BEYOND THE BINARY: AFFIRMATIVE MENTAL HEALTH CARE FOR TRANSGENDER AND GENDER DIVERSE PEOPLE

Rhonda G. Schwindt, DNP, PMHNP-BC, PMHCNS-BC
Associate Professor and Director, Psychiatric Mental Health Nurse Practitioner Program, The George Washington University School of Nursing

Presented at 2021 NEI Congress
Learning Objectives

• Explain mental health disparities across diagnostic categories within the context of a minority stress framework

• Describe culturally-informed clinical practices to optimize mental health outcomes for transgender and gender diverse (TGD) people

• Discuss psychopharmacological considerations in the care of TGD patients
Affirmative Mental Healthcare: Foundational Concepts

- Client centered
- Inclusive, nonbinary view of gender
- Multicultural
- Sex-positivity
- Intersectionality
- Trauma-informed and resilience-based

Diagnose and Treat Paradigm

1973
- Homosexuality removed from DSM

1980
- Transsexualism DSM-III

1994
- Gender Identity Disorder DSM-IV

2000
- Gender Identity Disorder DSM-IV-R

2013
- Gender Dysphoria DSM-5

Gender Dysphoria: Adolescents and Adults

- A formal psychiatric diagnosis given to individuals who experience difficulties due to the incongruence between their gender assigned at birth and their experienced/expressed gender
  - A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months duration—2 of 6 criteria
  - Clinically significant distress or impairment
  - Specify if—
    - with a difference of sex development or post-transition

Gender Dysphoria: Children

• A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months duration—**6 of 8 criteria**
  • Strong dislike of one’s sexual anatomy, strong preference for cross-gender roles in make-believe or fantasy play, a strong preference for playmates of the other gender, etc.

• Clinically significant distress or impairment in social, school, or other important areas of functioning

• Specify if—
  • with a difference of sex development

Moving Beyond the DSM: Questions to Ponder

• As a profession, can we:
  
  • uncouple gender diversity from the stigma of a diagnostic classification suggesting illness or disorder?
  
  • eliminate the assignment of a psychiatric diagnosis required by third-party payers for reimbursement or provision of gender-affirming care?
  
  • conceptualize gender identity outside a binary framework?
Gender Minority Stress Framework

General Psychological Processes

External Stigma Related Stressors

Internal Stigma-Related Stressors

Behavioral Health Problems

Physical Health Problems

Gender Minority Stress Perspective: Key Points

• Stressors specific to gender diverse people lead to poor mental and physical health outcomes
• Intersection of identities can further compound the impact of minority stress
• Discrimination and bias associated with higher rates of mental and physical conditions and illnesses
• Personal, family, and societal acceptance of sexual orientation and gender identity affects mental and physical health and personal safety

Downstream Effects of Gender Minority Stressors

- Suicidality
- Post-traumatic stress disorder
- Substance use and substance use disorders
- Depression and anxiety
- Disordered eating and body image disturbance
- Lack of access to culturally-informed mental health care


The Transgender National Health Survey ($N=27,715$)

- 30% had experienced homelessness at some point in their lifetime, and 12% reported experiencing homelessness in the year prior to completing the survey because they were transgender

- 33% of those who saw a health care provider had at least one negative experience based on gender identity

- 23% did not seek health care in the year prior to completing the survey due to fear of being mistreated as a transgender person

- 33% did not seek health care when needed for economic reasons

Case Study: Minority Stress or Pharmacology?

• Name: Michael
• Age: 25
• Gender identity: transgender male
• Sexual orientation: bisexual
• Race: white
• Pronouns used: He/him/his
• Lives alone, employed full-time
• Receiving gender-affirming hormone therapy with testosterone
• History of Major Depression, recurrent, severe
• Unremarkable medical history
• 6-month follow-up visit after symptom remission
  • Marked anxiety and irritability
  • Depressed mood and anhedonia with suicidal ideation
  • Weight gain (25 lbs.)
Case Study: Clinical Pearls

• It’s not all about psychopharmacology and prescribing practices!

