Exploring the Role of the Clinical Herbalist in Supporting Gender Affirmation, Expression, and Fluidity

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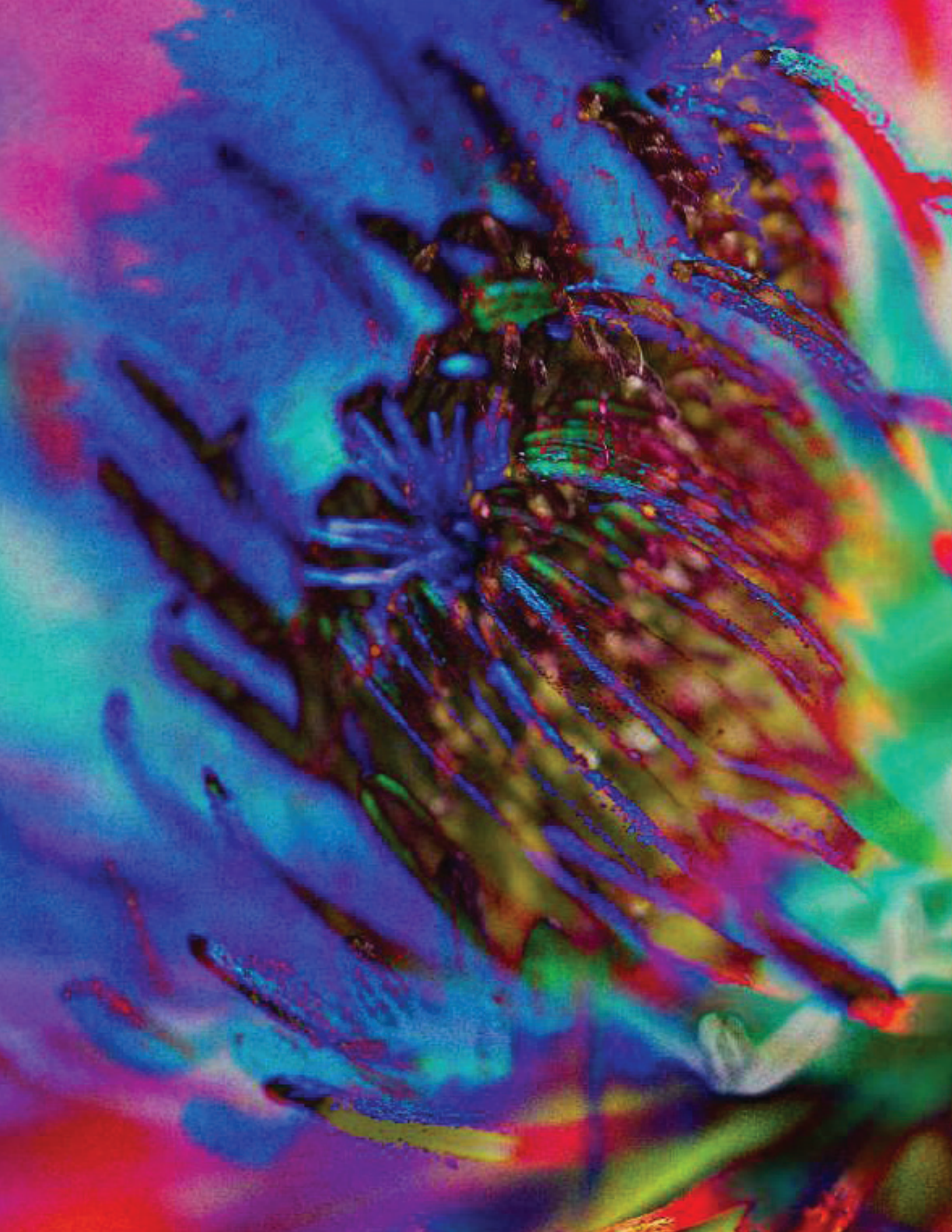
It is arguably impossible to see the world through the eyes of an individual who resides within a sociocultural reality which is completely divergent from your own (Ibrihim 1993, Kramsch 2008). As a clinical herbalist working with transsexual, transgender, genderfluid, and gender nonbinary individuals in my community, I must always remain humble to the reality that my empathy and compassion may have a limited embrace. Even in my earnest endeavors to see the world through my client's eyes, my clinical interpretation of my client's experiences and needs will inherently be a reflection of my cisgender identity, a gender identity that is congruent with my biological sex. It is from this perspective that I preface the following exploration of socioculturally competent care and support for gender affirmation, expression, and fluidity within the field of clinical herbalism. The following discussion is rooted in a review of medical and sociocultural research, as well as my clinical experiences working with individuals from within this unique population.

