Families in Transition: A Program for Youth with a Trans* Sibling

Erica Aten

A Dissertation Submitted to the Faculty of
The Chicago School of Professional Psychology
In Partial Fulfillment of the Requirements
For the Degree of Doctor of Philosophy in Psychology

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Abstract

One’s family system plays important roles throughout one’s lifespan. Of all the potential familial relationships, siblings share a unique, and oftentimes, life-long bond. When one person in a siblingship is experiencing hardship, it impacts both siblings and the family system as a whole. Because of the gap in the literature surrounding the experiences of youth with a trans* sibling, a needs assessment was conducted to determine the necessity, interest, feasibility, components, and potential benefits of group programming. Based on the needs assessment survey results, a group program was developed for 14 to 18-year-olds who have a trans* sibling. The goal of the program is to help participants identify their thoughts and feelings, develop coping skills, share their story, and feel a connection with other adolescents based on their shared experiences. Pre and post measures will be completed to assess the efficacy of the program.
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Chapter 1: Nature of the Study

Introduction

Various systems play important roles in children’s development, including family, school, health services, church, and peers. Of these systems, the family system is the first system for a child and therefore initially the most influential. Additionally, children’s families influence their biological, psychological, social, cognitive, and identity development (Miller, 2001). It is through one’s family that an understanding of the world is created. According to Bowenian family systems theory, all members of a family are connected to each other and families are viewed as a unit (Bowen, 1978). In the majority of families, this family system is made up of parents and children. Parents are typically an infant’s first connection with the world at birth and, as such, impact children’s experiences and view of the world. Children also learn important skills like trusting others, autonomy, and taking initiative from their caregivers (Erikson, 1950). Although parents are typically children’s first source of human connection, sibling relationships are also influential and an important factor in development.

According to Bowen (1978), all family systems have subsystems of people who can be considered allies of one another due to their inborn family alliances. This camaraderie is especially typical for siblings. One reason for sibling closeness is the length of that type of relationship. Most sibling relationships last an entire lifetime due to proximity of age (Lamb & Sutton-Smith, 2014). Additionally, siblings are typically part of the same cohort. Cohorts are groups of people who are born and raised during the same time period so their sociopolitical environment is the same. Assuming siblings grow up together in the same household, their home environment also serves as a unifying experience. Sibling dynamics are important to understand because they play a role in children’s overall development, including identity development.
The concept of identity is multifaceted and it is something that varies from person to person. Of particular interest, as it pertains to sibling relationships, is gender identity. Gender identity refers to a person’s “internal perception of their gender and how they label themselves” (Killermann, 2016, n.p.). For people who are cisgender, gender identity development likely was not a crisis and, instead, was a fairly natural occurrence; however, gender identity development can be extremely stressful for youth who identify as transgender. In this case, cisgender refers to individuals whose biological sex assigned at birth is aligned with their gender identity and transgender refers to any individuals who may or may not ascribe to the gender binary and do not identify as cisgender, such as transgender and transsexual. From this point on, “trans*” will be used as an inclusive term to refer to individuals who identify as transgender, transsexual, or transcend the gender binary. Individuals who identify as gender minorities typically experience crises as they are developing their identity and their families often have a difficult time adjusting as well.

A considerable amount of research has been done on families with a Lesbian, Gay, or Bisexual (LGB) member. The majority of LGB research covers issues surrounding sexuality, such as identity disclosure, bullying, and family acceptance. In the few studies that focus on gender identity, the topics are typically similar to those focused on sexuality; however, they are more exploratory and broad in nature. Regarding familial experiences with an LGBT member, most research covers either the family unit as a whole or the parents’ experiences specifically. The lack of research on sibling experiences is problematic. In particular, youth with a trans* sibling have not been studied. Because of the gap in the literature surrounding families with a trans* individual, as well as cisgender siblings’ experiences, there is a great need for better understanding of youth’s experiences of having a trans* sibling.
Although individuals’ life experiences vary, there are some common experiences among people who have a sibling who identifies as LGB. Oftentimes, those individuals experience changes in their relationships with their parents, siblings, and peers and they experience their siblings’ sexual identity in similar and different ways than their parents due to the dynamics of sibling relationships versus parent and child relationships (Dunlap, 2014; Rothblum, 2011). This researcher hypothesized that cisgender youth with a trans* sibling will experience changes in their relationships with their parents and sibling(s). The current study will be important for future work with trans* youth and their families, primarily in guiding psychological interventions.
Chapter 2: Literature Review

Because there is limited research on the influence of trans* identity in sibling relationships, this review will tie together existing theories and data that are deemed relevant to the proposed program. This chapter is divided into five sections. The first section will cover Bowenian family systems theory, then sibling relationships will be described in-depth. Next, illness in siblings will be described through various lenses, including chronic illness, Asperger’s, and traumatic brain injury (TBI). Lastly, gender identity and identity disclosure will be discussed while comparing gay and lesbian experiences to those who identify as gender minorities.

Bowenian Family Systems Theory

According to Murray Bowen (1993), families are dynamic by nature and represent a subsystem that is part of one’s worldwide system. All families experience anxiety due to familial discord, as well as environmental stressors. Within Bowen’s family systems theory, there are eight specific concepts which explain the various emotional and relational processes that occur in families and they are as follows: nuclear family emotional process, differentiation of self, triangulation, family projection process, multigenerational transmission process, emotional cutoff, societal emotional process, and sibling position.

Nuclear Family

The nuclear family refers to the intimately related individuals who are in a family system with one another. According to Minuchin (1988), family is described as a “complex, integrated whole” (p.8). Within families, there are common emotional experiences that occur such as anxiety, differentiation, reciprocity, conflicts, and distance (Bowen, 1993). Like any familial processes, these can be functional or dysfunctional depending on the family and level of intensity.
and frequency. Conflicts are a typical experience for families but they can become problematic when they lead to shame and criticism. Additionally, reciprocity, which is the giving and receiving of attention and love, is healthy and adaptive but when family members are overly reciprocal or neglect reciprocation, the family system becomes unbalanced and less able to manage anxiety. For example, families with a differently abled child have emotional experiences that lead to dysfunction (Degeneffe & Gagne, 2001; Dellve, Cernerud & Hallberg, 2000). Regarding families with an LGBT member, the majority of youth who come out as LGBT to their family members report their families experience stress due to their disclosure (LaSala, 2000).

**Differentiation of Self**

Differentiation of self describes the process people go through in developing coping strategies to adapt to life’s struggles (Bowen, 1993). This process begins at birth and continues throughout the lifespan. Differentiation is on a continuum, meaning all people are different and are at a unique level of differentiation. People who are less differentiated, as children are, tend to experience more anxiety because they are more sensitive to others’ feelings and behavior (Brown, 1999). Individuals at a higher level of differentiation are independent and able to adapt to emotional situations and difficult environments. Some signs of healthy differentiation in children are autonomous behavior, the ability to independently manage anxiety, and simultaneously caring for oneself and one’s family without overcompensating and overextending that care towards one’s family. Families with an LGBT member tend to be less differentiated, at least temporarily, because there is more stress and anxiety present that affects the members of the family, which impedes each individual’s ability to differentiate (Brown, 1999; Dunlap, 2014).
**Triangulation**

In all systems, including families, there are two person dyadic relationships that can waver and become unstable when faced with an increase in anxiety (Bowen, 1993). That two-person relationship becomes triangulated when a third person is pulled in to take the burden of the anxiety off of the original dyad members. Triangulation is a common occurrence and it can be a positive or negative process. When a third person becomes part of a triad and contains the anxiety for the original dyad, the system typically becomes relaxed. On the other hand, if the third person is unable to harbor the anxiety for the system, the system becomes overloaded and symptoms may develop. Here, symptoms are arguments and distance between family members. This is especially important in regard to families with a child who identifies as LGBT because that child is often the scapegoat, meaning he or she attempts to contain the family’s anxiety but is unable to due to the sheer amount of stress present and, thus, is blamed for creating the family’s dysfunction (Patterson, 2000).

**Family Projection Process**

The family projection process is especially important for clinical settings where children are being evaluated and treated because it emerges when parents push their concerns on a child, resulting in the development of symptoms in the child (Bowen, 1993). Oftentimes, parents seek professional help to alleviate their child’s symptoms without realizing the relational issues and anxiety in the home are influencing the symptoms in the child. When parents are able to manage anxiety and repair relational strains the child’s symptomology typically improves. This projection can occur in typically developing youth who have a sibling who is ill or differently abled (Degeneffe & Gagne, 2001; Dellve, Cernerud & Hallberg, 2000). Healthy children often
bear the weight of their family’s anxiety and relational discord especially when their sibling is the source of the increased stress level.

**Multigenerational Transmission Process**

The multigenerational transmission process is intuitive as it refers to the passing down of familial patterns of emotional process and ways of relating from generation to generation (Bowen, 1993). Many patterns can be passed down from parents to children such as triangulation, anxiety, level of differentiation of self, and emotionality. Oftentimes, parental relational and emotional process patterns can be understood by observing children’s interactions with one another. The way a sibling treats his or her LGBT identified sibling is typically determined by the way their parents act towards that same child (Norwood, 2013). Families that are more affected by change and become anxious during times of change tend to react more hastily to changes in a member’s identity.

**Emotional Cutoff**

As was mentioned previously, distancing is a process that occurs within families when one member either intentionally distances him or herself or is forcibly distanced by other family members. Emotional cutoff occurs when one family member is distant from the other members and those members stop emotional contact with that member (Bowen, 1993). Emotional contact can be cut off by physically cutting a member off from a family or by refusing to emotionally relate to that member. When a member of a family is emotionally cutoff, the rest of the system is vulnerable to developing symptoms because there is one less person available to manage anxiety within the family. Sometimes emotionally cutoff family members can be replaced by other relationships but that often takes time. Although it is less common now than it was in the past, youth who come out as LGBT to their families may experience emotional cutoff to varying
degrees (Dunlap, 2014). Sometimes the distancing behavior by families to the LGBT child is permanent while other times it is short-term.

**Societal Emotional Process**

Societal emotional process is similar to emotional processes that occur within families but it happens when the environment at-large is unstable, which creates anxiety and stress for families (Bowen, 1993). Some examples of stressors are epidemics, war, and a drop in economy. Although environmental stressors are not always present, they can cause issues for a few years until society is able to calm down again after a period of instability. Sociopolitical movements are relevant to this study because greater awareness and acceptance of sexual and gender minorities has led to less maltreatment of LGBT individuals; however, not all regions in the United States are supportive environments for LGBT individuals and some families that live in liberal areas do not ascribe to liberal values (Dunlap, 2014).

**Sibling Position**

Sibling position refers to the roles children take in families depending on their birth order and the family make-up (Bowen, 1993). Oldest children tend to take on more functional, parental roles in families whereas youngest children tend to be symptom carriers because they absorb the family’s anxiety most easily. The roles children take on affect their level of differentiation of self because they may be able to manage anxiety better or worse than siblings with other roles. Older siblings with a younger LGBT identified sibling tend to take on a caretaker role while younger siblings with an older LGBT sibling experience more stress and anxiety when faced with the changes in family dynamics (Brown, 1999).
Sibling Relationships

As of 2010, 82.22% of youth lived with at least one sibling (King et al., 2010). Because most youth in the United States have at least one sibling, understanding sibling relationships is important (Hernandez, 1997). In order to gain knowledge on a family’s functioning as a whole, sibling relationships must also be understood. Sibling bonds often last a lifetime and, as such, are typically people’s longest relationships in life (Feinberg, Solmeyer & McHale, 2011). Although sibling relationships are influential in many ways, they have been underestimated in past research.

Qualities of Sibling Relationships

Biological siblings, meaning those who have the same birth parents, share 50 percent of their genes (McHale, Updegraff & Whiteman, 2012). Although some similarities between siblings can be attributed to genetics, environmental influences are also important to consider (Rende et al., 1992). While some argue genetics influence sibling relationships more than childhood environments, and others argue the opposite, research shows sibling relationships are shaped by a variety of forces, including both intrafamilial and extrafamilial (McHale, Updegraff & Whiteman, 2012).

One reason for the difficulty in describing the importance of sibling relationships is due to their unique nature. Sibling relationships are similar to parent-child and peer relationships; however, they are also distinctly different from those types of relationships. Like most parent-child relationships, sibling relationships are nonelective, whereas peer relationships are elective (Hindman, Riggs & Hook, 2013). Although siblings may have some say in the amount of time they spend with each other, in the United States, European American children spend the majority
of their free time with their siblings (McHale & Crouter, 1996). The length of sibling relationships should be considered, as well as sibling roles and dynamics within a family.

In most family systems, siblings’ roles are equal (Hindma, Iggs & Hooks, 2013). Although children in a family are treated equally for the most part, birth order determines the hierarchical structure of roles children take on (Slomkowski et al., 2000). Older siblings tend to take on leadership roles within families, serving as models for their younger siblings. Older siblings are secondary caregivers in most families and give younger siblings advice, similar to the way parents rear their children. Younger siblings, on the other hand, tend to absorb families’ stress and ascribe to the role of a follower (Minuchin, 1988). In addition to role differences based on children’s birth order, there are variant dynamics in sibling relationships based on the gender make-up of the dyad, as well as the ages of the siblings.

In their study of adolescent sibling relationships, Cole and Kerns (2001) found gender and age differences in adolescent siblings’ perceptions of their relationship. Their research indicates prosocial relationship qualities increase as the age of siblings increases, meaning middle to late adolescent sibling dyads experience greater intimacy than early adolescent sibling dyads. In addition, Cole and Kerns (2001) found that sibling dyads made up of two females are the most intimate, whereas dyads with at least one male sibling are more conflictual. Boy-boy sibling dyads reported the highest amount of conflict and the least amount of intimacy. Taking the aforementioned study into account, gender and age are important factors in understanding the nuances of sibling relationships.

