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Health Care for Transgender and Gender Nonconforming Patients

University of Vermont

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Health Professionals
Advancing LGBT Equality

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Ensuring equality in healthcare for
LGBT individuals and
healthcare professionals since 1981

LGBT HEALTH GRADUATE CERTIFICATE PROGRAM

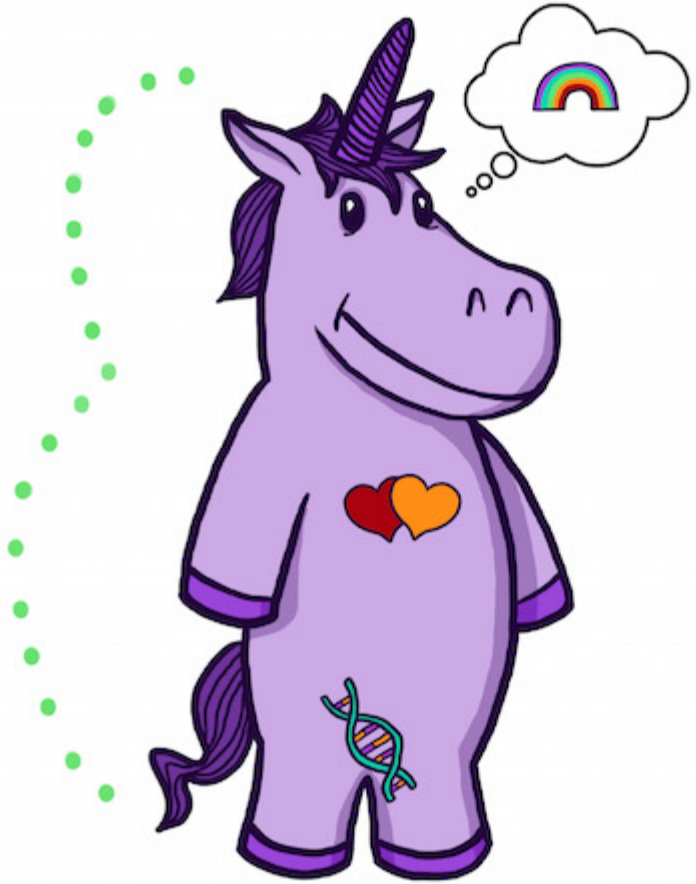
COLUMBIAN COLLEGE OF ARTS AND SCIENCES

Key points ("Transgender 101")

- Many people use the word transgender to mean different things
- Many patients may fit under the "Transgender umbrella" yet may not use term transgender
- Gender may be non-binary and may be fluid over time
- Gender ≠ Sex
- Gender identity is distinct from sexual orientation (though we often say "LGBT")

The Gender Unicorn

Graphic by:
TSER
Trans Student Educational Resources



Gender Identity

- Female/Woman/Girl
- Male/Man/Boy
- Other Gender(s)

Gender Expression/Presentation

- Feminine
- Masculine
- Other

Sex Assigned at Birth

Female | Male | Other/Intersex

Sexually Attracted To

- Women
- Men
- Other Gender(s)

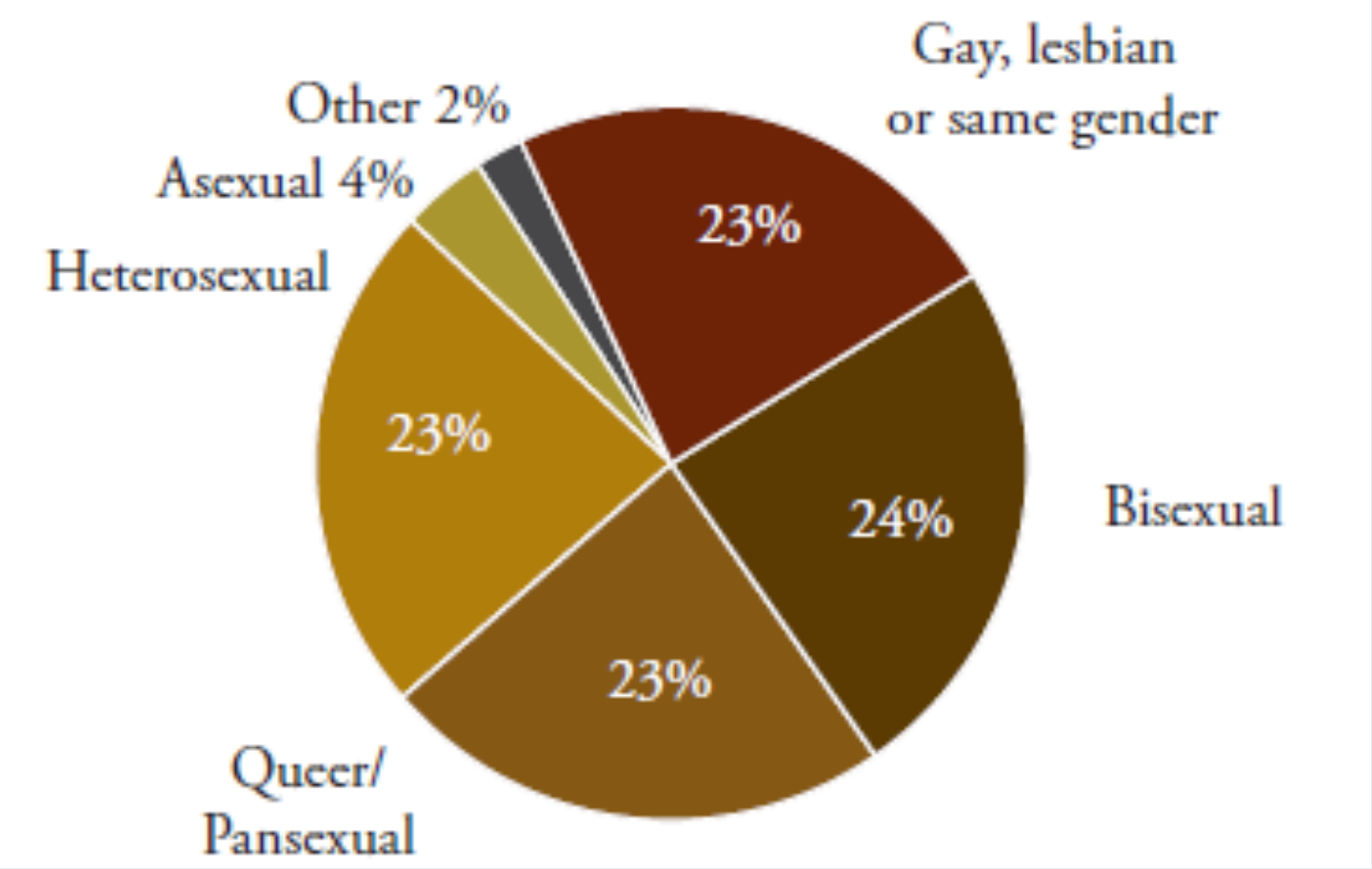
Romantically/Emotionally Attracted To

- Women
- Men
- Other Gender(s)

To learn more go to:
www.transstudent.org/gender

Design by Landyn Pan

Transgender people can have any sexual orientation



(Grant et al 2010)

Transgender Health Disparities

- Health Care Access
- Violence
- Mental Health Concerns
- Substance Abuse
- HIV

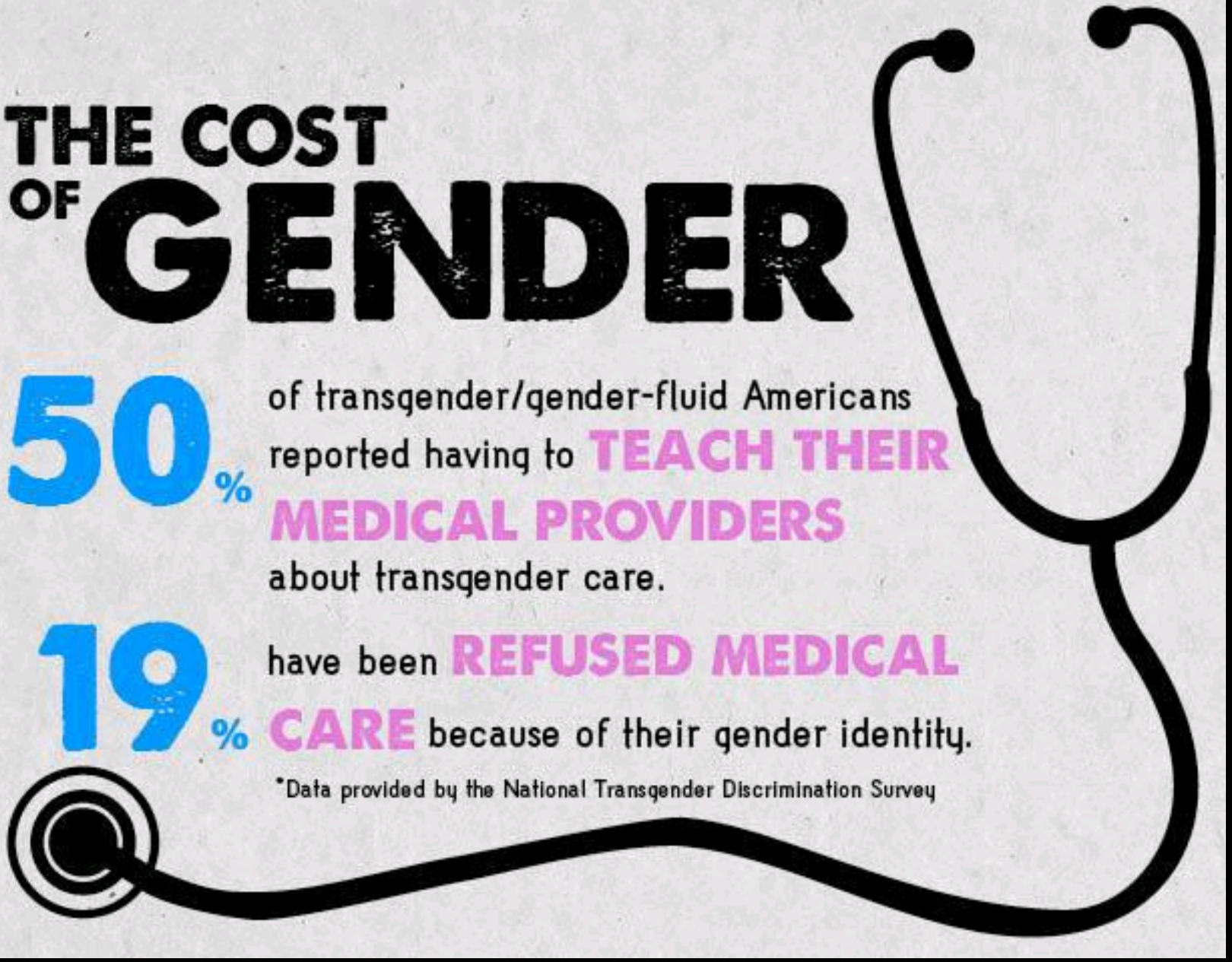
Access to Health Care

THE COST OF GENDER

50% of transgender/gender-fluid Americans reported having to **TEACH THEIR MEDICAL PROVIDERS** about transgender care.

