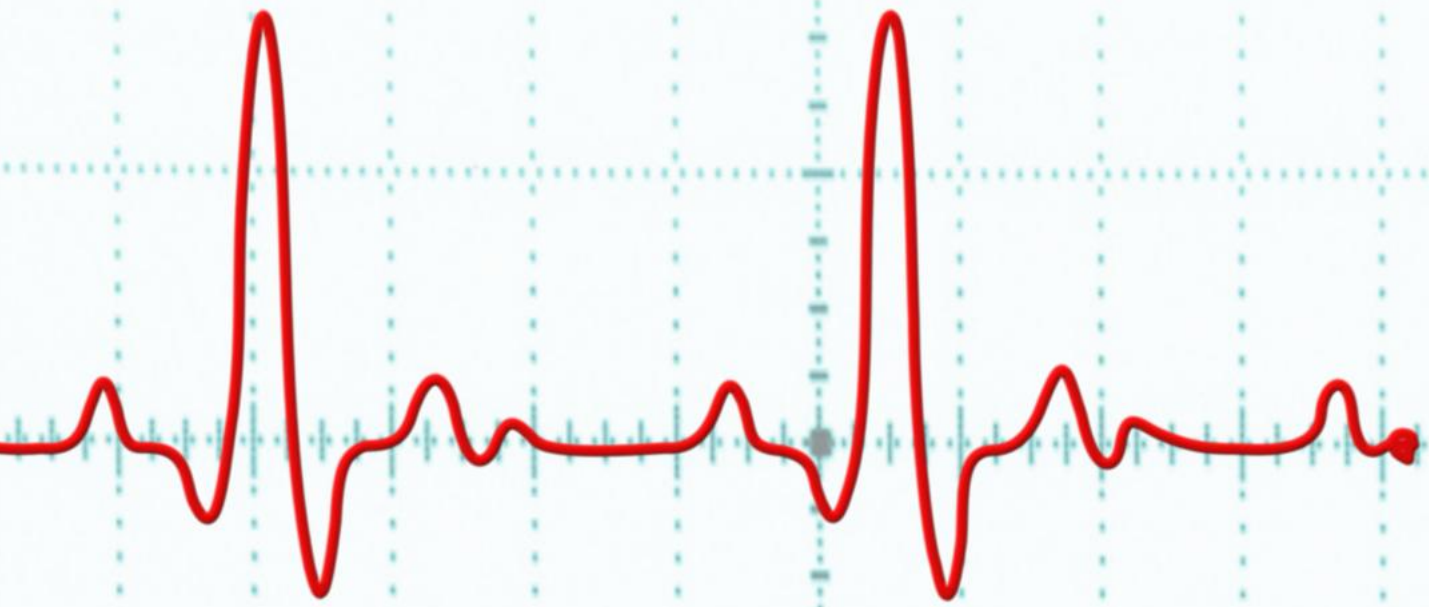


# **A Trans Health Overview for Healthcare Professionals**



by **Trans Pride Initiative**



## About Trans Pride Initiative

Trans Pride Initiative is a Texas nonprofit corporation working to empower transgender, transsexual, and gender nonconforming persons to rise above social barriers to equal education, employment, housing, and healthcare.

Our goals for accomplishing this mission are:

**General Support:** Provide a supportive network for all trans\* and gender nonconforming persons to better themselves.

**Education:** Improve educational opportunities by identifying and promoting safe educational environments and the means to finance education in these environments.

**Employment:** Improve employment opportunities by working with local employers to establish training and hiring programs, and by providing training and empowerment opportunities to help transgender persons prepare for and find gainful employment.

**Housing:** Reduce homelessness and discrimination in housing by working with organizations providing support and assistance housing, and by helping address problems of discrimination in commercial housing.

**Healthcare:** Improve access to adequate healthcare by identifying and monitoring "safe care" healthcare locations and by working with healthcare providers to address specific health care needs of transgender persons.



A Trans Health Introduction for Healthcare

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# A “What-Does-Trans-Mean?” Quick Reference

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Folks in the trans community use a number of words that non-transgender persons may have difficulty understanding. Definitions can even differ between various sub-groups in the trans community. Below are a few of the more common and confusing words one may hear used by or about trans persons.<sup>1</sup>

**cisgender/cissexual** *adj.* : A person whose gender identity and sex assigned at birth do not differ or do not substantially differ; a non-trans person. In informal speech, the term is often shortened to “cis.”

*Usage:* Usually modifies words like person, people, individual, or folks. “Most cis persons perceive sex and gender as the same thing. Trans folks perceive a distinction because they feel discord or dissonance between the two.”

**cross-dresser** *n.* : A person who wears clothing not typically associated with their sex assigned at birth.

*Usage:* Some in the trans community feel “cross-dresser” is a derogatory term. It should generally be avoided by persons who are not members of the trans community. Many persons who identify as trans, transgender, or transsexual will not want the term “cross-dresser” applied to them even if they do not consider the term derogatory. The broad definitions of “trans” and “transgender” do include persons who cross dress.

**FTM/F2M and MTF/M2F** *adj.* : female-to-male and male-to-female trans persons.

*Usage:* Describes a trans person in terms of “transition” from one gender to another. “Alice is an MTF child, whereas Joseph is FTM.”

**gender binary** *n.* : The idea that one is either a man or a woman, male or female, exclusively. Some trans persons strongly identify with a binary concept of gender, while others feel male/masculine and female/feminine are end points along a continuum.

**gender dysphoria** *n.* : Proposed diagnosis for the draft Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (American Psychiatric Association [APA], 2012), for trans and gender-nonconforming persons.<sup>2</sup> The term is controversial in the trans community because some feel any identification of trans identity under a mental diagnosis is problematic (further discussed in the “Standards of Care

and Informed Consent” section).

**gender expression** *n.* : Actions and behaviors through which one conveys association with social roles and practices generally perceived as masculine or feminine. Gender expression may be predominantly masculine or feminine, neither, or a combination.

**gender identity** *n.* : One's internal sense of being a woman, man, neither, both, or a combination. All persons have a gender identity.

**gender identity disorder (GID)** *n.* : The diagnosis defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (APA, 2000) for trans and gender-nonconforming persons. The term is controversial in the trans community. Some trans persons feel the term is offensive and that it stigmatizes non-cisgender persons. See also “gender dysphoria.”

**gender nonconforming** *adj.* : A person whose gender expression falls outside traditional social norms for male or female expression.

**genderqueer** *adj.* : A person who does not identify as man or woman, mixes masculine and feminine characteristics, has a gender expression that fluctuates or is “fluid,” or otherwise does not identify as part of the gender binary.

**intersex** *adj.* : A person born with reproductive anatomy that does not confirm to typical expectations for males or females, generally including characteristics of both.

