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Psychiatry and LGBT Patients: Reflecting on the Past to Provide Better Psychiatric Care to LGBT Patients in the Future

Mark Messih, M.D., M.Sc.

“The appearance in nineteenth-century psychiatry ... of a whole series of discourses on the species and subspecies of homosexuality ... made possible a strong advance of social controls into this area of “perversity”; but it also made possible the formation of a “reverse” discourse: homosexuality began to speak in its own behalf, to demand that its legitimacy or “naturalness” be acknowledged” —Michel Foucault. (1)

Psychiatry and the LGBT community have a long-standing history as reflected in the works of Foucault, a noted French scholar. The way in which mental health professionals understand LGBT identity influences the quality of care such patients receive and informs broader social perceptions. Accordingly, looking at from where psychiatry has come informs where the field needs to go. LGBT identity was first discussed as pathology, then as sexual immaturity, and ultimately as “normal variation” (2). Later, Freud would discuss homosexuality as being “produced by a certain arrest of sexual development” (3). He would ultimately argue against its classification as illness. Subsequent psychoanalysts disagreed with Freud’s work, viewing homosexuality as pathology, treatable with “cures” (4). This led to the addition of homosexuality as “sociopathic personality disturbance” in DSM-I in 1952, then as “sexual deviation” in DSM-II in 1968. In the context of social and political upheaval of the 1960s and 1970s,

By taking a moment to reflect on the history of psychiatry in relation to LGBT communities ... we can improve the therapeutic alliance and empower patients.

and the activism of psychiatrists, homosexuality was removed from DSM-III in 1973. Building on this progress, there is growing support for LGBT communities emerging from medical disciplines. Organizations such as the Association of Gay and Lesbian Psychiatrists show the significant advances made. Moving forward, psychiatrists are positioned to fight ongoing challenges. By taking a moment to reflect on the history of psychiatry in relation to LGBT communities, and the significant accomplishments we have made, we can improve the therapeutic alliance and empower patients.

As clinicians, we have the ability to learn from past experiences and current successes, to *do better* for our patients. What “better” consists of is debatable, but raises multiple questions. How well are psychiatrists trained about the challenges specific to LGBT patients? What

are unique stressors and barriers to care? Subsequently, how can psychiatrists empower and advocate for patients and assist them in meeting treatment goals?

In this issue of the *Residents’ Journal*, authors approach such questions from a variety of perspectives, from a case report on transgender mental health to topic reviews on aging LGBT individuals and substance use. These articles reflect the scale and scope needed to move forward. The field of psychiatry has taken significant steps forward in the treatment, and advocacy of, LGBT patients. This issue reflects these advances and seeks to carry that tradition into the next generation of psychiatrists.

Dr. Messih is a second-year resident in the Department of Psychiatry, Drexel University-Friends Hospital, Philadelphia, and Guest Editor for this issue of the *Residents’ Journal*.

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The Importance of Calling Transgendered Persons by Their Preferred Name

Saeed Ahmed, M.D.

On a recent Thursday in the psychiatry ER, I had a striking encounter with a patient in her early 20s, a transgender female who had been brought in by police due to suicidal ideations. A patient with no psychiatric history, transgender or not, suddenly presenting this way in the ER always triggers concern. But, in this case, with these symptoms exhibited by a transgender person, past experience dictated extra care because there can be some risk factors that might trigger suicidality in such a patient, especially if the patient had never been in a psychiatric emergency department before.

The patient was celebrating her 28th birthday, but she reported that the celebration had been cut short upon receiving a birthday card from her parents that addressed her by “his” original male birth name. To her, this represented a total invalidation of her core identity and complete rejection by her parents. She also said that compounding the problem was the fact that it had only been a year since she had outwardly identified and embraced her new gender and female name, debuting it across her social life, though never “officially” in legal contexts or identifying documents.

Her case reminded me that as a mental health care provider, it would be imperative to take special care in identifying and addressing the patient. Literature shows that transgender populations encounter more intimate identity issues, which may stem from moral and societal discrimination and be compounded by psychological trauma (1, 2).

Transgender youths are at an increased risk for adverse psychosocial consequences. This population sits at an approximately threefold higher risk for depression, anxiety, self-harm, and suicidal ideation (3). According to a report

Addressing transgender persons by their preferred names is a simple but important act of respect that might begin to repair damage to their self-esteem and identity.

by the National Transgender Discrimination Survey, nearly 41% of transgender youths report at least one suicide attempt in their lives, compared with 1.6% in the general population (2, 4).

These numbers compel a deeper search and wider survey into this community’s specific vulnerabilities. The high prevalence of suicide attempts and self-injury makes it vital to remain vigilant to the key risk factors increasing these tendencies in transgender persons. These risk factors include harassment, physical and sexual abuse, and being a victim of violence and/or discrimination (2). Risk factors also include internalized shame and complications caused by identity perceptions and preferences, as well as incongruent identity documents.

Among these vulnerabilities, as in the present case, parental rejection stands most prominently and occurs in up to 57% of cases (2). The odds that those who experience family rejection will attempt suicide are 3.5 times higher than those who do not experience familial rejection. Among those rejected by their

families, the odds of drug or alcohol abuse are 2.5 times as high (5).

Addressing transgendered persons by their preferred names is a simple but important act of respect that might begin to repair damage to their self-esteem and identity. Parents and family members should not only accept their child’s, or other family members’, new gender identity but also recognize them by their preferred name.

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Special Considerations in the Mental Health Evaluation of LGBT Elders

Mercedes Y. Driscoll, M.D., Kyle J. Gray, M.D.

CLINICAL VIGNETTE

When I first met “Ms. B,” she was sitting in the common area of the nursing home inviting anyone who walked through the door to join her for a fireside chat. I was 20 years old at the time and pre-med. I took her up on the offer. As we settled into our cups of tea, she began to tell me about her nursing career days and her roommate of 50 years named Helen. Listening to her story touched me deeply. It became clear that Ms. B’s feelings toward Helen went beyond a typical roommate relationship.