**Sibling Influences**

*Positive influences.* Siblings have several positive effects on one another’s overall functioning. Supportive sibling relationships are associated with academic engagement and the
ability to employ effective problem solving skills as needed (Bouchey, Shoulberg, Jodl & Eccles, 2010; Howe, Rinaldi, Jennings & Petrakos, 2002). When siblings have intimate relationships, they are better able to cope with intraparental hostility and lack of parental support (Dekovic & Buist, 2005; Milevsky & Levitt, 2005). Siblings serve as models for each other and their parents because they influence household expectations (Whiteman & Buchanan, 2002). Interpersonal skills are another area of development influenced by sibling relationships.

Sibling relationships teach youth important interpersonal skills and provide a setting for them to practice socializing (McHale, Updegraff & Whiteman, 2012). Perspective taking, negotiation, and conflict resolution are all important skills for day-to-day social interactions that are positively impacted by sibling relationships (Dunn, 2007; Howe, Rinaldi, Jennings & Petrakos, 2002). Other qualities like understanding emotion, empathy, and behaving in prosocial ways are also more developed in youth who have siblings (Brody, Kim, Murry & Brown, 2003; Tucker, Updegraff, McHale & Crouter, 1999; Updegraff, McHale & Crouter, 2002). Youth who have siblings are more competent socially than their only-child counterparts and they tend to be more accepted by peers (Updegraff, McHale & Crouter, 2002). Youth who grow up with siblings are better able to develop and maintain intimate relationships as they enter adulthood (Bank, Barrasson & Snyder, 2004). In addition to developing more adaptive social skills, people with siblings also experience advantages in regard to their mental health.

Youth who have close relationships with siblings have less depressive symptoms than youth without siblings (Kim, McHale, Crouter & Osgood, 2007). The more intimate a sibling relationship is, the less likely it is that either sibling will develop depressive symptoms. Sibling relationships also serve as a buffer for youth who live in stressful home environments because youth with siblings are better adjusted and have higher self-esteem than peers without siblings.
The presence of a sibling relationship is also indicative of one’s well-being in adulthood and it has positive implications for adjustment in old age (Feinberg, Solmeyer & McHale, 2012; Waldinger, Vaillant & Orav, 2007).

**Negative influences.** Typically, having siblings as models for socialization and prosocial behavior is positive; however, siblings also model problematic behavior for each other. For example, when one child in a family uses substances, it is likely younger siblings use substances (Slomkowski, Rende, Novak, Lloyd-Richardson & Njaura, 2005). Social learning also plays a role in siblings’ risky sexual behavior (Mcale, Bissell & Kim, 2009). Similarly, older siblings who exhibit externalizing behaviors influence younger siblings’ engagement in externalizing behaviors (Shortt, Stoolmiller, Smith-Shine, Eddy & Sheeber, 2010).

Discordant sibling relationships also impact individual youth’s functioning. Youth who have conflictual relationships with their siblings have more school problems, are subject to bullying, engage in internalizing behaviors, develop depressive symptoms, and are more aggressive (Bank, Burraston & Snyder, 2004; Bank, Patterson & Reid, 1996; Kim, McHale, Crouter & Osgood, 2007; Stocker, Burwell & Briggs, 2002). Marital conflict and conflictual sibling relationships are related because when one is present, the other likely is too. Marital discord can lead to sibling conflict, similarly, sibling conflict can lead to marital discord (Hetherington & Kelly, 2002).

**Sibling Relationships Over Time**

Because siblings develop simultaneously and their families also go through phases of the typical family life-cycle during their developmental years and beyond, siblings often navigate developmental tasks together (Goetting, 1986). According to Goetting (1986), there are four stages siblings go through that coincide with the family life-cycle. During the first phase, which
occurs during childhood, companionship and emotional support are the primary needs siblings fulfill for each other. Siblings are in need of each other’s support during childhood because they are discovering their worlds, and because they have similar experiences, they serve as ideal companions for each other. During adolescence, youth are confronted with the tasks of individuation and separation from their families. Sibling relationships are especially important through those developmental years because siblings are a support system for adolescents who are nearing adulthood and independence. With adulthood comes another set of challenges, which leads people to rely on their siblings for support.

Adulthood is a stage of life where many new things develop, including relationships and the birth of children; however, it is also a time when people experience losses due to the death of older family members. During adulthood, sibling relationships take on a companionship role (Goetting, 1986). Emotional support becomes a central need that is fulfilled by sibling relationships; however, sibling bonds may not be as strong as they previously were because adults typically have spouses to lean on for immediate support. Sibling relationships become essential again when siblings’ parents become ill. From approximately middle adulthood to the end of life, siblings usually become close and supportive, similar to the way they were during childhood. Sibling relationships serve as a way for adults to compensate for other losses, including their parents, spouses, and friends. During this time, siblings become nostalgic, discussing memories and often ameliorating sibling rivalry that occurred when they were younger. Sibling relationships continue to be supportive and intimate until one of the siblings passes away (Goetting, 1986).
**Family Influences on Sibling Relationships**

Families come in all shapes and sizes. Some live harmoniously while others’ equilibrium is highly conflictual. Historically, divorced families have been viewed as abnormal; however, divorce has positive and negative influences on sibling relationships (Kunz, 2001). In divorced families, siblings have closer, more positive relationships than siblings in families that are intact. At the same time, siblings from divorced or separated families have higher levels of conflict with one another (Noller, Conway & Blakeley-Smith, 2008). In negative, conflictual households, siblings form closer bonds, which is hypothesized to be compensatory due to living in a high stress environment (Jenkins, 1992). On the other hand, in families where the parents resolve conflicts peacefully and respectfully, siblings have fewer arguments and have more adaptive conflict resolution skills when they do fight with one another (Siddiqui & Ross, 2004). Sibling relationships are not only affected by children’s living environment because research signifies parenting style and parent-child relationships are indicative of the quality of sibling relationships within a family (Minuchin, 1985). Inversely, parent-child relationships are impacted by sibling relationships because sibling conflict is the most common reason behind disagreements between parents and their children (McHale & Crouter, 1996). One specific type of dynamic in households, parental differential treatment (PDT), leads to distinct issues in children’s relationships with each other (McHale & Crouter, 1985).

PDT occurs frequently, according to children, and it is influenced by many factors (Feinberg, Solmeyer & McHale, 2012). Several characteristics, such as behavior, personality, and other individual qualities, affect parents’ way of treating their children (McHale & Crouter, 2003). Children who are more difficult to discipline or relate to tend to experience PDT most often. Although PDT typically favors one sibling over the other(s), research indicates preferred
children experience adjustment difficulties and sibling conflict, similar to their non-preferred sibling (Kan, McHale & Crouter, 2011). Uniquely, nonpreferred siblings have higher rates of depression as compared to their preferred sibling (Shanahan, McHale, Crouter & Osgood, 2008). Even though PDT may only occur for a short period of time, depending on familial circumstances, it negatively affects sibling relationships through childhood and adolescence (Stocker, Dunn & Plomin, 1989). Additionally, PDT may be the result of parental discord, which is hypothesized to lead to scapegoating the non-preferred sibling or triangulation, resulting in changed family roles (Yu & Gamble, 2008). Although the cause of PDT has not been revealed, things like children’s individual characteristics and parental discord are associated with PDT. It is important to recognize the role PDT plays in sibling dynamics and family functioning as a whole.

**Individuals’ Influences on Sibling Relationships**

Although children’s families play a role in interfamilial relationships, the children themselves also influence their relationships with siblings. Even though families can create stressful circumstances for their children, children’s individual characteristics can exacerbate the level of distress in a family and lead to tension in sibling relationships (Stoneman, Brody, Churchill & Winn, 1999). For example, children who have difficult temperaments tend to have higher rates of relational difficulties, particularly with siblings (Stoneman & Brody, 1993). Even though children’s temperaments can lead to discord in sibling relationships, temperament is not the only individual factor that influences sibling relationships. Other individual characteristics like illness, disabilities, autism, Down syndrome, or traumatic brain injuries (TBIs) have been found to have both positive and negative effects on sibling relationships (Hastings, 2007; Rossiter & Sharpe, 2002; Stalker & Connors, 2004).
Differently Abled Sibling

Illness

As was previously explained, sibling relationships are important and impactful for youth. Many positive outcomes result from close sibling relationships. When one sibling has a chronic health condition, however, the other sibling often experiences difficulties psychologically (Sharp & Rossiter, 2002). In a meta-analysis by Rossiter and Sharpe (2002), a fairly large, negative effect was found for the experience of having a chronically ill sibling. In a separate meta-analysis completed by Howe (1993), it was found that youth who have a sibling with a chronic illness experience psychological problems and they tend to internalize their experiences rather than externalize them. Specifically speaking, those children tend to exhibit symptoms of depression and anxiety rather than oppositional or defiant behavior (Rossiter & Sharpe, 2002). Some other studies indicate children with a chronically ill sibling have difficulty adjusting, as well as low self-concept (Lavigne & Faier-Routman, 1992). Research done on nondonor youth with siblings who have had hematopoietic stem cell transplants (HSCT) to treat life-threatening illnesses shows those children experience a significant amount of difficulties including: poor psychosocial adjustment, school problems, low self-esteem, and post-traumatic stress (Packman, 2004). Although a sibling’s chronic illness affects siblings in various ways, the family system is also disturbed when one family member is ill.

Another dimension of pediatric chronic illness is the demand it puts on the children, parents, and family system (Patterson, 1988). When a child is chronically ill, a family’s resources are often extended in multiple ways in order to get that child proper treatment. Not only does illness cost money in the form of medical bills, but depending on the ill child’s age and diagnosis, a significant amount of a family’s time may be consumed by caretaking needs. Along
with physical resources, parents’ emotional capacity is stretched thin while caring for an ill child. Because parents’ resources as a whole are compromised when a child is chronically ill, the healthy children in the family are left to their own devices, in a sense, leading to the development of psychosocial difficulties.

Although there are ever-present negative experiences associated with having an ill sibling, there are positive outcomes as well (Limbers & Skipper, 2014; Sharpe & Rossiter, 2002). Because siblings tend to have close relationships, the diagnosis of a chronic illness in a child can be devastating for the other sibling (Sharpe & Rossiter, 2002). Even though studies show siblings experience psychological maladjustment, among other difficulties, due to their siblings’ chronic illness, Sharpe and Rossiter (2002) found several studies citing positive outcomes that come about from having a sibling who is chronically ill. In a meta-analysis, Sharpe and Rossiter (2002) found youth who have an ill sibling are resilient, meaning they are able to recover from the difficult experience of having an ill sibling. Resiliency often carries over to other life experiences, which means resilient siblings are better equipped for tough experiences throughout life. Some other positive aspects that develop due to having an ill sibling are compassion, empathy, and a greater understanding of others with disabilities (Limbers & Skipper, 2014). Having compassion, empathy, and a better understanding of others who are differently abled is a strength for youth. Those qualities also lead to prosocial behavior, which is a protective factor. Having a chronically ill sibling is certainly a difficult experience; however, the positive factors cannot be ignored as they can be life-changing as well.

**Autism Spectrum Disorder**

Autism spectrum disorder (ASD) ranges in severity but affects sibling relationships due to the developmental difficulties that youth with ASD have. According to research done on
neurotypical youth who have siblings on the spectrum, mild behavioral and emotional problems may develop, as well as adjustment problems (Delve, Cernerud & Hallberg, 2000; Yirimiya, Shaked & Erel, 2001). In a study done by Gamble and McHale (1989), children who have a sibling with ASD tend to think in certain ways in order to cope with their sibling’s disorder. For example, those youths may engage in blaming others and wishful thinking as a way to manage their emotions or self-soothe to cope with their sibling’s disability. Some typically developed youth experience loneliness, embarrassment, and aggression, and are the recipients of bullying due to their sibling’s disability (Bägenholm & Gillberg, 1991; Mascha & Boucher, 2006; Petalas, Hastings, Nash, Dowey & Reilly, 2009).

Although some youth experience difficulties due to their sibling’s disorder, many are well adjusted (Hastings, 2007). In supportive families, typically developing youth tend to develop a greater acceptance of diverse people, be more socially competent, and have more compassion for others (Dellve, Cernerud & Hallberg, 2000; Macks & Reeve, 2007; Wilson, Blacher & Baker, 1989). When siblings have been asked about what they need to feel supported through their experience, they have said being involved in their sibling’s care, understanding their sibling’s disability, positive reactions from parents and peers towards their sibling, and participating in support groups all contribute to better adjustment and a more positive relationship with their sibling (Dellve, Cernerud & Hallberg, 2000; McHale, Sloan & Simeonson, 1986, Petalas, Hastings, Nash, Dowey & Reilly, 2009; Roeyers & Mycke, 1995).

**Disability**

**Intellectual disability.** Although intellectual disabilities range from mild to severe, children who have a sibling with an intellectual disability report similar experiences and needs, regardless of their sibling’s functioning. One main concern for typically developing children
(TDC) is being treated equally by their parents (Moyson & Roeyers, 2012). They understand their sibling with a disability needs extra support but they want their parents to recognize their needs as well. Even though parents are children’s primary support system, youth report having friends and a typically developing sibling are alternate avenues for support. Even though children who have a sibling with an intellectual disability experience benefits due to their differently abled sibling, youth also report barriers that frustrate them.

According to Stalker and Connors (2004), TDC who have a sibling with an intellectual disability experience “barriers to doing” and “barriers of being” (p. 219). Youth reported there were certain activities or behaviors they could not engage in because of their sibling’s disability. Some specific examples are extracurricular activities and playing with their sibling. Some barriers are due to their sibling’s inability to engage in certain things, but others are due to parents’ attention and resources being extended to accommodate their sibling with a disability. TDC also experience barriers of being because their community may not react positively towards their sibling and they may experience ridicule from peers due to their sibling’s disability. These youth report their “being” is affected because they are treated differently due to their sibling’s disability.