**man or woman with a transgender past** : Used by some persons who view being transgender as a condition or birth defect that is remedied by transitioning. In this view, after transition, one is no longer transgender.

**MAAB/FAAB** *adj.* : Male-assigned-at birth and female-assigned-at-birth, respectively. These terms are used by some to emphasize that they had no role in being assigned “male” or “female”; it was something done without their consent. Can also be AFAB/AMAB for “assigned female/male at birth.”

*Usage:* Usually followed by other terms conveying current identification. “Jason is an FAAB boi.” “I am an MAAB woman.”

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1. All definitions are derived from author experience and from the following sources: Bostian, Hill, and Mays, 2012; Fenway Health, 2010; Gay and Lesbian Alliance Against Defamation, 2010; Intersex Society of North America 2008; and National Center for Transgender Equality, 2009.

2. The draft version of the section on gender dysphoria can be viewed at <http://www.dsm5.org/proposedrevision/Pages/GenderDysphoria.aspx>.

**sexual orientation** *n.* : A person’s physical, romantic, or emotional attraction to others. All persons have a sexual orientation, and it can encompass a single sex or gender, both (or a range of) sexes and genders, neither (asexual), and for some it may shift over time. Trans persons may be straight, lesbian, gay, bisexual, pansexual, fluid, or may use other terms to describe their orientation.

*Usage:* It is best to allow trans persons to affirm their own orientation rather than ascribe an orientation to them based on cisgender understandings of orientation.

**SRS/GRS/GCS** *n.* : Sex reassignment surgery (SRS) refers to surgeries altering genitalia and possibly other body attributes. Some prefer “GRS” as a more affirming term, variously defined as “genital reassignment surgery,” “genital reconstruction surgery,” or “gender reassignment surgery.” “GCS” is also used as an affirming term, meaning “gender confirmation surgery.” The terms “top surgery” and “bottom surgery” are also used as general terms for breast reduction or augmentation, and genitalia or reproductive organ surgeries, respectively.

*Usage:* All of these are preferred over the derogatory “sex change surgery.”

**stealth** *adj.* : Describes a trans person who does not reveal their sex assigned at birth.

**tranny** *n.* : Slang for “transvestite.” Nearly always derogatory, and may be associated with sex work.

*Usage:* Some trans persons view use of the term as empowering. Persons outside the trans community should avoid using as responses can be extremely emotional.

**trans** or **trans\*** *adj.* : Terms sometimes used to encompass transgender and transsexual. The asterisk is used to be inclusive of all “trans-“ identifiers. These terms are generally

used to avoid connotations sometimes associated with the words “transsexual” and “transgender.”

*Usage:* “Leslie identifies as trans.” “John is a strong ally of the trans\* community.”

**transgender** *adj.* : 1) A person whose internal gender identity or outward gender expression differs from their sex assigned at birth. 2) A broad term that includes transsexual, cross-dressing, androgynous, genderqueer, and gender non-conforming persons.

*Usage:* “Transgender” is not a noun or verb, it is an adjective. It is ungrammatical to add an “-s” or an “-ed” suffix to “transgender.”

*Improper:* “Transgenders” or “a transgender” as in “The transgenders meet here on Thursday evenings.”

*Preferred:* “Transgender persons” or “a transgender individual.”

**transsexual** *adj.* : A person whose gender identity is different from their sex assigned at birth, and who alters or wishes to alter their bodies through hormones or surgery so that their body matches their gender identity.

*Usage:* Some persons in the community prefer the narrower term “transsexual” to “transgender” as a more accurate and affirming term. Others prefer “transgender” or “trans” as more inclusive terms.

**transman** *n.* : FAAB person who identifies as a man.

**transvestite** *n.* : An older term meaning “cross-dresser.” Almost always considered derogatory, but not as inflammatory as “tranny.”

**transwoman** *n.* : MAAB person who identifies as a woman.

## Who Are Trans Persons?

### The Big-Picture Numbers

Trans persons may be a small minority of the general population, but our presence is pervasive. We know that trans persons are represented in every nationality, ethnic group, profession, income level, and every educational attainment. Trans persons can be conservative, liberal, gay, straight, queer.

Developing demographic generalizations about trans

persons is difficult because data collection—from census to health risk and outcome studies—have typically ignored gender identity, recording only sex assigned at birth. Even studies focusing on the LGBT community have tended to include transwomen among gay men, and transmen have been grouped with lesbian women. These groupings are misleading and inaccurate (Health Resources and Services Administration [HRSA], 2011, pp. 1, 5).<sup>3</sup>

Despite research limitations, some generalizations can be

3. For more information about transgender individuals throughout history, see for example Feinberg, 1997. For current demographics, see Grant et al., 2011.



made. Referencing the few broad reports that have included data about gender identity, a Williams Institute study (Gates, 2011) presents estimates that up to 2% of the population “have strong feelings of being transgender,” and between 0.1% and 0.5% take some steps to transition (Gates, 2011, p. 5). Based on the 2010 census of about 309 million persons in the US (US Census Bureau, 2012), this would mean approximately 6 million persons identify strongly as transgender, and between 309,000 and 1.5 million take some steps to transition.

“Transpeople come from every walk of life, every sexual orientation, and every region of the country. Some may identify not as transgender but simply as male or female, or they may choose not to identify with any gender labels at all. There are many cultures and subcultures represented within transgender communities, each with rich and varied expressions of gender identity.”  
 – HRSA, 2011, p. 1

## About the Biology

The popular understanding, even among some health-care professionals, is that sex and often gender are as simple as a quick nod to DNA: XX = girl and XY = boy. The determinant is the SRY (sex-determining region of the Y chromosome) gene, a so-called master switch that activates to trigger development as a male.<sup>4</sup>

The actual picture is much more complicated. The SRY gene does initiate testis development, but this is just one step in a series affecting male and female reproductive development. The SRY gene is regulated by upstream genes, and it in turn effects testis development through interaction with genes downstream along the pathway (Sarafoglou and Ostrer, 2012). The complex alternatives of development along this pathway mean sex divisions are better seen as a gradation between male and female, not polar opposites determined by binary operation of a single switch. Biologist and science historian Anne Fausto-Sterling notes in her introduction to *Sexing the Body* that

A body’s sex is simply too complex. There is no either/or. Rather, there are shades of difference. . . . One of the major claims I make in this book is that labeling someone a man or a woman is a *social decision* [emphasis added]. We may use scientific knowledge to help us make the decision, but only our beliefs about gender—not science—can define our sex. Furthermore, our beliefs about gender affect what kinds of knowledge scientists produce about sex in the first place [Fausto-Sterling, 2000, p. 3].