19% have been **REFUSED MEDICAL CARE** because of their gender identity.

*Data provided by the National Transgender Discrimination Survey



2008 National Transgender Discrimination Survey (n= 6450)

What is your primary gender identity today?

- ❑ Male/man
- ❑ Female/woman
- ❑ Part time as one gender, part time as another
- ❑ A gender not listed here, please specify_____

"Gender not listed here"= 860/6450

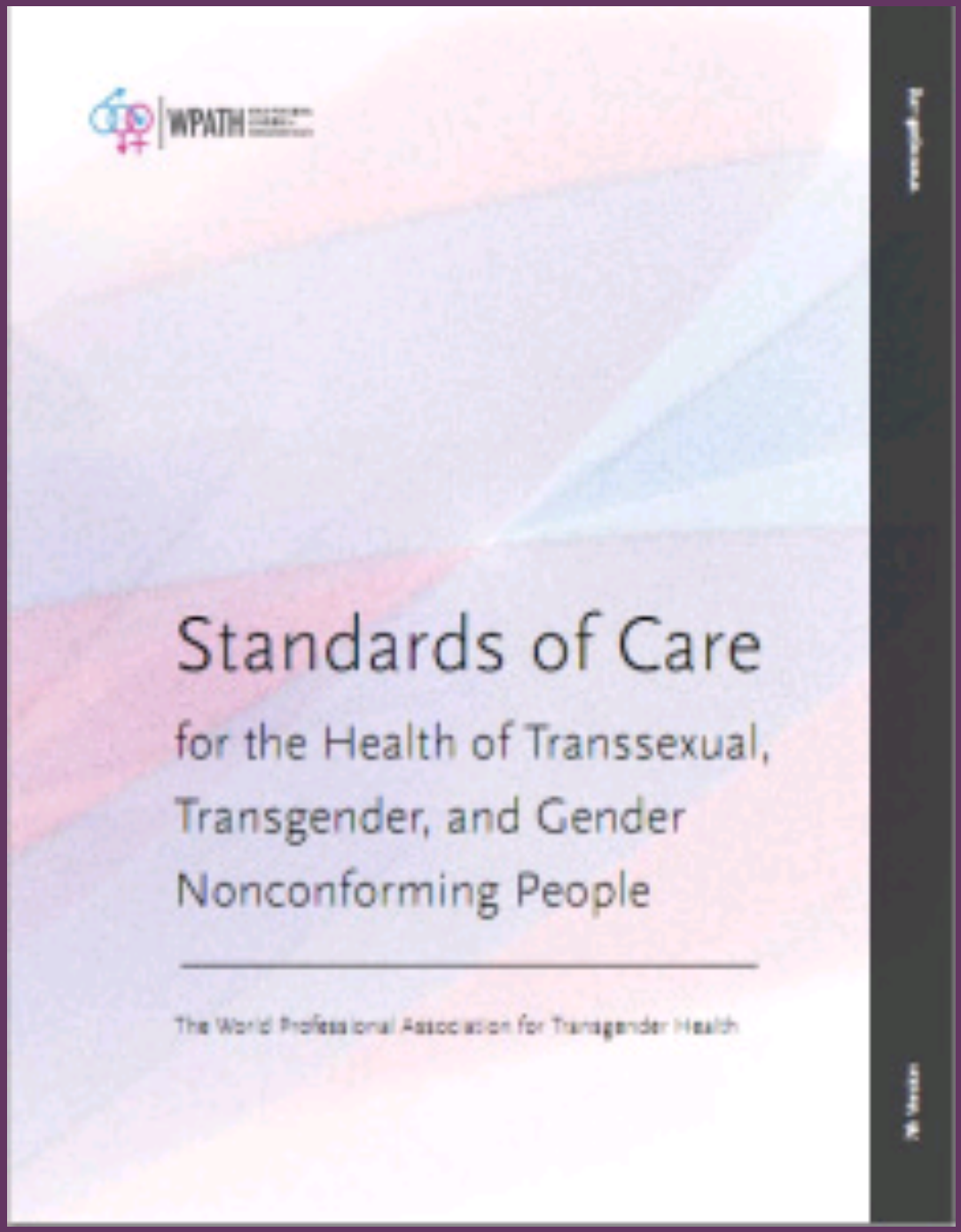
- Genderqueer
- Pangender
- Third Gender
- Genderfluid
- Hybrid
- In-between
- Non-binary
- Androgynous
- Blended
- Two-spirit

"Gender not listed here"

- Avoid or delay health care when sick or injured due to fear of discrimination 36%

- Physical assault 32%
- Sexual assault 15%
- Past suicide attempts 43%

2008 National Transgender Discrimination Survey


WPATH
Standards of Care
for the Health of Transsexual, Transgender, and Gender Nonconforming People
The World Professional Association for Transgender Health

Options for Medical and Psychological Treatment

- Changes in gender expression
- Hormone therapy
- Surgery
- Psychotherapy

Psychotherapy

- Explore gender identity, gender role and expression
- Address negative impact of gender dysphoria (if present) and stigma on mental health
- Alleviate internalized transphobia
- Enhance social and peer support
- Improve body image
- Promote resilience

WPATH 2012

Role of mental health provider

- A “letter” no longer required for initiation of hormones (most recent WPATH guidelines)

Change in gender expression

- Peer support resources
- Voice and communication therapy
- Hair removal
- Breast binding or padding
- Padding of hips and buttocks
- Genital tucking or prostheses
- Name and gender marker changes on identity documents

Hormone Therapy

- Feminizing or masculinizing hormone therapy is a **medically necessary** intervention for many people with gender dysphoria

Gender non-conformity ≠ gender dysphoria

Gender dysphoria:

> "Discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)"

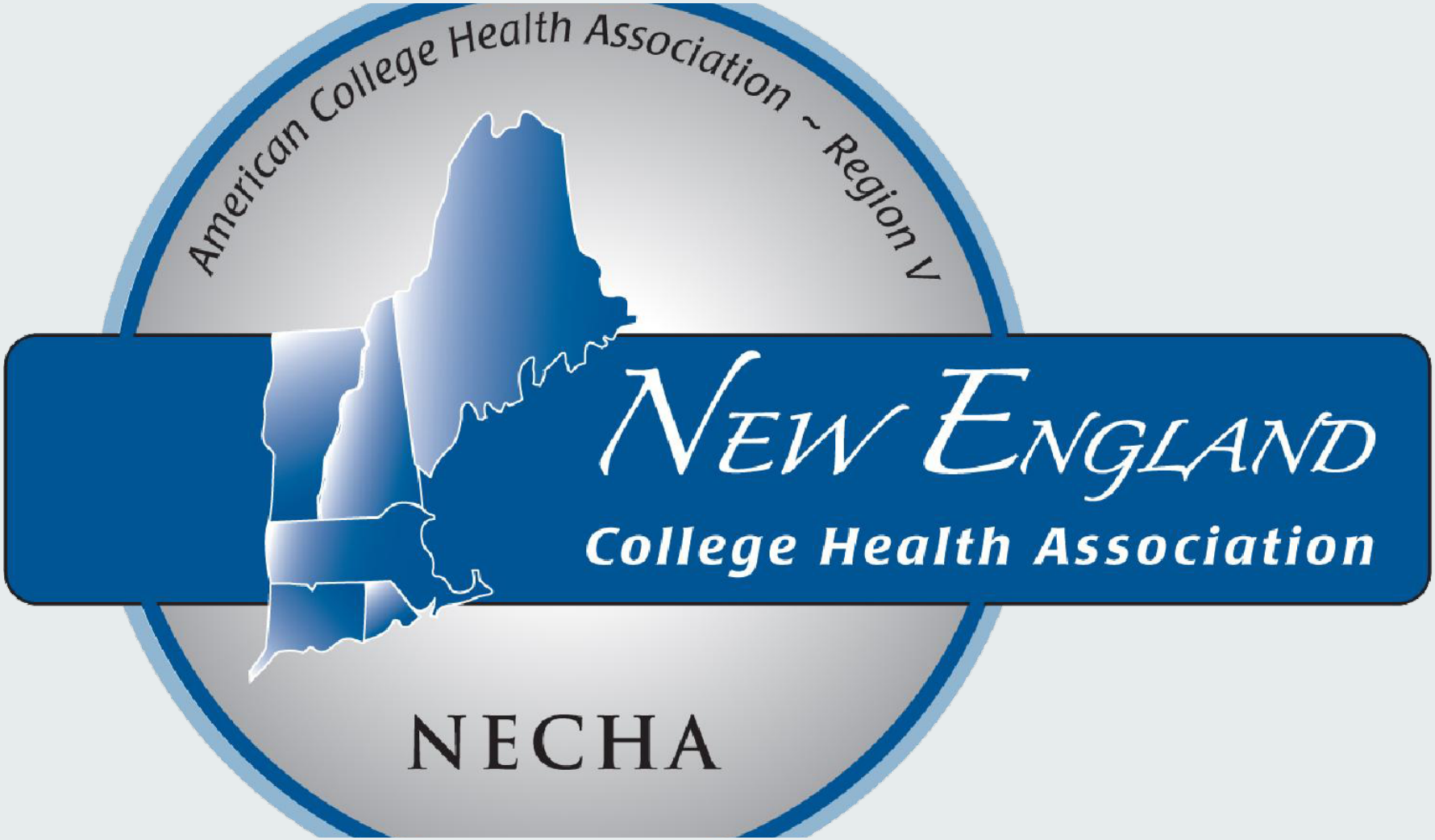
Criteria for hormone therapy

- Persistent, well-documented gender dysphoria
- Capacity to make a fully informed decision and to consent to treatment
- Age of majority
- If significant medical or mental health concerns are present, they must be reasonably well-controlled

Responsibilities of hormone-prescribing medical providers

- Initial evaluation (discussion of patient goals, health history, physical, risk assessment, relevant labs)
- Discuss expected effects
- Confirm capacity to understand risks and benefits
- Provide ongoing medical monitoring
- Communicate with any other members of team (mental health professional, surgeon)
- Provide any necessary documentation

Who best to do this?