• Assessing for gender minority stressors is an ongoing process

• It takes a multidisciplinary team to provide affirmative mental health care
Diagnostic Categories in the Context of a Minority Stress Framework
Borderline Personality Disorder

- Wide variability reported in the prevalence of borderline personality disorder (BPD) among TGD persons (1%-33%)

- Multiple stigma-related stressors experienced in daily life can produce symptoms and behaviors that resemble borderline psychopathology
  - Identity diffusion
  - Suicidal behaviors and non-suicidal self-injury
  - Rejection sensitivity
  - Impulsivity
  - Pronounced affective responses to perceived slights

Minority Stress Treatment Principles

- Embrace the client’s life experiences as the driving force behind all interactions and interventions
- Accept questioning of one’s gender identity as a process of clarification rather than a sign of identity diffusion
- Conceptualize symptoms and behaviors as a response to minority stress rather than as an indicator of a disordered personality

Minority Stress Treatment Principles

- Facilitate emotional awareness, regulation, and acceptance
- Empower assertive communication
- Restructure minority stress cognitions
- Support individualized expressions of gender
- Validate unique strengths and resilience of TGD persons

Suicidality

• Prevalence of past-year suicidal ideation (12x higher) and suicide attempts (18x higher) compared to the general population

• 40% had attempted suicide at one point in their life

• Factors associated with higher prevalence of past-year suicide attempts
  • Denial of treatment (13.4% vs. 6.3%)
  • Family rejection because of gender identity (10.5% vs. 5.1%)
  • Rejection from religious communities (13.1% vs. 6.3%)
  • Experiences of violence, including intimate partner violence (4x higher)

Suicidality & Gender Identity Conversion Efforts (GICE)

- 27,715 transgender adults who responded to the 2015 US Transgender Health Survey
- 14% reported exposure to GICE
- Recalled lifetime and childhood exposure to GICE associated with adverse mental health outcomes in adulthood compared with non-GICE exposure
  - Severe psychological distress during the previous month
  - Higher odds of lifetime suicide attempts
- Exposure prior to age 10
  - Higher odds of lifetime suicide attempts

Suicidal Ideation & Pubertal Suppression for TGD Youth

• Cross-sectional survey of 20,619 TGD adults aged 18 to 36 years

• Examined self-reported history of pubertal suppression during adolescence and associations between access to the treatment and adult mental health outcomes

• Of the 16% who reported that they ever wanted pubertal suppression only 2.5% received this treatment

• Those who received treatment with pubertal suppression compared to those who wanted treatment, but did not receive it, had lower odds of lifetime suicidal ideation (aOR =0.3; 95% CI= 0.2-0.6)

Suicidality: Risk & Protective Factors

• Experiences of violence, including intimate partner violence, associated with higher prevalence of suicidal thoughts and attempts

• “Outness” and disclosure—

  • Respondents who had not disclosed their transgender status to anyone were the least likely group to have reported lifetime attempts

  • Respondents who reported that others can always tell they are transgender had the highest prevalence of both lifetime and past-year suicide thoughts and attempts (6.3% vs. 12.2%)

Suicidality: Risk & Protective Factors

• Cumulative effect of minority stress is associated with higher prevalence of suicidality—

  • 97.7% of those who had experienced four discriminatory or violence experiences in the past year (being fired, eviction, homelessness, etc.) reported seriously thinking about suicide and 51.2% made a suicide attempt in the past year

• Those who are younger, assigned female at birth, have lower incomes and educational attainment, are not partnered, and do not identify as heterosexual or straight have higher prevalence of suicide attempts

Minority Treatment Principles

- Future areas of exploration—
  - Pinpoint particular time periods of vulnerability where intervention and prevention strategies would be most needed and most effective
  - Determine effective strategies to decrease minority stress, including structural stigma

- Treatment & support—
  - Screen every patient at every encounter for psychological distress
  - Assess minority stressors at every encounter
  - Refer to gender-affirming resources and follow-up

Lived Experience

“One of the primary barriers was a sense of feeling suicidal because you didn’t think you were worth it, and you didn’t want to live past a certain age anyway.” Ollie, 32-years-old
Post-Traumatic Stress Disorder