**Physical disability.** Unlike other kinds of disabilities, physical disabilities are visibly noticeable. Youth who have a sibling with a physical disability cannot necessarily hide their sibling’s impairment from others in the community. Because of this, children may experience bullying and other forms of negative attention from peers and community members (Stalker & Conner, 2004). Although that type of experience is not pleasurable for youth, siblings of children with disabilities act more empathically towards others and are rated as kind by parents (Cuskelly & Gunn, 2003). Children themselves indicate they do not experience competition with
their sibling; however, there are other types of conflict in their sibling relationship (Kaminsky & Dewey, 2001).

Having a child with a disability creates a stressful environment for a family. Even in families that are functioning well, TDC report relationship difficulties with their sibling who has a disability (Mulroy, Robertson, Aiberti, Leonard & Bower, 2008). Even though there is some conflict between siblings, youth also report warmth is present in their sibling relationship (Bellin & Rice, 2009). Because a physical disability requires caretaking, TDC typically aide parents in caretaking responsibilities. Youth who nurture their sibling with a disability have more positive relationships than their counterparts who do not have a caretaking role (Roper, Allred, Mandleco, Freeborn & Dyches, 2014). Although taking on extra responsibility in the home may lead to positive qualities in sibling relationships, higher levels of burden in a household is associated with distant sibling relationships. Even though it is beneficial for youth to help in the care of their sibling with a disability, there is a fine line between empowerment and becoming overburdened. Youth who have a trans* sibling likely have similar experiences as youth who have a sibling with autism, TBI, ID, or physical disability because of the impact on the family. To be clear, this researcher does not believe that a trans* identity indicated an illness or disability, although the period of adjustment may feel that way for family members.

**Gender Identity**

At birth, humans are assigned a sex based on their genital structures, which could be male, female, or intersex. Those who are assigned intersex can have any of several combinations of sex characteristics that are part of female and male anatomy. For children who are not born intersex, their gender identity is typically not a topic of discussion or worry until that child begins participating in gender expression. Once children begin expressing themselves in ways
that are not considered traditional or aligned with the stereotype in their culture, parents notice the discrepancy between the child’s behavior and their expectations for the child’s expression. It is only after parents grow concerned over a child’s expression or a child develops psychological issues that parents may seek services for their child, which could include medical or psychological evaluations.

Most, if not all identity statuses can be described using a developmental model. Some models are held in higher regard than others and some do a better job explaining minorities than others. Like other developmental models, gender identity models exclusively describe identity development in people who do not identify as cisgender. One model in particular, transgender emergence, applies to all people who identify as trans* (Lev, 2004). This model is a biopsychosocial model based on ecological social-work theories that describes gender identity development as a process within the context of individuals’ environment. There are six stages in the transgender emergence model, and although it is considered a stage theory, individuals do not have to arrive at or complete the stages in succession. The six stages include awareness, information/reaching out, disclosure to significant others, exploring identity and transition, exploring transition and possible body modification, and integration and pride. As is evident by the names of the stages, individuals experience something during each stage and those experiences build on one another as an individual moves through the stages toward integration and pride. Although this model applies to all people who identify as trans*, other models have been created to describe the identity development experiences for people who identify as transgender or transsexual specifically.

Devor (2004) studied female-to-male transsexuals (FTM) and created a 14 stage model of transsexual or transgender identity formation (Table 1). His model was influenced by a
homosexual identity formation model by Cass (1979, 1984, 1990), and as such, it is meant to serve as a guide to transgender and transsexual people’s experiences but not an all-encompassing model that describes every individual’s exact experience. Most important to the current study is the ninth stage, “acceptance of transsexual or transgender identity,” because that is the stage in which family members and peers become aware of the extent of a child’s gender variance.

Table 1

*Stages of Transsexual or Transgender Identity Formation*

<table>
<thead>
<tr>
<th>Stages of Transsexual or Transgender Identity Formation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Devor (2004)</td>
</tr>
<tr>
<td>Abiding Anxiety</td>
</tr>
<tr>
<td>Identity Confusion About Originally Assigned Gender and Sex</td>
</tr>
<tr>
<td>Identity Comparisons About Originally Assigned Gender and Sex</td>
</tr>
<tr>
<td>Discovery of Transsexualism or Transgenderism</td>
</tr>
<tr>
<td>Identity Confusion About Transsexualism or Transgenderism</td>
</tr>
<tr>
<td>Identity Comparisons About Transsexualism or Transgenderism</td>
</tr>
<tr>
<td>Identity Tolerance of Transsexual or Transgender Identity</td>
</tr>
<tr>
<td>Delay Before Acceptance of Transsexual or Transgender Identity</td>
</tr>
<tr>
<td>Acceptance of Transsexual or Transgender Identity</td>
</tr>
<tr>
<td>Delay Before Transition</td>
</tr>
<tr>
<td>Transition</td>
</tr>
<tr>
<td>Acceptance of Post-Transition Gender and Sex Identities</td>
</tr>
<tr>
<td>Integration</td>
</tr>
<tr>
<td>Pride</td>
</tr>
</tbody>
</table>
Although identity development models have been created to describe gender variance, people who identify as trans* are labeled with diagnoses by healthcare professionals and psychologists. Gender dysphoria, a psychiatric diagnosis listed in the Diagnostic and Statistical Manual, Fifth Edition (DSM-V; American Psychiatric Association, 2014) is often assigned to individuals who identify as trans* and individuals whose gender transcends the gender binary. The following criteria must be met for gender dysphoria (GD) to be diagnosed:

A. A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months’ duration, as manifested by at least six of the following (one of which must be Criterion A1):

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one’s assigned gender).

2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.

3. A strong preference for cross-gender roles in make-believe play or fantasy play.

4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.

5. A strong preference for playmates of the other gender.

6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
7. A strong dislike of one’s sexual anatomy.
8. A strong desire for the primary and/or secondary sex characteristics that match one’s experienced gender.

B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning (APA, 2014).

Before the current edition of the DSM-5, GD was called gender identity disorder (GID).

Although the criteria are similar in nature, better understanding of gender incongruence led psychologists to decide the previous diagnosis was pathologizing. In the International Classification of Disorders-tenth edition (ICD-10), however, children who are not cisgender are diagnosed with GID. The description of this diagnosis is as follows (2014):

Disorders, usually first manifest during early childhood (and always well before puberty), characterized by a persistent and intense distress about assigned sex, together with a desire to be (or insistence that one is) of the other sex. There is a persistent preoccupation with the dress and/or activities of the opposite sex and/or repudiation of the patient’s own sex. These disorders are thought to be relatively uncommon and should not be confused with the much more frequent nonconformity with stereotypic sex-role behavior. The diagnosis of gender identity disorder in childhood requires a profound disturbance of the normal sense of maleness or femaleness; mere “tomboyishness” in girls or “girlish” behavior in boys is not sufficient. The diagnosis cannot be made when the individual has reached puberty. (p. 215-216)

For youth who have reached puberty, the diagnosis is transsexualism, and the description is as follows (2014):
A desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one’s anatomic sex and a wish to have hormonal treatment and surgery to make one’s body as congruent as possible with the preferred sex. For this diagnosis to be made, the transsexual identity should have been present persistently for at least two years and must not be a symptom of another mental disorder, such as schizophrenia, or associated with any intersex, genetic, or sex chromosome abnormality. (p. 215)

While psychiatric diagnoses have a place in the U.S. out of necessity due to insurance coverage, diagnoses like GD and GID suggest there is something “wrong” with being trans* and that is both stigmatizing and demoralizing. It is important to note that not all trans* individuals feel that they experience gender dysphoria and thus, are improperly labeled.

Children who have been diagnosed with GD/GID can receive any number of psychological and medical services to aid them in affirming their identity. Medical interventions include puberty delaying therapy, hormone replacement therapy, and surgical procedures. Psychological services can be beneficial for children and families who have a gender variant member so they can gain a better understanding of the family member’s experiences, as well as learn about potential interventions that can help members who would like to transition. Before children seek interventions for GD/GID, they must disclose their identity to some, or all, family members, in order to receive certain services.

**Identity Disclosure**

Research on gender identity disclosure began after research on sexual identity disclosure was studied and gender variance became more prominent. Studies assessing sexual identity disclosure typically cover certain aspects of the coming out process, including who was told first,
people’s reactions initially, people’s responses later on, and the minority individual’s feelings after disclosure. Although 50 to 60% of LGB youth have disclosed their identity to at least one sibling, siblings are not typically the first member of the family that an adolescent comes out to (Savin-Williams, 1998). Mothers are most often the first family member that sexual identity is disclosed to with siblings often coming next, even though youth rate their siblings as more accepting than their parents (Savin-Williams, 1998; Weston, 1991). Savin-Williams (1998) found sibling relationships in particular are positively affected by sexual identity disclosure because disclosure leads to greater intimacy and closeness among siblings. Although Gorman-Murray (2008) also studied positive experiences of youth who have disclosed their sexual identity to family members, other research has shown negative effects of sexual identity disclosure to parents including greater victimization, verbal harassment, and rejection (D-Augelli, Grossman & Starks, 2008). Given the absence of research on trans* identity disclosure, these studies may provide some parallels that may be present in trans* identity disclosure in a family.

**Summary**

Research on trans* identity is trailing behind the contemporary emergence of gender variance. The extant literature typically describes individual issues surrounding trans* identity rather than the effects of trans* identity on other systems, like the individual’s family, for example. Because this study is exploratory in nature, the framework for understanding sibling experiences of having a trans* identified sibling is broad in nature and stems from theories, models, and previous research on similar experiences.

Honing in on the family system specifically, Bowenian family systems theory describes familial interactions as reciprocal and influential in positive and negative ways. Within families,
there are parent-parent relationships, parent-child relationships, and sibling relationships, all of
which serve specific purposes and can be experienced as intimate or detached. For children,
sibling relationships are often one of the most influential relationships in their lives.

A significant portion of trans* children in the United States have siblings. Sibling
relationships tend to last long-term and are often a child’s first representation of a mutually
bonding relationship with another person. Because sibling relationships are important and have
implications for children’s development, a disruption in one of the siblings’ lives can lead to the
development of emotional and behavioral difficulties for the other sibling. The physical health
of one child in a family has been shown to affect the siblings in that family, particularly when
one child is chronically or seriously ill. Children who have a sibling with chronic illness tend to
show internalized issues, like anxiety and depression, as well as externalizing behaviors like
acting out in school. Poor psychosocial adjustment and symptoms of post-traumatic stress are
other issues that have been found in children with a chronically ill sibling. Although some
positive outcomes occur from that experience, like resiliency and greater empathy for others, the
majority of children experience their sibling’s health crises as a negative experience for
themselves and their family. Different but also similarly, families with a trans* member also
experience a change in their system.

GD, a psychiatric diagnosis, is used as a label to describe individuals who do not feel
congruent with their sex assigned at birth. Although some individuals who identify as trans* are
diagnosed with GD, it is not universally the case for all individuals who identity as trans*.
Individuals whose sex assigned at birth does not align with their gender identity can seek various
psychological and medical interventions if they want emotional or medical support through their
journey, but again, not all trans* individuals want or need psychological or medical
interventions. While some gender variant individuals seek out hormone therapy or surgical procedures to affirm their gender identity, others may elect to keep their physical body as it is. As such, in the trans* community, there is a wide range of people who do not want or need any services, to others who seek out both medical and psychological services.

Youth who identify as trans* may experience victimization, bullying, and psychological instability and their families are also exposed to the stigma attached to gender variance. It is hypothesized that, similar to the experience of having a chronically ill sibling, youth with trans* siblings also experience challenges understanding their sibling’s identity and adjusting to it. Studies show families with ill children have less resources, including monetarily, physically, and emotionally. Those disparities affect all members of the family, including the healthy sibling. In cases of families with a trans* child, youth are typically evaluated by a physician, as well as a psychologist or psychiatrist, to determine their treatment plan for affirming that youth’s identity. Those doctor appointments and the experience of society’s stigmatizing view of it as something “being wrong” with a family member can exhaust parents, which is transferred to children because they receive less support from parents. The purpose of this study is to develop a group program that helps adolescents explore their experiences of having a trans* identified sibling, in hopes of fostering feelings of being supported and connectedness with peers who have similar experiences.
Chapter 3: Research Design and Methodology

**Purpose of the Program**

According to Calley (2010), clinical program development “refers to a systematic process that requires various stages of preplanning, planning, implementing, and sustaining effective mental health programming (p.8).” The logic model (Alter & Egan, 1997) is used widely in clinical program development because it systematically moves from “the identified need to the specific interventions to the intended outcomes of the interventions” (as cited in Calley, 2010, p.15). Program development begins with a review of relevant literature. From that literature, a target group is established and a needs assessment is conducted to determine ways to best serve the targeted population using specific interventions. Comprehensive clinical program development also includes means for evaluating the developed program in order to expand the knowledge of interventions for people with specific clinical presentations.

The population of youth who have a trans* sibling has not been researched. In other research conducted on siblings, it appears youth who have a sibling with physical, cognitive, psychological, and/or behavioral differences have both positive and negative experiences associated with their sibling’s diagnosis or difficulties. This program attempts to address the needs of adolescent youth who have a trans* sibling in a way that provides support and connection with peers who have similar experiences. Because of the limited research in this area, it is important to first conduct a needs assessment to better understand professionals’ ideas on the needs of cisgender youth who have a trans* sibling.
Research Question and Hypothesis

Research Question: Is there a need for a group therapy program for adolescent siblings of trans* youth to help them adjust to their sibling’s gender identity and give them an outlet to discuss their experiences with peers facing a similar experience?

$H_1$: There is a need for a group therapy program for adolescent siblings of trans* youth.

Needs Assessment Method

Rationale

Calley (2010) explained a comprehensive needs assessment is needed to make “sound decisions about initial program development that are supported by data” (p.35). The results of a needs assessment are important for determining feasibility, interest, need, and justification for programming. Because of the gap in research regarding the experiences of adolescents who have a trans* sibling, a needs assessment is imperative for gathering information to inform the Sib Support program.

