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IN BRIEF REPORT

Special-"T" Training: Extended Follow-up Results from a Residency-Wide Professionalism Workshop on Transgender Health

Jeremy D. Kidd[1] · **Walter Bockting**[1] · **Deborah L. Cabaniss**[1] · **Philip Blumenshine**[2]

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Abstract
Objective Transgender people face unique challenges when accessing health care, including stigma and discrimination. Most residency programs devote little time to this marginalized population.
Methods The authors developed a 90-min workshop to enhance residents' ability to empathize with and professionally treat transgender patients. Attendees completed pre-, post, and 90-day follow-up surveys to assess perceived empathy, knowledge, comfort, interview skill, and motivation for future learning.
Results Twenty-two residents (64.7 %) completed pre- and post-workshop surveys; 90.9 % of these completed the 90-day follow-up. Compared to baseline, there were statistically significant post-workshop increases in perceived empathy, knowledge, comfort, and motivation for future learning. However on 90-day follow-up, there were no statistically significant differences across any of the five domains, compared to baseline.
Conclusions This workshop produced significant short-term increases in resident professionalism toward transgender patients. However, extended follow-up results highlight the limitations of one-time interventions and call for recurrent programming to yield durable improvements.

Keywords Transgender persons · Professionalism · Internship and residency · Medical education

Transgender is a term that "encompasses individuals whose gender identity differs from the sex originally assigned to them at birth [and/] or whose gender expression varies significantly from what is traditionally associated with or typical for that sex. . . . as well as other individuals who vary from or reject traditional cultural conceptualizations of gender in terms of the male–female dichotomy" [1]. While reliable prevalence estimates are not available, researchers in Massachusetts using population-based data from the Behavioral Risk Factor Surveillance System found that 0.5 % of respondents identified as transgender [2]. This is likely an underestimate because it only represents individuals who transition along a male–female binary, excluding many others who fall within the larger "transgender" umbrella.

There is increasing evidence that transgender people face unique challenges in accessing health care. In a landmark report on lesbian, gay, bisexual, and transgender (LGBT) health, the Institute of Medicine (IOM) found that transgender people face stigma and prejudice at every life stage from childhood/adolescence to later adulthood [1]. The IOM concluded that such stigma often arises in health care settings, at both the provider and health systems levels. Transgender people experience fear of discrimination, lack of provider knowledge, dissatisfaction with the quality of care, and underestimation by providers regarding the seriousness of medical complaints. The IOM [1], Association of American Medical Colleges [3], American Medical Association [4], and American Psychiatric Association [5] have all called for increased provider education and improved access for transgender patients.

✉ Jeremy D. Kidd
kiddjer@nyspi.columbia.edu

[1] Columbia University/New York State Psychiatric Institute, New York, NY, USA

[2] University of Connecticut School of Medicine, Farmington, CT, USA

Available data suggest that residency training on transgender health lags behind public policy. While several studies have examined LGBT health collectively in medical education, only one study reported data separately for transgender-related topics. Ali et al. [6] found that psychiatry residents tended to have less negative attitudes toward transgender patients than undergraduate controls and that such attitudes were correlated with clinical exposure. Despite the need for increased education and training, a 2011 survey of 176 medical school deans found that schools devoted a median of 5 h across all 4 years to LGBT content [7]. This was generally confined to sexual history-taking and the authors do not specify how much, if any, of this time was spent discussing transgender identities. In a multi-specialty survey of 464 resident and attending physicians, Kitts et al. [8] found that the majority of respondents did not discuss sexual orientation or gender identity with their patients. Alarmingly, 41 % stated they would not discuss these topics with sexually active adolescents, even those presenting with depression or suicidality, citing lack of training as the major impediment. This data is concerning given the likely increasing number of transgender patients seeking care as a result of the 2010 Affordable Care Act and the expansion of several state Medicaid programs to cover gender transition-related health services.

In an effort to address these deficiencies, we developed and evaluated an innovative resident education program focused on training residents to work professionally with transgender patients. We had two objectives: (1) to improve residents' empathy with and respect for the diverse life experiences of transgender patients and (2) to increase their awareness of the need to consider issues of gender identity/expression when working with patients.

Method

Development/Context

We conducted this program at a large, urban adult psychiatry residency program that includes a mandatory annual "professionalism workshop" as part of the residency didactic curriculum [9]. According to the Accreditation Council for Graduate Medical Education (ACGME), residents are expected to "commit to high standards of professional conduct, demonstrating altruism, compassion, honesty and integrity…follow principles of ethics and confidentiality and consider religious, ethnic, gender, educational and other differences in interacting with patients…" As our residents had formally and informally requested more training in treating transgender individuals, we decided to make this the topic of our 2015 professionalism workshop.

