Things to consider when treating queer and transgender patients

Queer and transgendered (TG) individuals are a small, but growing group within the community at large and thereby also as potential patients. This group is increasingly visible, not because there are more people who are becoming or recognising that they are transgendered or queer, but because it is less stigmatised than only 10-15 years ago, in Western European. This though is of course relative. It is less stigmatised, than it was previously, but that is like saying it hurts less to be beaten 7 times a day with a bamboo rod, than to be beaten 15 times a day with a baseball bat!!

When treating transgendered (TG) and queer patients there are several factors that need to be taken into consideration. I have tried to summarise below some issues that it is useful to be aware of, both with regards to potential aetiology as well as understanding a patients background and situation.

Gender and sexuality are not related

It is important to be conscious and aware of the difference between gender identity and sexuality. In the same way that you cannot make assumptions about cisgender[1] patient's sexuality, the same is true of queer and transgender patients.

Pronouns

This is a minefield. You cannot be certain how to address a person who is queer or TG and many individuals can be offended or feel hurt, if you use he, she, him, her, his, hers etc. if it is not the gender that they identify with. Furthermore, there are also some who do not identify with either of the binary genders or identify with both of them.

Some are easy going around this issue, but for many transgender and queer this is a sensitive issue. The best policy is always to politely ask what they prefer, rather than just assume.

If you have an intake form that either you or the patient should fill out, there should be an option to write male, female, neither, both or not applicable.

Be frank and honest

You may well have doubts, questions and difficulty navigating in how to deal with someone whose gender identity or expression is not congruent with how you perceive them. It is always a better strategy to be frank and honest, but respectful. Admit to the patient that you are having difficulty navigating and ask the patient for guidance.

Relevant issues when diagnosing a TG or queer patient

Many of the issues below are not just relevant for TG patients, but also for many other patient groups, who have undergone cosmetic surgery or who are in some form of hormone therapy. Other issues are very specific and unique for queer and TG patients

Cosmetic surgery

Ask about whether they have undertaken cosmetic surgery and explain the relevance of your question. Surgery will always result in some degree of Blood stagnation.

1 Cisgender - a person whose gender that they were assigned at birth matches their perceived or expressed gender

The issue of cosmetic surgery is far from limited to TG patients and not all patients elicit that they have undergone cosmetic surgery. With all patients who have had cosmetic surgery, it is important to to gauge the sense of satisfaction and the subjective sense of success. This can often be difficult without being blunt and insensitive. Many patients, not just transgendered, invest their sense of happiness in an idealised physical body and hope they will feel harmonious, content and free when they have achieved this. Unfortunately this contentment does not always arise post-operation.

Hormonal treatment

Lets not beat around the bush. Artificial hormones are bad full stop, but so is the emotional pain and suffering of male and female secondary sexual characteristics, if you do identify with this gender. There is no ideal solution apart from magic wands and Glaxo-Klein are still working on the patent for this one. The reality for many transgendered individuals, is living the rest of their life on a regime of hormone therapy. They will have to both take hormones to repress their natural production of certain hormones, as well artificial supplementation with other hormones. This is necessary, otherwise the physical body starts returning to its original gender characteristics. This artificially disrupting the natural balance and flow of the endocrinal yin and yang is also seen in IVF patients, when they are being down-regulated. For post-operative and some other TG and queer patients, this though is a lifelong reality.

We do though in general practice see many, especially female, patients, who are on various forms of hormonal treatment p-pills, HRT, IVF etc., as well as patients of both genders whose metabolism is regulated through various forms of hormone therapy. Different bodies though react differently to the hormones. The original patterns of imbalance will always play a role. TG patient are no different to say IVF patients.

Clients transitioning from male-to-female (MTF) typically may be prescribed oestrogen or anti-androgens. Oestrogen (Premarin) side-effects may include thrombosis; hypertension; thyroid dysfunction; folate vitamin deficiencies; nausea and vomiting; weight gain; depression; hepatic impairment including tumours; breast cancer; impaired glucose tolerance; migraine and other headaches; oedema; emotional lability; and gallbladder tumours. Anti-androgen (Aldactone) side-effects may include diuresis; nausea and vomiting; acidosis; rash; gastritis; hypotension; breast cancer; cramping; diarrhoea; headache; and confusion[2].

Clients transitioning from female-to-male (FTM) often take testosterone and may experience side-effects that include hypertension; weight gain; liver function abnormalities; lipid abnormalities; fluid retention; loss of menses; polycystic ovarian disease; change in blood pressure; emotional lability; acne; and liver tumours.[3]

What we have to do here is no different from what we always have to do. We have to try and interpret the affects and reactions from a Chinese medicine (CM) perspective. Is this Heat? Is it Cold? Is it Dampness and Phlegm? Is it affecting the Liver? The Heart? stagnating qi? etc. The big difference here though, is that the client does not usually want to be drawn back to the original harmony of the body i.e. the pre-hormonal situation, but wants amelioration for some of the side effects of the hormones.

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2 http://www.acupuncturetoday.com/mpacms/at/article.php?id=28252 accessed 23/01/16
3 Ibid.

Do they still have ovaries and menstruation even though they present as a male?

Again beware of assumptions. It requires tact and tone, but it is relevant to gather this information, to be able to make a complete diagnosis.

Chest binding and taping of genitals

Many pre-operative FTM (female to male) or TG individuals bind their breasts, so that they are less conspicuous, making the appearance more male. Tight binding of the breasts can create a stagnation of qi and Blood in the breasts.

Some pre-operative MTF (male to female) or TG individuals as well as some transvestites tape their genitals, so that they are less conspicuous, making the appearance more female. Tight binding can create a stagnation of qi and Blood in the genitals.

Emotional stress

Emotional stress can often be an aetiological factor. The emotional stress can both be in the past and the present. It is very common for people who are TG or queer to experience ridicule, verbal abuse, sexual abuse, as well as job discrimination and social alienation. This is compounded for some, by having or having had difficulty accepting themselves for being who they are.

From a CM perspective growing up feeling different and alone, not being able to communicate about how you identify for fear of rejection will definitely affect the Heart qi, but also the Liver (due to frustration) and Kidney (due to fear) can also be affected.

TG also have a much higher incidence of being physically assaulted (*78 percent of survey respondents who suffered physical or sexual violence at school, 65 percent of respondents who experienced violence at work. Over half of those who experienced harassment or bullying in schools)*[4]. This can both give emotional trauma, as well as qi and Blood stagnation in the body.

A large proportion of TG have been alienated from their family, both alienation from parents/siblings, but also their own children, resulting in severe emotional stress. 57% of TG in the USA experience rejection and being ostracised by their family[5].

There is also the emotional stress described above, when the physical results of surgery, do not match the hopes and expectations that the person had.

All of these factors lead to TG having a significantly higher risk of suicide than the general population - 41%, which vastly exceeds the 4.6 percent of the overall U.S. population.[6]

4 The National Coalition of Anti-Violence Programs report 2014 accessed at: http://www.avp.org/storage/documents/Reports/2014_HV_Report-Final.pdf 23/01/16
5 Ibid.
6 Ibid.