Target Population of Needs Assessment

The target population for the needs assessment of the group therapy program for adolescent siblings of trans* youth was professionals who work with youth and families in some capacity and had an understanding of trans* identity, the transition process, and family dynamics. This included physicians, nurses, therapists, psychologists, social workers, and counselors. These individuals were at least 18 years of age and currently work with youth and families.
Method of Data Collection

The researcher developed an anonymous needs assessment survey to target the need for a group therapy program for adolescent siblings of trans* youth. The survey consisted of 38 questions, which were a mix of close-ended, open-ended, and Likert scale questions. Each item had a rationale for being included in the survey and the participants’ responses were essential for developing the program. The following demographic information was collected: age, gender, race/ethnicity, level of education and licensure, work setting, and job title. Participants were also asked about their experience, education, and understanding of youth, family dynamics, trans* identity, the transition process, and gender variance. This survey was administered electronically and demographic information was not linked to survey responses.

Survey Administration Method

Participants were recruited through electronic communication. Professionals who work with trans* youth were contacted via email to complete the needs assessment survey and were prompted to forward the survey to other professionals they thought fit inclusion criteria. Professionals were identified through a Google search of hospitals, community mental health centers, clinics, and other agencies around the country that provide services to trans* youth. Once a participant chose to participate, he or she completed the survey electronically. The researcher aimed to have 20 participants complete the survey.

Type of Data Collected and Data Analysis

Before completing the survey, participants were informed of the nature and purpose of the needs assessment. Electronic consent was obtained from participants as the first question in the survey. If participants had questions regarding the needs assessment survey and/or program at any point during participation, they could communicate with the researcher through email.
Once participants gave consent, they began the needs assessment survey. They did not have to complete the survey in one sitting and they could stop the survey at any point if they did not wish to complete the survey. Survey data were collected and analyzed descriptively to inform program development.

**Proposed Program Method**

**Target Population and Setting of Program**

The targets of the Sib Support program are cisgender adolescents, within the age range of 14 to 18, who have a trans* sibling and would like support adjusting to their sibling’s gender identity. This age range was chosen based on the likelihood that adolescents who are in the middle adolescence stage of development experience cognitive, physical, and identity-related changes that likely complicate their thoughts and feelings about their sibling’s gender identity. These adolescents may be referred for the program by mental health professionals, healthcare professionals, teachers, families, or self-referred with parental consent. The adolescents would complete one individual session with a group leader in order to describe and explain their experience having a trans* sibling. Through that initial intake, the group leader can determine whether the group program is a good fit for each individual adolescent based on their needs and the program’s deliverables.

Although this program could be done in various settings, due to space, resources, and the clientele, it will be held at LGBT community centers.

**Future Program Evaluation Method**

The outcomes of the program will be evaluated using a pre and post measure that assesses adjustment. During the initial intake, and the last group session, the group leader will administer the Mental Health Continuum Short Form (MHC-SF), a validated instrument. By
collecting pre- and postintervention data, an analytic evaluation can be completed to ensure the
efficacy of the Sib Support program. In addition, group participants will be given opportunities
throughout the program to give oral and written feedback to the group leader, which will be
incorporated in the overall evaluation of the program.

**Program Resources**

**Personnel.** The personnel needed for Sib Support include a clinical psychologist or other
licensed mental health professional. Graduate students in the mental health field may also
conduct the program if they have prior experience running group programming with adolescents
and receive adequate supervision.

**Materials.** The materials needed for Sib Support include the following: paper, writing
utensils, and art supplies.
Chapter 4: Findings

The present needs assessment was conducted to assess for the need of a program for adolescents who have a trans* sibling. The measure of central tendency used to represent the data collected from the needs assessment survey is the mode because the frequency of responses is the most statistically appropriate way to report this type of Likert scale data. Each question allowed for an “Other” response to enable qualitative responses when participants felt inclined to do so. The results of the responses are presented below.

Respondents and Population

Twenty-three individuals started the survey and filled out some of it, but only fourteen people completed it in its entirety. The ages of the respondents is seen in Figure 1, gender is reported in Figure 2, and racial background is listed in Figure 3. Of the respondents, most were between the ages of 25 and 54, with one individual under the age of 25 and two individuals over the age of 55. Eighty-six percent of responders were Caucasian while fourteen percent were biracial. Of those who reported their gender, 11 individuals identified as female/woman/cis-female, 2 as male, and 1 as transgender woman.
Table 2

*Age of Participants*

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>7.14% 1</td>
</tr>
<tr>
<td>25-34</td>
<td>35.71% 5</td>
</tr>
<tr>
<td>35-44</td>
<td>21.43% 3</td>
</tr>
<tr>
<td>45-54</td>
<td>21.43% 3</td>
</tr>
<tr>
<td>55-64</td>
<td>14.29% 2</td>
</tr>
<tr>
<td>65+</td>
<td>0.00% 0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
</tr>
</tbody>
</table>

Table 3

*Gender of Participants*

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>78.57% 11</td>
</tr>
<tr>
<td>Male</td>
<td>14.29% 2</td>
</tr>
<tr>
<td>Transgender</td>
<td>7.14% 1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
</tr>
</tbody>
</table>
Table 4

*Racial Background of Participants*

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<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>85.71%</td>
</tr>
<tr>
<td></td>
<td>12</td>
</tr>
<tr>
<td>Black or African American</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>American Indian or Alaskan Native</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Asian</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Native Hawaiian or Pacific Islander</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Biracial</td>
<td>14.29%</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td>I prefer not to answer</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
</tr>
</tbody>
</table>

**Knowledge/Experience with Target Population**

Respondents’ level of education varied, with the majority of respondents having completed a master’s or doctoral degree and currently work in the mental health field in some capacity.
Table 5

*Highest Education Degree*

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Bachelor's degree</td>
<td>7.14%</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Master's degree</td>
<td>28.57%</td>
</tr>
<tr>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Doctorate</td>
<td>57.14%</td>
</tr>
<tr>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Enrolled in a doctorate program</td>
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<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
</tr>
</tbody>
</table>

Table 6

*Profession*

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Professional</td>
<td>78.57%</td>
</tr>
<tr>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Other Related to Mental Health Field</td>
<td>7.14%</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Other Not Related to Mental Health Field</td>
<td>14.29%</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
</tr>
</tbody>
</table>

The modal response for participants to the statement “I work with youth in some capacity” was “strongly agree,” with 8 out of 14 participants answering in this manner. To the statements “I work with individuals who identify as trans*” and “I work with individuals whose gender does not fit the binary,” 9 out of 14 participants answered “strongly agree,” and 5 out of 18 answered “agree”. The modal response for participants to the statement “I work with parents
of trans* individuals” was “agree,” with 5 out of 14 participants answering in this category. When asked the statement, “I work with parents of individuals whose gender does not fit the gender binary,” 7 out of 14 participants answered “agree.” The modal response for participants to the statements “I work with siblings of trans* individuals” and “I work with siblings of individuals whose gender does not fit the gender binary,” was “agree” with 6 out of 14 participants answering in this manner. When asked the statement “I work with youth who have a trans* sibling,” 7 out of 14 responders said “strongly agree” or “agree.” The modal response for participants to the statement “I work with youth who have a sibling whose gender does not fit the gender binary” was “agree” with 5 out of 14 participants responding in this way.

Table 7

Experience with Youth

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>青春经历</td>
<td>57.14%</td>
<td>42.86%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>14</td>
</tr>
</tbody>
</table>

Table 8

Experience with Trans* (Transgender, Transsexual) Individuals

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>青春经历</td>
<td>64.29%</td>
<td>35.71%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>14</td>
</tr>
</tbody>
</table>

Table 9

Experience with Individuals Whose Gender does not fit the Gender Binary

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>青春经历</td>
<td>64.29%</td>
<td>35.71%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>14</td>
</tr>
</tbody>
</table>
Table 10

*Experience with Parents of Trans* Individuals

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>28.57%</td>
<td>35.71%</td>
<td>21.43%</td>
<td>7.14%</td>
<td>7.14%</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>14</td>
</tr>
</tbody>
</table>

Table 11

*Experience with Parents of Youth Whose Gender does not fit the Binary*

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>14.29%</td>
<td>50.00%</td>
<td>21.43%</td>
<td>7.14%</td>
<td>7.14%</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>7</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>14</td>
</tr>
</tbody>
</table>

Table 12

*Experience with Siblings of Trans* Individuals

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7.14%</td>
<td>42.86%</td>
<td>21.43%</td>
<td>7.14%</td>
<td>21.43%</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>14</td>
</tr>
</tbody>
</table>

Table 13

*Experience with Siblings of Individuals Whose Gender does not fit the Binary*

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.00%</td>
<td>50.00%</td>
<td>21.43%</td>
<td>7.14%</td>
<td>21.43%</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>7</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>14</td>
</tr>
</tbody>
</table>

Table 14

*I Work with Youth who have a Trans* Sibling

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>28.57%</td>
<td>21.43%</td>
<td>35.71%</td>
<td>0.00%</td>
<td>14.29%</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>0</td>
<td>2</td>
<td>14</td>
</tr>
</tbody>
</table>
Table 15

*I Work with Youth who have a Sibling whose Gender does not fit the Binary*

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.29%</td>
<td>35.71%</td>
<td>35.71%</td>
<td>0.00%</td>
<td>14.29%</td>
<td>14</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>2</td>
<td>14</td>
</tr>
</tbody>
</table>

To the statement “I have received education and/or training on gender variance, 7 out of 14 participants answered “strongly agree” and 6 out of 14 answered “agree.” When asked the statement “I have received education and/or training on trans* identity, 9 out of 14 participants answered “strongly agree,” while 5 participants responded “agree.” The modal response for participants to the statement “I have received education and/or training on how to give competent care to individuals whose gender does not fit the binary” was “agree” with 6 out of 14 participants answering in this manner and 5 out of 14 participants indicating they “strongly agree” with that statement. Similarly, when asked the statement “I have received education and/or training on how to give competent care to trans* individuals, 6 out of 14 participants answered “strongly agree” while 5 out of 14 participants answered “agree.”

Table 16

*Education/Training on Gender Variance*

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>50.00%</td>
<td>42.86%</td>
<td>0.00%</td>
<td>7.14%</td>
<td>0.00%</td>
<td>14</td>
</tr>
<tr>
<td>7</td>
<td>6</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>14</td>
</tr>
</tbody>
</table>

Table 17

*Education/Training on Trans* Identity

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>64.29%</td>
<td>35.71%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>14</td>
</tr>
<tr>
<td>9</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>14</td>
</tr>
</tbody>
</table>
Table 18

*Education/Training on Competent Care for Gender Variant Individuals*

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>35.71%</td>
<td>42.86%</td>
<td>21.43%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>14</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Table 19

*Education/Training on Competent Care for Trans* Individuals

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>42.86%</td>
<td>35.71%</td>
<td>21.43%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>14</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

The modal response for participants to the statement “I feel my input could contribute to group programming for adolescent siblings or trans* individuals was “yes” with 12 out of 14 participants responding in this manner.

Table 20

*I Feel my Input Could Contribute to Group Programming*

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>85.71%</td>
</tr>
<tr>
<td></td>
<td>12</td>
</tr>
<tr>
<td>No</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>14.29%</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
</tr>
</tbody>
</table>

**Need for the Proposed Program**

When asked the statement “There are already established programs that target adolescents who have a trans* sibling,” 7 out of 14 participants responded “disagree,” while 5
out of 14 participants responded “strongly disagree.” The modal response for participants to the statement “A group therapy program targeting adolescents who have a trans* sibling would be beneficial to their psychological well-being” was “agree” with 8 out of 14 participants responding in that manner. To the statements “A group therapy program targeting adolescents who have a trans* sibling is not the right approach to treating those individuals,” 10 out of 14 participants answered “strongly disagree” or “disagree.” Those who answered “strongly agree” or “agree,” elaborated by saying “Group therapy is just not [an] effective modality for all in any situation. Some siblings benefit more from their own individual therapy and/or a family approach” and “I also think that you need to work with families in general when working with trans youth, so family therapy or a family support group might be a better option.”

Table 21

*Established Programs Targeting Adolescents with a Trans* Sibling

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Unsure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00%</td>
<td>0.00%</td>
<td>7.14%</td>
<td>50.00%</td>
<td>35.71%</td>
<td>7.14%</td>
<td>14</td>
</tr>
</tbody>
</table>

Table 22

*Program for Adolescents with a Trans* Sibling is Needed

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Unsure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>21.43%</td>
<td>71.43%</td>
<td>7.14%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>14</td>
</tr>
</tbody>
</table>

Table 23

*Program for Adolescents with a Trans* Sibling Would be Beneficial

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Unsure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>42.86%</td>
<td>57.14%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>14</td>
</tr>
</tbody>
</table>
Table 24

A Group Program is not the Right Approach

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Unsure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.14%</td>
<td>7.14%</td>
<td>14.29%</td>
<td>35.71%</td>
<td>35.71%</td>
<td>0.00%</td>
<td>14</td>
</tr>
</tbody>
</table>

Interest in the Proposed Program

When asked the statement “I would support/be interested in the implementation of a group therapy program for youth who have a trans* sibling, within my work setting,” 6 out of 14 participants responded “agree” while 5 out of 14 responded “strongly agree.” To the statement “I would support/be interested in sending clients I work with to a group therapy program for adolescents who have a trans* sibling,” all 14 participants responded “strongly agree” or “agree.”

