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Brief Review: Best Practices for Interdisciplinary Gender-Affirming Care

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ABSTRACT

Prevalence of people who identify as transgender and gender diverse (TGD) is greater than previously recognized, yet community resources and accessible, inclusive healthcare remain limited. Research continues to reflect high rates of stigma, discrimination, unemployment, homelessness, violence, and poor health outcomes among TGD-identifying individuals.
Although ***not a disorder*** itself, the transgender identity may be associated with symptoms of gender incongruence or gender dysphoria, resulting in significant distress, and highly associated rates of self-harm, suicidality, and possible functional impairment. Gender-affirming medicine, which can include gender-affirming psychotherapy, exogenous hormones, surgery, or speech therapy, are safe and effective treatments in mitigating these symptoms. To better encourage provider competency in working with members of the TGD community, this article will discuss the various mechanisms of gender-affirming interventions, best practices for providing inclusive and gender-neutral environments, preventative medicine, and protocols for interdisciplinary referrals.

Key words: Transgender, Gender-affirming care, Gender minority, Best practices, Healthcare, Gender diverse, TGD

INTRODUCTION

Prevalence of people who identify as transgender and gender diverse (TGD) is greater than previously recognized.[1] Despite this, community resources have not expanded in a way that reflects trans-affirming care and continue to remain limited. TGD-identified individuals may further experience difficulty accessing healthcare due to fear of stigma and discrimination within healthcare agencies themselves.[2] Research continues to reflect that many TGD identified individuals live on the margins of society, facing stigma, discrimination, unemployment, homelessness, violence, and poor health outcomes.[1,2,3,4,5] Social support and affirmation of gender identity, however, envelops a critical role in improving resilience among TGD people.[1] A comprehensive understanding of biopsychosocial development and treatment interventions beyond the gender binary is thus essential to the knowledge of all providers.

Gender-affirming care is a fundamental concept, technique, and set of practices for medical providers aimed at providing inclusive, respectful, evidence-based, and affirming care to TGD patients. While many providers have positive intentions, physicians, advanced practice providers, and mental health clinicians often lack the education, knowledge, and resources needed to provide evidence-based care. In addition, many are not equipped to deliver comprehensive patient education and may be at risk to commit unintentional microaggressions. This article provides a brief review on evidence-based best practices for gender-affirming care, including recommendations on how to provide inclusive and gender-neutral environments, guidelines for preventative medicine, and protocols for interdisciplinary referrals.

GENDER NEUTRALITY

Providing an overall inclusive environment is paramount toward provision of gender-affirming care. This inclusive environment necessitates departing from the social framework

of the gender binary. A magnitude of evidence supports that gender exists outside of a binary construct of *male* and *female*[6,7,8] but rather is significantly more extensive, and includes *transgender*, gender *nonbinary*, and *two-spirit* identities, along with many more (Table 1).[9,10] Many microaggressions as well as overt hostilities both internal and external to the healthcare environment stem from conventional use of the gender binary.

Table 1. Gender identity terms and definitions[9]