Ms. B grew up in the era in which any indication of homosexuality was met with widespread stigma. Thus, accurate and reliable data about the elderly lesbian, gay, bisexual, and transgender (LGBT) population is difficult to come by. Some investigators estimate that there are over 2.4 million LGBT adults over the age of 50 in the United States, with the projection that this number will double by 2030 (1). The purpose of the present article is to shed light on some of the history of this population and the health disparities that they face. Appropriate clinical considerations are also discussed.

HISTORICAL AND SOCIAL CONTEXT

Many older LGBT adults came of age during a time when homosexuality and any gender nonconformity were criminalized, and many have remained invisible (2). Impactful movements for social acceptance began with the Civil Rights Movement in the 1960s; this generated the gay liberation movement, which allowed younger LGBT adults to begin

to emerge from the borders of society. Stonewall riots incited widespread protest for equal rights and acceptance in 1969. It was only in 1973 when the American Psychiatric Association ceased designating homosexuality as a disorder (3) and not until 2015 that same-sex marriage became legal nation-wide. The life experiences of the older LGBT group range from growing up in the Great Depression to being a part of the baby boom generation. Many of these older adults have spent the bulk of their lives concealing their sexual orientation and/or gender identity, with a major part of their life story ignored or invalidated. With this complex history, our older generations of LGBT individuals are different than the current generation and deserve special consideration.

SOCIAL AND MENTAL HEALTH DISPARITIES

The health of LGBT older adults was mostly ignored until more recently (1). In the present article, “older adults” are defined as individuals over 50 years old, since this is the age cutoff that is utilized in most literature.

LGBT older adults are at risk for significant mental and physical health disparities. They have higher rates of anxiety, depression, and substance use disorders and also are at increased risk for certain medical conditions, such as obesity, breast cancer, and HIV compared with a heterosexual cisgendered similar-aged population (1). D’Augelli et al. (4) reported that 13% of the LGBT population between the ages of 60 and 91 years old has attempted suicide. In this same study, it was noted that older

men reported significantly more internalized homophobia, alcohol abuse, and suicidality related to their sexual orientation compared with similar-aged LGBT women. (4) Another study found that the prevalence of excessive alcohol use, smoking, and high-risk sexual behaviors is higher in older LGBT populations compared with non-LGBT older adults (5). LGBT older adults are also more likely to avoid or delay health care or hide their sexual and gender identity from health care providers and/or social services personnel due to fear of discrimination (6). In a survey of 2,560 diverse LGBT older adults across the nation, ranging in age from 50 to 95 years old (with 10% age 80 and older, 25% age 70–79, 41% age 60–69, and 24% age 50–59), 68% had experienced verbal harassment, 43% had been threatened with violence, 21% did not disclose their sexual or gender identity to physicians, and 15% feared accessing health care outside the LGBT community (7).

Part of what may underlie the disparity of health outcomes for LGBT older adults is the difficulty they face in receiving formal health care and social supports compared with heterosexual cisgender adults. Until recently, same-sex couples faced discrimination in accessing federal government benefits. The U.S. Supreme Court, in *U.S v. Windsor* (2013), ruled that the federal government must treat married same-sex couples the same as married opposite-sex couples for the purposes of federal benefits.

Despite recently receiving this equal protection to health care access under federal law, stressors and other factors that disproportionately affect this population have not disappeared. Stressors

include coming out, prejudice, stigmatization, and anti-LGBT violence, as well as internalized homophobia. Risk factors associated with poorer health among LGBT older adults compared with heterosexual cisgendered older adults include social isolation/small social networks, minimal connection to the LGBT community, lack of connection to the larger community, income uncertainty, inability to access affordable housing, lack of health insurance or underinsurance, and chronic undertreated medical conditions due to lack of primary care (5, 7–9). Those who are “out” are more likely to be estranged from children or grandchildren, be single or without children, and have an extensive “chosen family” (composed of close friends) of support that can be threatened with aging and illness (8).

Discrimination is at the center of the substantial risk factors for this population and their communities, since it hinders both access and utilization of care (10). In one study of LGBT older adults (age >50 years; N=72 individuals) and their caregivers, one-half of the care recipients reported discrimination based on sexual orientation. Other types of discrimination they experienced included discrimination based on disability status (58%), age (47%), race or ethnicity (39%), gender identity and expression (29%), and gender (28%) (11). Likely both historical and current experiences of victimization hinder access and utilization of needed health and social support services (12). More research is needed to ascertain whether background features among LGBT older adults, such as biological sex, race and ethnicity, and gender roles and identity play into their ability to seek care (13).

THE WAY FORWARD

We are only beginning to understand the impact and etiology of health disparities facing the older LGBT population, but the existing data point to practices that mental health providers can immediately implement to better promote successful aging in this population.

One comprehensive approach is the “successful aging framework” proposed by Van Wageningen et al. (14) in their 2013

TABLE 1. Criteria for Mental Health Providers to Consider When Providing Care for LGBT Elders^a

Create a safe and welcoming environment for LGBT patients/staff, such as including LGBT images and language in all printed materials and brochures (see reference 16).
Develop and use standardized intake forms, templates, and procedures that include questions about gender identity, sexual orientation, and living situation. Do not make assumptions about answers to any of these questions (see reference 17).
Raise awareness among both administrative and clinical staff of their own feelings, attitudes, and prejudices toward LGBT individuals (see reference 18).
Explore whether the patient was ever coerced or forced into psychiatric treatment because being forced into treatment previously could negatively affect the patient’s view of mental health treatment in general.
Explore if, when, and how the person came “out” and any fears that surround being “out” and aging.
Identify risk factors for poorer physical and mental health (see references 7–9).
Search for and/or strengthen protective factors for better physical and mental health (see references 7–9).

^a For further details, see Yarns et al. (15).

study of LGBT older adults, which is based on findings from semi-structured guided interviews of 22 different LGBT older adults aged 60 years and older. They recommend incorporating the patient’s perspectives and experiences, seeking to understand their perceptions of positive and negative aging, and attending to the social contexts of the patient’s lives in clinical practice (14). Above all, they emphasize that LGBT older adults must be treated with dignity, while giving due consideration to their unique backgrounds and social experiences. The change begins at the individual provider level.