Table 25

Support/Interest in Implementing Group Program for Youth with a Trans* Sibling

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>35.71%</td>
<td>42.86%</td>
<td>14.29%</td>
<td>7.14%</td>
<td>0.00%</td>
<td>14</td>
</tr>
</tbody>
</table>

Table 26

Support/Interest in Sending Client to Group Program for Youth with a Trans* Sibling

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>50.00%</td>
<td>50.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>14</td>
</tr>
</tbody>
</table>
Feasibility of the Proposed Program

When asked the statement “A group therapy program targeting adolescents who have a trans* sibling would be feasible to implement within my work setting,” 8 out of 14 participants responded “neutral” or “disagree,” while 5 out of 14 participants responded “strongly agree” or “agree.” When asked “In your opinion, please choose the most beneficial setting for this program,” 1 participant indicated a children’s medical hospital, 5 participants indicated a community mental health center, 2 participants indicated a private practice, 1 participant indicated a school setting, and 5 participants indicated “other” and further explained that a community mental health center that serves the LGBTQ community would be the most beneficial setting for the proposed program. When asked “In your opinion, please choose the most feasible setting for this program,” 3 participants indicated a children’s medical hospital, 4 participants indicated a community mental health center, 0 participants indicated a private practice, 0 participants indicated a school setting, and 6 participants indicated “other” and further explained that a community mental health center that serves the LGBTQ community would be the most feasible setting for the proposed program.

Table 27

Feasible to Implement the Group in my Work Setting

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.29%</td>
<td>21.43%</td>
<td>28.57%</td>
<td>28.57%</td>
<td>7.14%</td>
<td>14</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>14</td>
</tr>
</tbody>
</table>
Table 28

**Most Beneficial Locations for the Group**

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Medical Hospital</td>
<td>7.14%</td>
</tr>
<tr>
<td>Community Mental Health Center</td>
<td>35.71%</td>
</tr>
<tr>
<td>Private Practice</td>
<td>14.29%</td>
</tr>
<tr>
<td>School setting</td>
<td>7.14%</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>35.71%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
</tr>
</tbody>
</table>

Table 29

**Most Feasible Setting for the Group**

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Medical Hospital</td>
<td>23.08%</td>
</tr>
<tr>
<td>Community Mental Health Center</td>
<td>30.77%</td>
</tr>
<tr>
<td>Private Practice</td>
<td>0.00%</td>
</tr>
<tr>
<td>School setting</td>
<td>0.00%</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>46.15%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

**Important Components for the Proposed Program**

When asked “In your opinion, what would be the most feasible length of this program in weeks,” responses varied. The shortest length of time indicated was 4 to 6 weeks, while the longest was 12 to 20 weeks or “ongoing.” The majority of responses were in the 6 to 12-week
range. Participants were asked to rate the importance of the following components: group format, individual format, inclusion of parents, inclusion of trans* siblings, psychoeducation on gender (i.e. gender variance, transition), relaxation, feeling identification, cognitive coping (i.e. exploring thoughts and correcting inaccurate or unhelpful cognitions), narrative (telling their story) and processing, and purely support group style. Group format, psychoeducation, and narrative and processing were indicated as the most important components to include with other components ranging in level of importance.
### Table 30

**Importance of Components**

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group format</strong></td>
<td>64.29%</td>
<td>35.71%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Individual format</strong></td>
<td>15.38%</td>
<td>30.77%</td>
<td>23.08%</td>
<td>23.08%</td>
<td>7.69%</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Inclusion of parents</strong></td>
<td>14.29%</td>
<td>35.71%</td>
<td>35.71%</td>
<td>14.29%</td>
<td>0.00%</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><em><em>Inclusion of trans</em> siblings</em>*</td>
<td>14.29%</td>
<td>28.57%</td>
<td>42.86%</td>
<td>14.29%</td>
<td>0.00%</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Psychoeducation on gender (i.e. gender variance, transitioning)</strong></td>
<td>71.43%</td>
<td>28.57%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Relaxation</strong></td>
<td>21.43%</td>
<td>35.71%</td>
<td>28.57%</td>
<td>14.29%</td>
<td>0.00%</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Feeling identification</strong></td>
<td>42.86%</td>
<td>42.86%</td>
<td>14.29%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Cognitive Coping (i.e. exploring thoughts and correcting inaccurate or unhelpful cognitions)</strong></td>
<td>42.86%</td>
<td>50.00%</td>
<td>7.14%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>7</td>
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<td><strong>Narrative (telling their story) and Processing</strong></td>
<td>78.57%</td>
<td>14.29%</td>
<td>7.14%</td>
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<td><strong>Purely support group style</strong></td>
<td>71.43%</td>
<td>42.86%</td>
<td>28.57%</td>
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Chapter 5: Summary, Conclusions, and Recommendations

Needs Assessment Overview

The results of the needs assessment indicated various mental health professionals feel there is a need for a group therapy program for adolescents who have a trans* sibling. Participants identified a need for this type of programming because of the lack of similar programs and the potential benefit the program could have on adolescents’ well-being.

Participants indicated they would support the implementation of this program in their work setting and send clients to this program if it is offered in a different location. With regard to feasibility, the participants identified a community mental health center that serves the LGBTQ community as the most feasible and beneficial setting for this program. Although participants’ responses varied when asked about the most feasible length of this program, the majority of them indicated the 6 to 12-week range.

In regard to the components of this program, results indicated professionals thought the use of a variety of modalities would be most beneficial to adolescents, with support group style being an especially important aspect of the group. Based on the results, the following components were deemed important to include: inclusion of parents, inclusion of trans* siblings, both group and individual formats, psychoeducation on gender, relaxation, feeling identification, cognitive coping, narrative, and processing.

Strengths and Limitations

Sib Support, like other group therapy programs, has strengths and limitations. Through reviewing literature and conducting the needs assessment, it became apparent that there is a need for interventions for adolescents who have a trans* sibling. Sib Support specifically addresses adolescents’ difficulties adjusting to their siblings’ identities. The variety in modalities allows
for various kinds of processing, with both structured and semistructured sessions. This well-rounded approach enables the group leader to address the multifaceted difficulties these youth likely experience. In terms of limitations, this needs assessment was only sent to professionals through social media and professional listservs, limiting the number of responders. Some participants were not in the mental health field, which likely limited their ability to comment on psychology-related questions and methodology. Overall, the response rate for the needs assessment survey was lower than expected.

**Program Overview**

Group therapy was chosen as the format for this program because of its effectiveness for children and adolescents. A large meta-analysis concluded group treatment is more effective than no treatment and the average child or adolescent in group therapy is 73% better off than their peers who are not in treatment (Hoang & Burlingame, 1997). Although individual therapy is also an effective treatment modality, group therapy is an especially good fit for this target population because clients in group therapy report a greater sense of connectedness after hearing group members discuss experiences that are similar to their own (Yalom, 1998). In order to address group members’ individualized unique needs and common experiences, various modalities will be used in this group therapy program. Even though some group therapists strictly follow one modality, Hoang and Burlingame (1997) found factors like treatment modality and therapist’s theoretical orientation did not have significant effects on outcomes, indicating the use of various modalities should be just as effective as using one treatment modality.

In looking at relevant literature and analyzing the results of the needs assessment survey, various modalities will be incorporated into this group therapy program, such as
psychoeducation, therapeutic processing, thoughts and feelings identification, coping skills, expressive arts, narrative story-telling, and advocacy.

Psychoeducation has been shown to be an effective treatment modality in groups for direct care workers in nursing facilities and patients with eating disorders (Barbosa, Marques, Sousa, Nolan & Figueiredo, 2016; Brewin et al., 2016). It has also been used effectively in family therapy to decrease relapses in patients with schizophrenia and bipolar disorder (Marvin, Miklowitz, O'Brien & Cannon, 2016). Psychoeducation is consistently used in individual treatment when explaining symptoms, diagnoses, and treatment options (Colom & Lam, 2005). Psychoeducation is important for this group program because LGBTQ identities, gender affirmation treatment options, and gender dysphoria must be understood by group members in order for them to more fully understand their siblings’ experiences.

Although group therapy techniques vary, most group therapy treatment includes some element of processing (Abraham, Lepisto & Schultz, 1995). One group of adolescents reported group therapy promotes “universality, group cohesiveness, catharsis, and existential awareness” (Chase & Kelly, 1993, p. 160). Adolescents in a residential setting identified relating to staff, peer relationships, and comfort level with peers were all enhanced because of being in a process group rather than a focus group (Abraham, Lepisto & Schultz, 1995). It is thought the ability to bond in a process group promotes adolescents’ feelings of relatedness. Because adolescents who have a trans* sibling may experience a sense of isolation, this formation of relatedness with others may ameliorate some of their feelings of aloneness.

In individual therapy, thought and feeling identification is commonly used, as both an intervention and skill building. It can also be an important component in group treatment. Children of divorce, ages 7 to 14, who received a group-based therapeutic program that included
identification of thoughts and feelings, were shown to have decreased conflict with their parents and a decrease in problem behaviors at school after attending the therapeutic program (Bornstein, Bornstein & Walters, 1988). This component is included in the Sib Support program because the identification of one’s thoughts and feelings is the first step of processing those things.

Coping skill development is a common intervention used in individual and group treatment. Dumont and Provost (1998) found “resilient” adolescents had more problem-solving coping strategies and self-esteem than their “vulnerable” counterparts, indicating effective coping skills are associated with positive adjustment in the face of stress and depression. As adolescents in this group adjust to their siblings’ identities, effective coping skills can be beneficial in decreasing the stress they may experience.

Even though it is not necessarily traditional to incorporate expressive arts in a nonexpressive therapy group, the use of art in group therapy can enhance the experience for group members (Liebmann, 1986). Liebmann (1986) posited that art may be a more effective avenue of communication for people who have difficulty with verbal expression, and it can lead to shared pleasure among group members. Incorporating this methodology into group programming ensures all participants can share their experiences either verbally or through artistic expression.

Narrative therapy and telling one’s story have been well-documented to be effective forms of treatment for people who have experienced trauma (Ikonomopoulos, Smith & Schmidt, 2015). Narrative therapy has also been useful in therapeutic work with parents of lesbian, gay, or bisexual adolescents (Saltzburg, 2007). For youth involved in the juvenile justice system, narrative therapy treatment was associated with a treatment effect, specifically, a decrease in mental health symptoms (Ikonomopoulos, Smith & Schmidt, 2015). Since narrative therapy and
telling one’s story can help with both individuals’ treatment and group cohesiveness, it will likely be a useful intervention for this specific group program.

Underprivileged youth, such as those who are LGBTQ, are most affected by inequities in school systems (Harley, Nowalk, Gassaway & Savage, 2002). Self-advocacy for LGBTQ youth is important for quality of life and to advance social justice (McCarther & Davis, 2015). It is thought that siblings can learn advocacy skills through Sib Support that can help them fight discrimination towards themselves and their siblings. The advocacy module is currently an optional module, depending on the group make-up. Some siblings may be seeking support only and not be in a place to become advocates for their trans* siblings. On the other hand, some siblings in the group may be ready to have conversations about advocacy and social justice because they want to defend or fight for their siblings’ rights.

**Feedback from participants.** At the beginning and end of each week, participants will be able to give their feedback either in written form or verbally, to ensure they are benefiting from the group and having a voice. Any feedback received from participants can be taken into consideration and incorporated if it seems relevant and helpful to the group. A record of feedback should be kept as it will be helpful for future revisions of this program, if they occur.

**Strengths and limitations.** The main strength of this program is that it addresses a need that is not being addressed. At the time this program was created, there was virtually no research on the experiences of siblings of LGBTQ youth. This program was developed to provide a supportive, therapeutic space for adolescents who have a trans* sibling. Within the program, the variety of modalities and subjects covered are strengths because they address a variety of needs that may arise from a diverse group of adolescents.
The main limitations of this program are the cost and time commitment for families and potential difficulty pulling resources together. Most families who are receiving services for gender affirmation spend a significant amount of time and finances for those services. Because this program may or may not be covered by some insurance companies, the cost for adolescents to attend may be a financial burden for families. Additionally, finding informed therapists, space, and funding for materials may be difficult.

**Recommendations for Future Research**

In the future, a qualitative study on siblings’ experiences would be a helpful addition to the literature. That research could be incorporated in both individual and group treatment for youth with a trans* sibling. Because the number of trans* youth is steadily increasing each year, the number of siblings of trans* youth is also likely increasing. The need to support them will only continue to grow.

Additionally, siblings should be included in family therapy and the outcomes of that experience could be studied. Oftentimes siblings are not included in family sessions with their trans* siblings so it would be beneficial to address that need and collect data to inform professionals of the positive and negative aspects of including siblings in family therapy.

**Evaluation**

According to Calley (2011), it is important to determine the effectiveness of a program after it has been developed and implemented. The validated instrument, Mental Health Continuum Short Form (MHC-SF), will be used as a pre and post measure to determine the effectiveness of the group program. Participants’ pre and post measures will be compared and analyzed to see if participants’ well-being increased. The outcome measure should demonstrate
that group participants benefited emotionally, psychologically, and socially from being part of this group program.

**Summary**

This researcher created a group program for adolescent who have a trans* sibling. The program seeks to meet the unique needs of these siblings, who are often left out of the treatment and family therapies. After conducting a needs assessment, it was determined that professionals see these youth as a group who could benefit from group programming. As a result, Sib Support, a program that incorporates psychoeducation, therapeutic processing, thoughts and feelings identification, coping skills, expressive arts, narrative story-telling, and advocacy, was developed. Overall the group aims to provide a sense of connectedness, support, and promote positive well-being for adolescents who have a trans* sibling.
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http://dx.doi.org/10.1002/chi.794


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http://dx.doi.org/10.1176/ajp.2007.164.6.949


Hello,

My name is Erica Aten and I am a Clinical PsyD student at The Chicago School of Professional Psychology, Chicago campus. I would like to invite you to participate in a research study for my dissertation. This study seeks to develop a support program for adolescents who have recently had a sibling come out as trans*.

Participation in this research study is completely voluntary, and you may withdraw your participation at any time if you feel the need to do so. You will be asked to complete a brief survey that should take approximately 10-15 minutes.

Requirements to Participate:
· Must be 18 or older
· Must work with trans* youth in some capacity

Thank you very much for your time and consideration. If you have any questions, please contact me at exa4937@ego.thechicagoschool.edu. If you would like to participate, please go to the following website:

https://www.surveymonkey.com/r/F8X2RXH

Thank you!