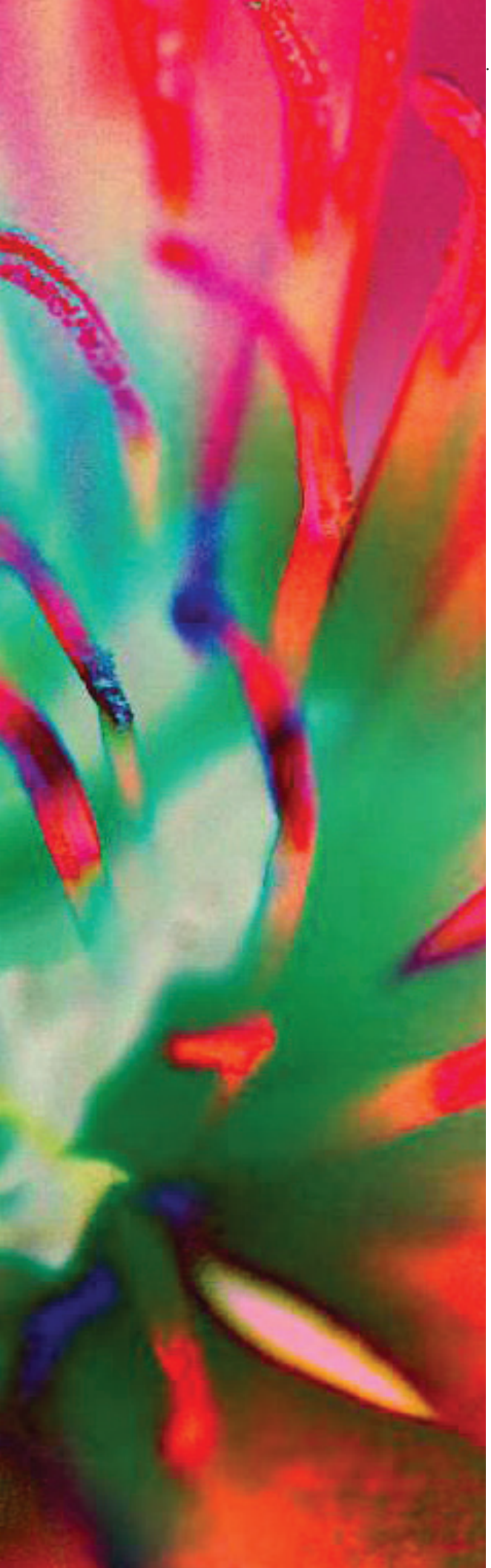
This article is an attempt to inspire further research for those within our professional community who identify as cisgender and who are not aware of or are perhaps even disinterested in the day-to-day sociocultural, economic, and health-related disparities experienced by transsexual, transgender, gender-fluid, and gender nonbinary people. In addition, this article seeks to encourage further dialog amongst members of our professional community in regards to adapting and incorporating the flexible and invaluable standards of care (SOC) conceptualized and published by hardworking medical professionals specializing in transgender health (Hembree et al. 2009, Deutsch and Feldman 2013, WPATH 2011, CoE 2016). In this regard, it is pertinent that as practitioners of clinical herbalism we remain true to the confines of our respective scopes of practice, specifically in the face of the dynamic yet potentially life-threatening health disparities and associated physical and mental illnesses that may present in transsexual, transgender, and gender nonbinary individuals seeking our clinical support (Lev 2004, CoE 2016).

Lack of Provider Knowledge at the Heart of Health Disparities

Transgender and gender nonbinary individuals report the lack of knowledgeable providers represents the greatest barrier to medical care (Gardner and Safer 2013). This is coupled with a national trend of negligible or absent financial resources due to higher levels of unemployment, lower wages, and/or lack of health insurance among these communities in comparison to the national average (Grant et al. 2011, Gardner and Safer 2013, Meyer et al. 2017).

