Behavioral Health Care for Transgender People

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Continuing Medical Education Disclosure

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- **Disclosure**: No relevant financial relationships. Presentation does not include discussion of off-label products.

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Gender Identity: The Basics

- Gender Identity
- Bisexual
- Queer
- Sexual Orientation
- Trans Man
- Trans Woman
- Trans Masculine
- Trans Feminine
- MSM
- FTM
- Ally
- Desire
- Behavior
- Gender Expression
- Genderqueer
- Straight
- Asexual
- Non-Binary
- Gay
- Lesbian
Gender Identity and Gender Expression

- **Gender identity**
  - A person's inner sense of being a boy/man/male, girl/woman/female, another gender, or no gender
  - All people have a gender identity

- **Gender expression**
  - How one presents themselves through their behavior, mannerisms, speech patterns, dress, and hairstyles
  - May be on a spectrum

A complete glossary of terms is available at [www.lgbthealtheducation.org/publication/lgbt-glossary/](http://www.lgbthealtheducation.org/publication/lgbt-glossary/)
Transgender (vs. Cisgender)

- Gender identity does not correspond with assigned sex at birth
- Alternate terminology
  - Transgender woman, trans woman
  - Transgender man, trans man,
- Non-binary, genderqueer
  - Genderqueer person
- Trans masculine, Trans feminine

www.lgbthealtheducation.org
In a 2013 community-based survey of 452 transgender adults, 40.9% of respondents described themselves as having a non-binary gender identity. (Keuroghlian et al., 2015)
DSM-5 Gender Dysphoria (F64._)

A. A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months duration ...

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning, or with a significantly increased risk of suffering, such as distress or disability

.1 adolescence & adulthood .8 other gender identity disorders .9 unspecified
Pronouns

- People may use a range of pronouns, including she/her/hers and he/him/his, as well as less-common pronouns such as they/them/theirs and ze/hir/hirs (pronounced zee/hear/hears).

<table>
<thead>
<tr>
<th>Subjective</th>
<th>Objective</th>
<th>Possessive</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>He</td>
<td>Him</td>
<td>His</td>
<td>He is in the waiting room. The doctor is ready to see him. That chart is his.</td>
</tr>
<tr>
<td>She</td>
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<td>She is in the waiting room. The doctor is ready to see her. That chart is hers.</td>
</tr>
<tr>
<td>They</td>
<td>Them</td>
<td>Theirs</td>
<td>They are in the waiting room. The doctor is ready to see them. That chart is theirs.</td>
</tr>
<tr>
<td>Ze</td>
<td>Hir</td>
<td>Hirs</td>
<td>Ze is in the waiting room. The doctor is ready to see hir. That chart is hirs.</td>
</tr>
</tbody>
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Gender Minority Stress Framework

External Stigma-Related Stressors → General Psychological Processes → Internal Stigma-Related Stressors → Behavioral Health Problems → Physical Health Problems

Adapted from Hatzenbuehler, ML (2009)
Interpersonal Stigma

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Structural Stigma

- Structural, or institutional discrimination includes the policies of private and governmental institutions that intentionally restrict the opportunities of certain people, as well as policies that unintentionally restrict these opportunities.

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Intrapersonal Stigma

“...And to the degree that the individual maintains a show before others that [they themselves] do not believe, [they] can come to experience a special kind of alienation from self and a special kind of wariness of others.” (Goffman, 1978)
Depression and Anxiety among Transgender Adults

- Prevalence of clinically significant depressive symptoms:
  - 51% of transgender women
  - 48% of transgender men

- Prevalence of clinically significant anxiety symptoms:
  - 40% of transgender women
  - 48% of transgender men

Health Disparities (2015 U.S. Transgender Survey)

- 39% of respondents experienced serious psychological distress in the month prior (compared to 5% of the U.S. population);

- 40% had lifetime suicide attempt (compared to 4.6% of US population);

Suicidality (2015 U.S. Transgender Survey)

In the preceding 12 months:
- 48% had seriously thought about suicide
- 24% made a plan to kill themselves
- 7% had attempted suicide
- 40% had attempted suicide at one point in their lives
- 34% had first attempt by age 13
- 92% had first attempt by age 25