• Higher rates of PTSD and greater severity and frequency of symptoms
• Factors associated with higher rates—
  • Increased exposure to everyday discrimination based on gender identity and gender expression
  • High visual gender non-conformity
  • Multiple minority identities
  • Unstable housing
• Factors associated with lower rates—
  • Younger age
  • Trans masculine gender identity
  • Medical gender-affirmation

Minority Stress Treatment Principles (Adapted)

• Cognitive-Processing Therapy for TGD people
  • Focus on how gender identity-specific stressors/experiences result in post-traumatic stress (e.g., hypervigilance, avoidance, mistrust, etc.)
  • Attribute challenges to gender minority stress rather than personal failings
  • Explore how discrimination and bias impact personal beliefs (e.g., expecting rejection, internalized transphobia, etc.)
  • Address avoidance and isolation
• Trauma-informed care
  • Ask about trauma history

Substance Use Disorders

• Substance use disorders (SUDs) among TGD people has been understudied

• Lack of evidence is further compounded by the practice of reporting aggregate data only

• General consensus, TGD people have an elevated prevalence of substance use disorders compared with the general population as a downstream effect of minority stress

Substance Use Disorders

- Transgender women who report a history of psychological abuse based on gender identity and gender expression
  - 3–4x higher odds of alcohol, marijuana, or cocaine use
  - 8x higher odds of any drug use

- TGD adults, independent of sexual orientation, have reported higher past 30-day use of tobacco products and current use of cigarettes (35.5% vs. 20.7%) compared to general population

- Transgender youth may have a higher lifetime risk of cocaine and methamphetamine use and are more likely to report past 30-day inhalant and prescription pain medications use

Gender Minority Stress & Substance Use Disorders

- Online survey of 5,542 adolescents ages 13 to 18 examining differences in bullying and substance use by gender identity

- 11.5% identified as TGD

- TGD youth had increased odds of past 12-month alcohol use, marijuana use, and non-marijuana illicit drug use

- TGD youth disproportionately experienced bullying and harassment in the past 12-months

- Bullying and harassment was associated with increased odds of all substance use

Minority Stress Treatment Principles

- Focus on counteracting situational triggers that can lead to substance use
- Discuss when substance use is in conflict with personal goals
- Validate heightened emotional response in the face of threats to identity and enacted stigma
- Attribute challenges to minority stress rather than personal attributes
“I would say stress and probably nerves about being out in the community, nerves of, you know, having people stare at you for smoking versus having someone stare at you because they think you’re dressing weird or they think that it’s weird you look like a man, but you’re in a dress.” Diana, 18-years-old
Disordered Eating & Body Dissatisfaction

- Gender minority youth are more likely to be dissatisfied with their bodies compared to non-gender minority peers.

- Trans masculine people may be at an increased risk for eating disorder psychopathology and other body-image related behaviors.

- Gender-diverse college students are more likely to be underweight or obese and less likely to meet recommendations for strenuous physical activity and screen time compared to non-gender-diverse students.

Disordered Eating

- Online survey of 923 transgender youth (aged 14–25)
- Enacted stigma was linked to higher odds of reported past year binge eating and fasting or vomiting to lose weight
- Family and school connectedness, caring friends, and social support were linked to lower odds of past year disordered eating
- Youth with the highest level of enacted stigma and no protective factors had high probabilities of past year eating disordered behaviors
Serious Mental Illness

- TGD people **are not more** likely to have a diagnosable SMI compared to general population

- TGD people with severe mental illness **are more** likely to experience dangerous array of vulnerabilities

- Growing body of evidence that psychotic symptoms may improve with gender-affirming treatment

- Stabilize psychiatric symptoms to facilitate gender identity discovery and affirmation

Serious Mental Illness

• Tendency to withhold gender-affirming medical treatment in the context of psychosis due to a fear of misdiagnosing

• TGD people may disclose their gender identity during an acute psychotic episode due to a disinhibited state

• Clear difference between bizarre beliefs related to gender delusions and realism of felt incongruence

• Gender dysphoria is separate from psychosis and often predates the onset of psychotic symptoms

• Overlap with period of vulnerability for first-episode psychosis and disclosure of gender dysphoria and a desire to transition