…and now for the hormones

Gender affirming hormones

- "The goal of transgender endocrine therapy is to change secondary sex characteristics to reduce gender dysphoria and/or facilitate gender presentation that is consistent with the felt sense of self. **In addition to inducing physical changes, the act of using hormones is itself an affirmation of gender identity**."

Vancouver Coastal Health

Risks of Hormone Therapy

Risk Level	Feminizing Hormones	Masculinizing Hormones
Likely increased risk	Venous thromboembolic disease Gallstones Elevated liver enzymes Weight gain Hypertriglyceridemia	Polycythemia Weight gain Acne Androgenic alopecia (balding) Sleep apnea
Likely increased risk with presence of additional risk factors	Cardiovascular disease	
Possible increased risk	Type II Diabetes	Destabilization of certain psychiatric disorders Cardiovascular disease Hypertension Type II Diabetes
No increased risk or inconclusive risk	Breast cancer	Loss of bone density Breast cancer Cervical cancer Ovarian cancer Uterine cancer

WPATH, Standards of Care, Vol 7

Patient goals

- Hormones?
  - What specific goals:
    - Breast concerns
    - Genital concerns
    - Sexual function
    - Fertility
    - Hair growth?
    - Body fat distribution
- Surgery?

Baseline labs

- For transmasculine patients:
  - Hemoglobin/Hematocrit
  - Lipids (depending on USPSTF guidelines)

Consent

- Many examples of consent forms exist (see resource list)
- UCSF guidelines no longer recommend written consent forms but support the documentation of an informed consent discussion

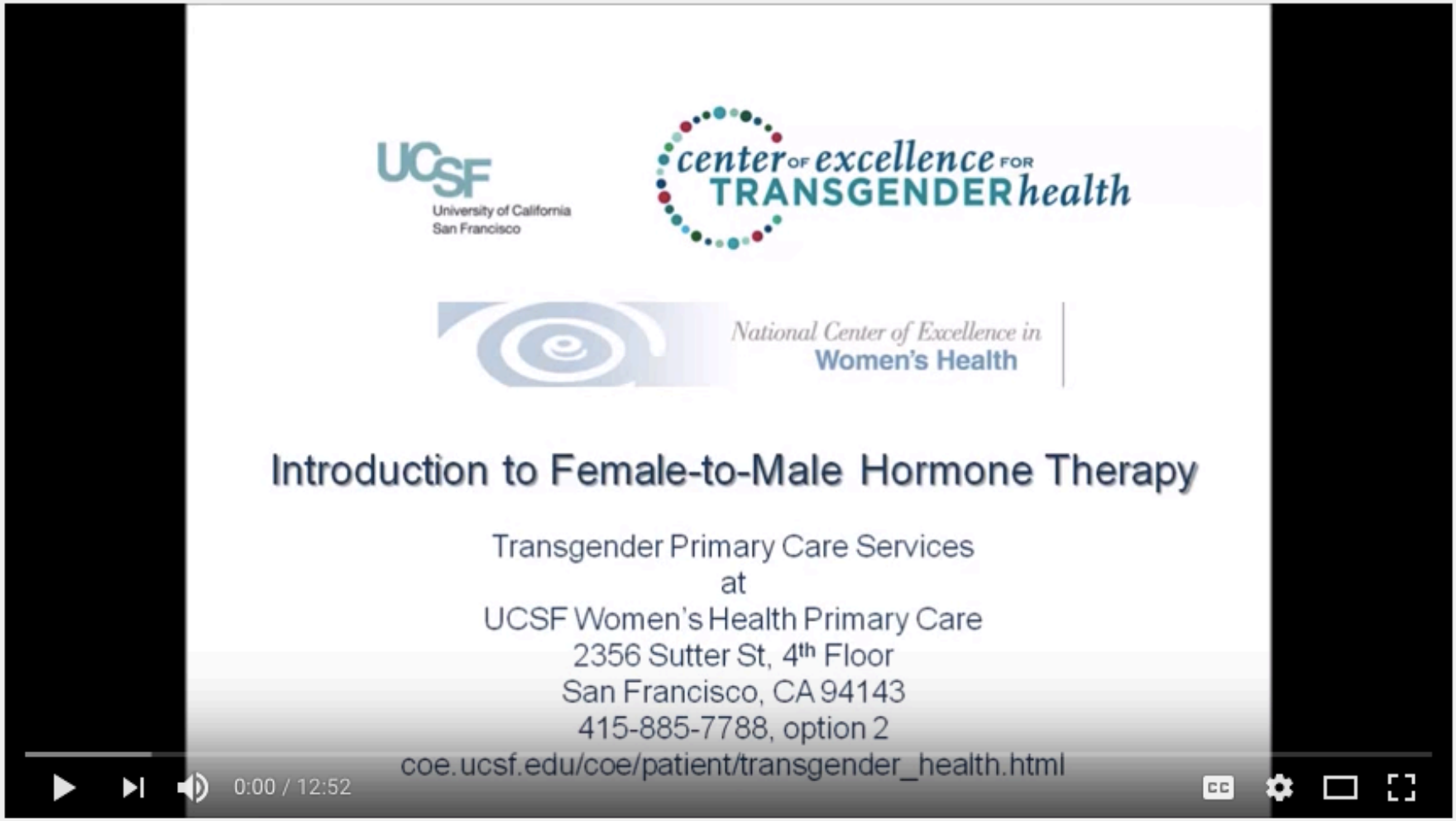
Reproductive health counseling

- Often ignored
- Need to discuss sperm banking or egg preservation prior to initiation of cross-gender hormones
- Patients need counseling re: contraceptive options
- MTF often permanent sterility within months
- FTM off hormones MAY be able to conceive

TABLE 1A: EFFECTS AND EXPECTED TIME COURSE OF MASCULINIZING HORMONES [A]

Effect	Expected onset[B]	Expected maximum effect[B]
Skin oiliness/acne	1–6 months	1–2 years
Facial/body hair growth	3–6 months	3–5 years
Scalp hair loss	>12 months[C]	Variable
Increased muscle mass/strength	6–12 months	2–5 years[D]
Body fat redistribution	3–6 months	2–5 years
Cessation of menses	2–6 months	n/a
Clitoral enlargement	3–6 months	1–2 years
Vaginal atrophy	3–6 months	1–2 years
Deepened voice	3–12 months	1–2 years

madeline deutsch



Androgen	Initial - low dose[b]	Initial - typical	Maximum - typical[c]	Comment
Testosterone Cypionate[a]	20 mg/week IM/SQ	50mg/week IM/SQ	100mg/week IM/SQ	For q 2 wk dosing, double each dose
Testosterone Enthanate[a]	20mg/week IM/SQ	50mg/week IM/SQ	100mg/week IM/SQ	"
Testosterone topical gel 1%	12.5-25 mg Q AM	50mg Q AM	100mg Q AM	May come in pump or packet form
Testosterone topical gel 1.62%[d]	20.25mg Q AM	40.5 - 60.75mg Q AM	103.25mg Q AM	"
Testosterone patch	1-2mg Q PM	4mg Q PM	8mg Q PM	Patches come in 2mg and 4mg size. For lower doses, may cut patch
Testosterone cream[e]	10mg	50mg	100mg	
Testosterone axillary gel 2%	30mg Q AM	60mg Q AM	90-120mg Q AM	Comes in pump only, one pump = 30mg

For first month on testosterone

TESTOSTERONE: Prescribe one month of ONE of the following hormones*:

Preferred Regimen

Injectable Testosterone	Dose	Route & Frequency[δ]	Amount	Refills
Testosterone cypionate or enanthate 200mg/ml[δδ]	0.5cc (100mg)	Intramuscular or subcutaneous, every two weeks	1cc	0

Alternate Regimen

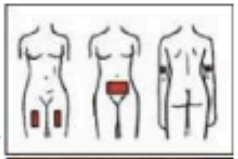
Transdermal Testosterone	Dose	Route & Frequency	Amount	Refills
Testosterone gel 1% (Androgel®, Testim®)**	2.5-5mg	One packet topically, daily	30 packets	0
Testosterone patch (Androderm®)	5mg	One patch topically, daily	30 patches	0

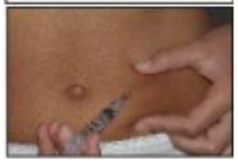
Callen-Lorde Protocols for the Provision of HormoneTherapy

Commercial break

Injections

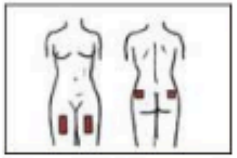
Subcutaneous Injections

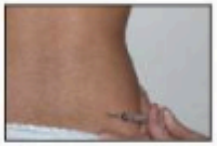




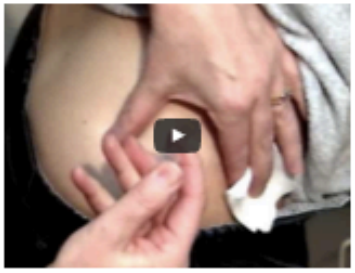
- Cleanse your selected SUBCUTANEOUS injection site with an alcohol wipe and allow to dry.
- While holding the syringe with your dominant hand between your thumb and finger (as you would a pencil), pinch the skin (with your other hand) at the site you have selected.
- With a quick, dart-like motion, insert the entire needle (up to the hub of the syringe) at a 90° or a 45° angle and depressthe plunger slowly and carefully.
- After the injection is complete, quickly pull out the needle. If bleeding, apply pressure to the injection site with a sterile gauze pad. If discomfort occurs after your injection, you maygently massage the injection site to alleviate your discomfort.
- After injecting the medication, dispose of the syringe into the Sharps waste container. It is unnecessary to recap the needle as this could cause injury.

Intramuscular Injections





- Cleanse your selected INTRAMUSCULAR injection site with an alcohol wipe and allow to dry.
- Hold the syringe with your dominant hand between your thumb and index finger (as you would a pencil). With your other hand, firmly stretch your skin at the selected injection site. Make sure you are using the intramuscularneedle (usually 1 ½ "). NOTE: To minimize bruising, firmly stretch the skin.
- With a quick, dart-like motion, insert the entire needle (up to the hub of the syringe) at a 90° angle into the stretched skin area between your thumb and index finger.
- Using either hand to stabilize the syringe, pull back slightlyon the plunger and watch for blood in the syringe. (This is rare). You may feel slight resistance or see a small bubble - this is normal. If blood is not seen in the syringe, the needle is inserted properly.If blood appears in the syringe, DO NOT INJECT YOUR MEDICATIONS. Withdraw the needle, cover the site with a gauze pad, and apply pressure. Discard the syringe into the Sharps container. Repeat mixing and injection instructions.
- Depress the plunger slowly and steadily.
- Pull the syringe out in one motion.
- After injecting the medication, dispose of the syringe into the Sharps waste container. It is unnecessary to recap the needle as this could cause injury.
- Apply pressure to the site with a gauze pad and gently massage the area to help disperse themedication and relieve discomfort. Apply a bandage if necessary.