Significant research has demonstrated that lack of provider knowledge and subsequent stigma and discrimination are at the heart of





A botanically inspired digital vision of "celebrating gender freedom" by Deedavee Easyflow.
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the many health disparities experienced by the transgender and gender nonbinary community at a national level (Grant et al. 2011, Shires and Jaffee 2015, CoE 2016, Henry 2017). For example, the 2011 National Transgender Discrimination Survey included over 6,000 participants from all 50 US states and found that 28% of respondents experienced discrimination within a primary care setting, 19% who were denied care outright, and an overwhelming 50% who had to teach their providers about their own healthcare (Grant et al. 2011). This type of discrimination has also been shown to be compounded by race and ethnicity (i.e., more common among non-white individuals), worse economic status, lesser employment status, lower level of education, previous or current use of hormones or surgery for medical transition, and possession of identification documents that list sex assigned at birth rather than preferred gender (Shires and Jaffee 2015).

Understanding how stigma and discrimination influence healthcare access is critical to addressing health disparities for transgender and gender nonbinary people.

Understanding how stigma and discrimination manifest and function in healthcare encounters and how stigma and discrimination influence healthcare access and utilization is critical to addressing health disparities for transgender and gender nonbinary people (Poteat et al 2013, Roche and Keith 2014, Reisner et al. 2015). It has been argued that lack of education within medical and adjunct healthcare fields influences ambivalence and/or uncertainty of healthcare providers' approaches to medical encounters with transgender and gender nonbinary individuals (Gardner and Safer 2013). This ambivalence and/or uncertainty can serve as a gateway to interpersonal stigma and stereotyping, which enables a dynamic of medical power and authority over the individual seeking care and their subsequent disempowerment (Poteat et al. 2013).

Research suggests that having a transgender-inclusive provider is associated with decreased rates of depression and suicidality for transgender people.

As a healthcare profession, it is important for herbalists to acknowledge the role of ambivalence and/or uncertainty in formulating stigmatizing attitudes and how these attitudes function to maintain systems of inequality that contribute to health disparities (Earnshaw and Quinn 2011, Poteat et al. 2013, Roche and Keith 2014) . It is possible that many herbalists do not consider themselves practicing within the healthcare paradigm examined in this type of research, and therefore unlikely to be a source of such discrimination and stigmatization. However, as transgender and gender nonbinary people are likely anticipate that providers will not know how to meet their needs (Grant et al. 2011, Poteat et al. 2013), it behooves us as a profession to be aware of how we may be perceived by members of the transgender and gender nonbinary community within the context of healthcare provision and support.

Becoming an Inclusive Provider by Learning to Listen

Research suggests that having a transgender-inclusive provider is associated with decreased rates of depression and suicidality for transgender people (Kattari et al. 2016) and that increased general health and wellbeing is associated with the perceived comfort of the healthcare provider regarding an individual's gender identity and/or expression (Stanton et al. 2017). However, in order to become culturally competent and humble practitioners, we must first learn how to listen to the gender narratives of our clients as well as those of the transsexual, transgender, and gender-variant community at large (Lev 2004). In my ongoing personal journey to become an ever more supportive resource, "learning to listen" includes ongoing dedicated self-study of medical, psychological, and social transgender research, reflective practice exercises, and networking with other medical professionals within my community that specialize in transgender health and who are amenable to both my questions and the role that clinical herbalism can play in the larger healthcare mosaic of their patients.

Some transgender and gender nonbinary individuals find empowerment from being a source of information for their healthcare providers, while others feel uncomfortable with this dynamic (Deutsch 2016). I am candid with my transgender and gender nonbinary clients by openly acknowledging my inherent cisgender bias and a desire to directly learn more through their experiences. Within this context is it important to be as educated and prepared as possible, rather than solely relying on clients' narratives (CoE 2016). In this regard, I endeavor to be well-versed and up-to-date with SOC and clinical practice guidelines provided by organizations such as World Professional Association for Transgender Health (WPATH 2011), Center of Excellence for Transgender Health (CoE 2016), and the Endocrine Society (Hembree et al. 2009).

