Acknowledgments

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• The National Trauma-Informed Care Education and Research Group (TIHCER).

• Other references available upon request.
Learning Objectives

1. Portray the range of stressors experienced disproportionately by TGD individuals.

2. Analyze how a lived experience of trauma can interfere with the formation of therapeutic relationships between TGD patients and providers.

3. Describe how to use universal trauma-informed approach to enhance engagement of TGD patients in care and promote their health and well-being.
LISTEN TO YOUR BODY. ITS SMARTER THAN YOU.
What is Trauma?

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma as "an **event**, series of events, or set of circumstances that is **experienced** by an individual as physically or emotionally harmful or life threatening and that has lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."
Types of Trauma

**Violence & Abuse**
- Adverse Childhood Experiences
- Intimate partner violence
- Sexual violence
- War & Terror
- Gun violence
- Slavery

**Discrimination**
- Sexism
- Racism
- Ableism
- Ageism
- Homophobia
- Transphobia
- Islamophobia

**Physical trauma**
- MVAs
- Falls

**Social Determinants of Health**
- Homelessness
- Food insecurity
- Economic instability
- Substance use

**Natural Disasters**
- Earthquakes
- Hurricanes

**Medical Trauma**
- Hospitalizations
- Death & dying
- Medical error
- Procedures
- Implicit bias

**Societal**

**Institutional**

**Interpersonal**

**Individual**
TGD People Experience a Disproportionate Burden of Trauma
Adverse Childhood Experiences (ACEs)

**ABUSE**
- Physical
- Emotional
- Sexual

**NEGLECT**
- Physical
- Emotional

**HOUSEHOLD DYSFUNCTION**
- Mental Illness
- Incarcerated Relative
- Mother treated violently
- Substance Abuse
- Divorce
ACEs are Common

n=200,000 adults in the 2011-2014 Behavior Risk Factor Surveillance System (BRFSS)

More common among TGD adults

Dose-Response Relationship with Health Outcomes
<table>
<thead>
<tr>
<th>BEHAVIOR</th>
<th>PHYSICAL &amp; MENTAL HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of physical activity</td>
<td>Severe obesity</td>
</tr>
<tr>
<td>Smoking</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>Depression</td>
</tr>
<tr>
<td>Drug use</td>
<td>Suicide attempts</td>
</tr>
<tr>
<td>Missed work</td>
<td>STDs</td>
</tr>
<tr>
<td></td>
<td>Heart disease</td>
</tr>
<tr>
<td></td>
<td>Cancer</td>
</tr>
<tr>
<td></td>
<td>Stroke</td>
</tr>
<tr>
<td></td>
<td>COPD</td>
</tr>
<tr>
<td></td>
<td>Broken bones</td>
</tr>
</tbody>
</table>
Mechanisms by which ACEs Influence Health and Wellbeing

- Death
- Disease, Disability, and Social Problems
- Adoption of Health-Risk Behaviors
- Social, Emotional, and Cognitive Impairment
- Disrupted Neurodevelopment
- Adverse Childhood Experiences

Conception → Death
LGBTQ Youth: Bullying, Family Rejection, Homelessness, Incarceration

Schools are **UNSAFE and UNWELCOMING FOR THE MAJORITY OF LGBT STUDENTS.**

- 65% Heard homophobic remarks frequently or often
- 30% Missed at least one day of school
- 85% Verbally harassed at school in the past year

LEARN MORE IN GLSEN’S LATEST NATIONAL SCHOOL CLIMATE SURVEY AT GLSEN.ORG/NSCS

**LGBTQ Youth Homelessness**

**Causes**

- Family Rejection
- Physical Abuse
- Sexual Abuse
- Neglect

**By the Numbers**

- 20-40% of youth experiencing homelessness are LGBT
- 5-7% of the US population is LGBT


**LGBTQ Youth Incarcerated in the Juvenile Justice System**

- LGB YOUTH OVERREPRESENTED IN THE CRIMINAL JUSTICE SYSTEM
- 26%
- 85% are youth of color

- OF GAY AND GENDER NON-CONFORMING YOUTH IN JUVENILE JUSTICE FACILITIES

**Youth in Juvenile Justice Facilities**

- Appropriate Placement
- Abuse by Other Youth
- Inadequate Health Care
- Challenges with Family and Friends
- Inappropriate Community Supervision
LGBTQ Domestic Violence/Hate Crimes

LGBTQ & Domestic Violence
from DomesticShelters.org

The facts about LGBTQ partner abuse/domestic violence are often hidden by numerous myths and misconceptions. Common myths and misconceptions include the belief that women are not violent, that men are not commonly victims, that LGBTQ domestic violence is mutual, and that there are no significant differences between heterosexual domestic violence and same-gender domestic violence. However, people who are lesbian, gay, and bisexual have an equal or higher prevalence of experiencing intimate partner violence, sexual violence, and stalking as compared to heterosexuals.