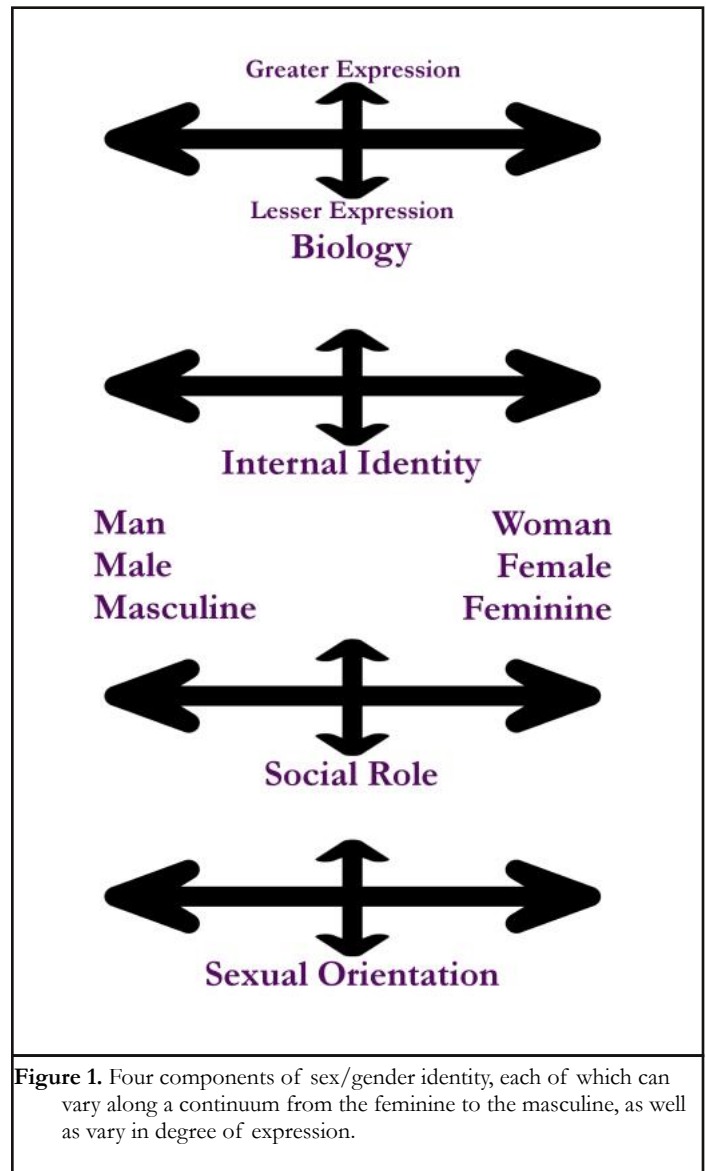
4. See Anne Fausto-Sterling’s (2000) *Sexing the Body* for an in-depth discussion of how this understanding came to be commonly accepted in the sciences.

5. This division is in part based on that defined by Arlene Istar Lev in her article *Transgender Emergence* (Lev, 2006). Some may further divide these groups so that, for example, sexual orientations includes separate components for sexual partners and relationship partners.

## Social and Personal Identity

There are four basic components to one’s experience of sex and gender: biology, internal identity, social role, and sexual orientation.<sup>5</sup> The varying mix of these components contributes to what makes us each unique persons and personalities. As shown in Figure 1, each of these components can vary in two dimensions: gradation along the woman/female/feminine to man/male/masculine continuum, and gradation from lesser to greater expression.

To illustrate using sexual orientation, any person can prefer or be attracted to other persons sexually, emotionally, and relationship-wise who fall at one extreme of men/male/masculine or women/female/feminine, or



they can be attracted to persons who fall between the extremes. The strength of the attraction can be greater or lesser, with asexual persons experiencing little attraction to either. Adding complexity, the attraction is unlikely to be a single point along the continuum, but a curve that varies in expression from one end to the other. Idealized heterosexual or homosexual attraction would show greatest expression at one end and only one end of the continuum. Actual experience for many is unlikely to fit the idealized popular concept. Attraction may extend over a wide range of the continuum, and it could also exhibit diachronic and situational variation.

Likewise, a person's internal identity may be predominantly masculine or feminine, may vary over time, and may be felt more or less strongly. One individual's sense of gender identity may even vary in different situations or states of mind (taking a bubble bath versus mowing the lawn). With the great potential for variability shown by this model, one can see that a person's experience of sex and gender can be viewed as a very complex matrix of identity, expression, and relations with others.

## Social and Cultural Measures

As noted above, few studies have focused on specifically analyzing the makeup of the trans community, but there is one very large exception. The National Center for Transgender Equality (NCTE), working with the National Gay and Lesbian Task Force, made huge strides in addressing the dearth of trans demographics with the 2011 release of *Injustice at Every Turn* (Grant et al., 2011). This study helps define who trans persons are in terms of their own experience living in a social system that most often stigmatizes or erases trans identities. Below are a few of the more important findings that specifically define trans experiences.

### Education

- ❖ K-12 experience of harassment (78%), physical assault (35%), sexual violence (12%)
- ❖ Dropout rate, 15%

### Employment

- ❖ 15% earn below 10k/year (cf. 4% of the general population)

- ❖ Double the national unemployment rate; for persons of color, almost four times the national rate
- ❖ Workplace experience of harassment (90%), experience of adverse job outcome (47%)
- ❖ 26% report having lost a job due to gender identity or expression (up to 36% for persons of color)
- ❖ 16% report being compelled to work in the underground economy to survive
- ❖ Suicide attempt rate for those who have lost a job due to bias is 55%
- ❖ Suicide attempt rate for those who work in the street economy is 60%

### Housing

- ❖ 19% refused a home or apartment, 11% evicted due to gender identity or expression
- ❖ Of those seeking services at homeless shelters, 55% were harassed, 29% turned away, 22% sexually assaulted by residents or staff
- ❖ 32% own a home (cf. 67% of the general population)

### Healthcare

- ❖ 19% have been refused medical care
- ❖ 50% report teaching medical providers about trans\* health concerns and risks
- ❖ 28% postpone care due to fear of discrimination, 48% due to inability to afford the cost
- ❖ Four times the national rate for HIV infection
- ❖ Overall, 41% report attempting suicide (cf. 1.6% of the general population)

### Resilience

- ❖ In spite of barriers to healthcare, 76% report they have received hormone prescriptions
- ❖ Despite high rates of harassment and abuse in schools, resulting in a high dropout rate, trans persons return to school after age 24 at rates far surpassing those of the general population
- ❖ 78% of those who have transitioned at work report being more comfortable at work, in spite of experiences of workplace bias and harassment

# Healthcare Concerns and Risk Factors

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Trans-specific healthcare needs may vary greatly from person to person, and can vary for the same person over time. For many trans persons, being trans is as much a process as it is an identity. As Arlene Istar Lev writes, it can be an emergence or stages of an emerging identity (Lev, 2006). Some trans persons will seek no body modifications or hormone medications, while some will seek surgeries (such as orchiectomy or hysterectomy) because they satisfy or sup-

plement hormone modification needs. Others may alter facial features through surgery or cosmetic procedures to provide a more masculine or feminine appearance. Breast enhancement or reduction (sometimes referred to as "top surgery") may be desired to bring their body in line with their identity or as a means of reducing stigma and harassment. And some will place a priority on genital surgeries such as metoidioplasty, phalloplasty, or vaginoplasty. There is



no one way to be trans, and there is no one way to seek medical intervention to better align one's body with one's sense of gender identity (HRSA, 2011, p. 5).