Others have identified actions providers can take to foster a more welcoming and responsive clinical environment for LGBT older adults (see Table 1). These recommendations come from literature that has previously been cited, as well as from a variety of guides, including recommendations from SAGE [Services and Advocacy for GLBT Elders], the Williams Institute, and the National Re-

source Centers on LGBT Aging (16–18). Many of these guides relied on multidisciplinary expertise, including economics, sociology, psychology, epidemiology, public health, and political science, pooled from decades of research. The goal is to change the system to diminish discrimination and stigma, which will in turn empower patients and enable them to access needed services (16, 17). Many LGBT older adults are also members of other groups that face discrimination, such as on the basis of race, language, ethnicity, degree of disability, and many more other demographic categories. However, LGBT older adults are largely overlooked in gerontology and gender and sexual minority research.

CONCLUSIONS

As we think about addressing healthy aging in our increasingly diverse society, we need to pay attention to the large portion of LGBT older adults living across the United States. At the founda-

KEY POINTS/CLINICAL PEARLS

- Older LGBT adults are at increased risks for certain mental and physical health conditions.
- This group is at risk for weaker support networks compared with cisgendered heterosexual aging groups.
- Actions to promote a more welcoming and responsive clinical environment for the older LGBT community begin at the individual provider level.

tion, their needs are the same as those for other groups of seniors—they need access to comprehensive primary care, as well as social support resources; however, their ability to access these services may be adversely affected by their unique backgrounds and feared or experienced discrimination. They deserve the ability to age with dignity in their communities, have access to services responsive to their particular needs, and protection from abuse and neglect.

Fortunately, Ms. B had the desire to share her story and was surrounded by a caring staff that listened. It would have been a disservice to her if they did not. It is key in practice to not assume that the patient is heterosexual and cisgendered. Not every patient will be as forthcoming as Ms. B. The practice of cultural sensitivity starts in training. The LGBT aging population is expected to increase in the coming years, and thus it is critical that we increase awareness of this at-risk population, who would best be served by more research to help determine how we can best address their specific needs.

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We thank all those who submitted CVs.

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Understanding the Mental Health of the Hijra Women of India

Vikas Jayadeva, M.D., M.S.

Transgender, transsexual, and gender non-conforming individuals are a part of cultures around the world. Yet, transgender populations encounter several unique obstacles in accessing health care. These barriers are reflected in the World Health Organization reports that estimate disproportionate HIV prevalence rates ranging from 8% to 68% among transgender people (1). Despite these high HIV rates, relatively few epidemiological studies among transgender patient populations exist. Aside from poor sexual health, this patient cohort experiences perceived and internalized stigma, isolation, discrimination, and victimization that predisposes them to mental health issues, such as depression, anxiety, and substance abuse (2).

The World Professional Association for Transgender Health published international standards of care for this vulnerable patient cohort in 1979 and updated these recommendations in 2012. These guidelines emphasize the important role mental health professionals play in mitigating the negative impact of stigma and prejudice, assisting others with becoming comfortable with alternate gender expression, and facilitating the process of transitioning and coming out (3).

The transgender community in India is highly vulnerable to mental and physical illness, in large part due to limited economic opportunities, forcing many of these women to engage in prostitution (4). Despite increased health risks, these transgender individuals face an increased number of barriers to health care (2). Understanding the barriers that prevent the Indian transgender community from receiving medical care is important so that health care professionals can more adequately address the unique

needs of transgender patients in India and around the world.

WHO ARE THE HIJRA?

The term *hijra* refers to a minority group of transgender females on the Indian subcontinent. Historically, these women have held a socially protected status as a “third gender.” They held positions of power in Mughal courts and are referenced in Hindu scriptures and ancient myths as having special powers, which conferred religious and cultural authority to these women (5). This religious significance continues today, as the hijra offer blessings at weddings and births, known as *badhai* (6). Although hijra refers to biological males whose gender and gender expression is female (7), their identity is shaped by a range of factors outside of sex and gender, including religion, culture, and community (8).

Since Indian independence, local laws and cultural attitudes reflect blatant stigmatization, prejudice, and mistreatment of this minority group (7). In October of 2013, India’s Supreme Court directed all Indian states to establish welfare agencies to enhance the health and medical needs of these women, but despite this ruling, the hijra continue to experience discrimination with regard to education, health care, and employment. (6). With limited economic opportunities, changing Indian social structures and increasing globalization, a growing number of hijra women are turning to sex work to make an income (4), as their traditional roles are becoming obsolete (5). This situation is further exacerbated by Indian law, which makes it almost impossible to vote, own property, or obtain official identification and documentation, such as a passport or driver’s license (5).

LIMITATIONS IN DEFINING HIJRA

The hijra have evolved as a distinct cultural group on the Indian subcontinent for thousands of years and have only become marginalized in modern times (5). The hijra differ from Western transsexual identities, in that they self-identify as a “third gender” that is distinct from their female identity (5). Though they outwardly acknowledge that they are women through sexual relationships, gender roles, and clothing, within themselves they are also aware that they are separate and distinct from biological females (4). The best way to understand hijra identity is to understand the individual’s own definition of his or her identity, as the term hijra is widely encompassing of a variety of identities, including intersex individuals born with ambiguous genitalia (7) and *zenanas* (feminine men) who take on hijra identities to have sex with other men (9). Consequently, hijra clans, known as *gharanas*, consist of gender dysphoric and gender variant individuals, rather than a homogenous population, who form a community and find support after being shunned by their family and society. Cultural perceptions of gender, coupled with a diverse and heterogeneous hijra population, make it difficult to create broad generalizations about mental health issues, including gender dysphoria.

