ntds
- Greytak, E. A., Kosciw, J. G., & Diaz, E. M. (2009). *Harsh realities: The experiences of transgender youth in our nation's schools*. New York, NY: Gay, Lesbian and Straight Education Network. Retrieved from <http://www.glsen.org>
- Grossman, A. H., D'Augelli, A. R., & Frank, J. A. (2011). Aspects of psychological resilience among transgender youth. *Journal of LGBT Youth, 8*, 103–115.
- Massachusetts Department of Elementary and Secondary Education. (2012). *Guidance for Massachusetts public schools creating a safe and supportive school environment: Nondiscrimination on the basis of gender identity*. Malden, MA: Author. Retrieved from <http://www.doe.mass.edu/ssce/GenderIdentity.pdf>
- Meier, C., Pardo, S., Olson, J., & Sharp, C. (2014). *Demographics of gender non-conforming children in the United States*. Submitted for presentation at the biennial symposium of the World Professional Association for Transgender Health in Bangkok, Thailand, February 2014.
- Meier, S. C., & Labuski, C. M. (2013). The demographics of the transgender population. In A. K. Baumle (Ed.), *International Handbook on the Demography of Sexuality* (pp. 289–327). New York, NY: Springer.
- National Association of School Psychologists. (2010). *Principles for professional ethics*. Retrieved from <http://www.nasponline.org/standards/>
- National Association of School Psychologists. (2012). *Nondiscrimination and equal opportunity policy*. Retrieved from http://www.nasponline.org/leadership/nondiscrimination_equal_opportunity.pdf
- NCTE. (2009, May). *Transgender terminology*. Washington, DC: National Center for Transgender Equality. Retrieved from http://transequality.org/Resources/NCTE_TransTerminology.pdf
- Ray, N. (2006). *Lesbian, gay, bisexual and transgender youth: An epidemic of homelessness*. New York, NY: National Gay and Lesbian Task Force Policy Institute and National Coalition for the Homeless. Retrieved from <http://www.thetaskforce.org>
- 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*, 410–417. doi:10.1542/peds.2011-180
- Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2011). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing, 23*, 205–213. doi:10.1111/j.1744-6171.2010.00246.x
- Spack, N. P., Edwards-Leeper, L., Feldman, H. A., Leibowitz, S., Mandel, F., Diamond, D., & Vance, S. R. (2012). Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics, 129*, 418–425. doi:10.1542/peds.2011-0907

- Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical child psychology and psychiatry, 16*, 498–516. doi:10.1177/1359104510378303
- 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*, 1580-1589. doi:10.1037/a0020705
- Toomey, R. B., Ryan, C., Diaz, R. M., & Russell, S. T. (2011). High school Gay–Straight Alliances (GSAs) and young adult well-being: An examination of GSA presence, participation, and perceived effectiveness. *Applied Developmental Science, 15*, 175–185. doi:10.1080/10888691.2011.607378
- Travers, R. (2012). Mental Health. In *Improving the health of trans communities: Findings from the Trans PULSE project*. Ottawa, Canada: Rainbow Health Ontario Conference.
- VandenBos, G. R. (Ed.). (2007). *APA dictionary of psychology*. Washington, DC: American Psychological Association.
- Werner, E. E. (1995). Resilience in development. *Current Directions in Psychological Science, 4*, 81–85.

Acknowledgement of position statement writing group members: Jill Davidson (chair), Karla Anhalt, Giorgio Jovani di Salvatore, Jim Hanson, Mary Beth Klotz, and Colt Meier. Acknowledgement is also extended to the Welcoming Schools Project of the Human Rights Campaign Foundation for their input.

Please cite this document as:

National Association of School Psychologists. (2014). *Safe schools for transgender and gender diverse students* [Position statement]. Bethesda, MD: Author.