Sanya Virani:

Hi, I'm Sanya Virani and I welcome you to Finding Our Voice - Fresh Perspectives in Psychiatry, a podcast series hosted by me. This podcast has been developed with the goal to address current issues as they pertain to psychiatry, with a special focus on including the viewpoints and opinions of younger groups, resident fellow members, and early career psychiatrists. Thank you for joining me as we continue our discussions on this segment of the podcast series about structural racism that affects patients and psychiatrists from minority and underrepresented ethnic groups. Today's episode will be focused on the LGBTQ community. And it is my absolute pleasure to bring as guests to this episode two friends and remarkably accomplished colleagues, Elie Aoun and Ali Haider, both based in New York. Dr. Elie Aoun is a psychiatrist in general addiction and forensic practice in New York, on faculty at Columbia University and at Central New York Psychiatric Center as the sex offender management liaison psychiatrist.

He completed his general psychiatry residency at Brown University in Providence, Rhode Island and forensic psychiatry fellowship at the Columbia University-Cornell University combined program and a fellowship in psychiatric research at Columbia University. He is the ECP trustee at large for the APA and the immediate past vice chair of the APA Council on Addiction Psychiatry. He works closely with medical students as well as psychiatric residents and fellows at Columbia University where he serves as a co-director of the Sexual Behavior Clinic and Rotation. Welcome, Dr. Elie Aoun, to our podcast.

Dr Elie Aoun:

Hello. Thanks for having me.

Sanya Virani:

All right. And Dr. Ali Haider completed his psychiatry residency at SUNY Downstate Medical Center in Brooklyn and is currently a PGY-5 child and adolescent psychiatry chief fellow at Mount Sinai in New York. His primary areas of interest include LGBTQ mental health, public psychiatry, cultural psychiatry, medical education, and global mental health, particularly displacement and migrations effect on the psyche. He is currently an AP leadership fellow and serves as ECP member of the APA Council on International Psychiatry and Global Health. Welcome, Ali.

Dr Ali Haider:

Hi, Sanya. Thank you for having me.

Sanya Virani:

Thank you. And since we're now in June and on the penultimate episode of this segment in Finding Our Voice, let me tell you some interesting facts about gay pride, also called LGBT Pride or LGBTQ Pride, which is the annual celebration usually in June in the US and sometimes at other times in other countries of the lesbian, gay, bisexual, transgender and queer. That is the LGBTQ identity. Gay Pride commemorates the Stonewall riots, which began in the early hours of June 28th, 1969 after the police raided the Stonewall Inn bar in New York City's Greenwich Village neighborhood. Gay Pride typically involves a series of events and is often kept by a parade with marchers and colorful floats from the LGBTQ community and its supporters. Now, before the Stonewall riots, LGBTQ individuals had generally not broadcast their sexual orientation or identity, but the event galvanized the gay community and sparked greater political activism.

In 1970, on the first anniversary of the riots, several hundred demonstrators marched along Greenwich Village's Christopher Street, which runs past the Stonewall in what many consider as the first gay pride march. Though other commemorations were also held that year, early gay pride events, often called

Freedom Day or Gay Liberation Day, were fiercely attended and encountered protests, particularly because of the outlandish costumes that some marchers wore. Now in 1978, what is perhaps the most recognized symbol of the gay bride made its debut at the San Francisco event, the rainbow flag. The flag with its eight colors, sexuality symbolized by hot pink, life by red, healing by orange, the sun by yellow, nature by green, art by blue, harmony by indigo, and spirit by violet was designed by San Francisco artist Gilbert Baker and has been adopted worldwide. The following year, a six-color flag, which is in common use today, appeared with red, orange, yellow, green, blue, and purple-violet.

