Trauma-Informed Care for Trans and Gender-Diverse Individuals

Trans Health Conference 2020

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Acknowledgments

• Samara Grossman and Sarah Berman, co-authors of *Trauma-Informed Care for TGD Patients.*

• Sadie Elisseou, co-author of *Trauma-Informed Physical Examination for TGD Patients.*

• Harvard Medical School’s Trauma-Informed Care Curricular Theme Steering Committee.

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

• 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 a *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

Discrimination
Sexism
Racism
Ableism
Ageism
Homophobia
Transphobia
Islamophobia

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

Social Determinants of Health
Homelessness
Food insecurity
Economic instability
Substance use

Natural Disasters
Pandemics
Earthquakes
Hurricanes

Medical Trauma
Invasive procedures
Hospitalizations
Death & dying
Medical error

Physical Trauma
Motor vehicle accidents
Occupational injuries
Falls
TGD People Experience a Disproportionate Burden of Trauma
Adverse Childhood Experiences (ACEs)
ACEs are Common

- **0 ACEs**: 38%
- **1 ACE**: 24%
- **2 ACEs**: 13%
- **3 ACEs**: 9%
- **4+ ACEs**: 16%

*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
### Behavior
- Lack of physical activity
- Smoking
- Alcoholism
- Drug use
- Missed work

### Physical & Mental Health
- Severe obesity
- Diabetes
- Depression
- Suicide attempts
- STDs
- Heart disease
- Cancer
- Stroke
- COPD
- Broken bones
LGBTQ Youth: Bullying, Family Rejection, Homelessness, Incarceration
IPV/Sexual Assault/Hate Crimes

LGBTQ & Domestic Violence
from DomesticShelters.org

The facts about LGBT 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 LGBT 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.

A GROWING ISSUE
Findings from the 2011 NCAVP Hate Violence Report

AN UPWARD TREND

22 ANTI-LGBTQ MURDERS

2011

30 HIGHEST EVER
reported by the NCAVP

out, gay, lesbian, bisexual, transgender, queer, and HIV-affected
murders have increased over the last 3 years.

1 IN 2
TRANSGENDER PEOPLE ARE SEXUALLY ASSAULTED

Sexual assault doesn’t discriminate. #UsToo

10% of reported hate murders were transgender hate murders, while representing only 10% of total hate violence survivors and victims.
Trauma and Social Location

Adverse Childhood Experiences*

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

Scientific gaps

Historical Trauma/Embodiment

- Early Death
- Burden of disease, distress, criminalization, stigmatization
- Coping
- Allostatic Load, Disrupted Neurological Development
- Complex Trauma/ACE
- Race/Social Conditions/Local Context
- Generational Embodiment/Historical Trauma

Microaggressions, implicit bias, epigenetics

*http://www.cdc.gov/violenceprevention/acesstudy/pyramid.html

RYSE 2015
Unemployed, Uninsured, Living in Poverty

Higher Unemployment Rates for LGBT People of Color

<table>
<thead>
<tr>
<th>General Population</th>
<th>Asian/Pacific Islander LGBT Adults</th>
<th>Latino LGBT Adults</th>
<th>African American LGBT Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>8%</td>
<td>11%</td>
<td>14%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Don't be a statistic

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><strong>Systems Level</strong></th>
<th><strong>Relationship Level</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>(“Way Things Are Done”)</td>
<td>(Who Has Power/Control)</td>
</tr>
<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
REALIZE the prevalence

RECOGNIZE the impact

RESPOND appropriately

RESIST re-traumatization

RESILIENCE through skill-building

4 (5) Rs of Trauma-Informed Care
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 individual wearing pants and a t-shirt. They do 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 & Power Dynamics
Ex. Cervical Cancer Screening

Gender Dynamics: Ask Everyone for Name, Pronouns

- What name do you go by?
- What are your pronouns?
Power Dynamics: Avoid ‘Power-Over’ Stances

- 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 anatomical inventory to know what body parts we need to consider when evaluating your current symptoms.

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

Please look over 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.

<table>
<thead>
<tr>
<th>Gendered Terms</th>
<th>Less Gendered Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breasts</td>
<td>Chest</td>
</tr>
<tr>
<td>Vulva</td>
<td>External Pelvic Area</td>
</tr>
<tr>
<td>Vagina</td>
<td>Genital Opening, Frontal Pelvic Opening, Internal Canal</td>
</tr>
<tr>
<td>Uterus, Ovaries</td>
<td>Internal Organs</td>
</tr>
<tr>
<td>Pap smear</td>
<td>Cancer screening</td>
</tr>
<tr>
<td>Bra, panties</td>
<td>Underwear</td>
</tr>
<tr>
<td>Period, Menstruation</td>
<td>Bleeding</td>
</tr>
</tbody>
</table>

*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” and “front hole”. 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 their pronouns are ‘they/them/their’. I am happy to discuss pronouns further with you anytime if you have questions.