## Standards of Care and Informed Consent

Trans persons are the *only class of persons* required to prove mental competency prior to receiving a desired medical procedure, intervention, or treatment—a requirement even for cosmetic procedures. The requirement is enshrined in the *DSM-4-TR* and (arguably to a lesser extent) the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming Persons* (SoC), Seventh Version (World Professional Association for Transgender Health [WPATH], 2009).

The *DSM-4-TR* applies a very stigmatizing phrase to trans\* persons by defining cross-gender identification as “gender identity disorder.” Significant changes have been proposed to the forthcoming *DSM-5*, and “gender identity disorder” was initially to be replaced by “gender incongruance” and then “gender dysphoria.” However, less stigmatizing is still stigmatizing, and less pathologizing is still pathologizing. These changes do not solve the problem.<sup>6</sup>

The WPATH SoC is essential reading for healthcare professionals working with trans persons, but not all trans persons—nor all healthcare providers—wholly accept the model of care provided in the document. The problems stem partly from the SoC's use of the stigmatizing and pathologizing phrase “gender dysphoria” for all persons who

seek any kind of medical intervention,<sup>7</sup> and partly from misunderstanding the flexibility built into the SoC. Both the SoC and the *DSM-4-TR* underscore social and cultural perceptions of trans identity as a “mental illness,” in turn reinforcing stigma against trans persons.

The WPATH SoC are widely used, and a majority of trans persons rely on these standards to define access to gender identity-related healthcare. However, strict adherence to the WPATH SoC is waning, and increasing numbers of trans persons and healthcare practitioners are turning to informed consent models as a basis for providing care—a more affirming perspective. One writer at *Campus Progress* succinctly conveys trans experience of the combined influence of the *DSM-4-TR* and SoC guidelines, and the negative effect these can have on healthcare.

While much media attention is paid to gender confirmation surgery, it's hormone replacement therapy that often makes the largest difference in the lives of transpeople. . . . But accessing these hormones can be very difficult, even for patients who are assertive and aware of what they want. Doctors often follow outdated standards, requiring a pathological diagnosis, extended counseling, or even a dangerous “real life experience” period in which non-passing individuals must live in their preferred gender role. Rather than jump through these seemingly endless and expensive hoops, trans people sometimes turn to dangerous black-market alternatives [O'Reilly, 2012].

The following is a list of some of the clinics and providers offering services for trans persons under an informed consent model. Links are provided to online informed consent documents or descriptions.<sup>8</sup>

- ❖ Howard Brown Health Center, Chicago, Illinois—a description of their informed consent procedure is available here: [http://www.howardbrown.org/uploadedFiles/Services\\_and\\_Programs/Primary\\_Care\\_Medical\\_Services/THInC%20BROCHURE.pdf](http://www.howardbrown.org/uploadedFiles/Services_and_Programs/Primary_Care_Medical_Services/THInC%20BROCHURE.pdf)
- ❖ Fenway Health, Boston, Massachusetts—see bottom of page for informed consent covering reproductive rights, estrogen therapy, and testosterone therapy: [http://www.fenwayhealth.org/site/PageServer?pagename=FCHC\\_srv\\_services\\_trans](http://www.fenwayhealth.org/site/PageServer?pagename=FCHC_srv_services_trans)
- ❖ Tom Waddell Clinic, San Francisco, California—intake procedure is provided online: <http://www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransgenderHlthCtrInfo.asp>
- ❖ Dimensions Clinic, San Francisco, California—informed consent documents and intake procedures online: <http://www.dimensionsclinic.org/transgroup.html>
- ❖ Mazzoni Center, Philadelphia, Pennsylvania—description of the Transgender Health Program: [http://mazzonicenter.org/sites/default/files/Transgender%20Health%20Program%20description\\_0.pdf](http://mazzonicenter.org/sites/default/files/Transgender%20Health%20Program%20description_0.pdf)
- ❖ Informed Consent for Access to Trans Health—providers in Washington State that work with the informed consent model: <http://www.icath.org/> (see the providers and links page for informed consent letter template and their informed consent process)

6. Howard Brown Health Center has published its detailed response to the APA's continued use of pathologizing definitions in the proposed *DSM-V*. The response provides a good overview of the arguments against pathologization. The letter of comment references “gender incongruence,” but the points are still valid for “gender dysphoria.” The letter is available online at [http://www.howardbrown.org/uploadedFiles/Services\\_and\\_Programs/HBHC%20APA%20COMMENT.pdf](http://www.howardbrown.org/uploadedFiles/Services_and_Programs/HBHC%20APA%20COMMENT.pdf).

7. Some sort of diagnosis is necessary due to the structure of the healthcare system, although a diagnosis of “hormone imbalance” could cover much. To cover all potential gender identity related medical treatments, one could state that a hormone imbalance in the fetus caused development that could require hormone therapy and corrective surgery.

8. Additional information about treatment protocols is available at the website of the Center of Excellence for Transgender Health Primary Care Protocol web page: <http://transhealth.ucsf.edu/trans?page=protocol-00-00>.

# Hormones

Popular culture tends to think surgeries altering genitalia are a major, if not *the* focus of trans persons who seek body conformity. And sometimes, that is correct. But as O'Reilly notes above, in the trans community, the first—and often most important, and sometimes the only focus—is hormones. Surgeries such as hysterectomies and orchiectomies are often sought because they help adjust the body's hormone levels.

Standard practice related to hormone regimens for trans persons is published in the guide from the Endocrine Society: *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline* (Hembree et al., 2009). The guidelines include limited discussion of the WPATH SoC requirements and mental health qualifications, so it is suggested that providers consult additional information such as that provided above in the Standards of Care and Informed Consent section of this document rather than rely on the Endocrine Society's cursory summary of the WPATH SoC.

The Endocrine Society guidelines provide an overview of recommended hormone regimens, as well as discussion of the risk factors and masculinizing/feminizing effects associated with hormone treatment. The guidelines also offer some discussion of clinical experience with regimens and reference to published reports, and there is a chapter specifically for adverse outcome prevention and long-term care (hormone maintenance).