Harmony replaced art as symbolized by blue in the flag partially because of the unavailability of some of the fabric colors. Here's to some people identifying as LGBTQ who have distinguished themselves in their chosen fields of work. Miley Cyrus, since graduating from the role of Hannah Montana in 2011, hasn't shied away from expressing her sexuality through performance art, sometimes downright scandalous effect. That said, it wasn't until 2015 that Cyrus announced that she was gender-fluid and became a passionate and vocal advocate for LGBTQ issues. With her open-minded performance style, provocative lyrics and massive LGBTQ fan base, it was not terribly shocking when pop star Lady Gaga identified as bisexual in a 2009 interview. And Elliot Page, famous for roles in Juno, Hard Candy, Tallulah, and Inception in 2014, declared his LGBTQ identity during a powerful speech at a human rights conference. Page came out as transgender in December 2020 and his public announcement was celebrated for giving hope to those struggling with identities or facing internal or external barriers to coming out publicly.

Also, Apple's CEO, Tim Cook, came out in 2014 in a poignant Bloomberg editorial. While Cook doesn't consider himself an activist, he did once tell Stephen Colbert that he felt a tremendous responsibility to speak up about LGBTQ status, particularly on behalf of all the young people who are bullied or even disowned because of their sexuality. And given the output sense of machismo that professional sports and its overzealous fan base, many LGBTQ athletes keep their sexuality a secret. Helping to change that is former NBA player Jason Collins, who became the first openly gay man to play in one of the four major professional team sports. And of course, we know this list goes on. Let me now turn it over to Ali, who will tell us about his recent experiences in fellowship and later about his clinical encounters with his teenage patients, Sammy and his parents. Ali.

Dr Ali Haider:

Thank you, Sanya. So as a child and adolescent psychiatrist, my role often is in helping my patients advocate for themselves or find their voice and get comfortable expressing their true selves to themselves and to their families. I work in very complex family situations where parents and children sometimes and often will try to navigate the parental expectations from the child and the child's own lived reality and sense of self. So we're making a lot of advances as a society in normalizing non-heteronormative sexual orientations and gender-fluid expressions, however, we still have to remember that just because the media has joined the fight for equal rights, that day-to-day experiences for many of our patients are still far from affirmative. Conversion therapy, for example, still happens in some areas in the United States and the fight for equality is far from over yet.

Sanya Virani:

Yeah, you're right. Allow me to pause you for a brief bit there, Ali. And just to let those of you listening and don't already know about this, conversion therapy is the pseudoscientific practice of trying to change an individual's sexual orientation using psychological, physical and spiritual interventions. Now, there is no reliable evidence that sexual orientation can be changed, and medical institutions warn that conversion therapy practices are ineffective and potentially harmful. Medical, scientific, government

organizations in the US and the UK have even expressed a concern over the validity, efficacy and ethics of conversion therapy, and various jurisdictions around the world have even passed laws against conversion therapy. What's the APA's take on it? The APA opposes psychiatric treatment based on the assumption that homosexuality per se is a mental disorder or based upon the priority assumption that a patient should change his or her sexual or homosexual orientation.

And it describes attempts to change a person's sexual orientation by practitioners as unethical. Now, it also states that the advancement of conversion therapy may cause social harm by disseminating unscientific views about sexual orientation. And therefore in 2001, United States Surgeon General, David Satcher, issued a report stating there is no valid scientific evidence that sexual orientation can be changed. So Ali, one thing I was thinking as you were talking about comfort with true expression that the element of cultural shading that plays into this, right? Where some families would actually consider it taboo to express their true selves, therefore, the child or the adolescent might be appropriately even reluctant to bring up his sexual identity. Now, perhaps that is because it's really the correct thing to do at the time. No? What are your thoughts on that?

Dr Ali Haider:

Sure. So I think queer forms of expression have been present throughout many cultures and traditions, but they were often obscured over the last few centuries and even criminalized by colonial laws. It's true that some cultures have yet to re-normalize those forms of expressions, but it's also true that in some countries, we have become more embracing of queer identities in recent years. But still, I think there are subcultures within the same city that still defer greatly are within the same country. When children grew up in a household where minority gender identities and sexual orientations are pathologized in the general family discourse, then you have to start thinking about that they might be inclined to hide those identities out of fear of rejection, regardless in which city they live in. There really is no way of predicting how one's parent will react to the coming out process and a young individual then has to travel through their own journey and they try to find their own path to self-expression.