Courtesy of Samara Grossman LICSW
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 (&quot;I am bad&quot;, &quot;No-one can be trusted&quot;)</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
# Trauma-Informed Interpretation

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Behavioral Manifestations</th>
<th>Unhelpful Clinician Interpretations</th>
<th>Trauma-Informed Interpretations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fight</strong></td>
<td>Animated, Impatient, Irritable, angry, Loud voice</td>
<td>‘Aggressive’, ‘Combative’, ‘Resistant’, ‘Provocative’, ‘Sullen’</td>
<td>Hyperaroused ‘Stuck on high’ Attempting to regain or hold on to personal power</td>
</tr>
<tr>
<td><strong>Flight</strong></td>
<td>Anxious, Confused, Forgetful, Restless, Fidgeting, Easily startled, Eyes darting</td>
<td>‘Non-adherent’, ‘Non-compliant’</td>
<td>Hyperaroused ‘Stuck on high’ Attempting to avoid or escape from those in power</td>
</tr>
<tr>
<td><strong>Freeze</strong></td>
<td>Acquiescent, Withdrawn, Distracted, not paying attention, Distant look to eyes, Quiet/faint voice</td>
<td>‘Passive’, ‘Disengaged’</td>
<td>Hypoaroused ‘Stuck on low’ Shutting down in response to power</td>
</tr>
</tbody>
</table>
Grounding Exercise: Feet, Seat and Back

Bring yourself back into your body by:

Rubbing your hands together quickly

Noticing your chest rise and fall as you breathe in and out 3 times

Putting your hand over your heart and feeling it beating
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 genitals
  – Transgender men: chest and genitals

• Non-suicidal self injury (e.g., cutting/burning):
  – Common among TGD individuals
  – May also focus on chest and genitals
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?
<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>
</table>
| Transparency | • I’d like to learn more about what has happened to you so that I can more fully understand your symptoms.  
• I will ask you some questions and you can answer in the ways that feel most comfortable.  
• If you feel overwhelmed or I notice you are overwhelmed, I may suggest we take a break. |
| Peer Support | • Would you like anyone with you while we talk about your history? |
| Collaboration | • 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. |
| Empowerment | • You decide what is important for me to know. |
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>Validate the decision to disclose</td>
<td>I understand it could be very difficult for you to talk about this.</td>
</tr>
<tr>
<td>Acknowledge injustice</td>
<td>Violence is unacceptable. I’m sorry that happened, that should not have happened.</td>
</tr>
<tr>
<td>Be clear that the patient is not to blame</td>
<td>What happened is not your fault.</td>
</tr>
<tr>
<td>Help the patient contain their story to reduce the risk of retraumatization</td>
<td>This information is really important... 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>Let the patient know that help is available</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>Collaborate with and empower the patient</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
## Evidence-Based Trauma Treatment

<table>
<thead>
<tr>
<th>Trauma-Focused Psychotherapy</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Processing Therapy</td>
<td>SSRI/SNRI</td>
</tr>
<tr>
<td>Teaches how to reframe negative thoughts about one’s trauma</td>
<td>Restores balance of chemicals in the brain</td>
</tr>
<tr>
<td>Talk about thoughts/writing assignments and worksheets</td>
<td></td>
</tr>
<tr>
<td>Call the trauma to mind while focusing on an external motion or sound</td>
<td></td>
</tr>
<tr>
<td>Talk about the trauma/start doing safe things one has been avoiding</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Movement Desensitization Reprocessing</td>
<td></td>
</tr>
<tr>
<td>Helps how to process and make sense of one’s trauma</td>
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<tr>
<td></td>
<td></td>
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<tr>
<td>Prolonged Exposure Therapy</td>
<td></td>
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<tr>
<td>Teaches how to regain control by facing one’s fears</td>
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Community Resources

FORGE
- Empowering
- Healing
- Connecting

the Network la Red
Survivor-led organizing to end partner abuse
Dirigida por sobrevivientes • Movilizando para acabar con el abuso de pareja
Case (Part 8)

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
## 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 until your bottom touches my hand”)</td>
<td>• Please move your body down until you’re right at the edge of the table.</td>
</tr>
<tr>
<td>• Allow your knees to fall to the sides as much as you can.</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.
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?
# Trauma-Informed Psychoeducation

<table>
<thead>
<tr>
<th><strong>Safety</strong></th>
<th>If at any point you have questions, disagree, want me to slow down, or repeat or change the subject, please let me know.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transparency</strong></td>
<td>I would like to explain to you how experiences from the past may be manifesting as symptoms in your body today.</td>
</tr>
<tr>
<td><strong>Peer Support</strong></td>
<td>Is there anyone you would like with you while we discuss your symptoms and next steps to take?</td>
</tr>
<tr>
<td><strong>Collaboration</strong></td>
<td>I consider everything we decide to do to address your current symptoms to be a plan we create <em>together</em>. 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.</td>
</tr>
<tr>
<td><strong>Empowerment</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Cultural Issues</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>

Courtesy of Samara Grossman LICSW
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>Safety</th>
<th>• Co-develop a safety plan to help the patient move back into their “window of tolerance” when they get triggered.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transparency</td>
<td>• Explain and normalize the fact that trauma-related symptoms are likely to wax and wane over time.</td>
</tr>
</tbody>
</table>
| Empowerment Peer Support | • 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). |
| Cultural Issues | • 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. |

Courtesy of Samara Grossman LICSW
Universal Application of TIC Principles Is Essential When Caring for TGD Patients and Includes…

<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>
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<tr>
<td>Obtaining the history in a patient-led manner</td>
<td>Recognizing and responding productively when a patient becomes distressed</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>
</tr>
<tr>
<td>Responding appropriately to trauma disclosure</td>
<td>Facilitating connection to TGD-sensitive trauma recovery services</td>
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<td></td>
<td>Recognizing, celebrating, and building on the patient’s strengths over time</td>
</tr>
</tbody>
</table>
Thank You!