TREATMENT IN PSYCHIATRY

Transgender Patient Care on the Inpatient Psychiatric Unit

Courtney Saw, M.D.

CASE VIGNETTE

"Juliette" is a 40-year-old transgender woman with bipolar disorder admitted to the inpatient psychiatric unit involuntarily following an interrupted suicide attempt. Juliette uses female pronouns, has been taking estrogen and spironolactone for several years, and is recognized by her family and coworkers as female but dresses androgynously. Her first episode of depression occurred before coming out as transgender, and she has continued to have manic and depressive episodes while living happily as a woman. During a disagreement over access to her belongings, staff on the unit inadvertently refer to Juliette as "he," provoking her to anger. During attempted verbal de-escalation, male pronouns are repeatedly used, further agitating Juliette and resulting in restraints and injection medication.

CREATING A THERAPEUTIC ENVIRONMENT

Special consideration for transgender patients should start prior to their arrival to the inpatient psychiatric unit. Many institutions room transgender patients with patients of the same assigned (by society to the individual at birth), but not affirmed (to which the individual has transitioned or is in the process of transitioning), gender. This can feel invalidating, traumatizing, and discriminatory to the patient, as well as confusing to the roommate. Patients should share a room with others of the same affirmed gender, and if this is not feasible, a private room should be assigned. Staff should be aware of the patient's desired name and pronouns, especially when these do not align with the medical record. In general, withholding an outpatient hormone regimen will acutely worsen dysphoria for patients. Similarly, affirming devices, such as chest binders or breast prostheses, should be permitted unless they pose a significant safety concern.

INITIAL INTERVIEW

Given its relatedness to the patient's core identity and the need for mental health providers to have a full developmental history, a basic understanding of the patient's gender journey is a crucial part of the psychiatric interview for all transgender patients (see Table 1). Questions about their relationships and response to their identity in their social environment can assess for risk and protective factors, especially since the absence of support or exposure to discrimination and violence increases the risk for psychological distress (1–3). When patients volunteer information, clarifying questions about their medical transition process should be asked. It is critical to frame such questions in a manner that will enable the patient to understand the rationale. In gathering this information, it is important to remember that it is never appropriate to ask patients directly about their genitals. Additionally, some individuals undergo social transitioning (usually involving dressing in a stereotypical masculine or feminine fashion) without ever undergoing medical transitioning via either hormones or surgery, and thus it is important to phrase questions in a manner that does not assume the patient desires further medical intervention. At the end of the interview, asking patients whether there is anything that can be done to make their stay on the unit more comfortable can open the discussion to addressing any missed issues.

FOLLOW-UP QUESTIONS AND ISSUES

Throughout the hospitalization, it is important to follow up on how the patient's gender identity has been affirmed

TABLE 1. Sample Interview Questions for the Psychiatric Unit

Initial Interview
"How do you like to be addressed? What name would you like us to use?"
"When people refer to you, do you prefer that they do so as he/him, she/her, they/them, or something else?"
"May we use your preferred name and pronouns during your hospital stay?"
"Thank you for sharing this with us. If it's all right with you, we'll let the staff know so that we can ensure we're addressing you correctly. If anyone has trouble doing so, please let us know, and we will do our best to advocate for you."
"In order for us to better understand your medical history, what steps have you taken toward physically transitioning?"
"Are there any steps you're planning in the near future?"
"Is there anything that we need to know about your transition that is relevant to your medical treatment here?"
Follow-up interviews
"Have you had any trouble with the staff using your preferred name or pronouns?"
"How about with the other patients?"

on the unit. When misgendering occurs, whether by use of an incorrect name or pronoun or disparaging remarks, acknowledge this mistake and facilitate an apology. Afterward, every effort should be made to avoid repeating the mistake and to focus on the therapeutic alliance and achievement of treatment goals.