Sanya Virani:

I understand what you mean. And before we move on to talk about Sammy and his parents, let me explain that we're taking note of the discrimination that is being made on the sexual orientation primarily, and of course, there are layers that add to that as far as race, appearance, color, and other minority aspects of the provider come into play, as Ali, you'll talk to us about. Now, might I add that the cases we are describing are a composite of experiences that have occurred and they do not actually refer to any specific program, trainee, director, attending or patient. So Ali, over to you about your patient Sammy and his parents.

Dr Ali Haider:

Thank you. So as an international medical graduate with an accented English and someone who's a dark-skinned Mediterranean, I often found it challenging to see what assumptions patients make about me. And since I come from Lebanese society, which in recent years has been less embracing of LGBTQ individuals, people made all kinds of assumptions about my background, my beliefs, or the attitudes I'm going to have towards their expressed identities. So for example, I'm going to talk about an encounter with Sammy, a 15-year-old LGBTQ patient and a child born in America to immigrant parents who came to the US sometime before he was born, so the child was born here.

The family assumed they would be okay with non-affirmative discourse because they came from a culture like mine. Additionally, in this process, the parents of Sammy urged me to help them make him

assume a heterosexual identity. I understood that the parents were driven by their beliefs that their child is ill, but it took me a lot of work to maintain a culturally-humble approach and to keep engaging the parents and explore how they could accept their child. As an LGBTQ person myself, it was quite difficult to navigate those assumptions about my background without falling into the question of self-disclosure.

Sanya Virani:

Yeah, that's a very interesting angle to view it from, especially as it pertained to your apprehensions about self-disclosure. But more striking to me is the fact that despite having moved to the US about 15 years ago at the time of Sammy's birth, and with apparent acculturation, Sammy's parents quite obviously retain a strong cultural identity with perhaps some of the areas of the Middle East where homosexuality is probably still considered to be an illness or a defect. Now, the other thing as you rightly pointed out was that Sammy's parents simply assumed that you were a psychiatrist and you would be just aligned with them based on their beliefs and that your values were just like theirs because you were from the Middle East yourself. Now, all these generalizations and assumptions are breeding ground for a lot of complications related to treatment. I would imagine you would have to first get a hold of and around the counter transference to begin with, and that would've been some task, no?

Dr Ali Haider:

Of course, it was very difficult to navigate that situation. I think many of us go into this field to be advocates for our patients and it's very easy to vilify the parents in this scenario and to lecture them about the history of homosexuality or to be appalled at how they pathologize homosexuality in this case, but we must also understand the situation within the cultural context. Patients make assumptions about us based on how we look, sound or even move. And sharing a culture can be very helpful in building rapport at times and also lead to unwarranted assumptions in other times. So it is very important that we decipher these nuances and stay attuned to them as we engage our patients.

Sanya Virani:

Yeah, absolutely. And I think that another side of it is just that, think about this, if an uninformed psychiatrist just might have the erroneous idea that this is the norm of the region and that he or she must just go by what the parents are saying, right? So while psychiatrists need to guard against the mistaken notion of aligning with cultural norms so to speak, they also need to be cautious against taking a very strong stance the other way. Like in this case, for example, it would've been catastrophic to the therapeutic relationship. In fact, to imply to Sammy's parents that their cultural values don't even mean anything and they would have been obviously deeply affronted. And this spells disaster I think for the therapeutic alliance from the get-go. What do you think of this, Elie?