Factors Associated with Higher PTSD Severity in Transgender Adults

- Higher everyday discrimination
- Greater number of attributed reasons for discrimination
- High visual gender non-conformity
- Unstable housing

(Reisner et al., 2016)
Factors Associated with Lower PTSD Severity in Transgender Adults

- Younger age
- Transmasculine spectrum gender identity
- Medical gender affirmation

(Reisner et al., 2016)
Addictions among Transgender People

- Studies examining substance use disorders (SUDs) among transgender people are rare
- Reporting of gender identity data (e.g., transgender status) in SUD-related research is limited
- In the few studies that exist, transgender people have elevated prevalence of alcohol and illicit drug use compared with the general population

(Flentje et al., 2015; Benotsch et al., 2013; Santos et al. 2014)
Gender Minority Stress and Substance Use among Transgender People

- Psychological abuse among transgender women as a result of non-conforming gender identity or expression is associated with:
  - 3-4x higher odds of alcohol, marijuana, or cocaine use
  - 8x higher odds of any drug use

- Among transfeminine youth, gender-related discrimination is associated with increased odds of alcohol and drug use

(Nutbrock et al., 2014b; Rowe et al., 2015)
Gender Minority Stress and Substance Use among Transgender People

- 35% of transgender people who experienced school-related verbal harassment, physical assault, sexual assault, or expulsion reported using substances to cope with transgender- or gender nonconformity-related mistreatment

- Psychological stress of health care access disparities faced by transgender people is believed to contribute to worse mental health, including disproportionate substance use as a coping strategy

(Grant et al., 2015; Poteat et al., 2013; Wilson et al., 2015)
Substance Use Disorders among Transgender Adults

- Among 452 transgender adults in MA, increased odds of SUD treatment history plus recent substance use were associated with:
  - intimate partner violence
  - PTSD
  - public accommodations discrimination
  - unstable housing
  - sex work

- Higher SUD prevalence increasingly viewed as downstream effects of chronic gender minority stress

(Keuroghlian et al., 2015)
Psychiatric Diagnoses, Acuity and Outpatient Engagement

- Retrospective review of EHR data from:
  - 201 transgender-identified patients,
  - 19-64 years old,
  - presented for one or more health-care visits between July 1, 2010 and June 30, 2015 at an urban community health center in Boston, MA.

- Not working associated with ANY DIAGNOSIS
- Suicide attempts and older age of hormone therapy initiation associated with SUBSTANCE USE DISORDERS
- Alcohol use disorder, MDD, PTSD, and absence of behavioral health integration associated with ACUITY
- MDD, anxiety disorders, and case management associated with OUTPATIENT TREATMENT ENGAGEMENT

(Keuroghlian et al., in preparation)
Gender-affirming Surgery and Age of Hormone Therapy Initiation

• Retrospective review of EHR data from:
  • 201 transgender-identified patients,
  • 19-64 years old,
  • presented for one or more health-care visits between July 1, 2010 and June 30, 2015 at an urban community health center in Boston, MA.

• Accessing gender-affirming treatments is associated with better mental health, higher socioeconomic status, and identifying as straight/heterosexual

(Beckwith, Reisner, Zaslow, Mayer, Keuroghlian, in press)
Effective Communication: The Whole Team
Affirmative Care for Transgender and Gender Non-Conforming People:

Best Practices for Front-line Health Care Staff

Updated Fall 2016

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Anticipating and Managing Expectations

- Transgender people have a history of experiencing stigma and discrimination in health care settings
- Don’t be surprised if a mistake results in a patient becoming upset
- Don’t personalize the reaction
- Apologizing when patients become upset, even if what was said was well-intentioned, can help defuse a difficult situation and re-establish a constructive dialogue
Avoiding Assumptions

You cannot assume someone’s gender identity based on how they look or sound

To avoid assuming gender identity with new patients:

- *Instead of:* “How may I help you, sir?”
- *Say:* “How may I help you?”
- *Instead of:* “He is here for his appointment.”
- *Say:* “The next person is waiting in the reception area.”
Gender Minority Stress Treatment Principles for Behavioral Health Clinicians