The guidelines also discuss puberty interventions and hormones for children. Early intervention in youth is becoming more common, and adolescents can now be offered medications that delay the onset of puberty. Such treatment is reversible if the child wishes to discontinue treatment, but so far that has been rare (HRSA, 2011, p. 6; Spack et al., 2012).

## Specific Risk Factors

There are two types of risk factors that healthcare providers should be aware of: risks related to medical intervention such as hormone regimens and surgeries; and risks related to being trans in a society that stigmatizes trans identities. Both should be considered to provide quality comprehensive care.

### Medical Risks

Transmen taking androgens should continue to have an annual Pap test if cervical tissue is present, and should have annual mammograms if a mastectomy has not been performed. After mastectomy, there will still be some breast tissue present, so mammograms or chest X-rays may still be needed, especially if there is a family history of breast cancer. Medical conditions possibly exacerbated by testosterone include breast and uterine cancer, erythrocytosis, and liver

dysfunction. Lipid profiles will likely show lowered HDL cholesterol and higher triglyceride levels; insulin sensitivity may also be altered in some individuals. Although there have been reports of increased cardiovascular risk, other studies have shown no increase in cardiovascular events. Bone mineral density may need monitoring, particularly in individuals who stop taking hormones after gonadectomy (Hembree et al., 2009, pp. 18, 23-24).

Transwomen taking spironolactone may need monitoring for excessive potassium, and all transwomen should be routinely screened for breast (if taking estrogen), colon, and prostate cancers. Lipid profiles often show increased HDL and decreased LDL values, possibly decreasing cardiovascular risks. With age and weight gain, glucose and lipid metabolism may need closer attention. As with transmen, bone mineral density may need monitoring, particularly in individuals who stop taking hormones after orchiectomy. Medical conditions possibly exacerbated by estrogen include thromboembolic disease, macroprolactinoma, liver dysfunction, breast cancer, coronary artery disease, cerebrovascular disease, and migraine headaches (Hembree et al., 2009, pp. 18, 23-24).

### Risks Related to Social/Cultural Stigma

[Trans persons] as a group experience health disparities including difficulty accessing care and a lack of medical providers able—or willing—to address their needs. Compounding these challenges, some transgender subgroups, such as recent immigrants, youth, the homeless, and those with unstable or no employment, often find themselves in transient circumstances, making engagement, enrollment, and retention in health care and social services all the more difficult [HRSA, 2011, p. 1].

A trans person's experience of stigma can begin before reaching school age if family members and others do not accept nontraditional gender expression. Persons expressing gender nonconformity in grades K-12 have reported experiencing harassment (78%), physical assault (35%), and sexual violence (12%). The abuse is not just from other students—31% reported harassment, 5% reported physical assault, and 3% sexual assault from teachers and staff. One large survey reported a dropout rate of approximately 15%, but other surveys have indicated the number may be as much as 50% for some subgroups (Grant et al., 2011, pp. 33, 35-38). The potential health impacts for these children include depression, anxiety, self-abuse, suicide, increased risk of unhealthy behavior (smoking, alcohol and drug abuse), and other health risks that accompany stress.

Life as an adult may continue the experience in school, further exacerbating the same health risk factors. If the person dropped out, a lack of education means lower prospects for employment. Trans persons overall appear to experience unemployment at about double the general population, while trans persons of color see up to four times the national rate.

This is compounded by discrimination at work, in the hiring process, and in denial of promotions. Harassment at work is close to universal, with 90% reporting harassment, mistreatment, or feeling forced to take protective actions in some way. For those that have work, they may be paid less or working in lower-paying jobs; 15% earn less than \$10,000 a year, compared to 4% of the general population. Among those who suffered mistreatment in school, 21% earn less than \$10,000 a year (Grant et al., 2011, pp. 2, 3, 51, 53-63; HRSA, 2011, p. 3).

Housing can also be a problem that compounds health risks. About 19% of trans and gender nonconforming persons have been denied a home or apartment, and 11% evicted due to gender identity or expression. Nearly one in five trans persons have been homeless at least once, which also increases their chances of having been incarcerated and engaging in sex work for survival. Almost a third have been turned away from shelters; when they are allowed in, they have greater than 50% chance of being harassed, physically assaulted, or sexually abused. It is not uncommon for trans persons to trade sex for a place to sleep to avoid going to shelters (Grant et al., 2011, pp. 106, 112-118; HRSA, 2011, p. 3).

Health insurance—or rather its sometimes selective accessibility—can impede access to quality healthcare. Hormone prescriptions are often excluded from coverage for trans persons, and body conformity surgeries are nearly always excluded. But it goes further, with some insurance companies denying necessary procedures (such as oophorectomy or hysterectomy for a transman who suffers from ovarian cancer or endometriosis) because it could also be considered as “sexual reassignment surgery.” It is important that providers use proper diagnostic and procedural codes to help limit this problem. In some cases, non-specific codes can help avoid insurance problems (HRSA, 2011, p. 4).

Directly affecting health is the depression often coincident with all of the above. Suicidal ideation among transwomen is alarmingly high—a Centers for Disease Control and

Prevention meta-analysis found suicidal ideation among 54% of transwomen, and lifetime attempts were reported on average at 31%. Many transmen also suffer from depression, suicidal thoughts, low self-esteem, and increased risk-taking (HRSA, 2011, p. 4).

Unemployed and underemployed trans persons are much more likely to participate in underground economies. The NCTE study *Injustice at Every Turn* found that participation in all types of underground work was 19% for male-to-female respondents and 15% female-to-male. The numbers specifically for sex work were 15% for male-to-female and 7% for female-to-male. Trans persons may be drawn to sex work as a means of survival as well as complex reasons related to identity reinforcement. Social relationships and support that may have been lost during transition may be realized again with alternate social structures found in underground cultures. For transwomen, sex work may reinforce a feminine identity and a feeling of desirability and beauty. Probably due to multiple facets of discrimination and stigma, persons of color participate in underground economies at a rate as high as 53% (Grant et al., 2011, pp. 64-65; HRSA, 2011, p. 3; Lombardi, 2011, pp. 221-222).

Because physical characteristics are important for getting by in street economies, and because “passing” can be essential to survival (in terms of helping avoid discrimination as well as hate crimes), transwomen may turn to risky behavior such as injecting silicone and hormones purchased illegally. Both carry high risks health complications.<sup>9</sup>

HIV and STD risk and infection rates among those participating in street economies are very high. Many trans persons believe they have a low risk of being infected with HIV and STDs and so are less likely to use precautions. They are also less likely to test. There are indications that a significant proportion of HIV-positive transwomen do not know their status. Among transmen, the overall risk is lower, but non-trans men who have sex with men (MSM) tend to have high rates of HIV infection, which places transmen who have MSM partners at greater risk (HRSA, 2011, pp. 2-3).