Dr Elie Aoun:

It's always a very difficult balance that we, as psychiatrists, we have to find regardless of whether the psychiatrist themselves, they identify as LGBT or not. And in situations like this one, what we have to remember is that our duty is to our patient and our patient exclusively. That does not mean that we want to pit the patient against their parents. In fact, when there's discord at home, this is likely to result in more stress for the patient. So we have to find a way to support the patient's self-efficacy needs in their journey towards self-acceptance, but at the same time helping them reestablish a healthy and supportive relationship with their families.

Sanya Virani:

Right. You mentioned the importance of maintaining a balance, which I think a psychiatrist actually must negotiate very skillfully, not only to help the patient primarily, but also to work with patients, with parents, excuse me, at the same time, especially if you're a child and adolescent psychiatrist, like Ali is. Now, in fact open discussion, I still think might not even be the timeliest option and the psychiatrist could even potentially advise against a teenager taking a blatant independent stance in front of his parents, in Sammy's case. But that said, let's hear from you, Elie, about this very interesting experience you've had in your specific area of expertise.

Dr Elie Aoun:

The patient that I'm going to talk about, obviously, I changed some of the information to maintain their confidentiality, but let's call them Bruce. So this guy, Bruce, is 26-year-old. I never talked to him before and he reached out to me to schedule a psychiatric evaluation. He saw my name listed on a website that focuses on LGBTQ mental health, called me. And when I spoke to him on the phone, we had a brief conversation just to screen whether or not he was appropriate for my practice. And what he said is, "Listen, I'm gay. I recently came out of a psychiatric hospital because I had an opioid overdose and they diagnosed me with bipolar disorder and prescribed me lithium" and he's been taking lithium. So I scheduled him for an appointment and he came to my office a week later. He was a lovely, lovely guy.

He was very pleasant, he was very easy to engage, he cooperated with everything that I asked for, but as soon as I met him, immediately, he was so focused and he was complaining about the weight gain he was experiencing since he started taking the lithium. So I started taking some history from him. He said that he's never had any kind of psychiatric treatment or mental health treatment before this recent hospitalization a few months before. So obviously, I had to ask him about the hospitalization, why did you go to the hospital? Or the circumstances, why you ended up being admitted to the inpatient unit? And that's when I started noticing that he was uncomfortable. He went from being happy and fun to being shy and avoidant, and it was a very significant change. So I asked him, "Okay, what's going on?" And he said, "Listen, it's embarrassing."

Sex, drugs and rock and roll, no one likes to talk about that, especially when it's in their personal lives. And I joked, I said, "Listen, I'm an addiction psychiatrist, I'm a forensic psychiatrist. I'm gay. I doubt that there's anything you can say that will shock me." And that made us both laugh. And he started telling me his story. So basically, he was born and raised in a rural village in West Virginia. He was gay but closeted, but he was outed as gay when he was maybe 13 or 14 when his classmate told the whole school that the two of them had... He told the whole school that my patient was gay. And ever since that day, my patient became the subject of bullying at school and at home, when in fact, what had happened is that the two had fooled around and in order to protect himself, the other guy outed my patient saying that my patient was gay and had hit on him.

So he had a rough time being an outed gay man in West Virginia and he decided that as soon as he could, he wanted to move to New York City, and that's exactly what he did. After he graduated from high school, he applied to NYU and he was accepted in NYU to study psychology. And moving to New York was good for him. He felt liberated and he decided that he wanted to explore his sexuality. He tried different things and he found a community with other men who were interested in BDSM, bondage, domination, sadism and masochism in the fetish community. And he also started to drink a lot of alcohol and use cocaine, and I asked him about that. Why were you using drugs and alcohol? He said the drugs and alcohol allowed him to feel disinhibited, allowed him to not feel ashamed. I mean, what he said is, "If I'm completely sober, I'm awkward, I get super anxious, but when I'm drunk or when I'm high, I can live in the moment. I'm able to be present with others and enjoy what I'm doing."