Gender Identity	Common Definition*
Cisgender	A person whose gender identity is the same as their sex assigned at birth (e.g., sex assigned at birth was female, and they internally identify as female)
Transgender male	A person whose gender identity is male and who prefers male or gender-neutral pronouns (e.g., he/him/his, they/them/theirs, etc.), but who was assigned female sex at birth. This person identifies as male.
Transgender female	A person whose gender identity is female and who prefers female or gender-neutral pronouns (e.g., she/her/hers, they/them/theirs, etc.), but who was assigned male sex at birth. This person identifies as female.
Gender nonbinary	A person who identifies as neither male nor female and who typically prefers gender-neutral pronouns (e.g., they/them/theirs, ze/hir/hirs, ze/zir/zirs, etc.)
Genderfluid	A person whose gender identity is not fixed in stone, but fluctuates on a daily, weekly, monthly, etc., basis. For example, this person may identify as female one day and male the next day, or may identify as nonbinary some days and male other days. Their identity and pronouns may similarly fluctuate.
Genderqueer	An umbrella term that defines a gender identity that may align with both male and female identities, neither male nor female, or somewhere in between male and female. This term is sometimes considered an umbrella term under which is included gender nonbinary, but the definitions may be variable.
Gender nonconforming	A person who does not identify with any particular gender. As gender is a social construct; this person does not identify with the social construct of gender and generally does not conform to any particular gender identify (i.e., not male [neither cisgender nor transgender], not female [neither cisgender nor transgender], not gender nonbinary, not genderfluid). Their pronouns may vary, but gender-neutral pronouns are typically appropriate.
Two-spirit identity	A person who identifies as having both a masculine and a feminine spirit, and is used by some Indigenous people to describe their sexual, gender and/or spiritual identity.
*It is important to emphasize that gender is a social construct, and thus these definitions are generally representative of the respective gender identities, but these definitions will vary and do not appropriately represent all people. The only definitive way to establish the definition of a person's gender is to ask them.	

Rather than limited use of the gender binary, gender-affirming care promotes using gender-neutral language and gender-inclusive terms such as "patients," "persons," and "folks," rather than binary terms such as "men/women" and "males/females." Similarly, gender-neutral pronouns including "they," "them," and "theirs" can replace "he/she," "him/her," and

"his/hers," leading to more inclusive terminology for gender-diverse patients. While these are more general and inclusive terms in the office environment, written use of these gender-neutral terms may also facilitate more inclusive intake forms, patient contracts, signage, and medical documentation. Gender-neutral restrooms are an additional means of creating an inclusive environment, either in replacement of or in addition to typical "male" and "female" restrooms. Studies including an integrated review from Lightfoot et al. (2021) show improved psychological and physical outcomes in gender-neutral or gender-affirming settings.[11] All written communication and electronic documentation should likewise use gender-neutral language, or should align with the patient's gender identity and chosen name. This is shown to produce enhanced patient wellness and improved rapport.[12] For example, a transgender male generally identifies as male but was assigned female sex at birth; male or gender-neutral pronouns would thus be appropriate (e.g. he/him/his or they/them/theirs); whereas female or gender-neutral pronouns would be appropriate for a transgender female patient (e.g. she/her/hers or they/them/theirs). For the purpose of the remainder of this article, the authors will use *transgender* and *gender minority* interchangeably, although *gender minority* exists as a more inclusive and broader identity than the specific transgender identity.

GUIDELINES FOR PREVENTATIVE MEDICINE

While it remains important to attend to transgender-specific preventative medicine needs, as follows, it is also important to advocate for patients to follow general preventative medicine guidelines, including but not limited to annual physical examinations, serial laboratory screens, vision screenings, and biannual dental evaluations. Many gender minority patients have experienced uncomfortable or overtly inappropriate experiences with the healthcare system, leading to an aversion to seemingly "unnecessary" healthcare encounters and decreased rates of preventative health visits.[13] Age-appropriate mental health screenings, including Patient Health Questionnaire (PHQ-2/9), Generalized Anxiety Disorder (GAD-7), and Mini Mental State Examination/Montreal Cognitive Assessment (MMSE/MoCA) should likewise be emphasized in this patient population as rates of psychiatric disease including substance use disorders, major depressive disorder (MDD), and suicidal ideation/suicide attempts (SI/SA) are higher than the general public, yet this population often experiences disproportionately lower frequencies of mental health encounters.[14,15] Indeed, an Australian study found that individuals with gender diversity are 27 times more likely than the general public to report a history of SA,[16] but demonstrate more promising outcomes associated with strength-based psychotherapy and greater prioritization regarding social determinants of health (SDH).[17]