CURRENT MENTAL HEALTH STUDIES

There exists a paucity of medical studies on the hijra, secondary to their marginalized status. Given the high rates of prostitution among the hijra, the majority of medical studies have focused on HIV/AIDS. Few existing studies exam-

ine the mental health of the hijra population, (4), despite data from several meta-analyses demonstrating that LGBT populations, like the hijra, have a higher prevalence of mental health issues compared with their heterosexual counterparts (10–12). Furthermore, the hijra are more predisposed to mental health issues given that they are more likely to receive money for sex, have an earlier sexual debut, and have a higher prevalence of HIV compared with men who have sex with men (13). One case study also suggested that they were more vulnerable to alcohol and substance use disorders compared with the general population (14).

Forty-eight percent of hijra participants in one study suffered from psychiatric disorders, ranging from alcohol abuse and dependence to depressive spectrum disorders, but despite the presence of psychiatric disorders in participants, none had ever had psychiatric consultation for these issues (9). Seeking help is not a viable option for these individuals due to perceived and real stigma from health professionals (14).

From the limited mental health studies that exist, issues with gender identity are a reoccurring theme. A cross-sectional study of 50 hijra women in Mumbai showed that 84% of participants met criteria for gender identity disorder according to DSM-IV-TR (9). This finding was supported by a subsequent qualitative study, in which researchers interviewed eight hijra in Bangalore, India, regarding what factors and unique experiences contributed to their well-being (4). Among this small sample size, there appeared to be a persistent need for sex change and gender change because they felt discordance between their internal and external identity (4). Other contributors to well-being among this sampling were joining a *gharana* and finding a community of similar people (4).

Aside from discordance between gender identity and natal role, there appear to be several sociocultural stressors for the hijra that predispose them to mental health issues. These include family pressures to conform to gender norms, coming to terms with sexual identity and orientation, and migration to cities with strong hijra communities (5). Poor self-

KEY POINTS/CLINICAL PEARLS

- Hijra is a term that refers to the transgender community in South Asia, particularly India.
- Like other transgender populations around the world, there exists a paucity of medical studies on the mental health of this patient cohort.
- The hijra community and other transgender communities could benefit from increased research into their mental health given their experiences with stigma, isolation, discrimination, and victimization.

and social acceptance as a teenager, traumatic transitions, and physical, verbal, and sexual abuse from family and law enforcement were also major stressors (4). The hijra continue to be disadvantaged within society as evidenced by the barriers to obtaining voter identity cards and ration cards, as well as acceptance to educational institutions. The hijra women commonly encounter a wide variety of discriminatory attitudes and institutional difficulties in meeting their basic needs or in having their gender identity respected. This discriminatory attitude toward the hijra is extremely invasive and destructive for their mental health and has created a strong sense of loneliness (15).

CONCLUSIONS

The hijra are an integral part of Indian society but have continued to be marginalized in terms of education, economic opportunity, and access to quality health care. Although there is increasing awareness of HIV/AIDS rates among this vulnerable patient cohort, there is extraordinarily limited research into the mental health of these women. Health care professionals are less equipped to deal with the mental health issues pertinent to these communities without population-specific data. In general, the hijra community remains unaware of the psychological interventions and services potentially available to aid in management of their stress and mental health needs (14). Existing literature tells us that we need further research into the mental status of the hijra, which will allow researchers to better understand determinants of their mood. Health care professionals can build on these studies by designing interventions that can re-

inforce the resilience and coping strategies of these women, while ameliorating the factors that negatively affect their mental health. Available data support the need for dedicated multidisciplinary gender management services that can address the multitude of problems that these women encounter. These efforts should be backed by population-specific research data with culturally sensitive interventions and outcome measures. Consequently, these efforts can serve as the catalyst for helping the hijra community achieve a more balanced mental state.


Dr. Jayadeva is a recent graduate of the University of Michigan Medical School, Ann Arbor, Mich., and will be starting her first year of residency in family medicine at Kaiser Permanente Los Angeles Medical Center, Los Angeles.

The author thanks her research mentor, Dr. Joanna Quigley, for assistance and guidance.

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CORRECTION

In the article titled "Recurrent Foreign Body Ingestions Following Rapid Methadone Taper: Neurological Aspects of Self-Injury and Opioid Therapy," by William A. Sterling and Zachary Wolner, published in the March 2017 issue of the *Residents' Journal*, an error occurred resulting in deletion of one paragraph in the issue PDF. The paragraph was reinserted, which is reflected in the full-text online version of the article.

A Brief Discussion on Mood Disorders in the LGBT Population

Sehba Husain-Krautter, M.D., Ph.D.

The LGBT community is a vulnerable population that faces higher rates of mood disorders, anxiety, alcohol, and substance use disorders (1). There is also a higher prevalence of suicide, with the rate of suicide attempts among LGBT youths being as high as four times that of a control heterosexual population in at least one study (2). Additionally, the LGBT population is at higher risk of being victims of aggression and physical and sexual abuse (3). Mood disorders comprise all types of depression and bipolar disorders, and when compared with the heterosexual population, one study found that “the risk for depression and anxiety disorders (over a period of 12 months or a lifetime) were at least 1.5 times higher in lesbian, gay and bisexual people” (4). However, a recent study reported higher odds of any lifetime mood disorder in sexual minority women who experienced discrimination compared with those who did not (3). The factors contributing to mood disorders in LGBT people may include a lack of acceptance by family and self that is reflected in internalized homophobia, shame, negative feelings about one’s own sexuality/gender, and uneasiness with one’s own appearance (5). LGBT youths typically disclose their sexual preference 2 years earlier than control peers and generally during a developmental period defined by strong peer influence and reactions, making them more susceptible to victimization with subsequent consequences, especially regarding mental health (6). The case report below demonstrates the importance of identification of the underlying problem when treating LGBT youths and young adults, in addition to formal assessment and evidence-based treatment of symptoms.