44% of bisexual women
61% of lesbian women
35% of gay men

26% of gay men
37% of bisexual men
29% of lesbian women

NEARLY HALF

There are many similarities between how abusers control their victims regardless of sexual preference.

In LGBTQ relationships, the abuser may use the additional tactic of threatening to “out” their victims to work colleagues, family, and friends.

A GROWING ISSUE
Findings from the 2011 NCAVP Hate Violence Report

ANTI-LGBTQH MURDERS
2009 2010 2011

30 HIGHEST EVER

22 27

AN UPWARD TREND

87% of anti-LGBTQH murder victims in 2011 were PEOPLE of COLOR

45% of reported hate murders were TRANSGENDER WOMEN

while representing only 10% of total hate violence survivors and victims.

Statistics via the National Coalition of Anti-Violence Programs
NCAVP is a program of the New York City Anti-Violence Project
1 in 2 transgender people are sexually assaulted.

Sexual assault doesn’t discriminate. #UsToo
Internalized Transphobia

- Early occurrence
- Being silenced or not believed
- Blaming or shaming
- Perpetrator is a trusted caregiver

Blaming or shaming

Being silenced or not believed

Perpetrator is a trusted caregiver

Early occurrence
Trauma and Social Location

Adverse Childhood Experiences*  
Disease, Disability, and Social Problems  
Adoption of Health-risk Behaviours  
Social, Emotional, & Cognitive Impairment  
Adverse Childhood Experiences

Historical Trauma/Embodiment  
Burden of dis/ease, distress, criminalization, stigmatization  
Coping  
Allostatic Load, Disrupted Neurological Development  
Complex Trauma/ACE

Race/Social Conditions/Local Context  
Generational Embodiment/Historical Trauma

*http://www.cdc.gov/violenceprevention/acetudy/pyramid.html
Unemployed, Uninsured, Living in Poverty

Higher Unemployment Rates for LGBT People of Color

Queer People Uninsured: 17%
Trans People Uninsured: 25%
Bisexual People Uninsured: 19%

Learn about your health insurance options now at www.healthcare.gov

Source: Center for American Progress, "Why Repealing the Affordable Care Act is Bad Medicine for LGBT Communities," 2017

#GetCovered #BeOutBeHealthy
Healthcare’s Failure to “Do no Harm”
Ex: Psychological Attempts to Change Gender Identity

<table>
<thead>
<tr>
<th>Systems Level (“Way Things Are Done”)</th>
<th>Relationship Level (Who Has Power/Control)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being treated as a number</td>
<td>Not being seen or heard</td>
</tr>
<tr>
<td>Being seen as one’s label (i.e., “addict”)</td>
<td>Violating trust</td>
</tr>
<tr>
<td>Having to continually retell one’s story</td>
<td>Failing to ensure emotional safety</td>
</tr>
<tr>
<td>Procedures that require disrobing</td>
<td>Failure to ensure physical safety</td>
</tr>
<tr>
<td>No choice in service or treatment</td>
<td>Does things “to”, “on”, or “for” rather than “with”</td>
</tr>
<tr>
<td>No opportunity to give feedback about service delivery</td>
<td>Use of punitive treatment, coercive practices, or oppressive language</td>
</tr>
</tbody>
</table>
We Can Trans-Form Healthcare
SAMHSA’S Six Principles of TIC

- Safety
- Trustworthiness & Transparency
- Peer Support
- Collaboration & Mutuality
- Empowerment, Voice & Choice
- Cultural, Historic & Gender Issues

SAMHSA, 2014.
Clinician-Patient Relationship
Foundation for Adaptive Coping and Resilience

“WITH”, rather than “ON”, “TO”, or “FOR”
Case (Part 1)

According to the EHR, your next patient is 22-years-old, has a male insurance sex, and a gender-neutral name. The MA lists “difficulty sleeping” and “feels tired all the time” as reasons for the visit. After knocking on the door and entering the room, you encounter an androgynous-appearing individual, who does not make eye contact with you as you introduce yourself.