As a general rule, it is appropriate for transgender individuals to follow all preventative care guidelines appropriate for their sex assigned at birth, with some additional screenings being recommended beyond that rule. Patients assigned female at birth should thus continue to receive regular mammograms and pap smears per typical "female" guidelines, unless in the absence of total mastectomy or trachelectomy/hysterectomy, respectively.[13,18] Patients assigned male at birth likewise should continue to receive regular Prostate Specific Antigen (PSA) checks for the remainder of their life with prostate exams if indicated, unless in the absence of total prostatectomy.[16] If ***any*** prostate, cervical, or breast tissue remains, however, these screenings should be followed as designated for the general population.[13,16] Per Endocrine Society guidelines, transgender women on hormone therapy (HT) should follow breast screening guidelines recommended for cisgender females.[19]

Additionally, sexual health screenings should be specific to the type of sexual intercourse in which the individual is engaging and should not be based on any assumptions regarding their gender identity. Any individuals engaging in oral sex should undergo oral sexually transmitted infection (STI) swabbing; anyone engaging in receptive anal sex should undergo anal STI swabbing; anyone engaging in penile or vaginal sex should undergo urine

STI testing or swabbing, as appropriate.[14] Due to higher transmissions of human immunodeficiency virus (HIV) between transgender individuals, it is important that patients likewise receive their one-time lifetime HIV test, or more frequent tests if indicated,[15,20] along with consideration of pre- and post-exposure prophylaxis for HIV (PrEP and PEP, with PrEP frequently being free for this population), human papillomavirus (HPV) vaccination, and regular hepatitis A and B laboratory testing. Furthermore, any patient receiving vaginal intercourse capable of becoming pregnant should receive pregnancy tests when indicated.[14]

Lastly, patients on hormone therapy (HT) should receive regular screening labs as indicated, as well as regular lipid panels, glucose screenings, and steroid levels, along with regular body-mass index (BMI) and blood pressure checks. Additional periodic screening labs should include prolactin levels for patients on estrogen therapy, hematocrit or hemoglobin for those on testosterone therapy, and electrolyte levels for those receiving spironolactone.[19] Bone marrow density should also be evaluated in any transgender patients who stop HT following gonadectomy, or those with other risk factors.[19]

GUIDELINES AND RESOURCES FOR INTRADISCIPLINARY REFERRALS

While gender minority patients are seen in every healthcare setting, the following section is categorized to address various specialty referrals when providing gender-affirming care for transgender patients, as indicated. These referral services include but are not limited to behavioral health services, surgery, endocrinology, social work, physical, occupational, and speech therapy.

Behavioral Health Services (BHS)

World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 (SOC-8) requires that any transgender patient beginning HT or gender-affirming surgery (GAS) first have a diagnosis of gender incongruence[21] (i.e., a gender identity or gender expression that differs from their sex assigned at birth[19]). Gender dysphoria was a requirement in past guidelines and remains a required diagnosis in alternative guidelines. While “gender dysphoria” is a diagnosis within the Diagnostic and Statistical Manual of Mental Disorders – Text Revision (DSM-5-TR, 2022)[22] and often viewed as pathological, the transgender identity itself is not a mental illness or psychiatric disease, and “gender incongruence” is less pathologized and is less stigmatizing but is still a recognized condition within the International Classification of Diseases and Related Health Problems (ICD-11).[21,23] WPATH Guidelines further recommend against requiring psychotherapy prior to gender-affirming treatment, although this may be desirable and beneficial for some patients.[21] When BHS are provided, care should focus on encouraging and empowering the development of social support systems, along with ensuring appropriate name and pronoun use and treating psychiatric illnesses if present.[17,21]