Workshop Overview

This 90-min professionalism workshop was mandatory for all on-service PGY1-PGY4 residents. We began with a 10-min didactic presentation that defined key concepts of sex, gender, gender identity, transgender, social sex role, and sexual orientation. We also described prevalence data and suggested questions to use when asking patients about gender identity, including topics to consider during clinical interactions with transgender patients (e.g., preferred name/pronoun and use of gendered bathrooms).

Next, we divided residents into four "role-play groups" and assigned each group a different clinical vignette and facilitator. Table 1 describes these clinical vignettes as well as the

Table 1 Clinical vignettes and role-play instructions for "clinician" and "patient" groups used in the role-play portion of this 2015 professionalism workshop on transgender health

Clinical vignettes
Case 1: You are working on an inpatient psychiatric unit and have been asked to admit a new patient. The chart states that the patient's name is Maria Smith, 38 years old and born in the Dominican Republic. The patient has a history of bipolar I disorder and was admitted overnight for a manic episode. You introduce yourself, "Hi, Ms. Smith. Can we speak for a few minutes?" To your surprise, the patient states that he is a man and raises his shirt to reveal bilateral mastectomy scars.
Case 2: You are conducting an outpatient intake evaluation. The intake form states that the patient is legally named Brenda. The patient is a 21-year-old Caucasian, female undergraduate referred for treatment after having several panic attacks at college, each occurring outside of the restroom. Early in the intake session, the patient indicates that they identify as "genderqueer" and go by the name Aiden. Aiden also prefers the gender-neutral pronoun "they" instead of "he" or "she."
Case 3: You are working on an inpatient psychiatric unit and are meeting a patient who was admitted 3 days ago after a suicide attempt. The chart states that the patient's name is Andrea, a 27-year-old Asian American transgender woman with a history of borderline personality disorder. After introducing yourself, Andrea explains that she wants her hormones, which she has not been able to take since being admitted to the hospital.
Case 4: You have been working for 3 months in psychotherapy with Alicia, a 46-year-old African American transgender woman with a long history of depression. Her family of origin does not accept her transgender identity and told her that she is not allowed in their house presenting in the female gender role. The only positive family connection is an aunt. Today, Alicia reveals that last Sunday after church her aunt told her, "I love the sinner but cannot condone the sin." Alicia is devastated.
Role-play group instructions
"Patient" group: Please discuss the patient's background, characteristics, and concerns as a group. Select a volunteer to role-play the patient and prepare that volunteer for the upcoming role-play.
"Clinician" group: Please discuss ways in which the clinician can communicate effectively with this patient. Select a volunteer to role-play the clinician and prepare that volunteer for the upcoming role-play. The goal is to obtain more information about the patient's concerns and how the patient's identity may have influenced these concerns.

instructions given to each group. A variety of clinical vignettes were used to emphasize the common applicability of these skills across treatment setting (e.g., inpatient and outpatient), treatment modalities, and symptom presentations. Facilitators were clinicians in the department with experience treating transgender patients, representing a variety of clinical disciplines (i.e., attending psychiatrists, residents/fellows, psychologists, and social workers). Prior to the workshop, we provided facilitators with a brief orientation to the workshop structure and objectives, advising them on how best to facilitate small-group discussions. We further divided each role-play group into a "patient group" and a "clinician group." Working with their facilitator, "patients" and "clinicians" spent 15 min preparing their respective roles. The patient group discussed background information, demographic characteristics, life experiences, and any concerns that the patient might have in the clinical scenario. The clinician group brainstormed ways to communicate effectively with this patient, topic areas on which to focus, and strategies for maintaining a respectful and empathic stance. A representative "patient" and "clinician" from each group then role-played the clinical vignette based on these discussions. Facilitators answered questions, provided guidance, and resolved disputes. The role-play itself lasted approximately 15 min. Still within their role-play groups, facilitators then led a 20-min debriefing to highlight aspects of the role-play that went well, challenges the groups encountered, and questions this activity generated. Residents were also encouraged to discuss any discomfort they may have felt during the role-play.