CASE

“Mr. J,” a 21-year-old Caucasian man, was admitted to our inpatient psychiatric facility on a 24-hour emergency detention for suicidal behavior. On the day prior to admission, he had an argument with his mother and ran out on the highway in front of a tractor trailer that just missed hitting him; he then attempted to step in front of another truck that slammed on its brakes just in time. He ran into the woods and was eventually located by a police helicopter. He was taken to a nearby hospital for evaluation but refused to give any information. He ran away from the hospital, and the police found him by a river. The patient had an extensive history of psychiatric hospitalization, suicide attempts, self-injurious behavior, and substance use since his late teenage years. During the initial intake interview at our facility, he was hypervocal but avoided most questions, although he expressed that he suffered from anxiety and panic attacks and that only benzodiazepines had helped him. When questioned about manic symptoms, he was vague and in general admitted to reckless behavior. When asked about the multiple linear scars on all his limbs, he stated that they occurred while he was sleeping and that he had no recollection or knowledge of them until after he woke up. Collateral information was obtained from his outpatient provider, who mentioned that the patient was known to be manipulative and impulsive and often engaged in risky behavior. He denied suicidal or homicidal ideations when first evaluated by the treatment team.

During the initial week of his hospital stay, the patient had several incidents of impulsive and provocative behavior that put him and others at risk, includ-

ing staff members. He assaulted several staff members, and on each occasion he did not show any remorse or regret. He refused to speak with the therapist and expressed that nobody could understand what he was going through. He also maintained an air of superiority and talked down to other patients on the unit, often boasting of his many girlfriends. On day 8 of hospitalization, Mr. J was found crying in his room and appeared very upset; he described experiencing “unbearable pain” and “guilt,” wishing to die. He agreed to sit down and talk to one of the psychiatry residents to whom he expressed that he was gay but did not want other patients to know. He expressed that he wished he was straight and was ashamed of his sexuality and had been to a conversion therapy center at his mother’s insistence, but it did not work for him. He admitted that he often cuts himself, puts himself in risky situations, and self-medicates because he “does not know what else to do.” He also stated that he often hurts other people so that they think he is a “strong man.” He admitted to feeling hopeless and unsure about his future and often wanted to “end it all.” Per assessment, he met the DSM-5 criteria for major depressive disorder and borderline personality disorder. After additional inpatient treatment that consisted of regular individual therapy, dialectical-behavior therapy for self-harm and provocative behavior, as well as selective serotonin reuptake inhibitors, Mr. J was discharged from the psychiatric unit. At the time of discharge, he reported that he was looking forward to spending time with his friends and looking for a job but was still uncomfortable with his sexual preferences. His insight and judgment, however, had improved,

and he expressed understanding of the fact that most of his actions stemmed from shame and negative feelings about his own sexuality.

DISCUSSION

One of the most conspicuous facts while treating the above patient was that the treatment team was not aware of his sexual preference until a week after he was admitted. Initially, he was perceived to be prone to dramatics and provocative and risky behavior; however, after the team was made aware of the underlying issue, the approach and diagnosis were accordingly modified. This case highlights the complex challenges psychiatrists face when treating LGBT patients. In addition to a formal assessment and evidence-based treatment of symptoms, identification of the underlying problem is of utmost importance. The above case exemplifies the prevailing challenges, approach aspects, and underlying framework one can use while treating mood disorders in such patients.

As with the patient in the above case, LGBT youths experience higher rates of depression, especially when dealing with stigmatized identity and the stressors that accompany it. It has been shown that family acceptance and support is one of the most important protective factors when dealing with negative emotions in the LGBT population (7). However, as with our patient, LGBT youths often experience diminished social support, social rejection, and isolation within their social circles (8, 9). Although attitudes toward same-sex relationships have generally become more positive, any breach from socially accepted gender roles is still questioned and frowned upon. For youths who have little to no social support, access to social networks and support groups, along with appropriate psychological interventions,

KEY POINTS/CLINICAL PEARLS

- While dealing with adolescents and young adults with emotional distress, one should keep in mind that a stigmatized sexual identity could be causing this distress.
- Adequate emotional support from family helps LGBT youths and young adults cope better with the stressors outside of home.
- For youths who have little to no social support, access to social networks and support groups, along with appropriate psychological interventions, should be made available.

should be made available. As mentioned above, teenagers may often experience bullying when they openly identify as LGBT; however, a recent study reported the benefits of being “out” during adolescence, relating it as a crucial period in which individuals identify who they are, which is essential to their mental health (10). In light of these conflicting studies, it is important to stress that there is no simple answer, and the emotional maturity and social environment of the individual has to be taken into consideration while talking about disclosing an individual’s sexual preference. Promoting a positive self-image is an essential but long-term process, and treating risky and self-harm-inducing behavior should be the priority.

Dr. Husain-Krautter is a third-year resident at Delaware Psychiatric Center, New Castle, Del.

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A Case of Klinefelter Syndrome and Gender Dysphoria

Yara W. Moustafa, M.B.B.Ch., Ph.D.

Disorders of sex development are estimated to be prevalent in 0.1%–2% of the general population, based on studies in Europe and the United States (1). Klinefelter syndrome is one example of a sex development genetic disorder due to the presence of a 47,XXY genotype, which means that there is an extra X chromosome in each cell of the body. It is estimated to occur in 150 per 100,000 male newborns each year and is usually characterized by tallness, underdeveloped testes, and cognitive impairment (2). Gender dysphoria affects between 8.5%–20% of individuals with disorders of sex development (1).

The author presents a rare case of Klinefelter syndrome in a transgender male-to-female seeking sexual reassignment surgery. The complexity of this case stems from the unusual presentation of a genetic disorder, classically encountered in males.