Therapy	Comments	Baseline	3 months*	6 months*	12 months*	Yearly	PRN
Lipids	No evidence to support lipid monitoring at any time; use clinician discretion	Based on USPSTF guidelines					X
A1c or fasting glucose	No evidence to support lipid monitoring at any time; use clinician discretion	Based on USPSTF guidelines					X
Estradiol							X
Total Testosterone			X	X	X		X
Sex Hormone Binding Globulin (SHBG)**			X	X	X		X
Albumin**			X	X	X		X
Hemoglobin & Hematocrit		X	X	X	X	X	X

* In first year of therapy only;

** is optional and may be helpful in complex cases (see text) Used to calculate bioavailable testosterone; monitoring bioavailable testosterone

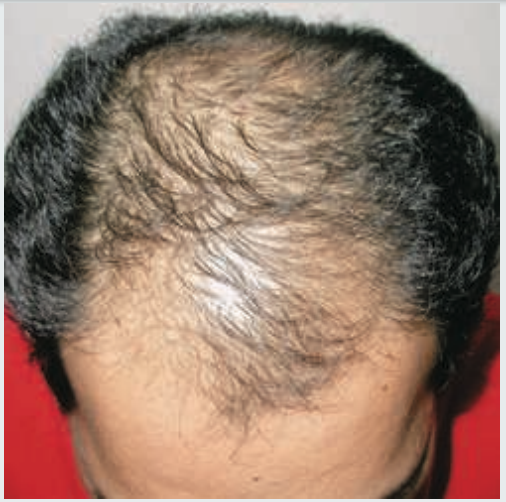
When to check labs with regard to injection schedule

- For topical testosterone, any time
- For injectable…
  - check mid-cycle
  - If any fluctuating symptoms, consider checking a peak (1-2 days after injection) and trough level. Consider increased frequency of injections (and decrease dose accordingly)

Titration of testosterone dose

- Driven by patient goals, while monitoring hormone levels and safety (Hgb/Hct)
- Clinical response: amenorrhea by 6 months
- Once within the mid-normal male range for total testosterone, no evidence that higher doses increase virilization
- Some genderqueer/GNC/GNB patients may wish to remain in low male range or below
- Once on stable dose, monitor yearly unless concerns arise

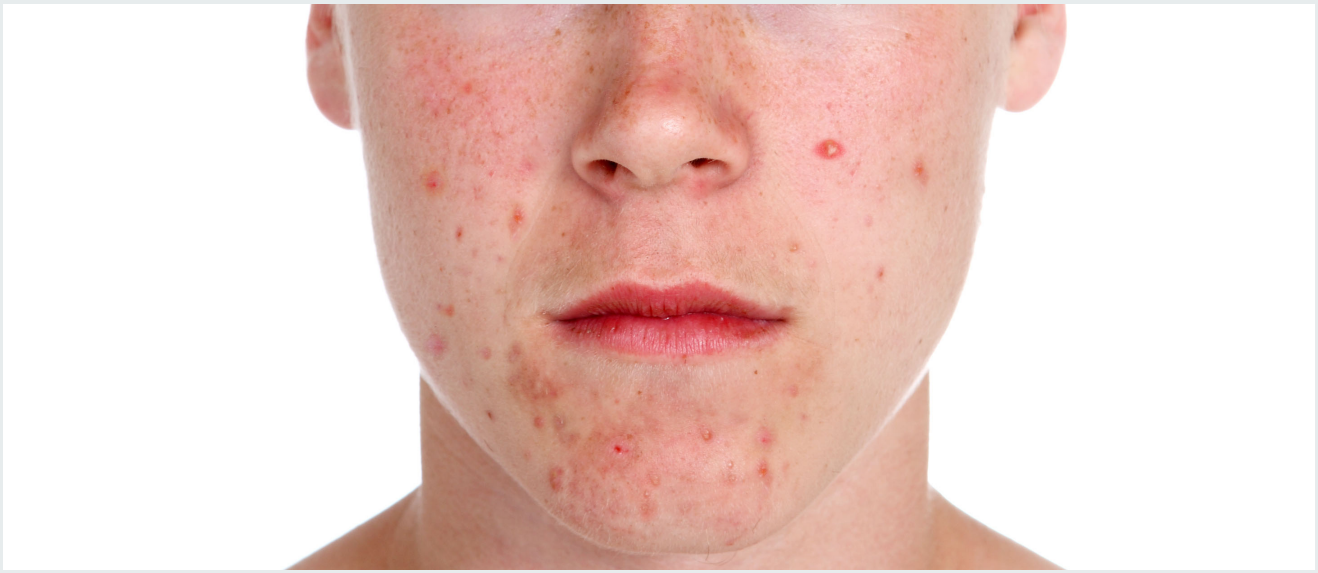
Management of male-pattern hair loss



- Manage as cis-gender men:
  - Topical minoxidil
  - Oral finasteride 1 mg (Propecia)
  - Note: as in cisgender men, avoid finasteride 5 mg as excess testosterone blockade may result (decreased virilization)

Acne

- Peaks in first year of testosterone
- Avoid supraphysiologic dosing, significant peak-trough swings and prolonged dosing intervals



Estrogens for transgender women

- Many forms of 17-beta estradiol available (referred to simply as estradiol)
- Conjugated equine estrogen (Premarin) no longer recommended (possible increased VTE risk; increased cardiac risk)
- Ethinyl estradiol (found in OCPs) not recommended (increased risk of VTE)

Choice of estrogens

- No evidence that one surpasses another with regard to feminization
- Anecdotal evidence that changes may be more rapid with IM estrogen, though cyclical mood swings and fluctuating levels may make this less appealing to some

TABLE 1B: EFFECTS AND EXPECTED TIME COURSE OF FEMINIZING HORMONES [A]

Effect	Expected onset[B]	Expected maximum effect[B]
Body fat redistribution	3–6 months	2–5 years
Decreased muscle mass/ strength	3–6 months	1–2 years[C]
Softening of skin/decreased oiliness	3–6 months	Unknown
Decreased libido	1–3 months	1–2 years
Decreased spontaneous erections	1–3 months	3–6 months
Male sexual dysfunction	Variable	Variable
Breast growth	3–6 months	2–3 years
Decreased testicular volume	3–6 months	2–3 years
Decreased sperm production	Variable	Variable
Thinning and slowed growth of body and facial hair	6–12 months	> 3 years[D]
Male pattern baldness	No regrowth, loss stops 1–3 months	1–2 years

Baseline labs

- For transwomen:
  - Lipids
  - Electrolytes and renal function (if considering use of spironolactone)
  - ? Liver function

Choice of estrogens

Hormone	Initial-low[b]	Initial	Maximum[c]	Comments
Estrogen				
Estradiol oral/sublingual	1mg/day	2-4mg/day	8mg/day	if >2mg recommend divided bid dosing
Estradiol transdermal	50mcg	100mcg	100-400 mcg	Max single patch dose available is 100mcg. Frequency of change is brand/product dependent. More than 2 patches at a time may be cumbersome for patients
Estradiol valerate IM[a]	<20mg IM q 2 wk	20mg IM q 2 wk	40mg IM q 2wk	May divide dose into weekly injections for cyclical symptoms
Estradiol cypionate IM	<2mg q 2wk	2mg IM q 2 wk	5mg IM q 2 wk	May divide dose into weekly injections for cyclical symptoms

Estrogens

- No outcomes studies
- May use oral estradiol sublingually
- Avoid oral estradiol in patients older than 35-40
- Avoid oral estradiol in smokers

- Start low, go slow

Concern re: prolactinoma

- Most groups no longer recommend baseline or periodic testing for prolactin unless patient develops symptoms of prolactinoma (new headaches, visual concerns, galactorrhea)

Anti-androgens

- Suppress or minimize male secondary sex characteristics (some permanent after puberty)
- Allow lower estradiol levels

Spironolactone

- Most commonly used
- Potassium-sparing diuretic
- Hyperkalemia most significant side effect, but rare if monitored appropriately and not used in patients with renal insufficiency

5- alpha reductase inhibitors

- Finasteride/dutasteride
- Block conversion of testosterone to potent dihydrotestosterone
- They don't block production of testosterone and are therefore less effective than spironolactone
- Good choice for those who cannot use spironolactone
- May use as single agent, espec for those considering partial femininization

Feminizing meds in patients post-orchiectomy

- No need for testosterone blockade
- May decrease estrogen dosing

Progestins

- Role is controversial
- No well-designed studies
- Anecdotal evidence that they may help with breast development
- Concerns raised by WHI likely not to be extended to transgender women (usually younger population, no use of equine estrogens)
- Possible negative effect on mood
- Most groups do not use at all

Table 2. Laboratory monitoring for feminizing hormone therapy

Test	Comments	Baseline	3 months*	6 months*	12 months*	Yearly	PRN
BUN/Cr/K+	Only if spiro used	X	X	X	X	X	X
Lipids	No evidence to support monitoring at any time; use clinician discretion	Based on USPSTF guidelines					X
A1c or glucose	No evidence to support monitoring at any time; use clinician discretion	Based on USPSTF guidelines					
Estradiol			X	X			X
Total Testosterone			X	X	X		X
Sex Hormone Binding Globulin (SHBG)**			X	X	X		X
Albumin**			X	X	X		X
Prolactin	Only if symptoms of prolactinoma						X

* In first year of therapy only

** Used to calculate bioavailable testosterone; monitoring bioavailable testosterone is optional and may be helpful in complex cases (see text)

Titration and monitoring

- General approach: increase both estrogen and testosterone blockade until estrogen in female range, then increase testosterone blockade
- Some providers don't recommend following hormone levels, but risk exists for under-feminization if testosterone levels not suppressed
- Endocrine Society recommends total T<55 ng/dl

Other considerations

- Tobacco use: increased risk VTE
  - Recommend transdermal estrogen
  - Consider ASA 81 mg (no data)
- Erectile dysfunction:
  - OK for use of sildenafil (Viagra) or tadalafil (Cialis)

Beyond the binary

Genderqueer

Gender non-binary

- WPATH guidelines now more inclusive
- For some, the process of gender affirmation and transition may be internal/limited to a social process
- For others, a variety of medical/surgical interventions

Gender non-binary

- Some on transmasculine spectrum may wish low dose testosterone (particularly if no dysphoria around menses)
- If dysphoria persists in patient with persistent menses on low-dose testosterone, consider addition of DepoProvera, or use of progesterone IUD or implant

Beyond hormones

- Tucking
- Binding
- Sexual health

COMFORT TIPS

- Duct tape is not recommended because it can tear hair and skin and cause rashes or irritation. However, *if you do use duct tape*, remember to shave (although not night before, as that can cause irritation) so that the tape does not pull hair. Soak in a warm bath before removal to make the tape less sticky.
- It's not possible to urinate while taped. Try to make time to relieve yourself before and after.
- Remaining taped for longer than 4–8 hours causes irritation, discomfort, and possible pain while urinating. Try not to tuck 24/7. Take breaks from it if you can.
- Trimming/shaving pubic hair generally helps with tucking.