Erica Aten, M.A.
Appendix B: Informed Consent

**Title:** Families in transition: A program for youth with a trans* sibling

**Investigator:** Erica Aten, M.A. and Braden Berkey, PsyD (Dissertation Chair)

I am a student at The Chicago School of Professional Psychology. This study is being conducted as a part of my dissertation requirement for the Clinical Psy.D. program. I am inviting you to participate in a graduate research study. Participation in this study is completely voluntary. Before participating in this study, please read this consent form carefully, as it describes the study and any risks that may be involved. If there is any information you do not understand, please ask the investigator before continuing on to participate.

**Purpose:**

Having a sibling who identifies as trans* comes with a plethora of stigma and challenges. Siblings’ experiences have been neglected in family therapy, as well as neglected in empirical research. Currently there are no empirical studies that examine the experiences of people whose siblings identify as trans*. This study seeks to develop a program to support siblings who may need professional and peer support while their family adjusts to having a trans* member.

**Procedures:**

You will be asked questions pertaining to your knowledge of gender variant youth, the gender transition process, and family dynamics. In addition, you will be asked to answer questions regarding the need, interest, feasibility, and important components of the program supporting youth with a trans* sibling. The survey should take approximately 10-15 minutes to complete.

**Risks to Participation:**

Participation in the study is expected to contain minimal risk. One risk is that you may feel pressured to answer questions in the survey. To mitigate this risk, you may skip and questions you do not feel comfortable answering. There is also minimal risk to your privacy/confidentiality. No identifying information will be collected unless you choose to give this investigator your email in order to be contacted in the future to review the completed program. Responses provided in the survey in Survey Monkey are kept separate without identifying information so no responses can be traced back to you. Survey Monkey is a secure and encrypted website.

**Benefits to Participants:**

There are no direct benefits for participants in this study. The knowledge gained from this study will help the investigator design a support program that may be beneficial in working with youth who have a trans* sibling.
What if I want to withdraw from this study?

Taking part in this study is voluntary. You have the right to choose not to take part in this study. If you choose to take part, you have the right to stop at any time. In addition, you have the right to withdraw at any time without consequences. You may exercise the option of removing your data from the study. You may also refuse to answer any questions you do not feel comfortable answering and still remain in the study.

Questions/Concerns:

Please contact Erica Aten at exa4937@ego.thechicagoschool.edu, or Dr. Braden Berkey, dissertation chair, at bberkey@thechicagoschool.edu with any participation related questions. If you have questions concerning your rights in this research study you may contact the Institutional Review Board (IRB), which is concerned with the protection of subjects in research project. You may reach the IRB office Monday-Friday by calling 312.467.2343 or writing: Institutional Review Board, The Chicago School of Professional Psychology, 325 N. Wells, Chicago, Illinois, 60654.

The research project and procedures have been explained to me. I agree to participate in this study. My participation is voluntary and I do not have to agree to participate if I do not want to be part of this research project. I agree to participate in the previously outlined research study, as well as to the conditions set forth in this consent form.

Agree
Disagree
Appendix C: Needs Assessment Survey

1. The research project and procedures have been explained to me. I agree to participate in this study. My participation is voluntary and I do not have to agree to participate if I do not want to be part of this research project. I agree to participate in the previously outlined research study, as well as to the conditions set forth in this consent form.

Agree
Do not agree

**Please answer the following demographic questions.**

2. What is your age?
   - 18-24
   - 25-34
   - 35-44
   - 45-54
   - 55-64
   - 65+

3. What is your gender?

4. What is your racial background?
   - White
   - Black or African American
   - American Indian or Alaskan Native
   - Asian
   - Native Hawaiian or Pacific Islander
   - Biracial
   - I prefer not to answer
   - Other (please specify)

5. What is the highest level of education you have earned?
6. What is your profession?

7. Years of Professional Experience

8. If you are licensed, what type of license do you have?

9. What is/are the setting(s) in which you work?

The following questions will tell me about your experience with the target population and what you may already know about transgender identity and family dynamics.

Please rate the following statements using these answer options based on your knowledge and experience: Strongly Agree, Agree, Neutral, Strongly Disagree, or I prefer not to answer.

10. I work with youth in some capacity.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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11. I work with individuals who identify as trans* (e.g. transsexual, transgender)

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<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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12. I work with individuals whose gender does not fit the gender binary (e.g. genderqueer, genderfluid, agender)

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<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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13. I work with parents of trans* individuals.

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<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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</table>

14. I work with parents of individuals whose gender does not fit the gender
15. I work with siblings of trans* individuals.

16. I work with siblings of individuals whose gender does not fit the gender binary.

17. I have received education and/or training on gender variance.

18. I have received education and/or training on trans* identity.

19. I have received education and/or training on how to give competent care to individuals whose gender does not fit the binary.

20. I have received education and/or training on how to give competent care to trans* individuals.
21. I work with youth who have a trans* sibling.

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<tr>
<th>Strongly Agree</th>
<th>Agree</th>
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<th>Disagree</th>
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22. I work with youth who have a sibling whose gender does not fit the gender binary.

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<th>Strongly Agree</th>
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<th>Disagree</th>
<th>Strongly Disagree</th>
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23. I feel my input could contribute to group programming for adolescent siblings of trans* individuals. Yes

Yes
No

The following questions will help me understand your opinion on the need for the proposed programming. In addition, it will ask you about your opinion on the interest and feasibility of the proposed program. The proposed program will be for siblings ages 13-18. Please keep that age range in mind when answering the following questions.

Please rate the following statements using these answer options based on your opinion and understanding: Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree.

24. There are already established programs that target adolescents who have a trans* sibling.

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<tr>
<th>Strongly Agree</th>
<th>Agree</th>
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<th>Disagree</th>
<th>Strongly Disagree</th>
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25. A group therapy program targeting adolescents who have a trans* sibling is needed.
26. A group therapy program targeting adolescents who have a trans* sibling would be beneficial to their psychological well-being.

27. A group therapy program targeting adolescents who have a trans* sibling is not the right approach to treating those individuals.

28. If you believe a group therapy program is not the right approach, please specify why and provide alternative approaches

29. I would support/be interested in the implementation of a group therapy program, targeting adolescents who have a trans* sibling, within my work setting.

30. I would support/be interested in sending clients I work with to a group therapy program targeting adolescents who have a trans* sibling.

31. A group therapy program targeting adolescents who have a trans* sibling would be feasible to implement within my work setting. If it is not feasible, please explain why.
32. In your opinion, please choose the most beneficial setting for this program.

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<td>School Setting</td>
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<td>Other</td>
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33. In your opinion, please choose the most feasible setting for this program.

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<td>Other</td>
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34. In your opinion, what would be the most feasible length of this program in weeks?

35. Important components to include

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<th>Component</th>
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<td>Individual Format</td>
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<td>Inclusion of trans* siblings</td>
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<td>Gender variance, transitioning</td>
<td>Relaxation</td>
<td>Feeling Identification</td>
<td>Cognitive Coping (i.e. exploring thoughts and correcting inaccurate or unhelpful cognitions)</td>
<td>Narrative (telling their story) and Processing</td>
<td>Purely support group style</td>
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36. Are there any additional components you feel should be included in the program?

Yes

No

37. Do you have any general thoughts about the proposed program?

**Thank you for your participation!!**

38. Would you like to be contacted to review the program once it is developed? If yes, please provide your email address.

Yes

No

Email address:
Appendix D: Program Manual

Sib Support

A Group for Adolescents with Trans* Siblings

Therapist Manual

Created by Erica Aten, M.A.
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   Rationale for Various Methodologies
   How to Use This Manual
   Necessary Materials and Staff
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Session 2: Psychoeducation on LGBTQ identities
Session 3: Group Process
Session 4: Thoughts and Feelings Identification
Session 5: Coping with Thoughts and Feelings
Session 6: Expressive Activities
Session 7: Narrative
   Session 8: (Optional) How to be an Advocate
Session 9: Closing- Entire Family

Appendix
   Icebreaker Activities
Introduction

Who is Sib Support Appropriate for?

Sib Support is a group-based program for adolescents, ages 14-18, who are seeking support as they adjust to their siblings’ trans* identity. It is important to note that as a program facilitator, you are agreeing to facilitate this group from a trans* affirming lens. Potential group members should be informed of this factor.

Rationale for Various Methodologies

Based on the integration of relevant literature and the results of the needs assessment survey, various modalities are incorporated into this group therapy program, such as: psychoeducation, therapeutic processing, thoughts and feelings identification, coping skills, expressive arts, narrative story-telling, and advocacy. Various methodologies are used in this program to address the variety of needs that may arise from a diverse group of adolescents.

How to Use This Manual

This manual should serve as a guide to you as you facilitate this program. Each session will be described and outlined, with specific directions, tools, and Powerpoints to aid in psychoeducation and the facilitation of activities and discussions. Due the range in age of the participants, it is imperative that the group leader is mindful of developmental appropriateness and adjusts verbiage and explanations accordingly.

This program is intended to take place in a location that can generate referrals from professionals who work with the LGBTQ community, youth, and families. Although various settings may be appropriate for this group, successful recruitment will likely depend on accessibility and a relationship between the group leader and a community mental health center that serves LGBTQ individuals.

Necessary Materials and Staff

- One licensed clinical psychologist is needed for this program. An additional co-facilitator can be another mental health professional who is either a licensed, practicing individual; a practicing unlicensed individual; or a graduate student in either counseling or clinical psychology.
- Each group member should have their own copy of the adolescent manual
- Pens and pencils, small mason jars, colored pencils, mandala coloring sheets, construction paper
Session 1: Combined Welcome Session

Schedule
• Welcome!
  o Ice breakers and meeting one another (see ice breaker options at end of manual)
• Explanation of the program
  o Sib Support is a group-based program for adolescents, ages 14-18, who are seeking support as they adjust to their siblings’ trans* identity. Each week will be different and group members can expect some discussion-based groups, expressive arts groups, and others focused on thoughts, feelings, and coping.
  o Explain confidentiality and ask the group members to come up with other group “rules.”
• Goal statements
  o Have adolescents write what they hope to gain from the group experience on the goal statement page. If they are comfortable, they can share with the group.
• Closing
  o Pass around feedback forms

Materials Needed
• Group member manuals
• Feedback forms
• Pens/Pencils
• Any materials needed for icebreaker activity

Session Format
• Combined parents and adolescents
Session 2: Discussion of LGBTQ identities

Schedule
- Welcome check-in
  - Do another icebreaker activity since this is the first time the adolescents are at group without their parents.
  - Ask group members to discuss their goal statements
- Go through the Powerpoint (LGBTQ definitions)
  - Time allowing- Identity Charades
    - put various identities/terms on notecards and have one person describe a term while the rest of the group tries to guess the term
- Closing
  - Pass around feedback forms

Materials Needed
- Group member manuals
- Feedback forms
- Any materials needed for icebreaker activity

Session Format
- Adolescents only
LGBTQ Definitions

Biological Sex – (noun) a medical term used to refer to the chromosomal, hormonal and anatomical characteristics that are used to classify an individual as female or male or intersex. Often referred to as simply “sex,” “physical sex,” “anatomical sex,” or specifically as “sex assigned [or designated] at birth.”

Gender Identity – (noun) the internal perception of one’s gender, and how they label themselves, based on how much they align or don’t align with what they understand their options for gender to be. Common identity labels include man, woman, genderqueer, trans, and more.

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Gender Variant– (adj) someone who either by nature or by choice does not conform to gender-based expectations of society (e.g. transgender, transsexual, intersex, gender-queer, cross-dresser, etc.).

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Lesbian – (noun) a term used to describe women attracted romantically, erotically, and/or emotionally to other women.

MSM / WSW – (noun) initialisms for “men who have sex with men” and “women who have sex with women,” to distinguish sexual behaviors from sexual identities (e.g., because a man is straight, it doesn’t mean he’s not having sex with men). Often used in the field of HIV/Aids education, prevention, and treatment.

Pansexual – (adj) a person who experiences sexual, romantic, physical, and/or spiritual attraction for members of all gender identities/expressions

Third Gender – (noun) a term for a person who does not identify with either man or woman, but identifies with another gender. This gender category is used by societies that recognise three or more genders, both contemporary
and historic, and is also a conceptual term meaning different things to different people who use it, as a way to move beyond the gender binary.

Trans*/Transgender – (adj) (1) An umbrella term covering a range of identities that transgress socially defined gender norms. Trans with an * is often used to indicate that you are referring to the larger group nature of the term. (2) A person who lives as a member of a gender other than that expected based on sex assigned at birth.

Transsexual – (noun & adj) a person who identifies psychologically as a gender/sex other than the one to which they were assigned at birth. Transsexuals often wish to transform their bodies hormonally and surgically to match their inner sense of gender/sex.