## Providing an Affirming Environment

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### A Trans Perspective of Healthcare

Healthcare access in general is a source of anxiety for nearly all trans persons. Part of the source of anxiety is almost certainly stigma, which may be internalized or may come from external experiences such as described above, or

both. Too, trans persons well know that revealing one’s trans status entails an element of personal danger.

Wendy Hussey (2006) has specifically studied trans perspectives of healthcare through a photography project. One participant, a transman, commented starkly about his unease:

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9. See Trans Pride Initiative’s “Factsheet: What You Need to Know About Injecting Silicone” for more information about the dangers of illegal silicone injection. The factsheet is available online at <http://tpride.org/resources/health.php>.

This is a hallway in a hospital, and it is leading straight down into a black hole. And here on the side is a gurney, and it's all ready there with a nice white sheet and it's just lonely. It's scary to me. It is not comforting or reassuring at all. . . . It's the system sitting out there waiting, and heaven forbid you end up on that gurney down into that black hole [Hussey, 2006, p. 135].

Another participant noted the special relationship trans persons have with emergency services.

I want to talk about how important and how frightening the emergency room is. It's important for everyone. It's absolutely terrifying for transsexuals [Hussey, 2006, p. 142].

Aspects of healthcare settings that others take for granted can undermine a trans person's identity and self-confidence, leaving one feeling exposed and vulnerable:

. . . this [gown] is what I have to wear when I am going to have testing done, and it makes me very uncomfortable. I am very vulnerable. . . . I was in this gown with nothing else on which is the first thing that puts a transsexual at a great disadvantage, and feeling very uneasy. . . . So again, I can be who I am as long as I don't have to take my clothes off, and I don't have to be examined [Hussey, 2006, p. 143].

## Identifying Structural Stigma

The “Who Are Transgender Persons” section discusses some of the stigma trans persons face to live their lives honestly. Most of the data covered obvious types of discrimination. But bias can be subtle, unintended, and perhaps not even recognized. This type of bias is often the result of structural stigma—discrimination that, intentionally or not, is built into procedures and processes.

Anti-trans structural stigma is very pervasive in the healthcare profession. It can be seen on intake forms that do not ask for preferred names and only allow a “sex” selection of “male” or “female.” It can be seen in electronic medical records that may reveal trans status when it should not be revealed for privacy concerns. It is seen in staff who look at legal sex assignments rather than seeing gender presentation and address transmen as “ma'am” or transwomen as “sir”—sometimes publicly “outing” them in crowded waiting rooms. It is seen in gender-based services such as insurance coverage denial because of a person's sex assigned at birth, and in difficulty accessing services such as breast exams for transwomen, transmen, and other gender minorities.

Before moving on to specific examples of how to provide greater affirmation for trans persons, it needs to be noted that there are times when trans persons—as can all persons suffering from stress—may seem to place obstacles in the way of well-meaning caregivers. Trans persons may deal with stigma and stress in a variety of ways, including quick defensiveness (having a chip on their shoulder) and near complete defenselessness, neither of which is conducive to effective communication. These are learned reactions that help, or feel like they help, one to survive. With patience, affirming interactions can help remove these communication barriers and create better provider-patient relationships (HRSA, 2011, pp. 2, 5).

“I had just transitioned about four years ago to start living as a man, when I was diagnosed with breast cancer I found that my breast surgeon was unable to call me even to give me my biopsy results. He did tell me very frankly and overtly that he had problems with my transgender status, and upon meeting me and learning of my transgender status he decided that his first impulse was to refer me to psychiatry.”

– Health and Hospitals Corporation (HHC), 2011

## The Affirming Provider

The following are some simple ways to provide an affirming setting for trans clients, and help address the fear of the healthcare system so many trans folks know too well.<sup>10</sup>

**Be welcoming.** This can be as simple as having a rainbow or trans pride sticker (such as the “Safe Care” sticker that Trans Pride Initiative can provide) at the entrance or in the waiting area. Posting nondiscrimination policies in waiting areas is also a way to indicate a welcoming setting.

**Affirming intake forms.** Ask for preferred names and pronouns on intake forms. Allow partner options outside the heterosexual binary gender choices. Include terms eliciting sex assigned at birth and gender identity rather than overly simplistic “sex = male/female.”

**Affirming recognition.** Use preferred names, pronouns, and other forms of address as indicated on intake forms. When unsure about preference in pronouns or names, ask in private conversation, and where uncertain in public use gender-neutral identifiers such as a birth date or last name only, for example, when calling in the waiting room. Importantly, direct to gender-appropriate restrooms if unisex restrooms are not available, and allow discrete disrobing and use of gowns in examination rooms.

10. Many of the following suggestions come from or were influenced by HRSA's discussion in CARE Action (HRSA, 2011).



**Ask and allow questions.** Ask questions based on sex assigned at birth and gender identity, as appropriate. For example, asking a transwoman if she has had a prostate exam and a breast exam may both be appropriate, and asking a transman if he has had a Pap test or has questions about male pattern baldness may both be appropriate. And encourage questions from patients concerning their care. At the same time, respect the patient's privacy by not asking questions simply out curiosity that have no medical purpose, and do not make an example of a trans person to students or interns unless the patient has made it clear that they understand the intent and are comfortable with being placed in that role.

**Be an appropriate authority.** Healthcare providers should not put their patients in the position of teaching their providers. Many trans persons have studied extensively about hormones and surgeries, but some of their knowledge may be suspect, some may be incomplete, and nearly all will lack the contextual understanding that comes from training and experience. However, trans patients will be the experts on

their own experiences and may have knowledge about specialized topics that not all providers have studied. JoAnne Keatley, director of the Center of Excellence for Transgender Health, says "I really advocate that physicians be willing to learn from their patients but not make the patients teach them. . . . Putting trans patients in the role of the educator is unfair. They don't have the medical background and, in fact, may have low health literacy" (HRSA, 2011, p. 6).

**"Know Who I Am."** In 2011, the New York City Health and Hospitals Corporation produced a training video advocating greater communication about sexual orientation and gender identity between healthcare providers and patients. The training video is titled "To Treat Me, You Have to Know Who I Am."<sup>11</sup> The title, and the video, convey what is perhaps one of the most important ways to be an affirming provider: To help give trans patients maximum quality of life, one should allow trans patients the dignity of getting to know who they are.

## Collecting Data

### Why Ask About Orientation and Gender Identity

Asking about orientation and identity is beneficial for three main reasons: it allows higher quality care, it expands understanding by providing data, and it helps convey social affirmation.