SAFER TUCKING

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HEALTH OUTREACH TO TEENS

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NEW YORK, NY 10011
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Being Healthy is Being HOTT!

HEALTH OUTREACH TO TEENS

WHAT IS TUCKING?

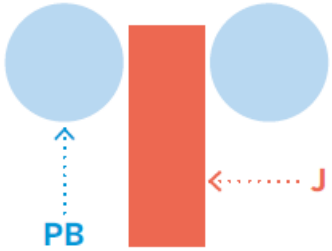
The goal of tucking is to make the underwear area look smoother. This can be done in multiple ways.

WHY DO SOME PEOPLE TUCK?

- It allows you to feel better about your body
- Tucking can make wearing some shorts, skirts, and pants more comfortable
- Tucking helps some people "pass", and that can make certain situations safer

SO WHERE DOES IT ALL GO?

*Some people prefer not to use anatomical terms to refer to their genitals, so from here on we'll call the parts **"PB & J"**



There are spaces in your pelvis (called ***inguinal canals***) right above your genitals that you can use to make your underwear area look flatter. You can push the PB up into these spaces and pull the J back.

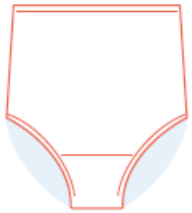
After you have been on hormones for a while, things will shrink and become more comfortable. This can all be secured using either medical tape or various clothing options.

WAYS TO TUCK

Control Briefs

$10–30

Often marketed for "tummy control", control briefs (like SPANX) are made of strong, elastic material. Pull yourself toward the back between your legs and pull the control briefs up snugly. You might have to readjust throughout the day. Some people prefer buying a size smaller than usual.



Another option is cutting the legs off a pair of panty hose and wearing them like control briefs.

Layering Undies

$10–30

Layering spandex undies might cause more irritation, so use cotton. Pull yourself toward the back between your legs and pull the underwear up snugly. Low waist/"hipster" styles don't work as well.

Taping

$5–10

(See "Comfort Tips" on the back). Avoid using duct tape. Wrap medical tape around the shaft and pull it down toward the back. Use more tape to secure. Medical tape removes less painfully, but does not stick when wet. Taping could make it painful to sit.

Gaff

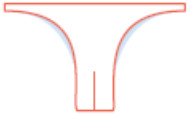
$20–30

Gaffs are worn like underwear and made of strong, elastic material to hold things in place.

Vee String

$200–500

Vee Strings are like gaffs but are made of latex rubber and the outside looks like a vagina.



HEALTHY BODIES SAFER SEX

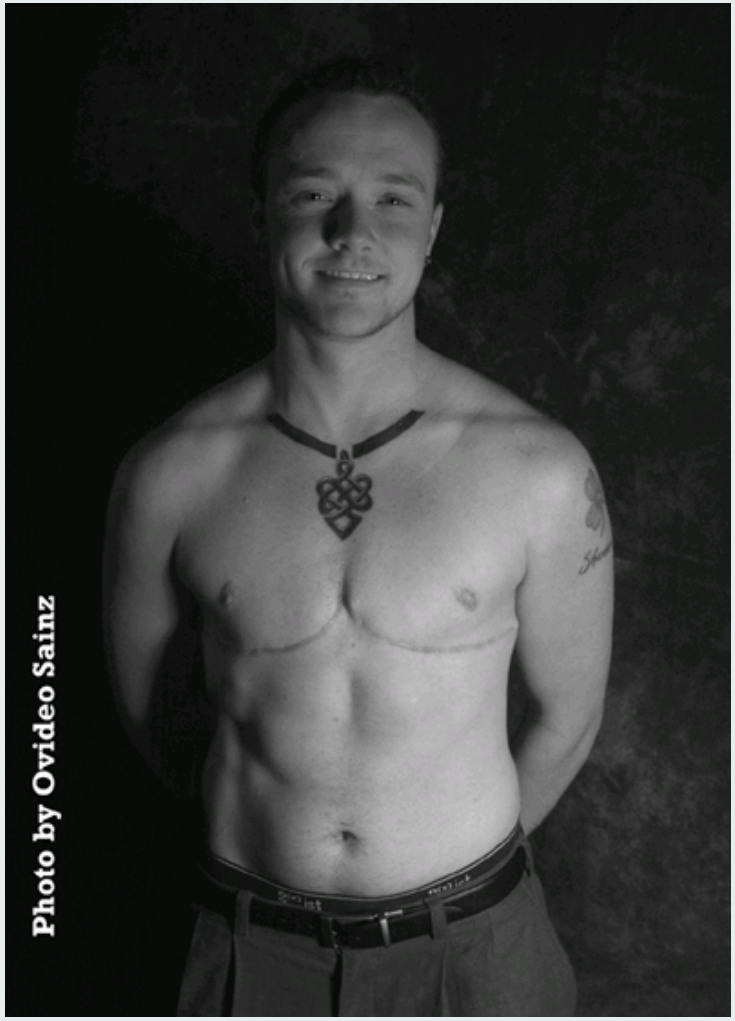
A comprehensive guide to safer sex, relationships, and reproductive health for trans or non-binary people and their partners

Beth Thompson & Anna Benbrook

Brief comments on surgeries

Surgical management FTM

- Chest reconstruction



"Bottom" surgeries for transgender patients

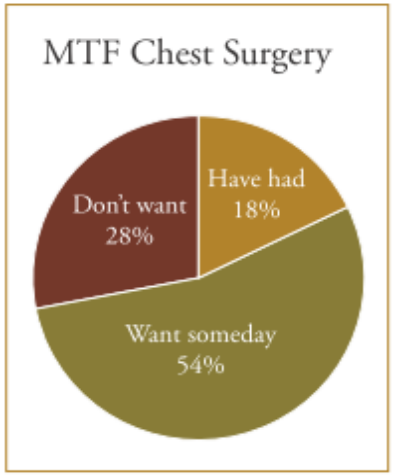
- Many different types
- All expensive
- Often complicated
- Beyond the scope of today's discussion
- Often not covered by insurance

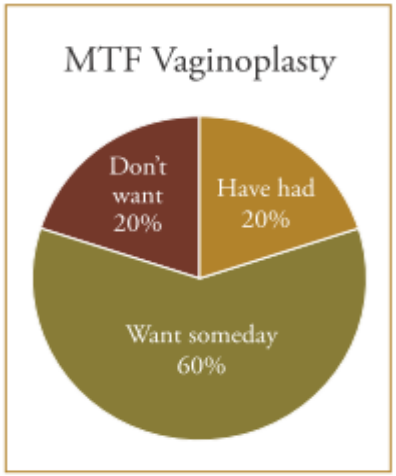
Diverse Bodies and Expressions

76% taking hormones whether monitored or not

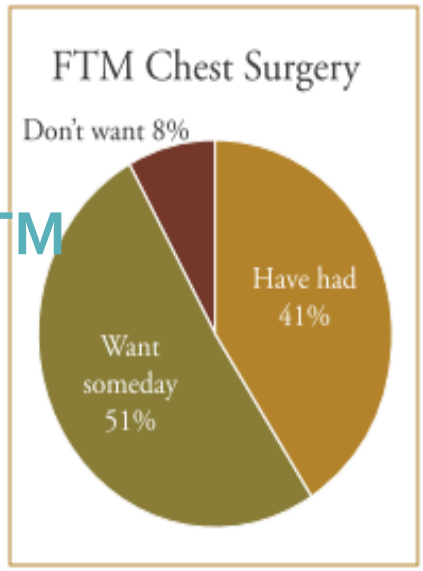
Surgical status and future desire to have surgery is diverse

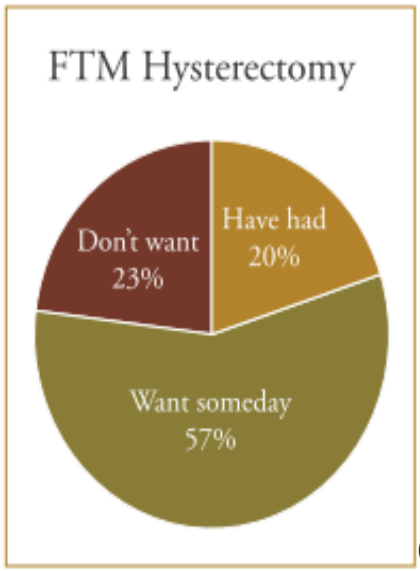
MTF

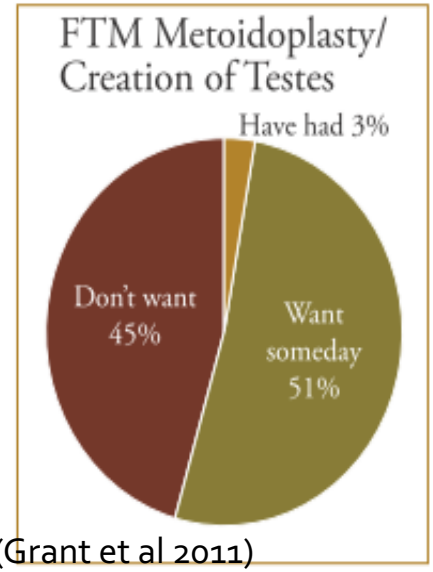


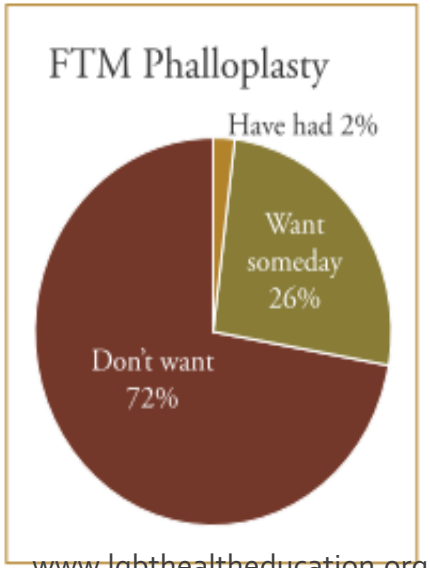


FTM









(Grant et al 2011)

Gender Affirmation Surgery (GAS)
Sex Reassignment Surgery (SRS)
Genital Reconstruction Surgery (GRS)

- Surgery has proven to be an effective intervention for the patient with gender dysphoria
- Patient satisfaction following surgery is high (Lawrence 2003), and reduction of gender dysphoria following surgery has psychological and social benefits
- As with any surgery, the quality of care provided before, during, and after surgery has a significant impact on patient outcomes
- Not for everyone! Is the patient ready?
- Insurance coverage often difficult to obtain

COLLEGES AND UNIVERSITIES THAT COVER TRANSITION-RELATED MEDICAL EXPENSES UNDER STUDENT HEALTH INSURANCE

Vermont Orders Insurers to Cover Gender Reassignment

It joins three other states and D.C. in having such a mandate.

