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

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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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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, disorganization, 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 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 a 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
- In 2013 community survey of 452 transgender adults, 40.9% endorsed non-binary gender identity
- 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 a 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 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
PTSD Among Transgender People

- Forty percent of transgender people and 65% of MTF sex workers report being physically assaulted; more than fifty percent of MTF report unwanted sexual activity.
- Sixty-one percent of young MTF have PTSD, which increases their odds of drug use.
- Recent trauma among MTF is linked to antiretroviral medication failure and condomless intercourse.
Minority Stress Framework

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

External Stigma-Related Stressors

Internal Stigma-Related Stressors

General Psychological Processes

Behavioral Health Problems

Physical Health Problems
Discrimination and Trauma

- Internalization of anti-transgender stigma through everyday discrimination experiences.
- Significant minority stress that can lead to worsening psychological health.
- Development of traumatic stress responses among transgender people from multiple acts of discrimination based on their gender-related identity as well as other stigmatized identities (e.g. minority race, SES, age).
Intersecting Discriminatory Experiences

- Among 452 transgender adults in Massachusetts:
  - Mean # of discriminatory attributions was 4.8
  - Five most frequently reported reasons for discrimination were:
    - Gender identity and/or expression (83%)
    - How masculine or feminine you appear (79%)
    - Sexual orientation (68%)
    - Sex (57%)
    - Age (44%)

(Reisner et al., *in press*)
Everyday Discrimination Experiences

- Factors predicting everyday discrimination scores:
  - MTF spectrum gender identity
  - Person of Color
  - High visual gender non-conformity
  - Greater number of attributed reasons endorsed for discrimination

(Reisner et al., in press)
Discrimination and PTSD Symptoms

- Factors associated with higher PTSD symptoms scores:
  - Higher everyday discrimination scores
  - Greater number of attributed reasons for discrimination
  - Social gender transition
  - High visual non-conformity

(Reisner et al., in press)
Discrimination and PTSD Symptoms

- Factors associated with lower PTSD symptoms scores:
  - Younger age
  - FTM spectrum gender identity
  - Medical gender affirmation

(Reisner et al., in press)
PTSD and Substance Use

- Among 452 transgender adults in Massachusetts, increased odds of having SUD treatment history alongside recent substance use were associated with:
  - Intimate partner violence
  - PTSD
  - Public accommodations discrimination
  - Low income
  - Unstable housing
  - Sex work

- SUDs increasingly viewed as downstream effects of internalized transphobia and stigma enacted by others as discrimination and abuse

(Keuroghlian et al., 2015)
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
Co-occurring 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
Individualized Psychotherapy

- Effective psychotherapy for integration of gender identity may involve focusing on:
  - Gender identity, expression, and role
  - Adverse effects of minority stress and stigma on psychological health
  - Reducing internalized transphobia
  - Building peer and social supports
  - Improving body image
  - Enhancing resilience
  - Considering “coming out” process (physical, psychological, social, sexual, reproductive, economic, and legal challenges)
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
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
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
Thank you!
References


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