Questions:
• What is the likelihood that this individual has experienced trauma or adversity?
• How would you begin the visit?
Gender and Power Dynamics

Ex. Cervical Cancer Screening

Peitzmeier et al. Culture Health Sexuality 2019; in press.
Gender Dynamics: Ask Everyone for Name, Pronouns

- What name do you go by?
- What pronouns do you use?
Use Gender Inclusive Diagrams

- TGD patients may not identify medical issues on gendered diagrams.
- Use gender-inclusive images to document areas of concern.

Power Dynamics

• Sit at eye level.
• Conduct the interview with the patient clothed.
• Speak slowly and clearly.
• Develop a shared agenda.
• Offer choices for disclosure, examination, procedures, treatment.
• Ensure that locus of control is with the patient at all times.
Case (Part 2)

Proceeding further with the interview, you ask for the patient’s name (Dayo), sex assigned at birth (AFAB), gender identity (genderqueer), and pronouns (they/them/their). Now that you know their gender identity, you find yourself wondering if they are using any gender-affirming hormones or have had any gender-affirming surgeries.

Questions:
• Is it relevant to ask TGD patients about hormones and/or surgeries?
• If so, how would you ask?
I’d like to take an organ inventory to know what body parts we need to consider when evaluating your current symptoms.

I ask all of my patients for this information. Is that OK with you?

Please take a look at this list and let me know which of these body parts you have present.

What words do you use to refer to these body parts?
GENDERED TERMS

These terms may be uncomfortable or distressing for trans men to hear.

- Breasts
- Vulva
- Vagina
- Uterus, Ovaries
- Pap smear
- Bra, Panties
- Period, Menstruation

LESS GENDERED TERMS

Try your best to use neutral and inclusive terminology to avoid patient discomfort. If you are unsure, ask what terms your client prefers.

- Chest
- External Pelvic Area
- Genital Opening, Frontal Pelvic Opening, Internal Canal
- Internal Organs
- Cancer screening
- Underwear
- Bleeding

*Language may be adapted to male external genital, anorectal, prostate exams. JGIM 2015;30:1857-64.
Case (Part 3)

Dayo volunteers that they started taking testosterone a year ago and stopped bleeding shortly thereafter. They haven’t had any gender-affirming surgeries yet. They use the terms “chest” (breasts) and “front hole” (vagina). As you begin to explore their presenting symptoms in more depth, one of the MAs knocks on the door and brings the patient a jacket they left in the waiting room. In thanking the MA, you use the wrong pronouns by mistake (“Thanks so much for noticing that she left her jacket out there”).

Questions:
• How might you feel after misgendering Dayo?
• How might you utilize TIC principles to handle this situation?
• If it had instead been the MA who misgendered Dayo, how could you have used TIC principles to supportively educate the MA and the rest of the office staff?
Possible direct response: I’m sorry I made that mistake. I will be conscious going forward to be correct in my use of your pronouns. I am open to talking about how that felt to you just now, if you would like.

When addressing others: I noticed you said ‘she’ to that patient. I wanted to let you know that they identify as non-binary, so it’s best to use ‘they’. I am happy to discuss pronouns further with you anytime if you have questions.

Courtesy of Samara Grossman LICSW
Case (Part 4)

After you offer a straightforward apology, Dayo responds by saying “I’m used to it”, continues to avoid making eye contact, and slumps back into their chair.

Questions:
• How do you interpret Dayo’s reactions?
• How might you respond?
## Post-Traumatic Stress Disorder