- Normalize adverse impact of gender minority stress
- Facilitate emotional awareness, regulation, and acceptance
- Empower assertive communication
- Restructure minority stress cognitions
- Validate unique strengths of transgender people
- Foster supportive relationships and community
- Affirm healthy, rewarding expressions of gender
Gender Identity and Co-occurring Psychiatric Disorders

- Often impede gender identity exploration and alleviation of distress
- Need to stabilize co-occurring psychiatric symptoms for facilitation of gender identity discovery and affirmation
- WPATH guidelines for reasonable control of co-occurring disorders
Role of Behavioral Health Clinician in Gender Affirmation Process

- Fostering gender identity exploration, discovery and affirmation
- Presenting appropriate non-medical and medical strategies for gender affirmation
- Assistance in making fully informed decisions regarding personalized gender affirmation process:
  - relevant options
  - risks/benefits
  - evaluate capacity for medical decision making/informed consent
  - arranging suitable referrals to care
Gender-affirming Behavioral Health Care

- Explore gender identity, expression, and role
- Focus on reducing internalized transphobia
- Help improve body image
- Facilitate adjustment through affirmation process (physical, psychological, social, sexual, reproductive, economic, and legal challenges)
Cognitive-behavioral Therapy for Substance Use Disorders

- Adapting selected topics and practice exercises from the manual by Carroll
- Focus:
  - Coping With Craving (triggers, managing cues, craving control)
  - Shoring Up Motivation and Commitment (clarifying and prioritizing goals, addressing ambivalence)
  - Refusal Skills and Assertiveness (substance refusal skills, passive/aggressive/assertive responding)
  - All-Purpose Coping Plan (anticipating high-risk situations, personal coping plan)
  - HIV Risk Reduction
Cognitive-behavioral Therapy for Substance Use Disorders

- Possible tailoring for transgender clients:
  - Minority stress-specific triggers for cravings (e.g. nonconformity-related discrimination and victimization, expectations of rejection, identity concealment, and internalized transphobia)
  - SUDs as barriers to personalized goals of adequate ART/PrEP adherence or consistent condom use
  - Assertive substance refusal with non-transgender sex partners; HIV risk from hormone and silicone self-injections; SUDs as barriers to personalized goal of successful gender affirmation
Cognitive Processing Therapy for PTSD

- Adapting selected components of cognitive processing therapy for PTSD

  **Focus:**
  - Education about posttraumatic stress;
  - Writing an Impact Statement to help understand how trauma influences beliefs;
  - Identifying maladaptive thoughts about trauma linked to emotional distress;
  - Decreasing avoidance and increasing resilient coping.
Cognitive Processing Therapy for Minority Stress

- Possible tailoring for transgender clients:
  - Focus on how transgender-specific stigma causes posttraumatic stress (e.g. avoidance, mistrust, hypervigilence, low self-esteem);
  - Attributing challenges to minority stress rather than personal failings;
  - Impact Statement on how discrimination and victimization affect beliefs (e.g. expecting rejection, concealment needs, internalized homophobia/ transphobia);
  - Decreasing avoidance (e.g. isolation from transgender community or medical care);
  - Impact of minority stress on PrEP adherence or condom use.
Safe Communities and Spaces

- Encourage clients to utilize peer support resources (online or in-person), and community organizations dedicated to affirming gender diversity
- Provide advocacy within public mental health systems for gender-variant residents of group homes and homeless shelters
- Transgender competency training for staff
Consideration of Clozapine and Gender-Affirming Medical Care for an HIV-Positive Person with Schizophrenia and Fluctuating Gender Identity

Adrienne T. Gerken, MD, Shunda McGahee, MD, Alex S. Keuroghlian, MD, MPH, and Oliver Freudenreich, MD

Keywords: acquired immunodeficiency syndrome, clozapine, gender identity, hepatitis C, HIV, psychotic disorders, schizophrenia, transgender persons

CASE HISTORY
M is a 52-year-old patient, assigned male sex at birth, with schizophrenia, posttraumatic stress disorder, and cannabis/alcohol abuse and is intrusive and sexually provocative. During exacerbations of psychosis the patient has had difficulty maintaining appropriate boundaries, resulting in numerous physical alter-
Clinical Case of Patient ‘M’

- 52-year-old assigned male sex at birth
- Psychiatric diagnoses of schizophrenia, PTSD, and polysubstance use disorder (no evidence of dissociative identity disorder)
- Medical diagnoses of HIV, hepatitis C, and non-insulin dependent diabetes
- Admitted to government-sponsored group home after two-year state hospitalization
HPI

- Psychotic illness beginning at age 17
- Over 40 hospitalizations for psychosis (delusions, hallucinations, disorganization) with belligerence, physical aggression, and suicidal or violent ideation
- Hospitalizations frequently associated with 1) use of marijuana, synthetic cannabinoids, crack cocaine or alcohol and 2) medication non-adherence
HPI

- During periods of better symptom control, M is friendly and able to engage with staff and peers.
- During periods of acute illness, M has paranoid delusions with themes of physical assault, sexual violation, or involuntary procedures.
- M has auditory and visual hallucinations of angels and demons, and grandiose delusions of becoming a famous recording artist.
HPI

- During exacerbated psychosis, M is intrusive, sexually provocative, and has difficulty maintaining boundaries, resulting in numerous physical altercations and A&B charges
- Never held criminally responsible due to mental illness, but held involuntary for long periods on forensic units
HPI

- M has diagnosis of PTSD related to multiple physical and sexual assaults
- Physical and sexual abuse in childhood by primary caregiver, numerous sexual assaults in adulthood while homeless and engaging in sex work (30-40 sexual assaults)
- PTSD symptoms include flashbacks, nightmares, avoidance of certain places, and difficulty recalling important details of assaults
HPI

- Homeless throughout most of 1990s, then hospitalized majority of 1998-2013
- Antipsychotic trials during this time chlorpromazine, fluphenazine decanoate, haloperidol, quetiapine, and risperidone (oral and long-acting intramuscular injections)
- Brief trial of clozapine in 2001-2002 with reportedly good results, discontinued in the setting of outpatient nonadherence
Substance Use History

- Substance use history notable for longstanding, problematic use of alcohol (binge pattern), crack cocaine, and marijuana
- In past three years also began to smoke synthetic cannabinoids (primarily “K2”), leading to worsening psychotic symptoms
Social History

- Born to intact African American family in small Southern town, eighth of 11 siblings
- Father diagnosed with schizophrenia
- First moved to Boston at 8 years old
- First sexual relationship at 17 years old, all sex partners have been cisgender men, intermittent sex work
- Has had some brief jobs, now receives SSDI
Gender Identity History

- Reports gender non-conforming behaviors since age 7, with associated harassment and sexual abuse by peers
- M reports having questions about male gender identity since puberty and recounts developing “female” legs and breasts
- M began to identify as a “gay man” in late adolescence yet also describes identifying as a woman during this time, dressed intermittently in feminine attire
Gender Identity History

- M describes having been “pregnant” at age 18 and losing the fetus after being kicked in the stomach
- Records from 2001-2014 indicate patient self-identified at times as female, at other times as male
- Clinical staff concerned that M tended to endorse female gender identity during periods of increased disorganization/psychosis, and male identity when psychiatric symptoms better controlled
Gender Identity History

- Over several years, intermittently used medically unmonitored feminizing hormones obtained from the streets
- When being introduced to others, M would provide a traditionally male first name assigned at birth
- Since discharge to group home, M intermittently attempted to wear feminine attire but was discouraged from doing so by group home due to concerns of assault for gender non-conformity
Recent Case History

- Over two months, M developed more distressing delusions (fearing harm from strangers on the street, reporting sexual assault at night by angels)
- Reports being pregnant, citing “contractions” and requesting referral to obstetrician “to take this baby out of me”
- Ultrasound showed no gallbladder or intra-abdominal pathology
Recent Case History

- Developed worsening paranoid delusions about being followed, threatened with a knife and raped
- Struck another group home client during an argument, resulting in acute psychiatric hospitalization
- Due to treatment-refractory psychosis, agitation, and physical violence, hospital initiated clozapine
Recent Case History

