WRIGHT STATE UNIVERSITY / BOONSHOFT SCHOOL OF MEDICINE / DEPARTMENT OF PSYCHIATRY

PROVIDING GENDER-AFFIRMING CARE FOR TRANSGENDER PATIENTS

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Purpose

To aid in recognition of the unique needs and obstacles of transgender patients, and to encourage gender-affirming care

Background

Gender versus Sex

- "Sex" or "sex assigned at birth" is generally defined as the biological sex of a person established at birth, often characterized as male or female, but is, in fact, nonbinary and may also be classified as intersex or within other nonbinary variations.[1]
- Gender is a social construct and is how a person self-identifies, and is similarly nonbinary. Gender may be classified as cisgender male or female, nonbinary, gender fluid, genderqueer, transgender male or female, et al. The binary construct of gender is one of Western context and is not absolute.[2]
- How a person externally represents themselves (i.e. through apparel, hair style, voice, behavior, etc.) is known as their gender expression, and may or may not correspond to their internal gender identity.[3] For various reasons, including but not limited to comfort, safety, self-realization, laws, institutional guidelines, and conformation to social norms, the gender expression of a person may not align with their identity.

Epidemiology and Health Disparities

- A 2016 systematic review by Collin et al. finds a prevalence of self-reported transgender identity as high as 0.1-0.7%, yet registration and intake forms typically provide only gender-binary options.[4]
- Studies show that up to 70% of gender minority adults self-report a history of discrimination from health providers.[5]
- Transgender patients experience radically increased rates of substance use disorders, tobacco use, major depression, suicidality, and other psychiatric diseases,[6] as well as suicide attempts (SA), higher still among transgender people of color or those with disabilities.[7]
- A study of 6,450 transgender and nonbinary people found that 41% self-reported a history of SA: a statistic 27 times that of the general public,[8] with similar statistics in an Australian study by Zwickl et al.[9]
- Nonaccess to gender-affirming surgery has demonstrated a 71% greater odds of SA in transgender patients.[9]
- In 2018, a survey found that 80% of medical students felt not competent at treating transgender patients, across 10 different medical schools.[5]

Diagnostic Criteria, *Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5)*

Gender dysphoria is briefly defined as incongruence in gender identity and sex assigned at birth causing significant impair and distress; it is important to note that gender dysphoria is not synonymous with being transgender.[3] However, many treatment options, such as gender-affirming surgery and hormone therapy, are frequently only accessible for patients classified with this DSM-5 diagnosis.[7]

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Case Presentation

Joshua H, a 16 year-old transgender male, using he/him/his pronouns

History of Present Illness:

- Presented to the children's hospital for intentional Tylenol overdose
- Presented with severe 10/10 abdominal pain, somnolence, and nonbilious emesis
- Initially admitted to the hospital pediatrics service for medical stabilization
- Inpatient psychiatry was consulted, but deferred treatment until medical clearance

Past Psychiatric History:

- No known psychiatric history or prior psychiatric treatment

Past Medical History:

- None

Initial Psychosocial History:

- No known alcohol, tobacco, drug use
- Parents live together in a single-family home with the patient; no siblings
- Currently in 10th grade, on track to receive honors

*Only 20% of medical students **felt competent** at treating transgender patients*[5]

Diagnosis and Hospital Stay

Hospital Day One

- Physical and mental status exam limited due to somnolence, no focal neurologic deficits
- Liver functions and INR were found to be elevated; CMP and CBC otherwise within normal limits
- Patient was promptly treated with N-acetylcysteine

Hospital Day Two

- Alertness and orientation were significantly improved; quiet but pleasant affect; appropriate mood
- Patient admitted to depression for the past two years, with two prior suicide attempts
- Inpatient PHQ-9 was found to be 29

Deeper Psychosocial History

- Joshua reported an affirming and supportive household; denies any history of physical or sexual abuse
- Reported consistent bullying and misgendering at school
- Reported that his peers and teachers refuse to use his preferred name and continue to refer to him as "a girl", harassing him every time that he uses male restrooms or locker rooms
- Never seen a mental health provider or received gender-affirming treatment, but desires hormone therapy

Diagnosis

- major depression and gender dysphoria

Intervention and Response

- Joshua's senior resident was adamant to use Joshua's preferred name and to consistently use appropriately male pronouns regarding Joshua, and to consistently present Joshua as a "16 year-old male"
- The senior resident insisted that the rest of her medical team likewise refer to Joshua using these terms
- The children's hospital used a standard electronic medical record system, which allowed for SOGIE (sexual orientation, gender identity, gender expression) data to be put into patients' charts, but did not allow providers or staff to change patients' names or genders
- The senior resident and medical team were thus intentional about using accurate pronouns and Joshua's preferred name in all of his notes, as well as on a "post-it" in his chart
- None the less, when running the list at the end of Hospital Day Two, the senior resident incorrectly named Joshua as "Allison" and misgendered him when going through his information; despite the team's best efforts, this was still the name and sex printed from the patient list and chart

*Incidence of **suicide attempts** in transgender people is as high as **1:27** that of the general public*[8]

Conclusion

This case study demonstrates a common barrier to affirmative care for transgender patients, expressed by the limits in the electronic medical record system. Transgender patients, who face significant disparities in depression, anxiety, and suicide, as well as frequently gender dysphoria, are extremely vulnerable to mistreatment within the medical community, including microaggressions of misgendering and incorrect name use, as well as frank harassment and abuse. Effective gender-affirming care thus necessitates a conscious effort by providers and medical staff of all specialties, with recognition of their shortcomings.

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