CASE

“Ms. N” is a 32-year-old single, transgender woman with no past psychiatric history, who was referred to the outpatient psychiatry clinic for further evaluation for sexual reassignment surgery to rule out psychiatric disorders and to assess for decision-making capacity. She wore full make-up, a colorful dress, and high-heeled shoes and appeared to be taller than the average woman. Strikingly, she told me, “I have a penis, and I want to remove it in order to be able to have babies.” She expressed mixed feelings of anxiety and frustration with her gender, and she wanted to get her sexual organs “repaired” in order to be able to conceive. She reported that since her early childhood she was different. She had never felt comfortable playing with other boys, and she did not show any interest in football or other cultur-

ally masculine-oriented physical sports. On the other hand, she preferred to play with dolls with her female siblings; she always assumed feminine roles in her imaginary plays. She also enjoyed watching her mother cook in the kitchen or gossiping with the neighbors over a cup of tea when her father was at work. As a teenager, she did not have the physical features expected for a male; she had scarce body hair, slightly enlarged breasts, increased abdominal fat, a soft voice, and small testis and penis, but she was unusually tall for her age. She had never had an erection like her brothers, and that made her more confident that she was not a man. Interestingly, these characteristics were due to her undiagnosed genetic disorder, but she interpreted these differences as evidence she was not, in fact, her biological gender.

She denied any suicidal or homicidal thoughts, depression or mania, delusions, or hallucinations at that time. She endorsed anxiety symptoms.

Ms. N reported that she was born male in a small town in Egypt and was the fourth child of seven siblings, with no complications at birth. She reported that her motor and language development were slower than her siblings, as well as her peers of similar age. She also stated that she was humiliated by boys at school, some of them had expressed interest in having anal sex with her, but she refused completely. Later, she decided to drop out of school before high school because “studying was very difficult” and she was getting poor grades. She stayed home for several years, helping with housework. However, she was in constant conflict with her family because she insisted that she wanted to be a woman, and she moved from her parents’ house in the countryside to work as a home-aide to a married lady in the city.

Ms. N disclosed to her employer that she was born male and that she wanted to undergo surgery for gender reassignment. Notably, the outpatient work-up for individuals seeking sex reassignment surgery revealed 47,XXY karyotype, and her blood tests showed low testosterone levels and raised gonadotrophins, which is consistent with Klinefelter syndrome. Moreover, her Wechsler Adult Intelligence Scale score of 75 disclosed “borderline intellectual functioning” according to DSM-IV criteria, although the IQ cutoff is no longer specified in DSM-5 (3).

Moreover, it was not clear whether sexual reassignment surgery would alleviate her stress or might increase suicide risk (reviewed in reference [4]).

DISCUSSION

Ms. N is a transgender woman with a sex development disorder and with some degree of challenged intellectual functioning.

A challenge for this patient is that she grew up in a rural environment that could not accept her as being different, and she had to suffer constant humiliation and feelings of inferiority, especially at school from her male classmates. Although her mother and female siblings seemed to be accepting of her, her father felt ashamed of her appearance and behavior. Therefore, the cultural impact is enormous in this case. Firstly, her feelings of being rejected by society were reinforced. Secondly, her frustration with her gender drove her to want to prove that she was not male. Therefore, she insisted that obtaining female genitals and reproductive organs was critical to helping her to feel accepted by society as a “complete woman.”

Her genetic disorder has likely predisposed her to gender dysphoria (5), al-

though it is a rare condition, since typically patients with Klinefelter syndrome identify or choose to identify themselves as males (2, 5). There is a dearth of literature on Klinefelter syndrome associated with gender dysphoria. Only few cases have been described in the literature (reviewed in reference [6]).

The main challenge for Ms. N's treatment team was explaining to her the nature of her genetic disorder and that even if the sexual reassignment surgery was performed, she would not be able to conceive like other females.

The patient's lack of understanding that could be explained by her borderline intellectual functioning represented a barrier for her to provide fully informed consent to undergo the operation, especially in appreciating the nature of her genetic disorder and its implications regarding her ability to conceive. Therefore, the team decided that she needed more time to be educated about the risks and benefits of the surgery and to appreciate the nature of the procedure and its consequences.

The patient was prescribed estrogen to promote the development of her secondary sexual characteristics, in addition to fluoxetine to help her with anxiety symptoms. Moreover, she received weekly individual psychotherapy sessions to help her have a safe transition to her full identity and to educate her about the nature of her genetic disorder and the implications of reassignment surgery. At first, she agreed to follow-up on a weekly basis and started taking her medications, but she was very frustrated that she would not achieve the same reproductive ability as other women. After a few weeks, she started to miss her appointments in the outpatient clinic and then discontinued her visits. All attempts to contact her were unsuccessful.

CONCLUSIONS

A major concern in patients with gender dysphoria is the risk of suicide (7). The above rare case raises awareness of the special needs of the transgender population and highlights the importance of having a well-prepared multi-disciplinary team to tailor a personalized plan

KEY POINTS/CLINICAL PEARLS

- Klinefelter syndrome is a chromosomal condition that strictly affects males.
- Gender dysphoria is an uncommon disorder in individuals with Klinefelter syndrome.
- Complex transgender cases should be approached by multidisciplinary teams to provide person-centered plan of care.
- Social and cultural stigma might heavily influence the treatment decisions taken by transgender individuals.

depending on each individual's unique situation.

Despite Ms. N not having any past history of suicidal ideation or behavior, this possibility had to be considered in the setting of increasing patient frustration and hopelessness. Therefore, targeted mental health intervention programs are necessary to address the exceptionally high suicide rates and increase treatment effectiveness (reviewed in reference [4]).

Dr. Moustafa is a second-year resident in the Department of Behavioral Health, St. Elizabeths Hospital, Washington, DC.

The author thanks his supervisors from the Department of Psychiatry at Cairo University Hospitals, Mahmoud El Batrawi, M.D., and Osama Refaat, M.D., for their assistance and supervision of this case during his residency training.

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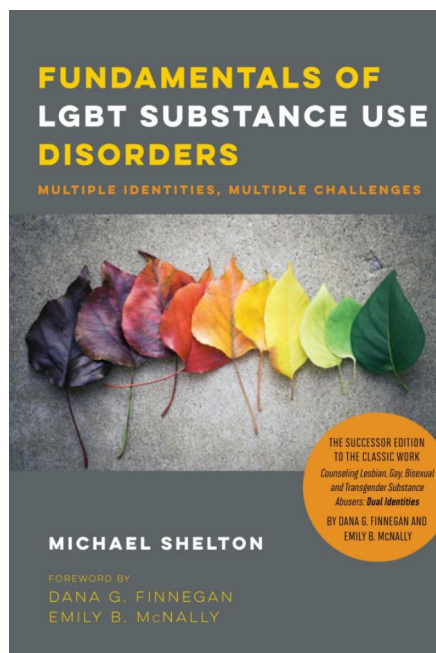
Fundamentals of LGBT Substance Use Disorders: Multiple Identities, Multiple Challenges

Reviewed by Karen T. Duong, D.O.