<table>
<thead>
<tr>
<th>Intrusion (Re-experiencing)</th>
<th>Avoidance of Potential Triggers</th>
<th>Changes in Thoughts and Feelings</th>
<th>Changes in Arousal and Reactivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involuntary memories</td>
<td>Avoiding trauma-related:</td>
<td>Inability to remember key features of event</td>
<td>Irritable behavior and angry outbursts</td>
</tr>
<tr>
<td>Traumatic nightmares</td>
<td>• Thoughts and feelings</td>
<td>Distorted beliefs about self or others (“I am bad”, “No-one can be trusted”)</td>
<td>Reckless or self-destructive behavior</td>
</tr>
<tr>
<td>Flashbacks</td>
<td>• Conversations and activities</td>
<td>Ongoing fear, horror, anger, guilt, or shame</td>
<td>Hyperarousal and hypervigilance</td>
</tr>
<tr>
<td>Intense or prolonged distress after exposure to reminders (triggers)</td>
<td>• People and places</td>
<td>Lack of interest in activities previously enjoyed</td>
<td>Exaggerated startle response</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sense of alienation and detachment</td>
<td>Sleep and concentration problems</td>
</tr>
</tbody>
</table>
Nervous System Regulation

Hyper-arousal
- Panic, implusivity, survival responses - fight/flight, hypervigilance, anger, agitation

Hypo-arousal
- Numbness, submission, desensitisation, poor self-care or boundaries, shut down

Window of Tolerance
- Feelings and responses are manageable and do not prevent thinking
<table>
<thead>
<tr>
<th>Reaction</th>
<th>Behavioral Manifestations</th>
<th>Unhelpful Clinician Interpretations</th>
<th>Trauma-Informed Interpretations</th>
</tr>
</thead>
</table>
| **Fight** | Animated
Impatient
Irritable, angry
Loud voice | ‘Aggressive’
‘Combative’
‘Resistant’
‘Provocative’
‘Sullen’ | Hyperaroused
‘Stuck on high’
Attempting to regain or hold on to personal power |
| **Flight** | Anxious
Confused
Forgetful
Restless
Fidgeting
Easily startled
Eyes darting | ‘Non-adherent’
‘Non-compliant’ | Hyperaroused
‘Stuck on high’
Attempting to avoid or escape from those in power |
| **Freeze** | Acquiescent
Withdrawn
Distracted, not paying attention
Distant look to eyes
Quiet/faint voice | ‘Passive’
‘Disengaged’ | Hypoaroused
‘Stuck on low’
Shutting down in response to power |
Optimal Arousal Zone

**Hyper-aroused:**
‘Fight’ - irritable, aggressive, agitated - Attempting to regain or hold on to personal power – Often labeled as “difficult”
‘Flight’ – avoidant, restless, confused - Attempting to avoid or escape from those in power- Often labeled as ‘noncompliant”

**Optimal Zone:**
‘Calm’ - responsive, engaged, relational - able to self regulate and/or interact with other/s in environment to address issues as they arise

**Hypo-aroused:**
“Freeze” – acquiescent, withdrawn, distracted, flat affect - Attempting to be invisible to those in power- Often labeled as “passive” or “disengaged”

To stay in the optimal zone:
- Increase physical and mental awareness of triggered states
- Practice self-regulation via deep, slow breathing; noticing immediate surroundings; fact checking safety; body movements that restore a sense of calm

Grossman, Berman & Potter 2020
Grounding Exercise: Feet, Seat and Back

Grounding Exercise

Name 3 Things:
- You see
- You smell
- You hear
- You feel

Breathe in and out slowly 3x
In recognition of Dayo’s strength in coming to the appointment and to restore their sense of power and control, you say, “I appreciate how difficult coming to this appointment may have been, and how being here now may still be difficult... Let’s take a break and check in. Is there anything you would like me to adjust right now?” Your question seems to ease the discomfort in the room, and Dayo agrees to tell you more about their presenting complaints. You learn that they suffer from fatigue, periods of forgetfulness, chronic undiagnosed stomach pain, and difficulty sleeping.

**Questions:**
- What presenting symptoms may suggest a history of trauma among TGD patients?
- What physical exam findings may suggest a history of trauma among TGD patients?
Symptoms Suggestive of Trauma

• Anxiety, depression, PTSD

• Fatigue, headaches, jaw pain related to teeth grinding, palpitations, GI symptoms, sexual difficulties, sleep disturbance, chronic pain.

• Many patients have been told that “nothing is wrong” or “it’s all in your head.”
Findings Suggestive of Trauma

• Common sites of injury:
  – Transgender women: face and genitalia
  – Transgender men: chest and genitalia

• Non-suicidal self injury (e.g., cutting/burning):
  – Common among TGD individuals
  – May also focus on chest and genitalia
How to Help Suicidal TGD Patients Access Higher Levels of Care

• Based on what you are saying I am going to need to call the ambulance to bring you to the ER. Do you have any questions about the process?