These documents, both individually and collectively, represent an enormous amount of work, research, and one-on-one experiences of professionals specializing in transgender physical and mental health. They are free, open-access documents, so neither clinical herbalists nor our clients have to climb over insurmountable paywalls to reach them. In addition to an overview of gender affirming treatments and procedures, hormonal and surgical protocols and monitoring, mental health evaluation recommendations, and physical examination protocols, there is also a wealth of information regarding subjects such as pelvic pain and persistent menses in transgender men, working with human immunodeficiency virus (HIV), Hepatitis C, and sexually transmitted infection (STI) diagnoses, and calculating and managing risks that may be associated with hormone use, including cardiovascular disease, blood sugar dysregulation, and osteoporosis.

In addition to these incredibly enlightening clinical recommendations and protocols, there are also rich and substantiated practical tips for creating a culturally competent practice. For example, clinical herbalists can learn the definitions and terminology preferred and used by transgender and gender nonconforming

Artist Scott Richard's work seeks to dismantle the ubiquitous rainbow image into "the explosion of the individual within the whole." *CREDIT: torbakhopper, CC BY-ND 2.0 Flickr*

Gender Terminology

Below is an abridged version of the gender terms and definitions adapted from the UC-SF Center of Excellence for Transgender Health document, *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People* (CoE 2016):

- GENDER IDENTITY: A person's internal sense of self and how they fit into the world, from the perspective of gender. A person whose gender identity differs from that which was assigned at birth, but may be more complex, fluid, or clearly defined than a transgender person is called GENDER NONCONFORMING or GENDERQUEER.
- GENDER EXPRESSION: The outward manner in which an individual expresses or displays their gender. This may include choices in clothing, hairstyle, speech, and/or behavior. Gender identity and gender expression may differ.
- BIOLOGICAL SEX or SEX: Refers to the sex assigned at birth, based on assessment of external genitalia, as well as chromosomes and gonads.
- SEXUAL ORIENTATION: Describes sexual attraction only, and is not directly related to gender identity or expression. The sexual orientation of transgender people should be defined by the individual; for example, a transgender woman attracted to other women would be a lesbian.
- TRANSGENDER: A person whose gender identity differs from the biological sex that was assigned at birth. A non-transgender person may be referred to as CISGENDER (in Latin, cis means "on this side of," while trans mean "across from"). A transgender or gender nonconforming person who identifies as neither male nor female is referred to as NONBINARY.

clients. Clinical herbalists can also learn how to create a safe and welcoming clinical environment through adjusting clinical intake forms, changing bathroom signage, and educating staff and coworkers. These documents have been so incredibly central to my ongoing work within my community that I firmly suggest them as required reading for herbalists, students and clinicians alike.

Health Disparities and Vulnerabilities: National vs. Local Trends

While national statistics regarding health disparities experienced by the transsexual, transgender, and gender nonbinary population can be incredibly helpful in orienting our clinical perspectives and anticipating the needs of prospective clients, it is important to note that focusing solely on national data and trends may serve as a source of stereotyping and subsequent stigmatization and discrimination of individuals within our local communities (Lee et al. 2017, Meyer et al. 2017). In addition, research into national health disparities and vulnerabilities is arguably a reflection of trends within a national healthcare system that is not necessarily congruent with the practice of clinical herbalism.

For example, the National Transgender Discrimination Survey (Grant et al. 2011) found that an overwhelming percentage of study participants had previous experiences with sexual assault and physical violence, family rejection and/or domestic abuse, HIV infection, alcohol and drug abuse, tobacco use, and suicide attempts as compared to the general population. In addition, there is an evident increased prevalence in these aforementioned health vulnerabilities among ethnic and racial minority groups and/or those who are considered lower-wage earners (Grant et al. 2011, Seelman et al. 2017). From this research it is clear that these experiences and the likelihood of accompanying or comorbid physical and mental health concerns are more likely to be a part of our transgender clients' narratives than those of the general population, especially if our clients are ethnic or racial minorities and/or living in poverty.