And then he told me about a recent sexual experience he had with a regular sex partner. And just for the sake of this case, let's give that person a name, let's called him Alex. So that night, Alex came over to Bruce's apartment and they had agreed to restrain Alex to the bed post. So that's exactly what he did. He restrained him to the bed using metal chains. And before starting to have sex, Bruce went, decided that he wanted to use some cocaine because that allowed him to feel disinhibited so that he's fully engaged in the encounter. And cocaine usually makes him feel normal, but it did not feel normal this time. He started to feel sick, he was breathing with difficulty, he was feeling lightheaded, he was feeling sleepy. He sat on the floor, he felt disoriented, he was confused, and that's when Alex started freaking out.

He was calling him, but my patient was unable to move. He lost consciousness for a few minutes, was nodding off, and Alex was still restrained to the bed with metal chains. And it lasted for a few minutes, but those few minutes really probably felt like hours to Alex. He was screaming and crying and all could think about was, "I'm going to die of starvation. I'm going to die of starvation, naked and tied to my patient's bed." Unfortunately, that didn't happen, that my patient woke up within minutes and slowly regained consciousness and was able to release Alex, they called 911, EMS came and picked him up and they went to the hospital. On the way to the hospital, EMS gave him a dose of Narcan and then he arrived to the emergency room. And their toxicology was positive for cocaine but also for fentanyl.

So the emergency doctor in the emergency room determined that my patient had an opioid overdose. That was shocking, that wasn't news to him because he never used opioid as far as he knew. In fact, the only drugs or substances he's ever tried were alcohol, marijuana, and cocaine. The emergency physician wasn't buying it. And in his attempts to convince the attending physician in the emergency room that he was not an opioid user, he told them about the circumstances, how he ended up in the hospital. He told them what happened with Alex. So the emergency room doctor consulted with psychiatry who came, saw the patient and determined that he met criteria for involuntary psychiatric hospitalization. They hospitalized him and he stayed in the hospital for eight days. The way he describes that hospitalization is very interesting. He said that literally, every clinician he talked to, whether it was the physician or the therapist or the social worker or the case manager, everyone seemed to only be focused on his sexual practice, that they diagnosed him with bipolar disorder.

They started him on lithium and they referred him to an intensive outpatient program, an IOP, and to an outpatient psychiatrist. So my patient completed the IOP program and met with the outpatient psychiatrist three times. He told me I couldn't see him anymore. He described feeling like an animal in a zoo. All anyone just wanted to talk to him about was his sex life, and that's why he decided to find a gay psychiatrist. He said, "I just wanted someone who could relate to my life." So when I met with him that day, I took a very detailed psychiatric history and then after he left, I reached out to the previous psychiatrist he was seeing, I reached out to the hospital to get their medical records. I talked to the attending psychiatrist at the hospital where he was admitted and in all of these records, and then in talking to all of these people, I didn't find any evidence supporting the diagnosis of bipolar disorder.

In fact, what it seemed like is that they heard his sexual practices and these sexual practices seemed so unusual to the treatment team that they felt like there's no way this is normal behavior. This is impulsive, this is grandiose, this is mania. Why does this guy feel dominant? Why does he feel like he's got the right to tie people to his bed? And all of this sounded like mania, and that's why they diagnosed him with bipolar and started him on lithium. After reviewing all of this, I disagreed with the diagnosis. In fact, all I could find any evidence for were diagnosis of depression and cocaine use disorder.

So after talking to him, I took him off the lithium and I prescribed him Wellbutrin Bupropion instead because of the effects of Bupropion on depression, but also because of the recent research that shows that it may help with cocaine use. And that was three years ago since he hasn't had any episode that

vaguely even resembles mania. And he continues to be absent from all drugs, from alcohol, he's participating in gay AA meetings and he graduated from college a few months ago. And that's pretty much it.