• Normally… (then describe each step that you reasonably think the patient can expect to experience).

• Would you like to take a moment to call anyone to meet you at the hospital/let them know that you are going?

• I will call ahead to the clinicians at the ER and explain to them why I sent you. Is there anything else you would like me to tell them?”

Courtesy of Samara Grossman LICSW
Case (Part 6)

Based on the symptoms Dayo is reporting, you begin to suspect a trauma history. You believe that it is important to obtain a more thorough, trauma-oriented history.

Questions:
- What are the potential benefits of trauma inquiry in this situation? What are the potential complexities?
- If you decided to obtain a trauma history, how would you proceed?
- How would you respond to positive disclosure?
# Trauma-Informed Trauma Inquiry

<table>
<thead>
<tr>
<th>Safety</th>
<th>If you feel uncomfortable at any time, please say pause and we will take a break. You get to lead this discussion.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transparency</td>
<td>I’d like to learn more about what has happened to you so that I can more fully understand your symptoms.</td>
</tr>
<tr>
<td></td>
<td>I will ask you some questions and you can answer in the ways that feel most comfortable.</td>
</tr>
<tr>
<td></td>
<td>If you feel overwhelmed or I notice you are overwhelmed, I may suggest we take a break.</td>
</tr>
<tr>
<td>Peer Support</td>
<td>Would you like anyone with you while we talk about your history?</td>
</tr>
<tr>
<td>Collaboration</td>
<td>We can work together to find a pace that works for you in telling me about your past as it relates to your current symptoms.</td>
</tr>
<tr>
<td>Empowerment</td>
<td>You decide what is important for me to know.</td>
</tr>
</tbody>
</table>

Courtesy of Samara Grossman LICSW
Case *(Part 7)*

After you ask an open-ended question, Dayo discloses a history of penile-frontal sexual assault 6 months ago. Luckily, a friend took them to the ED immediately afterward, where they received appropriate care, including medicines to prevent STIs and pregnancy. The ED also gave the patient a list of recovery programs, but they didn’t follow-up because, “None of the programs out there are going to want to see a person like me”.

**Questions:**
- What barriers might Dayo encounter when trying to access trauma recovery services?
- How would you locate TGD-sensitive trauma recovery services?
## Responding to Trauma Disclosure

<table>
<thead>
<tr>
<th>Communicate belief</th>
<th>That must have been frightening for you.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Validate the decision to disclose</strong></td>
<td>I understand it could be very difficult for you to talk about this.</td>
</tr>
<tr>
<td><strong>Acknowledge injustice</strong></td>
<td>Violence is unacceptable. I’m sorry that happened, that should not have happened.</td>
</tr>
<tr>
<td><strong>Be clear that the patient is not to blame</strong></td>
<td>What happened is not your fault.</td>
</tr>
<tr>
<td><strong>Help the patient contain their story to reduce the risk of retraumatization</strong></td>
<td>This information is really important and I wonder if telling it right now might be overwhelming to you or your body? Let’s take a moment to breathe and then tell me what you think.</td>
</tr>
<tr>
<td><strong>Let the patient know that help is available</strong></td>
<td>A next step that might be useful is to give you some referral options to (people) (programs) that specialize in healing and recovery. Do you feel this would be helpful to you right now?</td>
</tr>
<tr>
<td><strong>Collaborate with and empower the patient</strong></td>
<td>Are there resources you know of that you would like my help accessing? The next steps in referral are entirely up to you.</td>
</tr>
</tbody>
</table>

*Courtesy of Samara Grossman LICSW*
Resources for Healing and Recovery

theNetworklaRed
Survivor-led organizing to end partner abuse
Dirigida por sobrevivientes • Movilizando para acabar con el abuso de pareja
After responding appropriately to Dayo’s disclosure and offering a referral, they thank you for the suggestion, but say they want to think about it more before taking action. Dayo then returns to their presenting concerns: “First, I want to make sure we do something about what I came in here for today”.