#### Quality Care

In the training video "To Treat Me, You Have to Know Who I Am," Dr. Lisa Reeves notes that "[i]t's important to have an open and honest relationship with your patients, and so if you don't know how they identify, that patient is not going to tell you everything that they need to tell you for their proper medical care" (HHC, 2011). The Fenway Clinic's brochure discussing communication about orientation and identity echoes the same sentiment: "A provider's knowledge of a patient's sexual orientation and gender identity is essential to providing appropriate prevention screening and care. Patients who disclose their sexual orientation [and gender] identity to health care providers may feel safer discussing their health and risk behaviors" (Bradford, Cahill, Grasso, and Makadon, 2011, p. 3). And Joan Bennett, Certified Physician Assistant, adds the converse that not only does knowing improve care, not knowing can result in

inappropriate care: "Knowing a patient's gender identity and sexual orientation helps a practitioner to care appropriately for a patient. We see a lot of patients come in who may not be comfortable disclosing that information, and routine testing or screening may be missed for that patient" (HHC, 2011). Basic care arguably could be provided without knowledge of a patient's sexual orientation and gender identity, but quality care requires a provider-patient

"Throughout my pregnancy, I was very much genderqueer, and I did tell them about my pronouns, which ones I prefer, that I preferred gender-neutral or masculine pronouns. But the people who were dealing with me throughout my pregnancy, primarily my midwife and the nurses associated with them, were not responsive to my identity and didn't actually respect it. Certainly I feel that my healthcare has been impacted. I feel less genuinely listened to, and I feel like there's a huge discrepancy between the care I get versus other people who've gone to the same provider and reported very different experience."

– HHC, 2011

11. The press release and linked video may be accessed here: <http://www.nyc.gov/html/hhc/html/pressroom/press-release-20110525-lgbt-training.shtml>. The video may also be viewed on YouTube at <http://www.youtube.com/watch?v=NUhvJgxxgAac>.



relationship where these two important aspects of the patient's life can be honestly discussed.

### Data Collection

A number of reports have cited the dearth of health-related data for LGBT populations in general and the trans community in particular.<sup>12</sup> In its analysis of LGBT populations in the United States, the Williams Institute noted that data on the number of transgender persons are “very rare” (Gates, 2011, p. 5). At a minimum, the trans community needs data to be collected that reflects trans identity—namely some means of indicating a disparity between sex assigned at birth and gender identity. Checkboxes indicating “male” and “female” do not fully reflect trans experience, and whichever is marked, it is not going to be clear whether the mark reflects current identity or sex assigned at birth (or other possibilities for intersex persons). Only when data about trans identity is broadly collected will we have truly meaningful information about risk factors and health outcomes for trans populations.

Ideally, a standard will be developed that captures non-cisgender identities without being overly complex. Advocates at the Fenway Institute have stated that

Gathering sexual orientation and gender identity data in a standardized way will allow us to better understand LGBT health disparities, as well as to prevent, screen, and early detect conditions that disproportionately affect LGBT people. Gathering such data in clinical settings will allow providers to better understand and treat their patients, and to compare their patients' health outcomes with national samples of LGB or LGBT people from national health surveys” [Bradford et al., 2011, p. 2].

The Institute of Medicine has also advocated for standards,<sup>13</sup> and Section 4302 of the new Affordable Care Act (ACA) calls for the development of standard reporting criteria. However, the current ACA standards (as of May 2012) provide absolutely nothing in the way of capturing data that can reflect gender identity. Worse, the way the minimum standards are currently defined may even discourage such data collection. The definitions have been published as “minimum data standards” that allow additions, but in the category of sex, the only choices for rolling up

data are male and female. The Department of Health and Human Services, responsible for developing implementing regulations for this aspect of the ACA, has posted a timeline for addressing the need for a government-wide standard for collecting LGBT-related data, but there is no clear indication that gender identity will be part of the standards. Instead, HHS says that their Data Council will present “a strategy to include gender identity data collection” in the Spring of 2012, but specifically lists only the inclusion of sexual orientation at some point in 2013 in its timeline (Bradford et al., 2011; Office of Minority Health, 2011).<sup>14</sup>

### Social Affirmation and Stigma Reduction

As intake forms and conversations between providers and patients about gender identity (as well as orientation) become routine, more trans folks will feel included in the broad social structure, with a result in part that the stigma trans people feel at exposing that aspect of their identity to healthcare professionals will lessen.

“Mainstreaming” the fact that everyone has a gender identity, that the identity can vary greatly from individual to individual, and that gender identities correlate with health risks and benefits can provide broad improvements to the quality of life experienced by trans\* persons.

## How to Ask About Orientation and Gender Identity

The following provides some pointers and tips about interacting with trans persons in healthcare settings. These same practices may also be helpful in communications with masculine or androgynous cisgender females and feminine or androgynous cisgender males.

“I am going to ask you some questions about your sexual health and sexuality that I ask all my patients. The answers to these questions are important for me to know how to help keep you healthy. Like the rest of this visit, this information is strictly confidential” (Bradford et al., 2011, p. 4).

– HHC, 2011

### Initial Contact

Initial contacts with patients and clients are most likely phone conversations requesting an appointment. At the

12. Some of the more important studies, which in turn reference other studies regarding data needs, are: Bradford et al., 2011; Institute of Medicine (IOC), 2011; and somewhat older yet more stark in its description is Gay and Lesbian Medical Association and LGBT health experts, 2001, pp. 15-16.
13. See IOC, 2011. Problems caused by a lack of standards are discussed on pages 90-92 and 130; a pilot study investigating effective ways to collect data is briefly discussed on page 119; Recommendation 2 and its call for standards is on pages 299-302; and the Recommendation 4 call for standards is discussed on pages 303-304.
14. Further information about the implementation of data collection standards for the LGBT community under Section 4302 may be found at the following pages: “Final Data Collection Standards for Race, Ethnicity, Primary Language, Sex, and Disability Status Required by Section 4302 of the Affordable Care Act,” available at <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>. The final text of Section 4302, as published in the Congressional Record on November 19, 2009, is available at <http://www.gpo.gov/fdsys/pkg/CREC-2009-11-19/pdf/CREC-2009-11-19-pt1-PgS11607-3.pdf#page=127>. The page “Improving Data Collection for the LGBT Community” is available at <http://minorityhealth.hhs.gov/templates/content.aspx?lvl=2&lvlid=209&id=9004>.

initial contact, a trans person may identify themselves as trans (transgender, transman, transwoman), male, female, other, or may not specify without being asked; the latter is probably most likely. If the staff member taking the call infers the person's legal sex or sex assigned at birth, they should understand that the assumption may be wrong.<sup>15</sup> In some cases, it may be best to not make assumptions over the phone. To be truly affirming provider, it is best to ask initially and document preferred name and gender identity to hopefully put the patient more at ease when they arrive for their first appointment.