Sanya Virani:

Thanks, Ellie. I'm so glad it worked out for Bruce. I'm also very happy that he found you. And I was listening intently and a lot of things stood out to me. Foremost is what I will call "apparent colorblindness." Let's call it that. When many health professionals just attribute judgment on the sexual practices of LGBTQ persons, right? That is usually based on a healthcare professionals using a relative scale to assess I guess the propriety of a patient's sexual practices and if maybe the patient's sexual behaviors are vastly different than even those of the doctors, doctors also tend to pathologize that. So I think maybe that's how patients end up with judgemental labels, which we occasionally see in their medical records.

Words that, in this context, carry serious negative implications, words like deviant, promiscuous, hypersexual, for example. And another aspect I thought was the bias of assuming that the sexual practices or behaviors of individual LGBTQ persons is just representative of sexual practices of every individual in the LGBTQ community, over generalization. Now, we saw that happen in the 80s and 90s during the early years of the AIDS epidemic.

I was thinking. And finally, linking sexuality with the diagnosis of bipolar disorder, as you touched upon briefly, and I agree. I agree that it is an off-observed symptom, except until date. Even the DSM-5 does not really identify it as one of the core diagnostic criterion. So that said, misdiagnosis, of course, they occur and it leads to wrongful medication administration, even exposing patients to a wide area of dangerous side effects. But for that to happen on account of communal and cultural misassumptions, that is something else entirely different. Then also, it comes to mind that Bruce's relief with finding a gay psychiatrist is also in a way similar to Sammy's parents' satisfaction with finding a psychiatrist that hail from the same culture and geographic location as them, as Ali described. So again, this could bring up issues of bias and over identification. Now, what do you think about those things?

Dr Elie Aoun:

Yeah, of course, bias and over identification are huge issues that we really need to be super, super careful about. Listen, an experienced psychiatrist will be able to recognize these [inaudible 00:28:35]. We should be able to use them to our advantage clinically to help the patient rather than distance ourselves from the patient. I like to use the self psychology model, and here, we can think of it as the therapist is helping the patients address their mirroring deficits and their idealizing deficits, and that will help them restore a healthier sense of self.

Sanya Virani:

Yeah, that's a very nice way to wrap it up. So let's move on to the last example we have that Ali will describe to us. A fictional experience with his co-resident, former co-resident, whom we will refer to as Ben. And before we begin, Ali, I have noticed subtle ways in which LGBTQ trainees are looked at and sometimes even treated differently in professional settings. What's your take on that matter?

Dr Ali Haider:

I agree. I think LGBTQ-identifying psychiatrists will often experience subtle and even direct forms of discrimination in the work environment. Again, I mean, psychiatry is attempting to embrace queer identities further and it's... But it's still hard to shake away some of the dark histories of the field. At

best, I think people are encouraged to not ask nor tell in some situations when it comes to their non-heteronormative identities. So when the field became more open to LGBTQ individuals, they were expected to still tone down their queerness in a sense and to not stray too far away from what counts as a professional attire or professional behavior. So in that example, president's professionalism is often put into question when they wish to assume more fluid expressions of their identities and that for example, things that go beyond the heteronormative assumptions of female-presenting individuals wearing dresses and male-presenting individuals wearing ties.

Sanya Virani:

Yeah, exactly. And that has created the perfect segue for us to discuss the situation with your former co-resident, Ben, from a couple of years ago. Take it away.

Dr Ali Haider:

Right. So we're going to reemphasize again the fictionality of the situation because I do want to... We're going to talk about a lot of things that happened here that were very highly fictionalized. I was lucky to have very supportive people in my training, but we're going to talk about Ben, who incidentally happens to be a young gay man who was singled out as often being too gay. He was told he was making too many hand gestures and he soon found himself censoring his body language and in the meetings with the administration and when he's trying to talk to people in power, he would be thinking his every move and every word and whether it is too gay or not. So Ben also incidentally like to wear nail polish, and it had been in his style since he was a teenager. He was comfortable in his expression. He did not think much of it, and until one day, the unit chief took him to the side and to a separate room and tried to explain how his appearance, especially because of the nail polish, could be off-putting for some patients.