Studies show that lesbian, gay, bisexual, and transgender (LGBT) individuals face many barriers to treatment and have elevated rates of substance use when compared with the general public (1). Research on substance misuse in the LGBT community has been growing since the American Psychiatric Association (APA) removed homosexuality from the DSM-III in 1973 (2). Since then, the most significant advancement in the field has been the rethinking of why LGBT populations abuse substances and identification of barriers to treatment, specifically prejudice and discrimination.

Fundamentals of LGBT Substance Use Disorders is an expansive and updated third edition of the original literature, *Counseling Lesbian, Gay, Bisexual, and Transgender Substance Abusers: Dual Identities*, originally published in 1987 (revised and updated in 2002), written by Dana G. Finnegan and Emily B. McNally. In *Fundamentals of LGBT Substance Use Disorders*, Shelton builds on Finnegan and McNally's work by adding important concepts outside of addiction studies, such as homophobia, stages of identity development, and interdisciplinary terminology and perspectives, which will help psychiatrists adopt more culturally competent and holistic approaches to LGBT substance misuse treatment and health disparities.

The book consists of 12 chapters, divided into three main sections, beginning with a broad introduction to substance misuse research and LGBT history before specifically discussing each sexual minority group individually. Finally, the author explores the ways



by Michael Shelton and Dana G. Finnegan.
New York, Harrington Park Press, 2017, 422 pp., \$45.00 (paper).

in which sexual identity and substance misuse intersect with age, rural locality, and the criminal justice system. Shelton interestingly redefines “family” and how it plays an important role in the patient’s formulation of identity throughout the coming out process, as well as how family dynamics can affect the likelihood of successful recovery outcomes. The author demonstrates in depth, up-to-date knowledge about LGBT mental health, yet also highlights the need for others to continue conducting research. The text also includes great resources in the three appendices concerning assessment of

one’s individual or organization’s cultural competency in working with LGBT populations. Included is also an extensive guide to journals that focus on LGBT substance misuse and a listing of all organizations that can assist on issues and education concerning LGBT substance misuse and other LGBT-related topics.

Each chapter is consistent in format with sections such as chapter summary, case study, conclusions, and discussion questions that were most helpful in mastering the material. The discussion questions could be helpful in the setting of residency training didactics or any health care organization striving to assess their readiness and competence in understanding and treating LGBT populations. This book is highly recommended as a resource guide for psychiatrists of all career stages or others in the health care system in providing more culturally competent care to LGBT populations.

Dr. Duong is a first-year psychiatry resident at the University of Texas at Southwestern Medical Center.

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Lack of Clear and Convincing Superiority of Clozapine Limits Potential Success of Clozapine Clinics

Yash B. Joshi, M.D., Ph.D., M.B.E., Michael Langley-Degroot, M.D.

To the Editor: We read the commentary by Drs. Hughes and Singh (1) in the July 2016 issue of the *Residents' Journal* with great interest, in which the authors pointed out the low rate of clozapine usage among psychiatrists, as well as the need to create more clozapine clinics in order to bolster trainee familiarity with this medication, thereby lowering the barrier to prescribe it in their future practice. Undoubtedly, such clinics would offer many boons to residency training, but this must be balanced with clozapine's documented clinical effectiveness.

We take issue with the statement that there is "consistent evidence of superior efficacy, improved outcomes, and improved morbidity." Indeed, a recent network meta-analysis by Samara and colleagues (2) assessing randomized controlled trials (RCT) of clozapine showed little evidence to justify that clozapine ought to be used with more frequency in treatment-resistant schizophrenia when considering its monitoring demands and adverse side effects (2). There is open controversy about how to weigh more recent RCTs and data (such as the work by Samara and colleagues) with the original study by Kane and colleagues (3) and other open-label trials demonstrating clozapine's superiority. As Kane and Correll (4) point out, the label of "treatment resistance" appears to be applied with significant variability since their initial published article, making direct

comparisons difficult between trials. Much of the evidence of clozapine's superiority in treatment-refractory schizophrenia comes from open-label studies that were excluded from consideration in the meta-analysis by Samara and colleagues (5). It is unclear whether clozapine patients who are able to complete the more rigorous, blinded RCTs considered in this meta-analysis are generalizable to the broader population of treatment-refractory patients typically on clozapine and who tend to experience greater severity of symptoms and functional deficits. Nevertheless, it must be pointed out that even Kane and Correll (4) have remarked how it is very surprising that after 25 years following their seminal work, controversy still remains over clozapine. Residents should be aware of all of these studies as they initiate and follow-up patients on clozapine.

With all of that said, there is no doubt that in the right context and patient, clozapine can induce profound clinical improvement. In line with the general view of Drs. Hughes and Singh, we agree categorically that no resident's training is complete without exposure to clozapine initiation and follow-up management. If at all possible, this should not wait until the second or third year of training when most programs have the majority of their outpatient clinic experience, and it ought to be in-folded early in the PGY-1 or PGY-2 experience. We believe that this approach would be more effective

than a push for increase in the total numbers of clozapine clinics.

At the time this letter was accepted for publication, Dr. Joshi and Dr. Langley-Degroot were residents at the University of California, San Diego, La Jolla, Calif.

Drs. Joshi and Langley-Degroot contributed equally to this letter.

Dr. Joshi was supported by a training grant from the National Institute of Mental Health (grant R25 MH101072).

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Residents' Resources

Here we highlight upcoming national opportunities for medical students and trainees to be recognized for their hard work, dedication, and scholarship.