However, a more recent smaller national study found that transgender individuals did not

differ from cisgender individuals with respect to prevalence of chronic diseases or depressive disorders, or in terms of health behaviors such as smoking and binge drinking (Meyer et al. 2017). An even smaller study within a community health clinic found the prevalence of HIV, substance abuse, and smoking did not differ significantly for transgender and cisgender patients. However, transgender patients were more likely to report a lifetime suicide attempt and/or ideation in addition to social stressors (such as violence, discrimination, childhood abuse) relative to cisgender patients (Reisner et al. 2014).

Yet even the vulnerability of suicide attempts and ideation is not easily assumed. For example, in a recent meta-synthesis of published transgender suicidality research, Adams et al. (2017) found that within the 42 studies included, an average of 55% of respondents ideated about and 29% attempted suicide in their lifetimes, representing averages 14 and 22 times greater than that of the general public. Suicidal ideation was higher among male-to-female (MTF) than female-to-male (FTM) transgender people and lowest among those who were gender nonconforming. However, suicide attempts conversely occurred most often among FTM individuals in comparison to MTF individuals, followed by gender nonconforming individuals.

I bring to light the complexity of interpreting national statistics of health disparities and vulnerabilities as indicative of local community needs as a result of my own clinical experiences working within a very different clinical reality than what is generally represented in the research. Although I have no actual statistics to publish here, my work within the transgender and gender nonbinary community is represented entirely by a university student population of mixed ethnicity and race, all of whom have access to transgender-inclusive student healthcare and insurance plans which provide coverage for hormonal, and in some cases, surgical interventions, counselling, and preventive health services. In addition, the university provides social support services in the form of a LGBTQ+ education center and gathering space. There is also a local non-profit center dedicated to supporting the psychosocial needs of the LGBTQ+ population.

While many of my transgender and gender nonbinary clients have significant stories to tell from previous trauma, abuse, violence, and ongoing discrimination, the majority of their mental health concerns are seemingly focused around anxieties related to performance in their university programs, intimate relationships, and finances, not around their gender identities and expressions or other mental health concerns including gender dysphoria. Some, but not all, of my clients are concurrently working with counsellors, psychologists, or psychiatrists. An even lesser number have been prescribed or are taking psychiatric drugs, such as serotonergic antidepressants, anxiolytics, lithium, or anticonvulsants (such as carbamazepine). A number of my clients have undergone surgical transition procedures, and there are some that would like to in the future. However, not everyone is interested in surgical procedures. The majority of their health concerns are around weight gain (college years or due to hormonal transition), skin problems (including acne due to use of testosterone, or eczema, dermatitis, and fungal infections as a result of binding or tucking practices), digestive health (lots of heartburn and acid reflux), stress management and sleep hygiene, and a general lack of immune vitality. In my experience, there is no more likely to be a history of substance abuse (alcohol, tobacco, or otherwise) than there is among the cisgender university students who also seek my support.

My experiences, and those of my transgender and nonbinary clients, do not necessarily represent those elicited by national statistics. In my learning, I have had to reach beyond the statistical and theoretical research in order to provide culturally competent clinical support for the transgender and gender nonconforming individuals in my community. In this regard, networking with the LGBTQ+ centers, maintaining friendships within the LGBTQ+ community through my participation in local events, meetings, and activities, and creating professional relationships with trans-inclusive healthcare providers have all been at the forefront

of creating a welcoming and inclusive clinical environment and highlighting the supportive role that clinical herbalism can provide. The only clinical assumption I have ever made in regards to working with transgender and gender nonbinary individuals, is that it is never a good idea to assume anything at all.

However, national health disparities trends and statistics can serve as a call to action. For example, in the National Transgender Discrimination Survey (Grant et al., 2011), study participants were less likely to have health insurance and more likely to be covered by public programs such as Medicare and Medicaid than the general population. In fact, this study found that health insurance was a significant factor in delayed care, whether acute or preventative. In regards to delaying preventative care, participants without health insurance reported an inability to afford it much more frequently than those with private or public insurance. Although times are constantly changing in regards to national healthcare and health insurance, many professional herbalists' services are unlikely to be covered by health insurance. These national statistics emphasize the reality that culturally competent and inclusive healthcare, preventative or otherwise, is not likely to be affordable, and this would be no different in seeking the support of a clinical herbalist. In this regard, cultural competence and inclusivity has required that I provide free and sliding-scale appointments to my local transgender and gender nonconforming community.