Questions:
• How would you approach performance of a physical exam to evaluate Dayo’s symptoms?
Any exam or procedure has the potential to be traumatizing.
More common with ‘vulnerable’ (i.e., chest, genital, rectal) exams
Common Experiences

• Prior exposure to traumatic/voyeuristic exams
• Inappropriate gendering of certain exams (pelvic = “well-woman exam”)
• Dysphoria during examination of body parts that are discordant with one’s gender
• Dysphoria if provider uses triggering terms to refer to body parts
Trauma-Informed Physical Exam

ask First
Creating a Culture of Consent
# TI Exam: General Principles

| **Safety** | • Avoid potentially triggering language (e.g., words with sexual or violent connotations).  
|            | • Stay within the patient’s line of sight at all times.  
|            | • Maintain an appropriate physical distance. |
| **Transparency** | • Explain reasons for performing the exam and what it will entail. |
| **Peer Support** | • Ask if the patient would like to have a trusted companion in the room during the exam. |
| **Collaboration** | • Review options to optimize patient comfort during the exam.  
|            | • Check in periodically to ask how the patient is doing. |
| **Empowerment** | • Ask before touching throughout the exam (i.e., when moving from one part of the body to another).  
|            | • Obtain permission before proceeding.  
|            | • Stop immediately if requested by the patient. |
# Pelvic Exam Modifications

<table>
<thead>
<tr>
<th>Exam Element or Technique</th>
<th>Modification Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chaperone</td>
<td>Patient’s choice of support person</td>
</tr>
<tr>
<td>Positioning for exam</td>
<td>Feet on table rather than ‘footrests’</td>
</tr>
<tr>
<td>Speculum selection</td>
<td>Pedersen long narrow or pediatric speculum</td>
</tr>
<tr>
<td>Lubricant use</td>
<td>• Non-carbomer-containing water-based</td>
</tr>
<tr>
<td></td>
<td>• Consider use of topical lidocaine</td>
</tr>
<tr>
<td>Speculum insertion</td>
<td>Self-insertion</td>
</tr>
<tr>
<td>Cervical sampling</td>
<td>Trans male with prior unsatisfactory cytology: pretreat with 2 weeks of vaginal estrogen</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phrases to Avoid</th>
<th>Use Instead</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Don’t be scared, everything will be fine.</td>
<td>• What are you most afraid of?</td>
</tr>
<tr>
<td>• How can we help you through this?</td>
<td>• How can we help you through this?</td>
</tr>
<tr>
<td>• Stirrups</td>
<td>• Footrests</td>
</tr>
<tr>
<td>• Avoid unnecessary touching of the patient (e.g., “Scoot down on the table</td>
<td>• Please move your body down until you’re right at the edge of the table.</td>
</tr>
<tr>
<td>until your bottom touches my hand”)</td>
<td>• Allow your knees to fall to the sides as much as you can.</td>
</tr>
<tr>
<td>• I’m going to insert the speculum.</td>
<td>• I’m going to place the speculum now.</td>
</tr>
<tr>
<td>• I’m going to come into you now.</td>
<td>• It’s normal to feel a little pressure.</td>
</tr>
<tr>
<td>• I’m going to open the blades of the speculum.</td>
<td>• I’m going to open the speculum.</td>
</tr>
<tr>
<td>• I’m going to take the sample now... you may feel a “poke” [“prick”].</td>
<td>• You may feel a little discomfort or cramping.</td>
</tr>
<tr>
<td>• Hold still</td>
<td>• If you need to move, wiggle your toes or squeeze your hands.</td>
</tr>
<tr>
<td>• Relax</td>
<td>• Try to keep your pelvis resting on the table.</td>
</tr>
</tbody>
</table>

Adapted from: J Gen Intern Med 2015; 30: 1857-64.
Normalize Trans Bodies

• Curtail your curiosity– only ask questions that are medically necessary.
• Remember to use the patient’s terms when referring to anatomical structures.
• Do not visibly react to or comment on the patient’s body.
• Limit the number of providers the patient has to see.
Padding/Tucking

Tucking Tips:

• Using a gaff is the safest route.
• Never use duct tape.
• If it hurts; stop. Give your body a break.
• A tight pair of panties or shape-wear work great.
• High waisted bottoms work best; they help keep everything in place.
Binding/Packing

TOP TIPS FOR STAYING SAFE AND GETTING THE MOST OUT OF YOUR BINDER

1. Don't try to put on a wet binder.
2. Don't wear a size too small.
3. Don't pull your binder over your hips.
4. Don't wear your binder for more than 8 hours.
5. Don't exercise in your binder.
6. Don't use ace bandages or duct tape on your binder.
7. Take breaks, listen to your body, and stay safe.