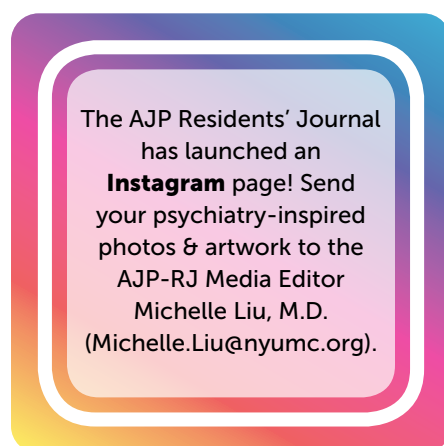
**To contribute to the Residents' Resources feature, contact Oliver Glass, M.D., Deputy Editor (glassol@ecu.edu).*

JUNE DEADLINES

Fellowship/Award, Organization, and Deadline	Brief Description and Eligibility	Contact and Website
American Academy of Child and Adolescent Psychiatry (AACAP) Educational Outreach Program (EOP) for General Psychiatry Residents AACAP Deadline: June 30, 2017	The EOP provides the opportunity for general psychiatry residents to receive a formal overview to the field of child and adolescent psychiatry, establish child and adolescent psychiatrists as mentors, and experience the AACAP Annual Meeting in Washington, DC, October 23–October 28, 2017 <ul style="list-style-type: none"> General psychiatry residents who are AACAP members or have pending AACAP membership. 	AACAP Assistant Director of Training and Education E-mail: training@aacap.org Phone: 202-587-9663 https://www.aacap.org/aacap/Awards/Resident_and_ECP_Awards/AACAP_Educational_Outreach_Program_for_General_Psychiatry_Residents.aspx
AACAP Educational Outreach Program for Child and Adolescent Psychiatry (CAP) Residents AACAP Deadline: June 30, 2017	The EOP provides the opportunity for child and adolescent psychiatry residents to receive a formal overview to the field of child and adolescent psychiatry, establish child and adolescent psychiatrists as mentors, and experience the AACAP Annual Meeting in Washington, DC, October 23–October 28, 2017. <ul style="list-style-type: none"> Child and adolescent psychiatry fellows who are AACAP members or have pending AACAP membership. 	AACAP Assistant Director of Training and Education E-mail: training@aacap.org Phone: 202-587-9663 http://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/AACAP_Educational_Outreach_Program_for_CAP_Residents.aspx

JULY DEADLINES

Fellowship/Award, Organization, and Deadline	Brief Description and Eligibility	Contact and Website
Webb Fellowship Program Academy of Psychosomatic Medicine (APM) Deadline: July 1, 2017	This fellowship is designed to support residents and fellows in psychosomatic medicine at an early stage in their career. One-year appointments in which each fellow will have a designated mentor and present a paper at the Annual Meeting. Financial support will be provided for each fellow's organizational membership for one year and for Annual Meeting registration fees. <ul style="list-style-type: none"> PGY-3 psychiatry resident or psychosomatic fellow. 	N/A http://www.apm.org/awards/webb-fship.shtml
Trainee Travel Award APM Deadline: July 1, 2017	To encourage psychosomatic fellows, residents, and medical students to join APM, attend the Annual Meeting. A limited number of monetary awards are given to help offset the cost of attending the Annual Meeting. <ul style="list-style-type: none"> Medical students, residents, and fellows. 	N/A http://www.apm.org/awards/trainee-travel.shtml



Author Information for *The Residents' Journal* Submissions

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Senior Deputy Editor

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(Yale)

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(East Carolina)

The Residents' Journal accepts manuscripts authored by medical students, resident physicians, and fellows; attending physicians and other members of faculty cannot be included as authors.

To submit a manuscript, please visit <http://mc.manuscriptcentral.com/appi-ajp>, and select a manuscript type for *AJP Residents' Journal*.

- 1. Commentary:** Generally includes descriptions of recent events, opinion pieces, or narratives. Limited to 500 words and five references.
- 2. History of Psychiatry:** Provides a historical perspective on a topic relevant to psychiatry. Limited to 500 words and five references.
- 3. Treatment in Psychiatry:** This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2–4 multiple choice questions based on the article's content. Limited to 1,500 words, 15 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.

- 4. Clinical Case Conference:** A presentation and discussion of an unusual clinical event. Limited to 1,250 words, 10 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.
- 5. Original Research:** Reports of novel observations and research. Limited to 1,250 words, 10 references, and two figures. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.
- 6. Review Article:** A clinically relevant review focused on educating the resident physician. Limited to 1,500 words, 20 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.
- 7. Drug Review:** A review of a pharmacological agent that highlights mechanism of action, efficacy, side-effects and drug-interactions. Limited to 1,500 words, 20 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.

- 8. Perspectives in Global Mental Health:** This article type should begin with a representative case or study on psychiatric health delivery internationally, rooted in scholarly projects that involve travel outside of the United States; a discussion of clinical issues and future directions for research or scholarly work should follow. Limited to 1,500 words and 20 references.
- 9. Arts and Culture:** Creative, nonfiction pieces that represent the introspections of authors generally informed by a patient encounter, an unexpected cause of personal reflection and/or growth, or elements of personal experience in relation to one's culture that are relevant to the field of psychiatry. Limited to 500 words.
- 10. Letters to the Editor:** Limited to 250 words (including 3 references) and three authors. Comments on articles published in the *Residents' Journal* will be considered for publication if received within 1 month of publication of the original article.
- 11. Book and Movie Forum:** Book and movie reviews with a focus on their relevance to the field of psychiatry. Limited to 500 words and 3 references.

Upcoming Themes

If you have a submission related to the themes shown at right, contact the Section Editor listed below the topic.

Please note that we will consider articles outside of the theme.

If you are interested in serving as a **Guest Section Editor** for the *Residents' Journal*, please send your CV, and include your ideas for topics, to Rachel Katz, M.D., Senior Deputy Editor (rachel.katz@yale.edu).

War, Terror, and Psychopathology

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