IMPLICATIONS OF HORMONAL THERAPY

There are many questions regarding the long-term impact of hormonal therapy for medical transitioning. However, given its comparatively recent arrival in the medical field, knowledge of this subject is limited. For patients with serious mental illness and coincidental gender variance, it is important to consider the patient's psychiatric course prior to hormone therapy and whether something else might be driving the psychiatric presentation before concluding that the hormones are responsible for decompensation. Based on the available research data, the World Professional Association for Transgender Health has recognized a "possible increased risk" of manic and psychotic symptoms that "appears to be associated with higher doses or supraphysiologic blood levels of testosterone" (4). To date, there are no data supporting the role of estrogen in psychiatric decompensation (4). Further research needs to be conducted on the natural history of psychiatric symptoms surrounding the initiation of hormone therapy before conclusions can be drawn regarding its impact on serious mental illness.

DISCUSSION

Lesbian, gay, bisexual, and transgender (LGBT) patients have consistently been identified to have health risks and outcomes that are distinctly different from those of non-LGBT patients (5). Relative to cisgender people, whose sex assigned at birth aligns with their gender identity, transgender individuals, whose gender identity does not align with their assigned sex, have higher rates of tobacco use, HIV infection, and, increasingly, behavioral health concerns (6). Although transgender people are not more likely to have mental illnesses, given that the rate of suicidal ideation and attempt in this population is nine times that of the overall population (7), it is imperative that behavioral health providers be skilled in supporting and treating transgender individuals in the acute setting. Future avenues of research might include evaluation of the impact of specific affirming interventions on transgender patient perceptions of psychiatric hospital stays in the short- and long-term, as well as rates of engagement and re-engagement with behavioral health care by these patients as a function of such interventions.

KEY POINTS/CLINICAL PEARLS

- A basic understanding of the patient's gender journey is a crucial part of the complete psychiatric interview for all transgender patients, with the goal of screening for risk factors, as well as protective factors, that play a role in the patient's mental health; discrimination and violence are major predictors of psychological distress.
- There are limited available data on the effect of hormone therapy on psychiatric symptoms, and thus it is critical to consider the patient's psychiatric course prior to and since the initiation of hormone therapy in addition to whether something else might be driving the psychiatric presentation.
- Special considerations for the treatment of transgender patients on inpatient psychiatric units include the display of symbols indicating acceptance of LGBT patients, continuing hormone regimens, the accommodation of affirming clothing and devices used by patients to align their physical appearance with their gender identity, and rooming patients with other patients of the same affirmed gender or utilizing private rooms if this is not feasible.
- When misgendering or disparaging remarks occur, acknowledge the mistake, facilitate a sincere apology if possible, and return the focus to the therapeutic alliance and achievement of the treatment goals.

Dr. Saw is a third-year resident in the Department of Psychiatry at the University of Pennsylvania, Philadelphia.

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REFERENCES

1. Basar K, Oz G, Karakaya J: Perceived discrimination, social support, and quality of life in gender dysphoria. J Sex Med 2016; 13:1133–1141
2. Mustanski B, Liu R: A longitudinal study of predictors of suicide attempts among LGBT youth. Arch Sex Behav 2012; 42:437–448
3. Golub S, Walker J, Longmire-Avital B, et al: The role of religiosity, social support, and stress-related growth in protecting against HIV risk among transgender women. J Health Psychology 2010; 15(8):1135–1144
4. World Professional Association for Transgender Health: Standards of care for the health of transsexual, transgender, and gender nonconforming people. https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf
5. National Academy of Medicine: The health of LGBT people: building a foundation for better understanding. Washington, DC, 2011
6. Reisner SL, White JM, Bradford JB, et al: Transgender health disparities: comparing full-cohort and nested matched-pair study designs in a community health center. LGBT Health 2014; 1(3):177–184
7. James SE, Herman JL, Rankin S, et al: Executive summary of the report of the 2015 US Transgender Survey. Washington, DC, National Center for Transgender Equality, 2016