And I'm using a lot of air quotations here that will not appear on the podcast. But further, he was asked whether he would consider taking it off. Ben naturally took offense to that, and as I were talking to him, we got to know that he disclosed this conversation that he had the attending to us. He talked to us in confidence, but then it got to the chief resident of course, and then it became a bigger deal and he was taken to the training office where he was [inaudible 00:31:46] the program director was involved as well. There was a lot of conversations around there where people were talking to Ben, were asking him to try to explain his side of it and whether he's willing to compromise or reach a middle ground with regard to this whole situation.

Sanya Virani:

Yeah. Okay. Let's pause you there for a second and ask exclusively from Ben's point of view, and I know you mentioned it a little bit, he took offense and things like that, but how did he react to being called into the training director's office for a conversation?

Dr Ali Haider:

I mean, I think, I believe that the subtle microaggressions are often unnoticed because as the field advances, LGBTQ individuals remain a minority, and we often learn to comply with the rule of the majority to fit in. In this scenario, this is micro and even a macro aggression. Not to mention there was a massive power differential, right? When a person in power in the administration is communicating to you what professional demeanor is and you're a trainee, you don't really have power to question that. And who gets to determine what a professional demeanor is? So on the other hand, when you're a minority trainee like Ben, you often will be asked to have the burden to be tokenized and to be the reference person for your cohort to explain about the minority status. So we're getting these mixed

signals of we want you to talk to us about what LGBTQ individuals want or patients that we're going to encounter.

We want you to be the spokesperson for them. On the other hand, we don't want you to express yourself differently from what we agree with. So it is a lot of confusion that you're getting in terms of signals, but it's often also, it falls on the LGBTQ trainee inherently to teach their classes about what LGBTQ literacy is and how to... What special considerations to take when working with that population. And again, we all want to advocate for our patients, but the onus should not be falling on the trainee, it should be on the training program. It should adopt curricula for LGBTQ competency for their trainees.

Sanya Virani:

Yeah. And I was thinking that on the flip side, Elie, this one's for you. What if Ben's appearance truly made some patients uncomfortable? What if they became more explicit in their aggression with regards to this issue? Maybe with regards to the nail polish, for example.

Dr Elie Aoun:

I mean, it's an interesting case. And listen, I think that asking Ben to modify their looks so that they don't offend a patient is basically like, it's the same as treating our patients as if they're babies, where you have to baby-proof the house to make it safe for them. We cannot treat our patients like they're babies, they're not. I'd argue that it's not even ethical. Remember the ethical principles in medicine, the principles of autonomy and integrity. Patients should have the opportunity to seek treatments wherever they want, and some patients don't like their doctors wearing nail polish. Other patients don't like going into a doctor's office that doesn't have windows and some patients insist on seeing a male or a female, a younger or an older doctor. The patient's choices should be respected.

And if a given facility, if a hospital, clinic doesn't offer what they're seeking, it's our duty as physician to encourage the patients to go get care elsewhere, somewhere where they feel comfortable. That's not rejecting them, it's rather respecting their autonomy, it's respecting their rights to integrity. And if that means receiving care from a physician who meets their needs by not wearing nail polish, we should encourage them to seek that elsewhere. And if there's a mismatch, like the lock and key example, if there's a mismatch between the lock and the key, we shouldn't try to force the key in. We should help the key find the lock that works. But remember, the most important thing is we should never, ever deny our physicians their identity or make them reject who they are.

Sanya Virani:

Yeah. And so with those words of wisdom about baby-proofing households and lock and key, I was thinking, what if this program was in a geographical location? This is a program we're talking about is in New York, but what if this wasn't a geographical location where patients have, let's just put it this way, more conservative values? Now, how much more complicated do you think this could have gotten? Because I don't always think that it is a coincidence that a lot of LGBTQ-identified trainees end up matching in New York.