Transvestite – (noun) a person who dresses as the binary opposite gender expression (“cross-dresses”) for any one of many reasons, including relaxation, fun, and sexual gratification (often called a “cross-dresser,” and should not be confused with transsexual)

Two-Spirit – (noun) is an umbrella term traditionally used by Native American people to recognize individuals who possess qualities or fulfill roles of both genders

List found at: http://itspronouncedmetrosexual.com/2013/01/a-comprehensive-list-of-lgbtq-term-definitions/#sthash.SuKTI3w8.dpuf
Session 3: Group Process

Schedule
- Welcome
- Prompts for processing:
  - How is your experience?
  - What things are difficult?
  - What positive things would you like to share with the group?
  - How are things going with your families and peers?
  - What are your concerns/worries?
  - What do you hope for in the future?
- Closing
  - Pass around feedback forms

Materials Needed
- Group member manuals
- Feedback forms

Session Format
- Adolescents only
Session 4: Thoughts and Feelings Identification

Schedule

- Welcome
- For this activity, you will be writing down your thoughts and feelings about your experience, as it relates to your sibling’s identity. You can decorate your jar first as you are processing your thoughts and feelings. The purpose of the jar is to help you feel a release by having a safe place to hold your thoughts and feelings, besides in your mind. Similar to journaling, it is helpful to identify your thoughts and feelings and put them on paper as a way to express yourself. There is a list of emotions in your Powerpoint if you want to reference it. Once you are finished decorating your jar, write down your thoughts and feelings on pieces of paper and put them in your jar. After you have released all of your thoughts and feelings into the jar, you can close it.
- Closing
  - Pass around feedback forms

Materials Needed

- Group member manuals
- Mason jars
- Craft supplies for decorating jars
- Blank paper and construction paper
- Pens and pencils
- Feedback forms

Session Format

- Adolescents only

Activity

- Jar of thoughts activity
Session 5: Coping with Thoughts and Feelings

Schedule
- Welcome
- Today we will be discussing ways to cope when you are experiencing negative thoughts or feelings. For our first activity, we will be coloring mandalas while listening to calming music. A mandala is a spiritual and ritual symbol used in Buddhism. Since Mandalas are associated with calmness, their use has expanded to a relaxing coloring activity. When paired with calming music, coloring mandalas can promote relaxation.
- For the second activity, we will be doing a relaxation exercise. Here is the link if you would like to use the audio version: http://www.ideafit.com/fitness-library/guided-relaxation-script-breathing-the-body
- Closing
  - Pass around feedback forms

Materials Needed
- Group member manuals
- Mandala coloring pages
- Colored pencils
- Relaxation script or audio device to play it
- Feedback forms

Session Format
- Adolescents only

Activity
- Mandala coloring sheets with calming music
- Relaxation activity
Tips for using this relaxation script:

Use your natural teaching voice, rather than an artificial “relaxing” voice. Pause regularly. Leave space for students to shift their focus inward. The relaxation script shouldn’t fill up the entire relaxation period, and will take about 7 minutes to read, with appropriate pauses throughout. Shorten this script for shorter relaxations, so that there is time for extended silence. The guided audio version has 2 minutes of silence near the end of the relaxation; in classes or private sessions this silence can be much longer.

Give students time to settle into a relaxation pose and quiet down before you begin leading them through this script.

“As you settle into relaxation pose, relax the weight of your body into the support of the floor. Notice how the body makes contact with the support of the floor. Relax the back of your legs “the back of your hips “your lower back, middle back and upper back. Relax the back of your shoulders “the back of your arms “the back of your neck “and the back of your head. Make any adjustments you need to, to relax the body into the ground more fully. Relax into the support of floor, completely.

“Relax the muscles of your face. Relax your eyes and your forehead. Relax your temples and cheeks. Relax you mouth and jaw. Relax your whole face. Place your hands on your belly. Feel the rise and fall of your belly as you breathe. Notice each inhalation as it enters the body, and each exhalation as it exits the body. Let your breathing be soft, full and easy. No effort. Let the body be breathed. As you inhale, say silently in your mind, ‘Let.’ As you exhale, silently say ‘Go.’ Inhale, ‘Let.’ Exhale, ‘Go.’

“Continue to observe the breath, letting the body sink deeper and deeper into relaxation. Let your arms rest by your side. As you exhale, make a soft fist with each hand. As you inhale, relax the fist, and let your hands remain softly curled and relaxed. Let the body sink deeper and deeper into the support of the floor.

“Now, bring your awareness to your feet. Feel the soles of your feet, and all 10 toes. Imagine that you could inhale and exhale through the soles of your feet. Imagine the breath entering the body through the soles of the feet, and exiting the body through the soles of the feet. Inhale. Exhale.

“Now, bring your awareness to your hands. Feel the backs of the hands, the palms of the hands and all 10 fingers. Imagine that you could inhale and exhale through the palms of your hands. Imagine the breath entering the body through the palms of your hands, and exiting the body through the palms of your hands. Inhale. Exhale.

“Now, bring your awareness to your belly. Feel the belly rise and fall as you breathe. Imagine that you could inhale and exhale through the navel. Imagine the breath entering the body through the navel and filling the belly. Imagine the breath exiting the body through the navel. Inhale. Exhale.
“Now, let your mind relax deeper, below awareness of the breath. Let the mind relax below the level of concentration on anything, including the breath. Let the body and mind let go. Let go, completely.

[Let students or client relax. When you are ready, continue.]

“Notice your breathing. Notice each inhalation as it enters the body and each exhalation as it exits the body. Bring your hands back to the belly, and feel the belly rise and fall. Let your breathing be soft, full and easy. Notice the whole body. Notice the whole body supported by the floor. Notice how easy it is to be in your body, in this moment. Feeling fully supported, in this pose, and in all areas of your life.

“When you’re ready to begin moving out of relaxation, gently move the fingers and toes. Let some sensation spread into the hands and feet. Stretch or move in any way that feels good. Then roll onto your right side, and rest there. Breathe easily. Take the best feeling of this relaxation with you.”

Google Images
Google Images
Session 6: Expressive Activities

Schedule
- Welcome
- Today we will be doing expressive activities as a way to express thoughts, feelings, and experiences without having to verbalize them.
- For the first activity, we will be doing a little warm-up exercise. You will need a piece of paper and any materials you would like for drawing a picture. Take a few minutes to think about your first memory with your sibling(s). When you are ready, please draw that memory however you would like it to be represented on paper. Drawing ability does not matter. This activity is about expressing yourselves through art.
- For the second activity, we will be doing an activity that involves all the members of your family. On your piece of paper, draw a decent-sized heart for each of your family members, including yourself. Try to make these large enough to color and design on the inside but also leave a small space on your paper for a key. Now, make a key on your paper, assigning emotions to colors. You can add designs as well. (for example- making stars in purple for optimistic). When you are finished with your key, take some time to think about yourself and your feelings. Please design and color in your heart based on the emotions you experience and how you feel most accurately represented. Then, take your time, and complete a heart for each of your family members
  - When everyone is done, discuss the process of making the art. Open the discussion up for people who want to share their work but do not force members to share their work with the group.
- Closing
  - Pass around feedback forms

Materials Needed
- Group member manuals
- Paper
- Colored pencils, pencils, pens, markers
- Feedback forms

Session Format
- Adolescents only
Session 7: Narrative

Schedule

- Welcome
- Today we will be doing a storytelling activity to help us better understand our own and others’ experiences. (There are several prompts - pay attention to time when deciding how many to complete)
- For this activity, you will be telling your life story - specifically, what it has been like for you having a sibling who is trans*. Start by describing your first memory of understanding your sibling was not cisgender. Describe your thoughts, feelings, experience, and any details you feel are necessary for your story.
- Now focus on the past 6 months. What has the past 6 months been like? Please take some time to think about this and describe it.
- Tell about a time when you felt thankful for your sibling.
- Tell about a time when you felt angry at your sibling.
- Please take some time to think about the ways your sibling’s identity has impacted your life. Please write about those impacts.
- When it comes to your and your sibling, what is something you wish for?
- When everyone is done writing, have them get into pairs or small groups and share with one another. Once they are done sharing, have them share similarities and differences in their stories with the group. Have them process what it was like sharing their story and hearing others’ stories.
- Closing
  - Pass around feedback forms

Materials Needed

- Group member manuals
- Paper
- Pens/pencils
- Feedback forms

Session Format

- Adolescents only
Session 8: (Optional) How to be an Advocate

Schedule
- Welcome
- Today we have a panel of teenagers who are here to discuss advocacy with you all. Have the panelists introduce themselves and state their sibling’s age and gender.
- To begin, we are going to go over some of the privileges cisgender people have, to put into perspective the difficulties trans* individuals face on a daily basis.
- Have each panelist describe in what ways they advocate for transgender rights. If it applies, you can also have panelists talk about ways in which they break down the gender binary.
- Closing
  - Feedback forms

Materials Needed
- Group member manuals
- Feedback forms

Session Format
- Adolescents
- Guest speakers (older adolescents who are advocates for their trans* siblings)
30 EXAMPLES OF CISGENDER PRIVILEGE

If you identify with the gender you were assigned at birth, here are a bunch of unearned benefits you get that many folks do not. Read them and consider them. It’s not about shame. It’s about understanding.

Written by social justice comedian Sam Killerman, this is an adaptation of an article originally posted on ItsPronouncedMetrosexual.com

Last Edited August 10, 2014

Following is a list of cisgender identity privileges. If you are cisgender, listed below are benefits that result from your alignment of identity and perceived identity.

If you’re not familiar with the term, “cisgender” means having a biological sex that matches your gender identity and expression, resulting in other people accurately perceiving your gender. If you are cisgender, there’s a good chance you’ve never thought about these things (or even your cisgender identity). Try and be more cognizant and you’ll start to realize how much work we have to do in order to make things better for the transgender folks who don’t have access to these privileges. If you’re unsure of what it means to be “transgender” you can read about it in my gender identity guide.

Use public restrooms without fear of verbal abuse, physical intimidation, or arrest
Use public facilities such as gym locker rooms and store changing rooms without stares, fear, or anxiety.

Strangers don’t assume they can ask you what your genitals look like and how you have sex.

Your validity as a man/woman/human is not based on how much surgery you’ve had or how well you “pass” as non-transgender.

You have the ability to walk through the world and generally blend-in, not being constantly stared or gawked at, whispered about, pointed at, or laughed at because of your gender expression.

You can access gender exclusive spaces such as the Michigan Womyn’s Music Festival, Greek Life, or Take Back the Night and not be excluded due to your trans status.

Strangers call you by the name you provide, and don’t ask what your “real name” [birth name] is and then assume that they have a right to call you by that name.

You can reasonably assume that your ability to acquire a job, rent an apartment, or secure a loan will not be denied on the basis of your gender identity/expression.

You have the ability to flirt, engage in courtship, or form a relationship and not fear that your biological status may be cause for rejection or attack, nor will it cause your partner to
question their sexual orientation.

If you end up in the emergency room, you do not have to worry that your gender will keep you from receiving appropriate treatment, or that all of your medical issues will be seen as a result of your gender.

Your identity is not considered a mental pathology (“gender identity disorder” in the DSM IV) by the psychological and medical establishments.

You have the ability to not worry about being placed in a sex-segregated detention center, holding facility, jail or prison that is incongruent with your identity.

You have the ability to not be profiled on the street as a sex worker because of your gender expression.

You are not required to undergo an extensive psychological evaluation in order to receive basic medical care.

You do not have to defend you right to be a part of “Queer,” and gays and lesbians will not try to exclude you from “their” equal rights movement because of your gender identity (or any equality movement, including feminist rights).

If you are murdered (or have any crime committed against you), your gender expression will not be used as a justification for your murder (“gay panic”) nor as a reason to
coddle the perpetrators.

You can easily find role models and mentors to emulate who share your identity.

Hollywood accurately depicts people of your gender in films and television, and does not solely make your identity the focus of a dramatic storyline, or the punchline for a joke.

Be able to assume that everyone you encounter will understand your identity, and not think you’re confused, misled, or hell-bound when you reveal it to them.

Being able to purchase clothes that match your gender identity without being refused service/mocked by staff or questioned on your genitals.

Being able to purchase shoes that fit your gender expression without having to order them in special sizes or asking someone to custom-make them.

No stranger checking your identification or drivers license will ever insult or glare at you because your name or sex does not match the sex they believed you to be based on your gender expression.

You can reasonably assume that you will not be denied services at a hospital, bank, or other institution because the staff does not believe the gender marker on your ID card to match your gender identity.
Having your gender as an option on a form.

Being able to tick a box on a form without someone disagreeing, and telling you not to lie. Yes, this happens.

Not fearing interactions with police officers due to your gender identity.

Being able to go to places with friends on a whim knowing there will be bathrooms there you can use.

You don’t have to convince your parents of your true gender and/or have to earn your parents’ and siblings’ love and respect all over again.

You don’t have to remind your extended family over and over to use proper gender pronouns (e.g., after transitioning).

You don’t have to deal with old photographs that did not reflect who you truly are.

Knowing that if you’re dating someone they aren’t just looking to satisfy a curiosity or kink pertaining to your gender identity (e.g., the “novelty” of having sex with a trans- person).

Being able to pretend that anatomy and gender are irrevocably entwined when having the “boy parts and girl parts” talk with children, instead of explaining the actual
complexity of the issue.

www.ItsPronouncedMetrosexual.com
Session 9: Closing

Schedule
- Welcome
- Today, we would like to process what this group was like for everyone and inform your parents of ways to continue these conversations as a family.
- What has it been like being part of this group?
- What activities or parts did you enjoy?
- What activities or parts did you dislike?
- What would you like your parents to know about what we discussed here?
- How can your parents best support you?
- Closing
  - Feedback forms

Materials Needed
- Group member manuals
- Feedback forms

Session Format
- Adolescents
- Parents
Icebreaker Activities

**Interviews**
Each teen interviews the teen next to him or her for 2 minutes and then introduces the teen to the group. I would give out a list of questions for them to work off of.

**Would you rather…?**
Gross and funny questions of would you rather are great party starters. Have one side of the room be one answer and the other side be the other answer and have them switch sides depending on their choice and then they can easily see who would rather eat their own puke or eat a dead bug.

**I never ever**
Give each of teen in a circle 10 jellybeans or pennies. In turn, each teen tells something they have never done. Anyone who has done it gives the speaker one of his or her pennies. After going around the circle twice, the person with the most jellybeans or pennies wins. For example: I have never traveled outside to Europe. I have never eaten thai food. I have never played the piano.

**Two Truths and a Lie**
In turn, teens each tell two true things and one false thing about themselves. The group tries to guess which one is the lie.

**Famous People**
Tape names of famous people on the teens’ backs. They have to ask each other yes or no questions until they can guess who they are. For example: Am I a man? Am I a singer? The trick is the can only ask one question to each person.

**Toilet Paper**
Pass around a toilet paper roll, have teens take as little or as much as they want then they have to tell something about themselves for every piece of toilet paper they have.