Importantly, not all mental health providers specialize in or feel competent in gender-affirming care. If possible, patients should be referred to therapists who specialize or are competent in trauma-informed care (TIC), gender-affirming care, and/or LGBTQ+ care.[21,24] Links to U.S. and international WPATH-associated providers with these specialties, searchable by nation, city, and state can be found at https://www.wpath.org/member/search[24]; self-reported gender-affirming therapists in the United States, searchable by zip code or name, can be found through Psychology Today at https://www.psychologytoday.com/us/therapists/transgender.[25] A directory of therapists who personally identify as queer and trans people of color (QTPOC) is also available from the National Queer & Trans Therapists of Color Network at https://nqttcn.com/en/mental-health-directory/.[26] Moreover, TIC should be a mainstay of any treatment for all transgender and nonbinary individuals.[27]

Endocrinology

WPATH SOC-8 and Endocrine Society guidelines depart from previous guidelines in that they no longer require a diagnosis of gender dysphoria, but do require that any transgender patient beginning HT meet criteria for marked and sustained gender incongruence, with no stipulations regarding gender expression.[19,21] Other guidelines may additionally require letters of referral from 1 to 2 healthcare providers.[21] Options for HT include estrogen, anti-androgens (e.g. spironolactone), testosterone, and gonadotropins (i.e. GnRH agonists).[19]

Subcutaneous, intramuscular, and transdermal (e.g., patch or gel) testosterone is available for transgender male patients in the United States. Adverse effects include erythrocytosis, metabolic effects, hypertension, sleep apnea, salt retention, and acne. Transgender females typically opt for oral, transdermal (i.e., patch), or intramuscular estradiol +/- anti-androgens or GnRH agonists. A serious adverse effect of estrogen therapy is thromboembolism; however, thrombophilia screening is not recommended in the absence of personal or family history of thrombotic disease. Other adverse effects include liver dysfunction, hypertension, hyperprolactinemia, and breast cancer.[19]

Endocrine Society clinical guidelines advise that transgender adolescents who desire HT be treated with puberty blockers (i.e., GnRH agonists) beginning when they first exhibit physical changes of puberty, followed by potential hormone treatment typically starting at age 16 years.[19]

Surgery

While urology, gynecology, and breast surgery likely first come to mind, additional surgical specialists including plastic surgeons and ear, nose, and throat (ENT) surgeons also provide gender-affirming care. While the list of surgical interventions is extensive, a few of the most common GAS procedures are briefly defined here (Table 2,3). WPATH guidelines require that patients undergoing GAS must demonstrate emotional and cognitive maturity and as previously mentioned, must first receive HT for at least 6 months (or 12 months in adolescents) as well as show marked and sustained gender incongruence. [21] Alternatively, Endocrine Society Guidelines require that patients be the age of majority (typically age 18 years+), have a diagnosis of gender dysphoria, and have completed 12 months of HT and 12 months of "full-time living in the new gender role."[19] Again, patients may additionally require letters of referral from 1 or 2 healthcare providers.[21]

Contrary to popular belief, many transgender patients do not, in fact, seek GAS; indeed, rates of bottom surgery in transgender males are <5%. For those patients that do seek gender-affirming breast or urogenital surgery, they may choose to undergo "top surgery" (e.g., breast surgery), "bottom surgery" (i.e., urologic/gynecologic surgery), or both. For transgender females, top surgery typically involves breast implants or fat grafting, whereas bottom surgery typically involves vaginoplasty (i.e., penile inversion or intestinal reconstruction of a neovagina). For transgender males, top surgery typically involves partial or complete mastectomy (e.g., breast removal) and/or chest masculinization (i.e., plastic surgery chest reshaping), whereas bottom surgery typically includes hysterectomy and/or phalloplasty/metoidioplasty (i.e., surgical construction of a phallus via peripheral or genital tissue, respectively). Complications of male or female bottom surgery may include urologic or sexual dysfunction, stenosis, or colorectal injury.[28] GAS is associated with improved rates of depression and suicidality and very few reports of "regret," including in studies among adolescents;[28,29] overall rates of regret due to bottom surgery are <2.2%.[30]