We spent the final 10 min of the workshop in a large-group debriefing to emphasize four key concepts: (1) the importance of incorporating discussions of gender identity and gender expression into conversations with patients; (2) the similarities between empathizing and showing respect for transgender patients as compared to working with other stigmatized minority groups, (3) the clinical relevance of empathizing with the diverse life experiences of transgender people; and (4) the ways in which better understanding the patient's perspective and identity can strengthen the therapeutic alliance. This was accomplished by inviting participants to share reactions to and insights from their individual role-play experience in order to emphasize how these concepts can be applied broadly to a variety of treatment setting, modalities, and diagnostic categories. After the workshop, we distributed a resource/referral list to residents via email that included mental health, primary care, housing, and legal services as well as specific resources for survivors of trauma, transgender youth, and transgender older adults.

Evaluation

We administered matched pre- and post- surveys to all workshop attendees along with a 90-day follow-up survey. Because no unique identifier linked all three surveys at the individual level, the 90-day follow-up surveys were unmatched. The pre-workshop survey collected demographic information on level of training and past clinical experience treating transgender patients. The post-workshop survey contained a series of open-ended questions to obtain formative feedback about the workshop. We assessed main outcome variables on all three surveys by asking respondents to subjectively rate (1–5) their perceived competency in five domains: (1) empathy, (2) knowledge, (3) comfort, (4) interview skill, and (5) motivation for future learning. The institutional review board (IRB) determined that this study did not meet the criteria for human subjects research.

Statistical Analysis

We utilized Microsoft Excel (2010) to investigate differences across time-points in the main outcomes. Continuous respondent ratings were coded categorically such that 1 and 2 represented "disagree/strongly disagree," 3 was "neutral," and 4 and 5 were "agree/strongly agree." We used Fischer's exact tests for categorical variables given the small sample size and *t* tests for continuous variables, utilizing a paired *t* test for comparisons of matched pre- and post-workshop data.

Results

Demographics

Out of 34 on-service PGY1-PGY4 residents, 22 (64.7 %) completed both pre- and post-workshop surveys. The 90-day follow-up survey was completed by 90.9 % ($n = 20$) of the original respondents. The majority of respondents (77.3 %) were PGY2 and PGY3 residents. Regarding past clinical exposure, half of residents had treated only one transgender patient in the last 4 years and none had treated greater than five transgender patients.

Main Outcome Measures

Figure 1 illustrates results from categorical, pair-wise comparisons of the five main outcome measures. Compared to pre-workshop baseline, there were statistically significant immediate post-workshop increases in the percentage of respondents who agreed/strongly agreed with statements about perceived levels of empathy (36 vs 73 %, $p = 0.03$), knowledge (5 vs 55 %, $p = 0.0006$), comfort (36 vs 73 %, $p = 0.03$), and motivation for future learning (36 vs 73 %, $p = 0.03$). There was no significant change in perceived interview skill immediately post-workshop.

The 90-day extended follow-up data were surprising. Despite immediate post-workshop increases in four out of five

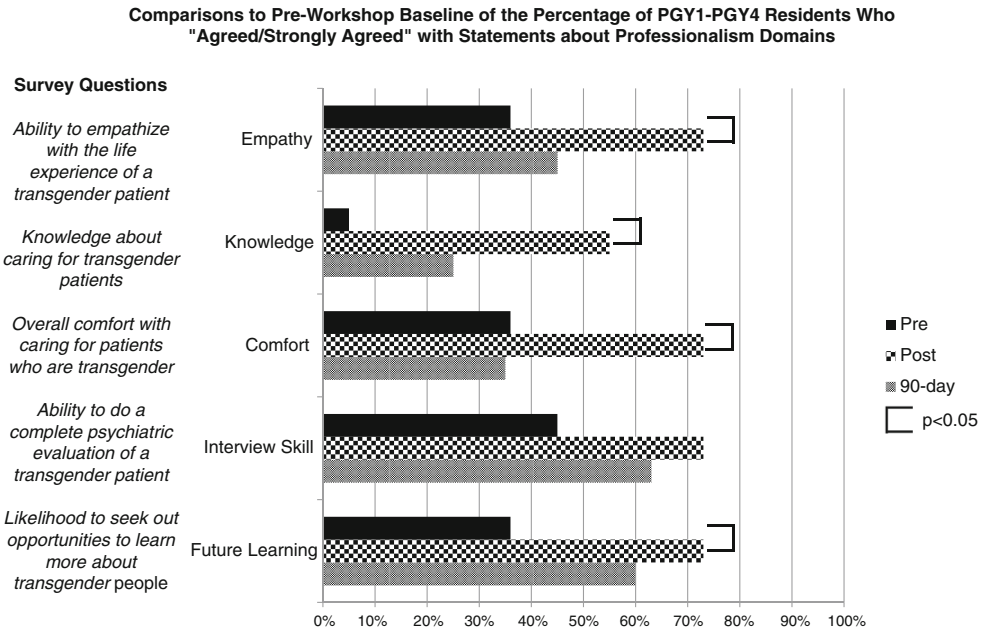

Fig. 1 Comparison of the percentage of residents who "agreed/strongly agreed" with statements regarding professionalism domains immediately post-workshop and on 90-day follow-up, as compared to pre-workshop baseline