Dr Ali Haider:

So again, if we're talking about a program in New York, maybe you're right, New York tends to be more embracive of LGBTQ identities because of all the history that you've talked about, and there's a solid history in psychiatry in New York as well about that. But it brings back again the topic we discussed earlier about subcultures within one nation, right? So the hospital staff is expected generally to reflect the population it serves. I don't think there's any area in the country where queer people do not exist.

And from that perspective, I think geography should not be a deterrent to self-expression. To Elie's point, patients are free to seek other care, but asking the trainee to compromise would be, at times, doesn't make sense most of the time. I mean, as psychiatrists, we may choose to adopt a neutral posture because we want to engender further counter transference and we want to have free associations and we want patients to maybe tell us about what they think about us and how they perceive us, but we may also use our identities, to Elie's point, as strength to forge rapport with our patients.

Sanya Virani:

Yep. Yeah, it's nice to know your viewpoint on this matter. One more question for you. How do you think this would eventually... I don't know if there was a finality to the conversation between the training director and Ben, but how do you think that should have ideally played out?

Dr Ali Haider:

I think any training director should be supportive of their minority trainees, of course. It's a question to me that in a scenario like this, Ben would be supported. It's not a question, he should be supported and advocated for by his training director and by his chiefs. It takes a lot of courage, I think, for a trainee to stand the ground and defend their beliefs, especially when they're really early in their training and a program director should try their best to validate the experiences of the training.

Sanya Virani:

Yes. Thank you for that. Now finally, Elie, how do you think that on a broad level, LGBTQ trainees, since you're a little further up in your career as compared to Ali and I, how do you think LGBTQ trainees can be supported by training directors or faculty in general?

Dr Elie Aoun:

Thank you for calling me old. I think training directors should always remember that their trainees have left their homes, they often moved from out-of-state from another country in order to participate in these training programs. So the training programs for these trainees become like a new home, like a new family. And if that's the case, that makes the training director the head of the family, the parents for these trainees. They have a responsibility to protect their residents and fellows, they have a responsibility to promote their growth. And I'm not just talking about professional growth, but I'm also talking about personal growth because these two goals are so clearly interconnected, right? When you grow personally, you're going to become better professionally, you're going to be a better resource for your patients. So what we need is training directors who are fearless in protecting their trainees.

A training director who's not fearless is a failing training director. There's no nice way to say, right? You fail in your job when you're not protecting your trainees. LGBTQ trainees, they're still very vulnerable. Even in psychiatry, which is a more liberal field than other specialties of medicine, even in psychiatry, we still see a lot of overt discrimination, but also a lot of microaggressions targeting LGBTQ trainees and patients also. We have to give LGBTQ trainees a voice, making sure that we're not just tokenizing them. We have to make sure that our training environments are really inclusive 365 days a year, not just during pride month in June. Training directors should not only enable, but also empower all of their trainees to speak up about all the issues they think are wrong because when you're encouraging all your trainees to speak up, when all the trainees are feeling empowered, then LGBTQ trainees specifically will feel more comfortable correcting their attending or correcting other staff members when they say something that's offensive.

Sanya Virani:

Thank you so much, Elie, for nicely putting a bow tie to that discussion. And with that, we come to the end of our sixth episode of Finding our Voice. Our deepest gratitude to our guests, Dr. Haider and Dr. Aoun. We are so thankful for your time, the stories you discussed and the insights you provided. We really enjoyed learning from you about your various experiences as LGBTQ providers in psychiatry, both with your colleagues and patients.

Dr Ali Haider:

Thank you for having us, Sanya.

Dr Elie Aoun:

Thanks for having us, Sanya.

Sanya Virani:

If you take away nothing from this podcast, but the idea that the experiences we share with you are leading you to discovering an individual and collective identity within psychiatry and within society, I will have accomplished a great deal. I'd like to leave you with one final thought. Life is offered to us as a means of self-expression, and the highest form of this expression is through acts of kindness. I hope that we will always remember this in all our interactions with people going forward. I'll you again soon with more guests and more stories. Until then, take care and be well.

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Speaker 4: