ADVANCING EXCELLENCE IN TRANSGENDER HEALTH

Assessment and Care for Transgender Clients in the Setting of Severe Mental Illness or Trauma

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Consideration of Clozapine and Gender-Affirming Medical Care for an HIV-Positive Person with Schizophrenia and Fluctuating Gender Identity

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CASE HISTORY

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

Agenda

- Clinical Case of ‘M’
- Gender Identity
- Psychosis
- Gender Diversity
- Posttraumatic Stress Disorder (PTSD)
- Discrimination and Trauma
- Clinical Management
- Update on ‘M’

Clinical Case of Patient 'M'

- 52-year-old assigned male sex at birth
- Psychiatric diagnoses of schizophrenia, PTSD, and polysubstance use 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 non-adherence

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 nonconforming 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 nonconformity

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

- 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 mental health clinicians to assist clients in exploring and understanding gender identity (fluid over time, non-binary, etc.)

Gender Diversity

- Gender is non-binary and not restricted to either masculine or feminine categorical states
- In 2013 community survey of 452 transgender adults, 40.9% endorsed non-binary gender identity (Keuroghlian *et al*., 2015)
- M may have an intrinsically non-binary gender identity and has not yet developed conceptual framework, language, or self-awareness to describe this

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

Definition of Trauma-informed Care

- According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), a trauma-informed service organization:
  - Realizes widespread impact of trauma and understands potential paths for recovery;
  - Recognizes signs and symptoms of trauma in clients, staff, and others involved with the system;
  - Responds by fully integrating knowledge about trauma into policies, procedures, and practices;
  - Seeks to actively resist re-traumatization.

Trauma-informed Service Environment

- Priority is to promote a sense of safety
- Prior traumatic experiences influence reaction in subsequent interactions, such as the process of seeking care.
- A history of interpersonal trauma can contribute to mistrust of caretakers and increased likelihood of being re-traumatized.
- Retention in care for patients with trauma histories requires engagement through collaboration, transparency, trust, and consistent supportiveness.

Brezing and Freudenreich (2015)

Screening for and Identifying Trauma and Its Mediators

- Screening all patients for a trauma history
  - Extra attentiveness for subpopulations with an even higher risk of trauma, who may have heightened sensitivity
  - Screening for intimate partner violence.
- If trauma is identified, care team ought to assess specifically for posttraumatic stress symptoms
  - Hypervigilance; avoidance, numbing, re-experiencing through intrusive thoughts, flashbacks, nightmares; psychological dissociation, including amnesia, depersonalization, and derealization.

Brezing and Freudenreich (2015)

The Primary Care PTSD Screen (PC-PTSD)

Exhibit 1.4-5: PC-PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, *in the past month*, you…

1. Have had nightmares about it or thought about it when you did not want to?
   YES NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
   YES NO
3. Were constantly on guard, watchful, or easily startled?
   YES NO
4. Felt numb or detached from others, activities, or your surroundings?
   YES NO

Source: Prins et al., 2004. Material used is in the public domain.

SAMHSA (2014)

Intimate Partner Violence Screening Tool

Exhibit 1.4-4: STaT Intimate Partner Violence Screening Tool

1. Have you ever been in a relationship where your partner has pushed or Slapped you?
2. Have you ever been in a relationship where your partner Threatened you with violence?
3. Have you ever been in a relationship where your partner has thrown, broken, or punched Things?

Source: Paranjape & Liebschutz, 2003. Used with permission

SAMHSA (2014)

PTSD Checklist

Exhibit 1.4-7: The PTSD Checklist

Instructions to Client: Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully and circle the number that indicates how much you have been bothered by that problem *in the past month*.

1. Repeated, disturbing memories, thoughts, or images of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
2. Repeated, disturbing dreams of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
4. Feeling very upset when something reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
6. Avoiding thinking about or talking about a stressful experience or avoiding having feelings related to it?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
7. Avoiding activities or situations because they reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
8. Trouble remembering important parts of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
9. Loss of interest in activities that you used to enjoy?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
10. Feeling distant or cut off from other people?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
12. Feeling as if your future will somehow be cut short?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
13. Trouble falling or staying asleep?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
14. Feeling irritable or having angry outbursts?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
15. Having difficulty concentrating?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
16. Being “super-alert” or watchful or on guard?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
17. Feeling jumpy or easily startled?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

Source: Weathers et al., 1993. Material used is in the public domain.