BY TRUDY RING
APRIL 29 2013 9:29 PM EDT

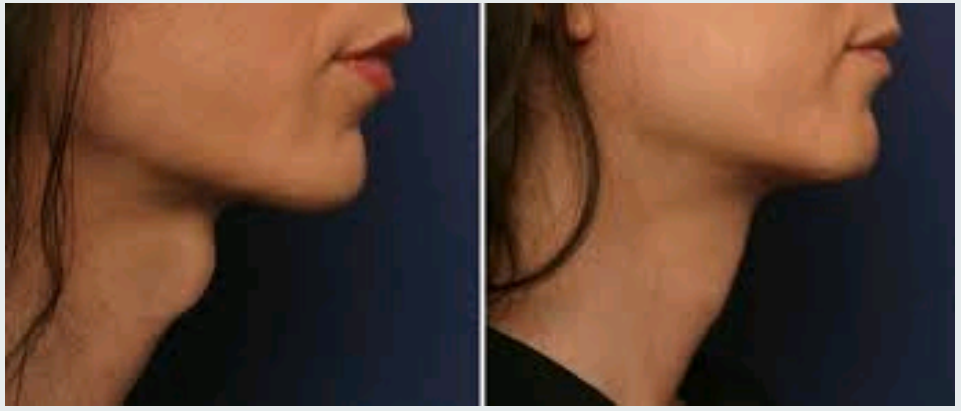

I
Vermont

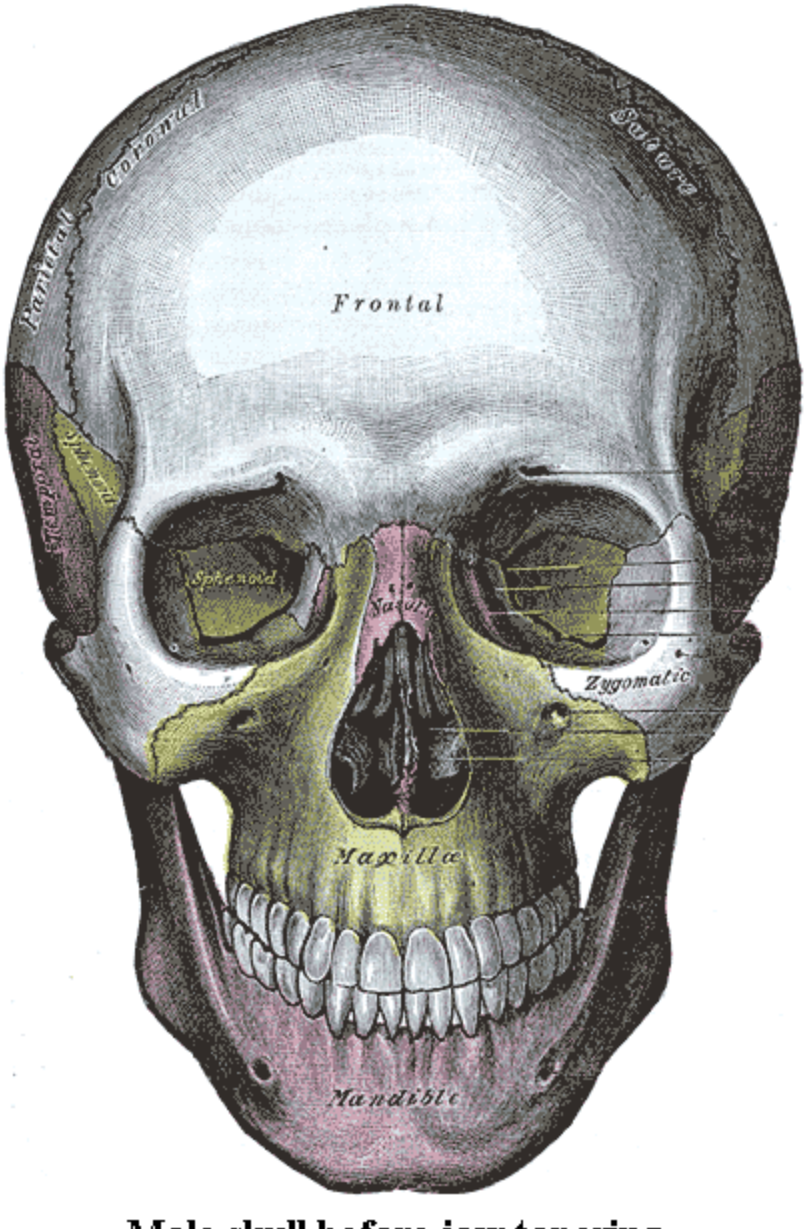
Surgical management- MTF

- Facial feminization surgery (FFS)
  - Sliding genioplasty
  - Brow shave
  - Scalp reduction
  - Hair transplantation
  - Rhinoplasty

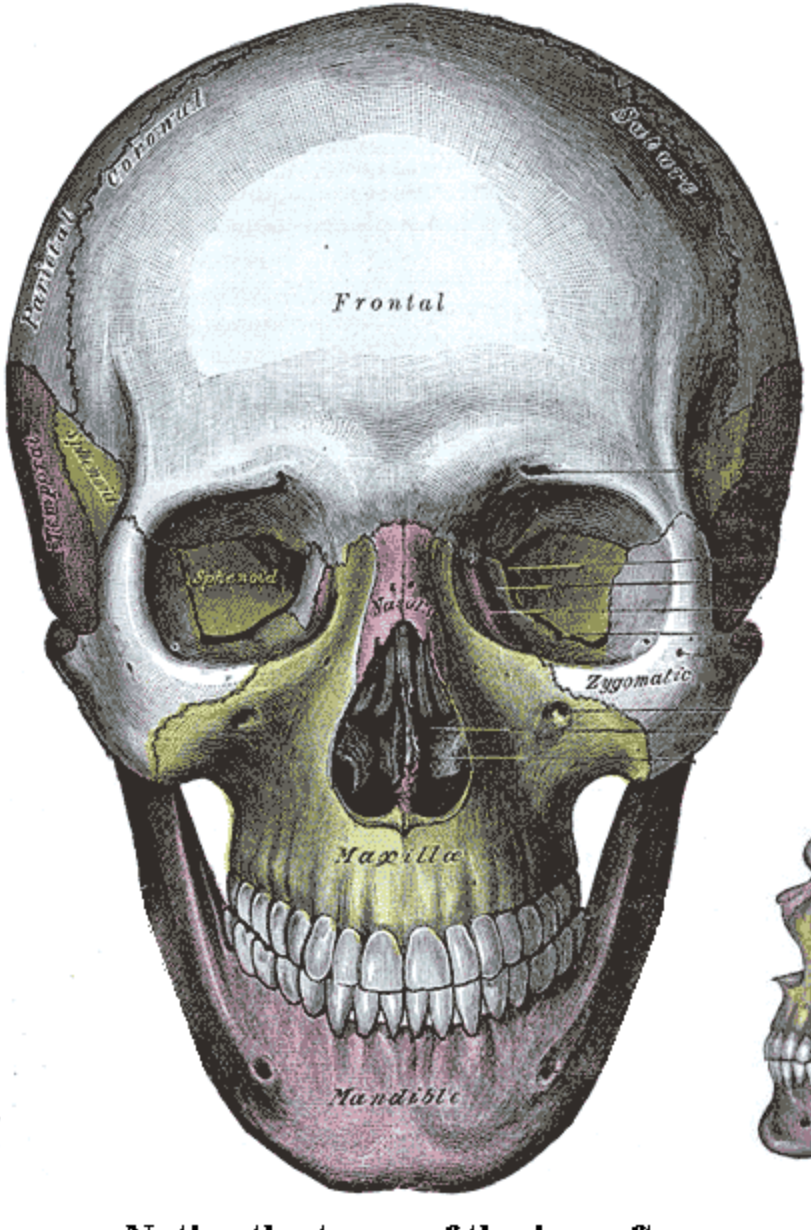
Surgical management MTF

- Facial hair removal
  - Electrolysis
  - Laser
- Tracheal shave
  - Most common surgical procedure
  - Potential for scarring (rare)
  - Vocal damage (rare)

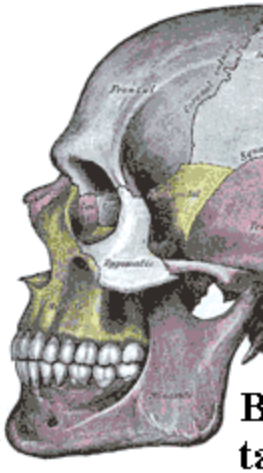




Male skull before jaw tapering. Notice the outward flare on the left and right before the jaw tapering procedure.



Notice the taper of the jaw after the flare on the right and left have been removed.