If requesting specific information, the questions asked should be specific to a trans perspective. Instead of asking for "name," ask for "legal name" if the name needs to match identification documents such as a driver's license. If it needs to match insurance documents, preface with something like "Please provide the following as on file with your insurance company," and ask for name and sex as needed. To anticipate future contact with the patient, consider asking if the patient has a preferred name or a way they would like to be addressed. In some cases, it may be necessary to know a person's sex assigned at birth, and if so, one should specifically ask for that.<sup>16</sup> If warranted, gender identity could be solicited at this point by asking if the patient "identifies" as male, female, or other. Consider carefully, though, whether sex assigned at birth or gender identity is actually necessary at this point, or whether it could wait for the patient to specify on an intake form.

### Waiting Room and Intake Forms

The waiting room can be a place of anxiety for trans\* persons. The reception desk is busy and semi-public, so a private conversation about preferred name and gender identity is usually not possible there. "Outing" a person in a public space (calling a transman or other male-identifying person "ma'am" or a transwoman or female-identifying person "sir") is uncomfortable, embarrassing, insulting, disrespectful, and *can put a trans person at greater risk of experiencing violence*. The risk of outing a person in public should not be taken lightly. Outing someone whose

preferred name and gender presentation differ from their legal documentation may also be considered a violation of patient privacy.

Ideally, intake forms will include data fields soliciting information covering all provider needs and requirements. Fields should include legal name and preferred name, and some means of distinguishing legal gender from gender identity, if different.<sup>17</sup> When providing patients with intake forms that do not solicit such information, it is good to let patients know that they may make corrections or additions to forms if needed. One way to do so may be to say "You are welcome to add a preferred name or other information you feel we need to know if not asked on the forms."

Few studies looking at effective means of gathering health information from trans persons have been undertaken, but Fenway Clinic has done some work on asking about sexual orientation that may be relevant. Their recent data collection effectiveness project found that more people responded when asked about orientation in this way: "Do you think of yourself as:" followed by choices of 1) lesbian, gay, or homosexual; 2) straight or heterosexual; 3) bisexual; 4) something else; 5) don't know (Bradford et al., 2011, p. 2). The study also found that respondents are about 1.5 times more likely to indicate same-sex preference on a survey conducted privately by audio software than by a live person, and it is thought that computerized intake forms might also elicit more openness. One reason may be due to fears about confidentiality and privacy of information handed in at a semi-public space such as a reception desk. Conversely, computerization of health records, and discomfort about security of those records, may have a damping effect on the effectiveness of collecting data through the use of audio or other digital software (Bradford et al., 2011 pp. 5-7). It is not clear whether these same practices would work with trans clients, but somewhat similar results can likely be assumed.

For the near future, most intake documentation will likely be gathered by having the client fill out a form. An example of a trans-friendly intake form can be seen at the website for Whitman-Walker Health.<sup>18</sup>

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15. "Documentation" is a significant issue for the trans community. Not all trans persons will want to legally change their name or gender marker (the latter traditionally changed by court order to alter or amend the birth certificate, although some new federal regulations are making this less necessary). Without a gender marker change, some trans folks are not willing to legally change their name because changing one without the other can cause problems. If they do want to change either or both, they have to be able to afford the costs. Hiring a lawyer to try to get a court order amending the gender on a birth certificate can run into the thousands of dollars. A name change costs less, but can run to several hundred dollars even without using a lawyer (costs are set by local authorities). If one can afford the cost and wants the gender marker change, they then have to navigate the array of varying legal requirements, which differ at state and federal levels.
16. Although some trans persons will take the word "sex" in a healthcare setting to mean "sex assigned at birth," not all do. "Sex" has multiple meanings beyond what most cis persons feel it asks, namely: "Do you have a penis or a vagina." For trans persons, the word "sex" has social identity and personal identity meanings that generally take precedence over cisgender concepts based on an understanding of "sex" as a simple biological binary.
17. For persons who have changed their name and gender legally, details concerning physical body attributes and gender identity in relation to healthcare concerns should be discussed privately with the physician and other medical staff as needed. Although they should be encouraged to provide it, these patients should be allowed to opt out of revealing such information purely for demographic data collection purposes.
18. The website home page is located at <http://www.whitman-walker.org/>, and the intake form may be viewed at <http://www.whitman-walker.org/document.doc?id=85>.

## Doctor/Staff-Patient Relations

Regardless of what the intake forms include, the doctor-patient interview should be used as an opportunity to gather gender identity information. “I think it’s very important to know that what people write on forms does not represent necessarily their reality, and it does not take the place of a provider opening the door to ask questions” (Ed Goldberg, MD, in HHC, 2011).

Providers can start with open-ended questions such as “Tell me a little about yourself,” which may bring up information about identity. Providers can also signal acceptance by using inclusive language such as “do you have a partner” instead of “are you married”, and “male-bodied,” “female-bodied,” “male-identified,” and “female-identified” instead of simply using “male” or “female.” As with any discussion regarding gender identity or sexual orientation, providers should ask if they can include information in their medical record about these topics, and respect patient wishes on the matter. This is a good place to reiterate that all information in the patient’s medical history is private and confidential.

If the general questions do not bring out enough information, the provider can ask about sexual history to address sexual health and risk factors (see the sidebar for an example). Prior to moving to the more direct questions, the provider may want to note that these are questions asked of all patients because they help the provider give the best quality care. One way to approach the subject of gender identity is to ask if the patient has any questions or concerns about their sexuality, sexual orientation, gender identity, sexual desires, or any health recursions related to these topics (Bradford et al., 2011, pp. 3-4).

Not all trans patients will be forthcoming and disclose information with these steps, but these procedures do help bring out information where patients have concerns and where patients just need a sign from their provider that it is ok to talk about these issues. Over time, as more providers ask such questions, more patients will learn to self-disclose as well.

Some providers may feel interviews like this are too time-consuming for the high patient volume required in most healthcare settings, but the strong connection between sexual orientation, gender identity, and health make these topics integral to quality care (Bradford et al., 2011, p. 7).

The Department of Health and Human Services has suggested the following as a sample approach to asking potentially touchy questions:

I will be discussing some sensitive topics with you today. I will be asking you questions about your sexual behavior and will ask you what body parts you use for sexual activity. I am asking you these questions in order to help you best assess your HIV and STD risks [could substitute “healthcare risks” or other as warranted by the situation] so that we can keep you and your partners healthy. I do not want to assume anything, and most of all I want you to feel comfortable speaking with me today. If you prefer I use other language or words to describe a body part or activity, just let me know. Please feel free to ask me questions any time [HRSA, 2011, p. 6].

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