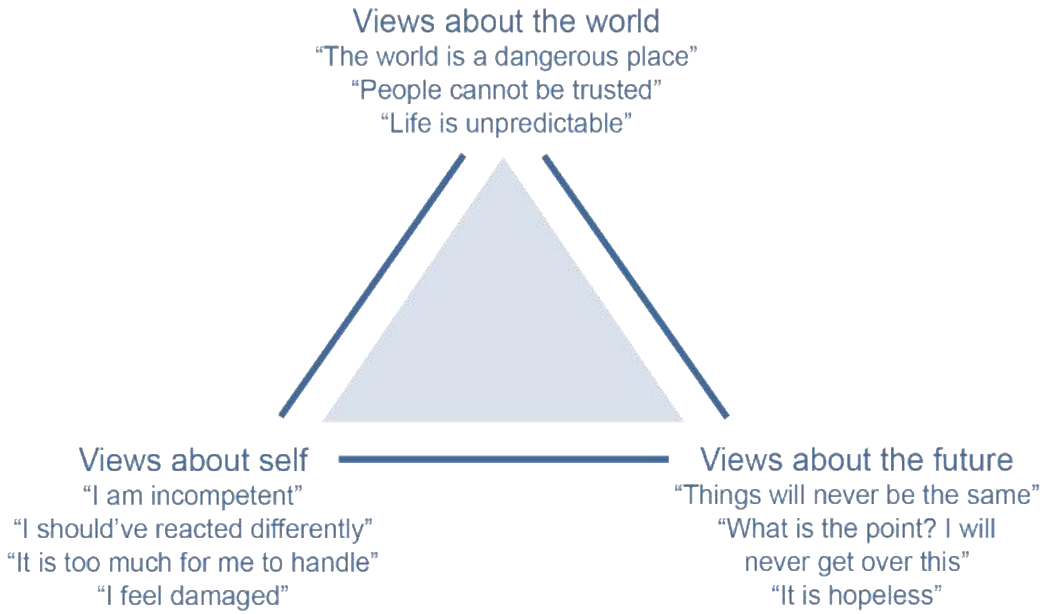
SAMHSA (2014)

Cognitive Processing Therapy for PTSD

- Adapting selected components of cognitive processing therapy for PTSD (Resick, Monson and Chard, 2016)
- 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 Triad of Traumatic Stress

Exhibit 1.3-2: Cognitive Triad of Traumatic Stress



SAMHSA (2014)

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 transphobia);
  - Decreasing avoidance (e.g. isolation from transgender community or medical care);
  - Impact of minority stress on PrEP adherence or condom use.

Role of Clinicians

- Fostering gender identity discovery
- Ethical obligation to present client with appropriate non-medical and medical strategies for gender affirmation
- Need to assist client 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

Psychiatric Disorders

- Often impede the process of gender identity discovery
- 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

WPATH Eligibility Criteria for Gender-Affirming Hormone Therapy

- Persistent, well-documented gender dysphoria, capacity for fully-informed decision making and consent to treatment, and reasonably good control of any physical or mental health concerns

WPATH Eligibility Criteria for Breast Augmentation Surgery

- Same criteria as gender-affirming hormone therapy plus recommendation (not requirement) for 12 months of feminizing hormone therapy to maximize breast growth for optimal aesthetic outcomes

WPATH Eligibility Criteria for Vaginoplasty

- Same requirements as breast augmentation surgery plus 12 continuous months of living in a gender identity-congruent role, in order to allow sufficient time for patients to adjust socially to their new gender role

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 feminizing hormone therapy as a gender-affirming medical intervention
- She and her treatment team actively discuss her gender identity and related goals

Systems of Care for Transgender Clients with Severe Mental Illness

- Evidence of effectiveness of Assertive Community Treatment (ACT) teams and wraparound services
- 24-hour coverage by multidisciplinary treatment teams, integration of treatment and rehabilitation, small caseloads and frequent client contact, and close attention to illness management and daily living problems
- Training staff on how to engage in effective, sensitive communication, and how to create gender-inclusive care environments for transgender people

Burns *et al.* (2007)

Thank you!