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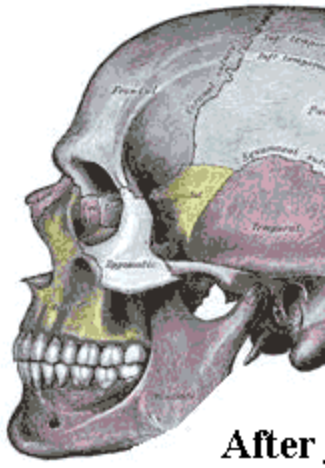


After
taperi

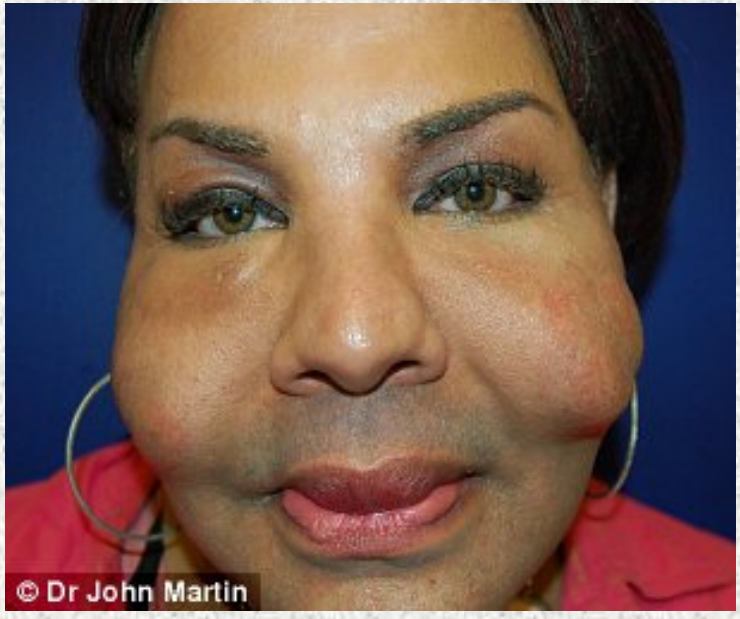
Transgenderzone.com

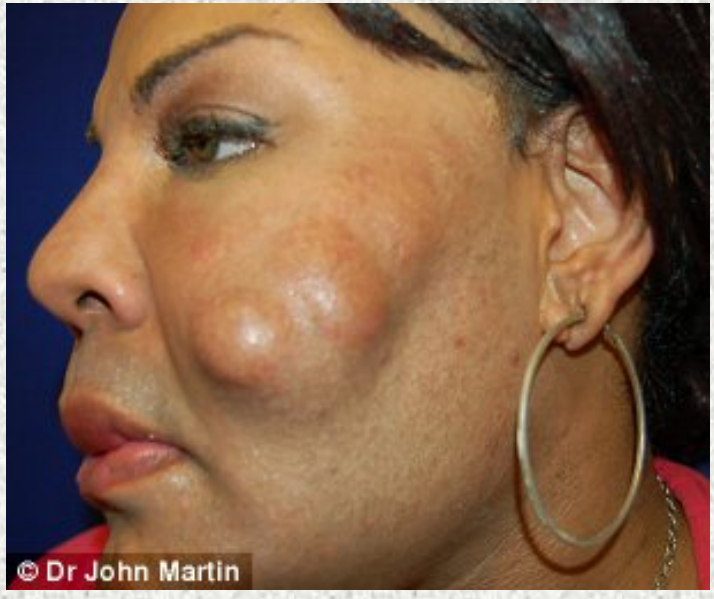
Facial Feminization surgery

www.drspiegel.com

Silicone

Beware of silicone "pumping parties"



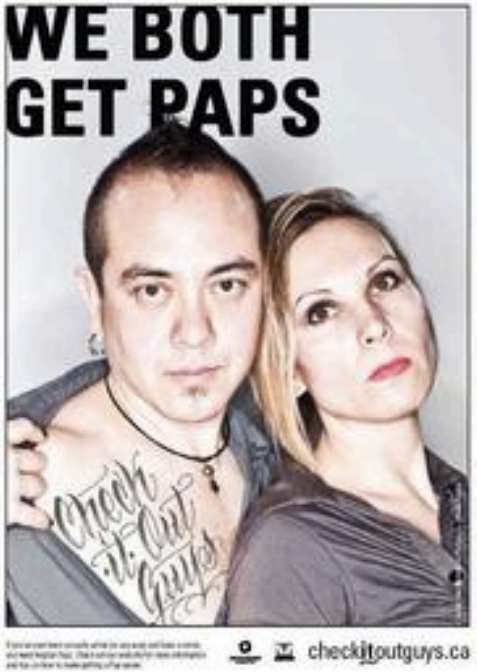


Cardiovascular Health

- Transgender patients may be at increased risk of both heart disease and stroke
  - Hormone use
  - Increased smoking
  - Obesity
  - High blood pressure
  - Lack of appropriate screening

Cancer

- "If you still have the parts, they need to be screened."
  - Mammograms
  - Prostate cancer
  - Paps



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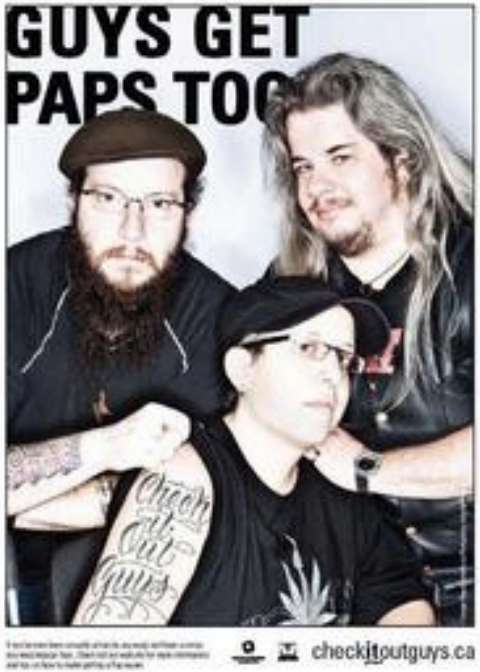

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checkitoutguys.ca

checkitoutguys.ca

Pelvic exams in transgender men

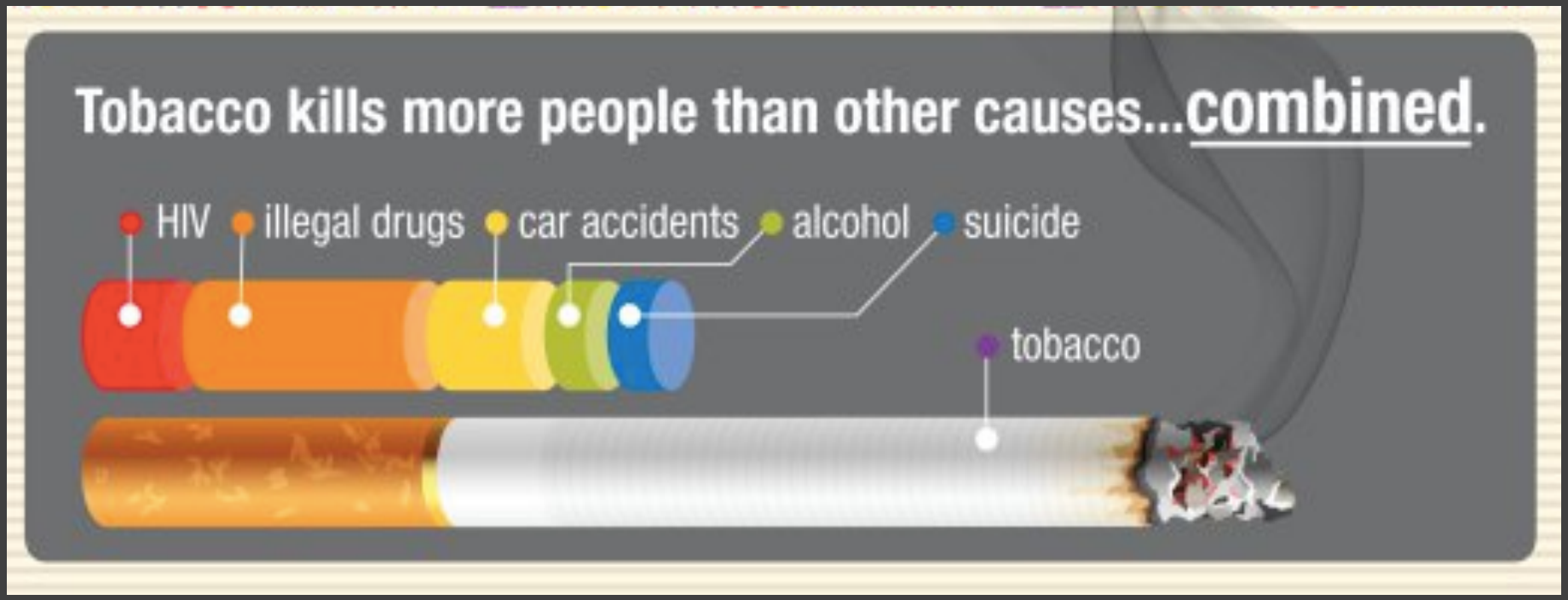
- May be anxiety-provoking
- Transmen more likely to be behind on cervical cancer screening/have inadequate sampling
- Be sure to document that it is a cervical pap (so not run as an anal pap if male gender marker)
- Indicate amenorrhea/testosterone use, if applicable

Pelvic exams in transgender men

- Offer support person in room if desired
- Discuss all steps thoroughly in advance
- Avoid using medical terminology unless discussed in advance. Some transmen refer to vagina as "front" or "front-hole" for example
- Self-collection of samples other than pap, if needed
- Consider use of vaginal estrogens for 1-2 weeks prior to exam in men on long-term testosterone

Alcohol, tobacco and other drugs

- Transgender patients at increased risk of drug and alcohol abuse
- Substance use often a way to deal with stigma


Tobacco kills more people than other causes...combined.
HIV
illegal drugs
car accidents
alcohol
suicide
tobacco

HIV and Transgender patients

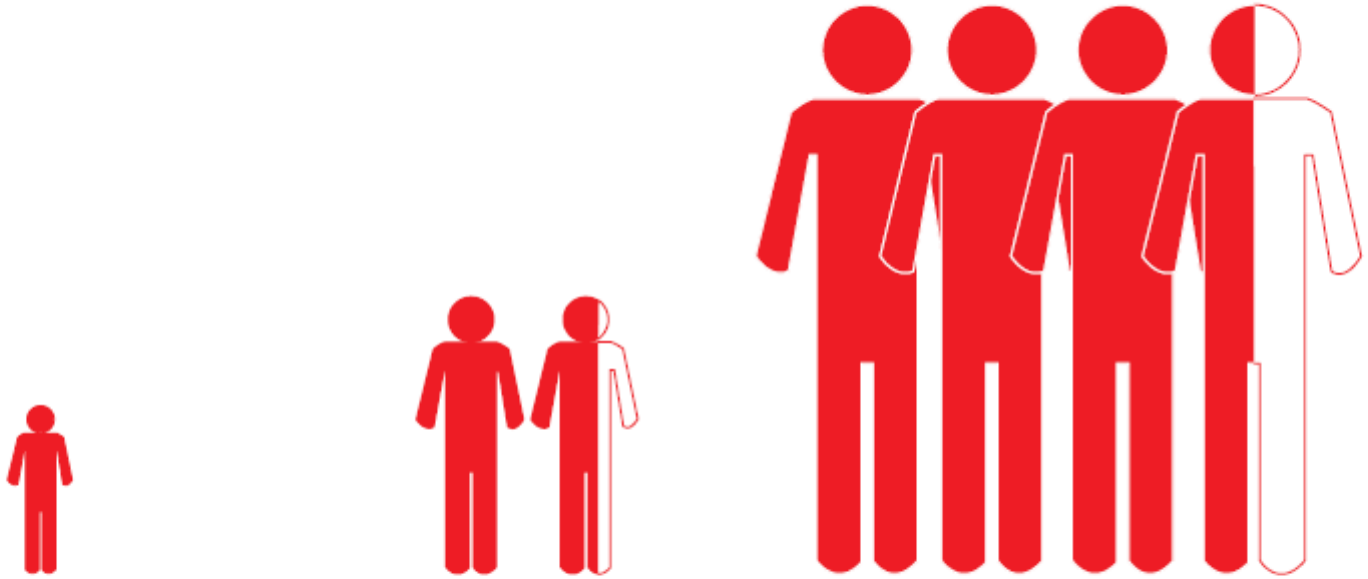
- Stigma, discrimination, social isolation, possible racism
- Stigma may lead to dropping out of school and to homelessness at a young age.
- Some TG patients may turn to substance use to deal with stress
- Some may turn to sex work for survival