[Images of different binders and tips]

[Images of penises and packaging]

[Images of a person wearing a binder and thumbs up]

[Images of a drawing and a person holding a package]
Dayo agrees to a physical exam, minus inspection of their chest and genitals, which you agree are not relevant to perform at this visit. Examination of their head, neck, lymph nodes, lungs, heart, abdomen, extremities, skin, and neurological system is normal. After completing the exam, you leave the room so Dayo can dress. After waiting a suitable period, you knock on the door to see if they are ready, and Dayo gives you permission to come back into the room.

Questions:
• How would you incorporate TIC principles into discussion of possible reasons for Dayo’s presenting symptoms and decision-making regarding next steps?
• What follow-up plans would you make?
| **Safety** | If at any point you have questions, disagree, want me to slow down, or repeat or change the subject, please let me know. |
| **Transparency** | I would like to explain to you how experiences from the past may be manifesting as symptoms in your body today. |
| **Peer Support** | Is there anyone you would like with you while we discuss your symptoms and next steps to take? |
| **Collaboration** | I consider everything we decide to do to address your current symptoms to be a plan we create *together*. I may make suggestions, including lab work to get done, or specialists to visit, and I understand you may disagree with these suggestions-- please let me know if you do. I am completely open to this. |
| **Empowerment** | I consider you to be in the ‘driver’s seat’ of your care. I want to hear your ideas about how to approach your current symptoms so that I can figure out how to best support you. |
| **Cultural Issues** | The symptoms you are having now may stem from prior experiences, but they are not your fault. They reflect a society that allows events like discrimination and oppression to happen. |

Courtesy of Samara Grossman LICSW
Case (Part 10)

Dayo chooses to have a panel of lab tests checked (all of which return normal), and to try CBT techniques to improve their sleep (with subsequent positive results). They return for monthly follow-up visits, during which they continue taking testosterone, accomplish all of their recommended health screenings, start seeing an individual therapist, and join a local TGD-sensitive violence recovery group. Six months later, they are feeling much better and making plans for top surgery.

Question:
• What else might you do to support Dayo’s ongoing recovery and resilience?
# Trauma-Informed Follow-Up

<table>
<thead>
<tr>
<th><strong>Safety</strong></th>
<th>Co-develop a safety plan to help the patient move back into their optimal zone when they get triggered.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transparency</strong></td>
<td>Explain and normalize the fact that trauma-related symptoms are likely to wax and wane over time.</td>
</tr>
<tr>
<td><strong>Empowerment</strong></td>
<td><strong>Peer Support</strong> Educate the patient on resilience factors. Name and celebrate the patient’s strengths. Help the patient build on their strengths by engaging in positive coping skills of the patient’s choice (connecting with peers, building community, engaging in health-promoting activities and activities that bring pleasure and joy).</td>
</tr>
<tr>
<td><strong>Cultural Issues</strong></td>
<td>Emphasize that social policies that negatively impact the human rights of TGD populations can cause TGD patients to feel triggered and experience decreased mood or other health consequences. Check in with patients at such times, to encourage an office visit and promote connection to community/activist groups.</td>
</tr>
</tbody>
</table>

Courtesy of Samara Grossman LICSW
<table>
<thead>
<tr>
<th>Affirming the patient’s gender throughout the encounter</th>
<th>Performing the exam in a collaborative manner that resists retraumatization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending to power dynamics throughout the encounter</td>
<td>Recognizing symptoms and exam findings that may suggest a history of trauma</td>
</tr>
<tr>
<td>Obtaining the history in a patient-led manner</td>
<td>Recognizing and responding productively when a patient becomes dysregulated</td>
</tr>
<tr>
<td>Asking about trauma in a manner that resists retraumatization</td>
<td>Co-developing care plans that are patient-empowering and enable mutual respect, safety, and ongoing engagement</td>
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<tr>
<td>Responding appropriately to trauma disclosure</td>
<td>Facilitating connection to TGD-sensitive trauma recovery services</td>
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<tr>
<td></td>
<td>Recognizing, celebrating, and building on the patient’s strengths over time</td>
</tr>
</tbody>
</table>

Courtesy of Samara Grossman LICSW
Thank You!