main outcome measures, there were no statistically significant differences across any of the five domains at 90-day follow-up compared to pre-workshop baseline. When looking at the data continuously rather than categorically, there was a modest but statistically significant increase in mean rating for perceived knowledge compared to pre-workshop baseline (mean score 2.4 vs 3.0, $p = 0.009$).

Qualitative Responses

Small-group facilitators reported that residents were highly engaged in the role-play activity. They reported lively discussions related to both the simulated clinical encounters and residents' subjective experiences of asking questions related to gender identity. Similarly, the majority of survey respondents (72.7 %) cited the role-play activity as the most helpful aspect of the workshop. One participant commented, "The role-plays from the perspective of the patient were helpful as a way to brainstorm issues that transgender people might face." Seven respondents answered questions about areas for improvement and all cited time constraints as a disadvantage.

Discussion

To our knowledge, this is the first systematically evaluated residency education intervention specifically focused on treating transgender patients. Our findings demonstrate significant improvement immediately post-workshop in residents' perceived empathy, knowledge, comfort, and motivation for future learning on this topic. However, they also indicate that ongoing training may be necessary to sustain these results. The fact that initial improvements in professionalism measures after the workshop did not persist on extended follow-up calls into the question the effectiveness of so-called "one-shot" educational interventions, on which much of residency education relies. While adding a single lecture or presentation to an existing curriculum may be an efficient way to cover new topics, it may not necessarily result in sustained improvements.

Several aspects of this systematically evaluated program make it unique. This may be one of the first residency education interventions focused specifically on treating transgender patients, and it demonstrated initial positive impact. We were also able to examine the durability of our immediate findings by using an extended follow-up measure. Our low attrition rate is another important strength, with nearly all of the original respondents completing both follow-up assessments. Our intervention is also highly replicable. We used facilitators with a variety of different training backgrounds (e.g., attending physicians, residents/fellows, psychologists, and social workers), which increases the feasibility for replicating the workshop in training programs that may not have access to MD-level faculty with experience in transgender health.

The generalizability of our findings is limited primarily by sample size and reliance on data from a single residency program. These results may not be generalizable to smaller training programs or those located in more suburban or rural areas. The pre-post evaluation design also carries with it the possibility of response-shift bias such that the intervention itself alters the respondent's ability to appraise their own competence [10]. Additionally, due to lack of a unique identifier linking all three surveys, we were not able to match data at the individual level in the 90-day follow-up survey.

Nevertheless, the aggregate data allowed us to draw conclusions about the collective impact of the intervention on a cohort of residents across all four levels of training. Finally, while a majority (64.7 %) of workshop attendees completed both pre- and post-workshop surveys, our conclusions are limited to only those attendees who completed these assessments.

Future research is needed to revise and reevaluate this program with the ultimate goal of producing durable improvements in residents' attitudes, skills, and behaviors relative to transgender patients. Such research should examine the potential for recurrent educational programming to yield sustainable changes in residents' ability to emphasize with and professionally treat transgender patients. One potential strategy for accomplishing this would be to introduce topics developmentally across years of training, building on and reinforcing material year-to-year. This model is consistent with the ACGME's Milestone method of resident performance evaluation [9]. Our findings also indicate that more medical education evaluation studies should incorporate extended follow-up into their methodologies to assess for longer-term gains in addition to short-term, immediate changes. Transgender patients face unique challenges in accessing health care and such programs would allow residency training to meet the educational needs of trainees and enable them to empathically, professionally, and competently care for this marginalized patient population.

Implications for Educators

- Nationally, the amount of training that residents receive regarding the care of transgender patients is insufficient.
- Patient–clinician role-plays can be effective in increasing residents' ability to empathize with the diverse life experiences of transgender patients.
- One-time interventions may not be sufficient to improve residents' knowledge, attitudes, and behavior relative to transgender patients.
- Educators and education researchers should consider incorporating extended follow-up assessment in order to better describe long-term effects on training outcomes.

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Compliance with Ethical Standards

Ethical Approval The NYSPI IRB determined that this study did not meet the criteria for human subjects research.

Disclosures On behalf of all authors, the corresponding author states that there is no conflict of interest.

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