HIV

- Estimated HIV prevalence in transgender women
  - 28% in US
  - 56% in African-Americans
  - 18-22% worldwide
- Higher rates in unemployed persons, and persons who have engaged in sex work and IV drug use

(Baral, 2013; Herbst, 2008; Schulden, 2008)

Risk for HIV Infection



Level of Family Rejection

Ryan, Family Acceptance Project, 2009

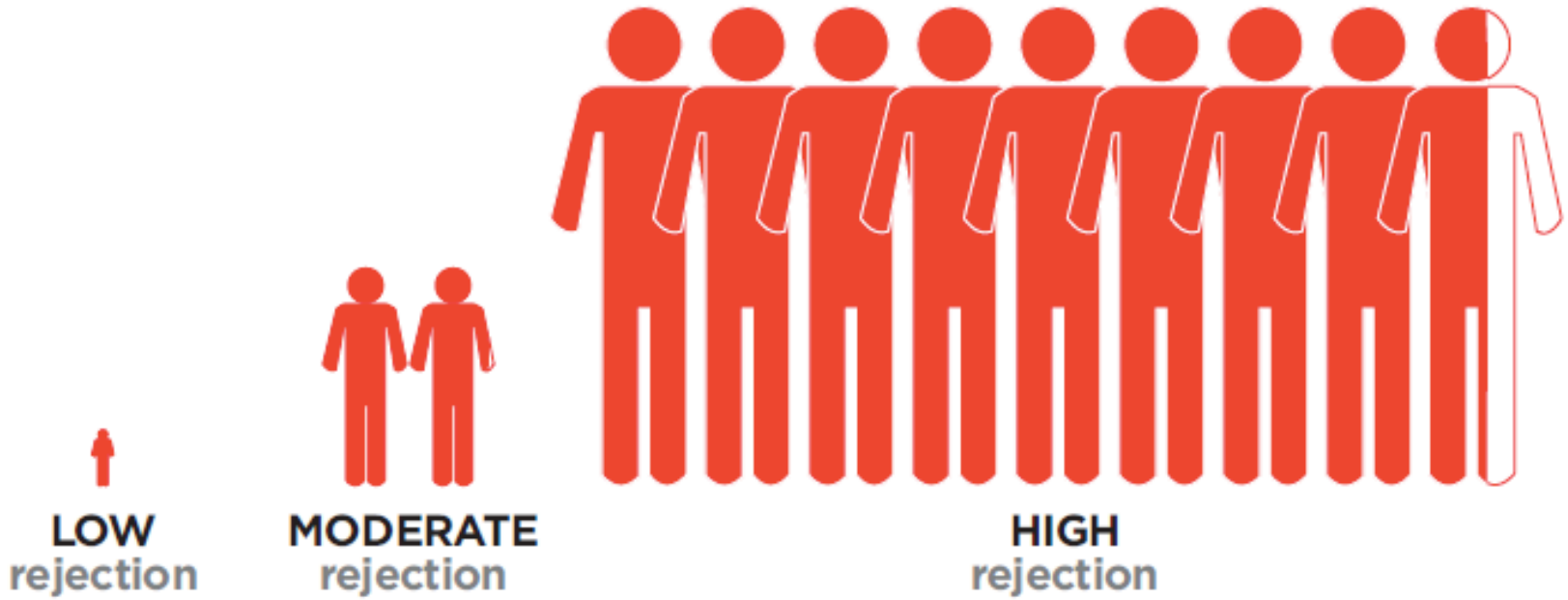
Depression/Anxiety

The Impact of Stigma on Mental and Behavioral Health: The Research

- Majority of studies on transwomen (MTF) only
- Suicidal thoughts (54%) attempts (31%) (Herbst et al., 2008)
- Depression (62%) (Clements-Nolle et al., 2001)
- Substance abuse
  - IDU (12%)
  - Crack or other Illicit drugs (27%)
- HIV prevalence: (Herbst et al., 2008)
  - ~16% white and Hispanic
  - 56% African-American

Lifetime Suicide Attempts for Highly Rejected LGBT Young People

(One or more times)



Ryan, Family Acceptance Project, 2009

WHEN TRANS PEOPLE GET THE CARE THEY NEED

OVERALL MENTAL HEALTH IMPROVES

78% OF TRANS PEOPLE HAD IMPROVED PSYCHOLOGICAL FUNCTIONING AFTER RECEIVING GENDER-CONFIRMING TREATMENT.

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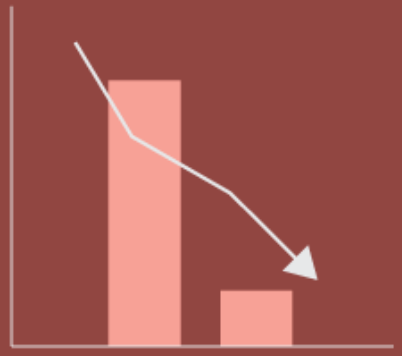


SUICIDE RATES DROP DRASTICALLY

FROM A RANGE OF 29% TO 19% BEFORE GENDER-CONFIRMING TREATMENT, TO A RANGE OF 6% TO .8% AFTER TREATMENT.

+

MEDICAID MONEY IS SAVED

TRANS PEOPLE WHO RECEIVE GENDER-CONFIRMING TREATMENT HAVE FEWER MENTAL HEALTH AND SUBSTANCE ABUSE COSTS, WITH HIGHER RATES OF EMPLOYMENT.

Take home points

- Transgender is a broad term
- Many patients don't fit into a binary model
- Transgender patients are an underserved population with significant health disparities
- Respect and confidentiality are key
- Much care of transgender patients may be performed in a primary care setting…

- And we in college health can (and should) be providing that care!

Want to learn more?

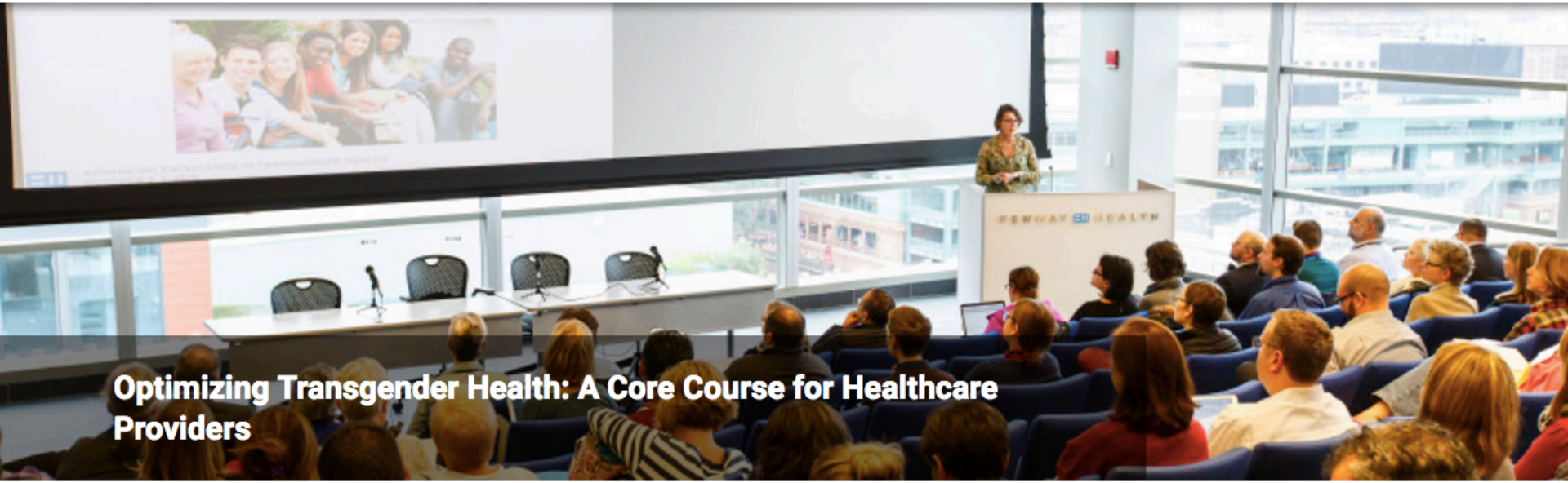
Excellent resource for primary care protocols

Excellent LGBT health resource and online educational modules

www.lgbthealtheducation.org

NATIONAL LGBT HEALTH EDUCATION CENTER
A PROGRAM OF THE FENWAY INSTITUTE

Home Education News & Events About Us Contact



Optimizing Transgender Health: A Core Course for Healthcare Providers

Introducing *TransTalks* – a new online training series on the health care needs of the transgender community for medical professionals. This new series, featuring presentations given by nationally-recognized experts at Fenway's *2015 Advancing Excellence in Transgender Health Conference*, covers topics critical to the foundation of quality care for the transgender community, and and will provide free continuing education credits for medical professionals.

The training, comprised of six videos, each dedicated to a critical topic – from primary and preventative care to surgical options and hormone treatments; to caring for youth and adolescents and case scenarios – will be made available over the next three weeks, with two videos released every week.

TRANSTALKS
TRANSGENDER TRAINING FOR HEALTHCARE PROVIDERS

WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

GEI Training
Surgical Course
Foundations Course
OTHER UPCOMING GEI EVENTS
GEI News

Foundations Course

Foundations Course

WPATH Certified Foundations Training Course
Transgender Health: Best Practices in Medical and Mental Health Care

December 2-4, 2016 Arlington, Virginia
Marriott Crystal Gateway Hotel

Questions? Comments?

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