- Ongoing nightmares, visual hallucinations of angels, auditory hallucinations of demons; resolved delusions of ongoing sexual assaults
- Ongoing belief about being pregnant and able to give birth, but only mentions this when asked directly and no longer requesting to see an obstetrician
- Improved mood stability, behavioral regulation, and ability to engage calmly with staff and peers
Recent Case History

- Significantly more able to participate in long-term planning of routine medical care
- Expressing interest in feminizing hormones (obtained from street in the past) and breast augmentation surgery
Questions

1. How do we assess, diagnose, and treat transgender clients with co-occurring severe mental illness?
2. How do we assess, diagnose, and treat transgender clients with co-occurring PTSD?
3. How do we identify and address the adverse effects of everyday discriminatory experiences when treating transgender clients?
Gender Identity

- Marked misalignment between internal gender identity and sex assigned at birth of at least 6 months duration (DSM-5)
- Reports experiencing gender misalignment consistently for the past year
- Has presented as only female for several years in the remote past
Gender Identity

- Recurring incongruence between internal gender identity and physical sex characteristics
- Marked desire to replace certain male sex characteristics with female ones via feminizing hormones and breast augmentation surgery
Gender Identity and Psychosis

- M exhibited female gender identity in early adolescence, several years prior to onset of psychotic symptoms at 17yo
- Female gender identity persists, even now that less preoccupied with delusions of pregnancy and significantly more capable of participating in planning own medical care
Gender Identity and Psychosis

- Is female identity derived from, or amplified by, psychosis?
- Alternative hypothesis: during psychiatric decompensation and disinhibition, less concerned about stigmatization, rejection, and abandonment
- Psychotic episodes may involve more unfiltered expression of innate gender identity
Gender Identity and Psychosis

- Inconsistent use of male vs. female pronouns in a given conversation and self-report of female anatomy or being pregnant may indicate presence of disordered thinking, not absence of real gender misalignment.
Gender Diversity

- Cannot assume fluctuations in gender identity over time could only result from psychiatric instability
- Gender identity often fluid and evolves naturally over time
- Some people live most comfortably part-time in alternating masculine and feminine gender roles
Gender Diversity

- Fluctuating gender presentation may be prolonged process of gender identity exploration until transitioning full time to a single gender expression.
- In other cases, people feel most comfortable with fluid gender expression that fluctuates long-term without needing to settle on one permanent gender expression.
Gender Diversity

- Gender is non-binary and not restricted to either masculine or feminine categorical states.
- M may have an intrinsically non-binary gender identity and has not yet developed conceptual framework, language, or self-awareness to describe this.
Gender Diversity

- Inconsistent endorsement of male and female gender identities within single conversation may indicate thought disorganization, or challenge in conceptualizing and communicating core experience of non-binary gender identity

- Important role for behavioral health clinicians to assist clients in exploring and understanding gender identity (fluid over time, non-binary, etc.)
Gender Identity and PTSD

- Patient continues to experience symptoms of PTSD related to physical and sexual abuse
- If psychosis reasonably well controlled, would benefit from evidence-based trauma-focused treatment (e.g. Cognitive Processing Therapy)
- Important to discuss limitation of medical gender affirmation for relieving persistent symptoms of psychological trauma stemming from sexual abuse
Co-occurring Psychiatric Disorders

- Need to make every effort to stabilize co-occurring symptoms of psychosis, PTSD, and substance use.
- Cannot withhold information about gender-affirming medical care from patients if co-occurring psychiatric disorders reasonably controlled.
Harm Reduction

- In cases where co-occurring psychiatric disorders remain unstable despite full treatment, harm reduction principles must guide clinical management.
Clinical Case: Update on ‘M’

- Currently presents as conventionally male (manicured beard, short hair, masculine clothing)

- Acknowledges male sexual anatomy

- Using she-series pronouns and traditionally female name
Clinical Case: Update on ‘M’

- Continues to express interest in hormone therapy and breast augmentation surgery
- Recently prescribed spironolactone as a gender-affirming medical intervention
- She and her treatment team actively discuss her gender identity and related goals