**Zip Zap Zooop**
Start by having all the teens sit in a circle. One of the teens points to someone next to him or her and says, “Zip!” The teens point and repeat, “Zip!” around the circle in one direction. At any time, a teen can say, “Zap!” “Zap!” changes direction, with the teens pointing and saying, “Zip!” around the circle in the opposite direction. At any point, a person told, “Zip!” may choose to say, “Zoop!” If they do so, they point at someone anywhere in the circle who can then restart the “Zip” in any whichever direction they choose.
Sib Support

A Group for Adolescents with Trans* Siblings
Session 1: Combined Welcome Session

Schedule
- Welcome!
- Ice breakers and meeting one another
- Explanation of the program
- Rules
- Goal statements
- Closing

Rules

Goal Statement
Feedback Form: Week 1

How much did you enjoy this activity?

Not at all     Somewhat     A lot

How helpful was this activity?

Not at all     Somewhat     Very helpful

Comments:
Session 2: Discussion of LGBTQ identities

Schedule
- Welcome check-in
- Discuss goal statements
- Go through LGBTQ Identity Charades
- Closing
LGBTQ Definitions

**Biological Sex** – (noun) a medical term used to refer to the chromosomal, hormonal and anatomical characteristics that are used to classify an individual as female or male or intersex. Often referred to as simply “sex,” “physical sex,” “anatomical sex,” or specifically as “sex assigned [or designated] at birth.”

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Drag Queen – (noun) someone who performs femininity theatrically.

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Homosexual – (adj) a [medical] term used to describe a person primarily emotionally, physically, and/or sexually attracted to members of the same sex/gender. This term is considered stigmatizing due to its history as a category of mental illness, and is discouraged for common use (use gay or lesbian instead).

Intersex – (noun) someone whose combination of chromosomes, gonads, hormones, internal sex organs, and genitals differs from the two expected patterns of male or female. In the medical care of infants the initialism DSD (“Differing/Disorders of Sex Development”). Formerly known as hermaphrodite (or hermaphroditic), but these terms are now considered outdated and derogatory.

Lesbian – (noun) a term used to describe women attracted romantically, erotically, and/or emotionally to other women.

MSM / WSW – (noun) initialisms for “men who have sex with men” and “women who have sex with women,” to distinguish sexual behaviors from sexual identities (e.g., because a man is straight, it doesn’t mean he’s not having sex with men). Often used in the field of HIV/Aids education, prevention, and treatment.

Pansexual – (adj) a person who experiences sexual, romantic, physical, and/or spiritual attraction for members of all gender identities/expressions.

Third Gender – (noun) a term for a person who does not identify with either man or woman, but identifies with another gender. This gender category is used by societies that recognise three or more genders, both contemporary
and historic, and is also a conceptual term meaning different things to different people who use it, as a way to move beyond the gender binary.

Trans*/Transgender – (adj) (1) An umbrella term covering a range of identities that transgress socially defined gender norms. Trans with an * is often used to indicate that you are referring to the larger group nature of the term. (2) A person who lives as a member of a gender other than that expected based on sex assigned at birth.

Transsexual – (noun & adj) a person who identifies psychologically as a gender/sex other than the one to which they were assigned at birth. Transsexuals often wish to transform their bodies hormonally and surgically to match their inner sense of gender/sex.

Transvestite – (noun) a person who dresses as the binary opposite gender expression (“cross-dresses”) for any one of many reasons, including relaxation, fun, and sexual gratification (often called a “cross-dresser,” and should not be confused with transsexual)

Two-Spirit – (noun) is an umbrella term traditionally used by Native American people to recognize individuals who possess qualities or fulfill roles of both genders

- See more at: http://itspronouncedmetrosexual.com/2013/01/a-comprehensive-list-of-lgbtq-term-definitions/#sthash.SuKTI3w8.dpuf
Feedback Form: Week 2

How much did you enjoy this activity?

Not at all      Somewhat      A lot

How helpful was this activity?

Not at all      Somewhat      Very helpful

Comments:
Session 3: Group Process

Schedule
- Welcome
- Process
- Closing

Space for Notes
Feedback Form: Week 3

How much did you enjoy this activity?

Not at all  Somewhat  A lot

How helpful was this activity?

Not at all  Somewhat  Very helpful

Comments:
Session 4: Thoughts and Feelings Identification

Schedule
- Welcome
- Thoughts and Feelings Jar
- Closing

List of Emotions

<table>
<thead>
<tr>
<th>Amazed</th>
<th>Foolish</th>
<th>Overwhelmed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angry</td>
<td>Frustrated</td>
<td>Peaceful</td>
</tr>
<tr>
<td>Annoyed</td>
<td>Furious</td>
<td>Proud</td>
</tr>
<tr>
<td>Anxious</td>
<td>Grieving</td>
<td>Relieved</td>
</tr>
<tr>
<td>Ashamed</td>
<td>Happy</td>
<td>Resentful</td>
</tr>
<tr>
<td>Bitter</td>
<td>Hopeful</td>
<td>Sad</td>
</tr>
<tr>
<td>Bored</td>
<td>Hurl</td>
<td>Satisfied</td>
</tr>
<tr>
<td>Comfortable</td>
<td>Inadequate</td>
<td>Scared</td>
</tr>
<tr>
<td>Confused</td>
<td>Insecure</td>
<td>Self-conscious</td>
</tr>
<tr>
<td>Content</td>
<td>Inspired</td>
<td>Shocked</td>
</tr>
<tr>
<td>Depressed</td>
<td>Irritated</td>
<td>Silly</td>
</tr>
<tr>
<td>Determined</td>
<td>Jealous</td>
<td>Stupid</td>
</tr>
<tr>
<td>Disdain</td>
<td>Joy</td>
<td>Suspicious</td>
</tr>
<tr>
<td>Disgusted</td>
<td>Lonely</td>
<td>Tense</td>
</tr>
<tr>
<td>Eager</td>
<td>Lost</td>
<td>Terrified</td>
</tr>
<tr>
<td>Embarrassed</td>
<td>Loving</td>
<td>Trapped</td>
</tr>
<tr>
<td>Energetic</td>
<td>Miserable</td>
<td>Uncomfortable</td>
</tr>
<tr>
<td>Envious</td>
<td>Motivated</td>
<td>Worried</td>
</tr>
<tr>
<td>Excited</td>
<td>Nervous</td>
<td>Worthless</td>
</tr>
</tbody>
</table>

Space for Notes
Feedback Form: Week 4

How much did you enjoy this activity?

Not at all  Somewhat  A lot

How helpful was this activity?

Not at all  Somewhat  Very helpful

Comments:
Session 5: Coping with Thoughts and Feelings

Schedule
- Welcome
- Mandala activity
- Relaxation exercise.
  - Here is the link if you would like to use the audio version at home:
- Closing
Feedback Form: Week 5

How much did you enjoy this activity?

Not at all  Somewhat  A lot

How helpful was this activity?

Not at all  Somewhat  Very helpful

Comments:
Session 6: Expressive Activities

Schedule

- Welcome
- Expressive Activities
  - First memory with your sibling(s). When you are ready, please draw that memory however you would like it to be represented on paper. Drawing ability does not matter. This activity is about expressing yourselves through art.
  - For the second activity, we will be doing an activity that involves all the members of your family. On your piece of paper, draw a decent-sized heart for each of your family members, including yourself. Try to make these large enough to color and design on the inside but also leave a small space on your paper for a key. Now, make a key on your paper, assigning emotions to colors. You can add designs as well. (for example- making stars in purple for optimistic). When you are finished with your key, take some time to think about yourself and your feelings. Please design and color in your heart based on the emotions you experience and how you feel most accurately represented. Then, take your time, and complete a heart for each of your family members
- Closing
FIRST MEMORY
HEART ACTIVITY
Feedback Form: Week 6

How much did you enjoy this activity?

- Not at all
- Somewhat
- A lot

How helpful was this activity?

- Not at all
- Somewhat
- Very helpful

Comments:
Session 7: Narrative

Schedule
- Welcome
- Today we will be doing a storytelling activity to help us better understand our own and others’ experiences.
- For this activity, you will be telling your life story—specifically, what it has been like for you having a sibling who is trans*
- Closing

Start by describing your first memory of understanding your sibling was not cisgender. Describe your thoughts, feelings, experience, and any details you feel are necessary for your story.

Now focus on the past 6 months. What has the past 6 months been like? Please take some time to think about this and describe it.
Tell about a time when you felt thankful for your sibling.

Tell about a time when you felt angry at your sibling.

Please take some time to think about the ways your sibling’s identity has impacted your life. Please write about those impacts.
When it comes to your and your sibling, what is something you wish for?
Feedback Form: Week 7

How much did you enjoy this activity?

Not at all  Somewhat  A lot

How helpful was this activity?

Not at all  Somewhat  Very helpful

Comments:
Session 8: How to be an Advocate

Schedule
• Welcome
• Today we have a panel of teenagers who are here to discuss advocacy with you all.
• To begin, we are going to go over some of the privileges cisgender people have, to put into perspective the difficulties trans* individuals face on a daily basis.
• Closing
30 EXAMPLES OF CISGENDER PRIVILEGE

If you identify with the gender you were assigned at birth, here are a bunch of unearned benefits you get that many folks do not. Read them and consider them. It’s not about shame. It’s about understanding.

Written by social justice comedian Sam Killermann, this is an adaptation of an article originally posted on ItsPronouncedMetrosexual.com

Last Edited August 10, 2014

Following is a list of cisgender identity privileges. If you are cisgender, listed below are benefits that result from your alignment of identity and perceived identity.

If you’re not familiar with the term, “cisgender” means having a biological sex that matches your gender identity and expression, resulting in other people accurately perceiving your gender. If you are cisgender, there’s a good chance you’ve never thought about these things (or even your cisgender identity). Try and be more cognizant and you’ll start to realize how much work we have to do in order to make things better for the transgender folks who don’t have access to these privileges. If you’re unsure of what it means to be “transgender” you can read about it in my gender identity guide.

Use public restrooms without fear of verbal abuse, physical intimidation, or arrest
Use public facilities such as gym locker rooms and store changing rooms without stares, fear, or anxiety.

Strangers don’t assume they can ask you what your genitals look like and how you have sex.

Your validity as a man/woman/human is not based on how much surgery you’ve had or how well you “pass” as non-transgender.

You have the ability to walk through the world and generally blend-in, not being constantly stared or gawked at, whispered about, pointed at, or laughed at because of your gender expression.

You can access gender exclusive spaces such as the Michigan Womyn’s Music Festival, Greek Life, or Take Back the Night and not be excluded due to your trans status.

Strangers call you by the name you provide, and don’t ask what your “real name” [birth name] is and then assume that they have a right to call you by that name.

You can reasonably assume that your ability to acquire a job, rent an apartment, or secure a loan will not be denied on the basis of your gender identity/expression.

You have the ability to flirt, engage in courtship, or form a relationship and not fear that your biological status may be cause for rejection or attack, nor will it cause your partner to
question their sexual orientation.

If you end up in the emergency room, you do not have to worry that your gender will keep you from receiving appropriate treatment, or that all of your medical issues will be seen as a result of your gender.

Your identity is not considered a mental pathology (“gender identity disorder” in the DSM IV) by the psychological and medical establishments.

You have the ability to not worry about being placed in a sex-segregated detention center, holding facility, jail or prison that is incongruent with your identity.

You have the ability to not be profiled on the street as a sex worker because of your gender expression.

You are not required to undergo an extensive psychological evaluation in order to receive basic medical care.

You do not have to defend you right to be a part of “Queer,” and gays and lesbians will not try to exclude you from “their” equal rights movement because of your gender identity (or any equality movement, including feminist rights).

If you are murdered (or have any crime committed against you), your gender expression will not be used as a justification for your murder (“gay panic”) nor as a reason to
coddle the perpetrators.

You can easily find role models and mentors to emulate who share your identity.

Hollywood accurately depicts people of your gender in films and television, and does not solely make your identity the focus of a dramatic storyline, or the punchline for a joke.

Be able to assume that everyone you encounter will understand your identity, and not think you’re confused, misled, or hell-bound when you reveal it to them.

Being able to purchase clothes that match your gender identity without being refused service/mocked by staff or questioned on your genitals.

Being able to purchase shoes that fit your gender expression without having to order them in special sizes or asking someone to custom-make them.

No stranger checking your identification or drivers license will ever insult or glare at you because your name or sex does not match the sex they believed you to be based on your gender expression.

You can reasonably assume that you will not be denied services at a hospital, bank, or other institution because the staff does not believe the gender marker on your ID card to match your gender identity.
Having your gender as an option on a form.

Being able to tick a box on a form without someone disagreeing, and telling you not to lie. Yes, this happens.

Not fearing interactions with police officers due to your gender identity.

Being able to go to places with friends on a whim knowing there will be bathrooms there you can use.

You don’t have to convince your parents of your true gender and/or have to earn your parents’ and siblings’ love and respect all over again.

You don’t have to remind your extended family over and over to use proper gender pronouns (e.g., after transitioning).

You don’t have to deal with old photographs that did not reflect who you truly are.

Knowing that if you’re dating someone they aren’t just looking to satisfy a curiosity or kink pertaining to your gender identity (e.g., the “novelty” of having sex with a trans- person).

Being able to pretend that anatomy and gender are irrevocably entwined when having the “boy parts and girl parts” talk with children, instead of explaining the actual
complexity of the issue.

www.ItsPronouncedMetrosexual.com
Feedback Form: Week 8

How much did you enjoy this activity?

Not at all        Somewhat        A lot

How helpful was this activity?

Not at all        Somewhat        Very helpful

Comments:
Session 9: Closing

Schedule

- Welcome
- Today, we would like to process what this group was like for everyone and inform your parents of ways to continue these conversations as a family.
- What has it been like being part of this group?
- What activities or parts did you enjoy?
- What activities or parts did you dislike?
- What would you like your parents to know about what we discussed here?
- How can your parents best support you?
- Closing

Congratulations!
You have completed the Sib Support Program
Feedback Form: Week 9

How much did you enjoy this activity?

Not at all     Somewhat     A lot

How helpful was this activity?

Not at all     Somewhat     Very helpful

Comments:
References


http://itspronouncedmetrosexual.com/

Google Images- Mandalas