Other plastic surgery interventions include facial feminization and facial masculinization.[28] While HT is typically effective for masculinizing voice in transgender men, it is not effective at feminizing voice in transgender women. "Feminizing" ENT interventions include laryngoplasty (e.g., glottoplasty, i.e., vocal cord reduction) and cricothyroid

approximation (i.e., increasing tension between thyroid and cricothyroid cartilages) which may raise a person's voice, as well as chondroplasty (i.e., reduction of the thyroid cartilage) for a feminizing appearance.[31,32,33] Less commonly, "masculinizing" interventions include relaxation laryngoplasty (e.g., thyroplasty, i.e., cartilage or muscle partial excision) to reduce tension and deepen voice as well as thyroid cartilage grafting for a masculinizing appearance.[31,34]

Table 2. Examples of Gender Affirming Surgeries (GAS): male-to-female patient[1,2,28,31,32,33]

Surgery	Description
Breast/chest surgery	• Augmentation mammoplasty
Genital surgery	• Penectomy • Orchiectomy • Vaginoplasty • Clitoroplasty • Vulvoplasty
Non-genital, non-breast GAS	• Facial feminization surgery • Liposuction • Lipofilling • Glottoplasty (laryngoplasty) • Cricothyroid approximation • Chondroplasty (thyroid cartilage reduction) • Gluteal augmentation • Hair reconstruction

Table 3. Examples of Gender Affirming Surgeries (GAS): female-to-male patient[1,2,28,31,34]

Surgery	Description
Breast/chest surgery	• Subcutaneous mastectomy, complete or partial • Chest masculinization
Genital surgery	• Hysterectomy, total or partial • Ovariectomy • Vaginectomy • Urethra reconstruction • Metoidioplasty • Phalloplasty • Scrotoplasty • Implantation of erection • Implantation testicular prostheses
Non-genital, non-breast GAS	• Rhinoplasty • Liposuction • Lipofilling • Thyroplasty (relaxation laryngoplasty) • Thyroid cartilage grafting • Pectoral implants

Speech, Occupational, and Physical Therapy

Gender-affirming speech therapy is a promising field of gender-affirming medicine. Like its counterpart in laryngoplasty, speech therapy may assist patients in masculinizing or feminizing vocal pitch through voice exercises in adjunct to or in replacement of surgery. Speech therapists can further improve congruent gender expression via patient education and exercises in vocal inflections, articulation, and resonance, as well as vocabulary, syntax, body language, and facial expressions typically considered "masculine" or "feminine".[34,35,36]

Occupational therapy may serve similar purposes in achieving affirming gender expression by addressing challenges in new ways of dressing and new hair styles, as well as through assisting patient in navigating gender roles in the work environment and in navigating restrictive dress codes.[37]

The literature also suggests an increased prevalence of pelvic floor dysfunction in transgender individuals even prior to surgery.[38] However, evidence supports improved outcomes in pain, urinary incontinence, and vaginal dilation with both presurgical and postsurgical physical therapy for at least those transgender women who undergo bottom surgery.[39]

Social Work

Social work (SW) is an integral part of comprehensive gender-affirming care.[38] Similar to its BHS counterparts, SW may help validate the transgender identity and connect patients with support networks and advocacy services.[40] SW may further engage in fighting discriminatory policies and legislation.[41]

CONCLUSION

While gender-affirming medicine constitutes a vast array of methodologies, a general provider need only focus on their patient-provider relationship and have a basic education in these topics. Conscious use of inclusive and gender-neutral language as well as nonjudgmental attitudes will go a long way toward improving rapport and the therapeutic alliance. Likewise, basic knowledge of referral options for endocrine, surgical, and therapeutic gender-affirming medicine, along with understanding of preventative guidelines can significantly improve patient outcomes and healthcare experiences. Through these simple yet conscious interventions, every practitioner holds the ability and responsibility to achieve successful gender-affirming care.

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