Hormonal Transitions: Respecting Standards of Care and Scope of Practice

Another assumption that is readily yet inappropriately made is all transgender

Artist Barbara Gilhooly's "Two Flowers" speaks of a nonbinary world.
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and/or gender nonbinary people are seeking some type of hormonal or surgical intervention (WPATH 2011, CoE 2016). For some individuals, the process of gender affirmation and expression is limited to a personal and/or social process, rather than medical and/or surgical intervention (Lev 2004, WPATH 2011, CoE 2016). Although transgender individuals are more likely to seek hormonal or surgical transition than gender nonbinary individuals (Grant et al. 2011), it is important to not assume that every transgender or gender nonbinary individual seeking herbal support will be doing so with the main goal of hormone ecology augmentation.

From the research it is clear that access to prescribed hormones is often denied due to non-inclusive healthcare settings and/or lack of insurance coverage (Grant et al. 2011). However, in some cases prescribed hormones may be denied to an individual due to preexisting and/or uncontrolled physical or mental health diagnoses (Deutsch and Feldman 2013). Although outright denial of transitioning hormones is frowned upon by experts in the field of transgender health (WPATH 2011, Deutsch and Feldman 2013, CoE 2016), prescription of transitioning hormones offers its own complexity within primary care settings and requires that prescribers not only feel confident with recommended guidelines but are also proactive in regards to monitoring and interpreting ongoing bloodwork (Deutsch and Feldman 2013, Gardner and Safer 2013, Roberts et al. 2014, CoE 2016). In this regard, and in my own clinical practice, I feel it is prudent to acknowledge my professional scope of practice. It is much more complex than "herbs for hormonal transitioning," and many of these complexities are liable to be outside of an herbalist's clinical reach and expertise.

In addition, it is my personal and professional opinion that herbs, nutrition, and lifestyle practices (such as avoiding xenoestrogens) alone are not enough to alter hormone ecology to the same extent as pharmaceutical approaches. Although the efficacy of herbs in transitioning hormone ecology to meet the needs of our clients is highly debatable and incredibly individualistic, I firmly believe it is very important to read and respect the previously discussed SOC documents in regards to hormonal transitioning before attempting to provide such support to our clients, lest we begin to work outside of our respective scopes of practice and/or against the grain of our clients' healthcare team (if one exists).

For many clinical herbalists working with the transsexual, transgender, and gender nonbinary community, it is likely that our clients will not have access to inclusive healthcare services due to discrimination, lack of financial resources, or other such aforementioned disparities (Grant et al., 2011, Gardner and Safer 2014). It is also possible that transgender and gender nonbinary individuals seeking herbal support will be approaching clinical herbalists as primary care providers in the absence of a larger healthcare team with whom to confer, and this may more likely be the case in free or sliding-scale clinical environments.

Our "client-centered" approach puts clinical herbalists in a unique position to offer support, encouragement, and empowerment where it is critically needed…

Doing What Herbalists Do Best: Honoring the Individual

Transgender health is a deep, complex, and multifaceted topic and not all aspects, arguments, or opinions could possibly be covered here. The "individualistic" or "client-centered" approach that serves as a tenet of our profession puts the practice of clinical herbalism in a unique position to offer support, encouragement, and empowerment where it is critically needed, especially from clinical herbalists who offer free or sliding-scale clinical services. There is much that herbalism can offer the transgender and gender-variant community, as evidenced by the work of our colleagues Kara Siglar, Mica and Kenzie McDonald, and Larken Bunce, to name a few among many.

However, culturally competent care requires us to be avid researchers. This especially is the

case when approaching clients' experiences that are new or foreign to us. In closing, I shall leave you with a quote from CoE SOC (2016):

> *Cultural humility is a concept through which individuals recognize that their own experiences or identities may not project onto the experiences or identities of others. Each patient should be approached as an individual with no preconceptions. Individual preferences of terminology, complex or novel gender identities, and differing desires for gender-affirming treatments will be encountered daily in the clinic. Meeting patients "where they are" without judgment or editorializing (including in some cases, even positive remarks about appearance) will enhance the patient-provider relationship and avoids the perception of stigma or pathologization.*

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