Minority Stress Treatment Principles

• Conduct a thorough history of gender identity development

• Recognize the difference between the bizarre beliefs expected with delusions and the incongruence between sex assigned at birth and gender identity

• Understand that fluctuations in gender identity and gender expression are common and are not indicative of psychiatric illness

• Provide resources and support to empower patients to make informed decisions

Pharmacological Considerations for Treating TGD People
Gender-Affirming Hormone Therapy

• Significant improvement in mental health, functioning and quality of life associated with gender-affirming treatments, including gender-affirming hormone therapy (GAHT)

• No evidence linking worsening of severe mental illness with use of GAHT

• Can treat psychiatric co-morbidities in patients who are receiving GAHT

Gender-Affirming Hormone Therapy

- Consider that something else might be driving the psychiatric presentation before concluding GAHT is responsible for decompensation or current symptoms

- Distinguish between symptoms related to gender dysphoria and those related to co-morbid psychiatric illness or other factors

- Consider onset and severity of symptoms, level of clinical distress, and duration of GAHT to determine treatment options

GAHT: Testosterone

- Standard medication used to lower the pitch of the voice, increase facial and body hair, redistribute fat from the hips and buttocks to the abdomen and increase muscle mass

- Effective at suppressing the body’s production of estrogen and many of it’s effects on the body

- Does not reliably prevent pregnancy

- Several options for administration of testosterone
  - Injectable formulation most common

GAHT: Estrogen & Anti-Androgens

- Standard medication used to soften the skin, decrease muscle mass, increase breast growth, slow androgenic hair loss, and redistribute fat to the hips and buttocks
- Several options for administration
- Can suppress testosterone and its effects, but it alone may not be enough to suppress sufficiently for some patients
  - Adjunctive treatment with androgen blockers – antiandrogen therapy— can further suppress the body’s production or response to the effects of testosterone
  - Spironolactone is anti-androgen of choice in the United States

GAHT: Progesterone

- Benefit of progestins for gender affirmation is not well-studied

- Providers have reported that it may improve breast development, mood and libido

- Known to cause weight gain, fatigue, irritability, and negative mood changes

Drug Interactions

• Spironolactone reduces the renal clearance of lithium

• Lamotrigine and estrogen-containing products
  • Oral contraceptives may alter the blood levels and efficacy of lamotrigine by decreasing its concentration by about 50% (range 41–64%)

• Testosterone increases the clearance of propranolol

• Tobacco use
  • Increased risk of venous thromboembolism with estrogen-containing products
  • Transdermal estrogen is preferred route

Summary

- Transgender and gender diverse identities and expressions do not constitute a mental disorder
- Variations and fluctuations in gender identity and expression are normal aspects of human diversity
- If a mental health issue exists, it is often a downstream effect from minority stressors
- Gender-affirming care effectively treats gender dysphoria, reduces suicide risk factors, suicidality, and improves mental and physical health outcomes
- Affirmative mental health care requires a holistic, person-centered approach
Gina is a 24-year-old patient (sex assigned at birth female) who is currently hospitalized due to an acute psychotic episode. While experiencing acute psychotic symptoms, Gina asked to be called Tony and stated he identifies as a transgender male. Which of the following offers the most likely explanation for Tony’s disclosure at this time?

1. TGD people are more likely to experience serious mental illness compared to the general population.

2. During an acute psychotic episode, it is not uncommon for patients to experience delusions related to gender.

3. During an acute psychotic episode, disinhibition can lead to disclosure of pre-existing gender diversity.

4. TGD people are more likely to display bizarre behavior during inpatient hospitalization.
Posttest Question 2

Which of the following statements is true?

1. Gender-affirming hormone therapy with testosterone has the potential to cause mood changes and is contraindicated in patients with a history of a mood disorder.

2. Gender-affirming hormone therapy should not be prescribed for gender dysphoria until all co-morbid psychiatric conditions are well-managed.

3. Gender-affirming hormone therapy may lead to improvements in mental and physical health outcomes.

4. Estrogen-containing products can worsen depression in transgender women and should be prescribed at lower doses, if there is a history of any mood disorder.
Jaz, a 32-year-old non-binary person, is seeking care for persistent anxiety. They are receiving masculinizing hormone therapy with testosterone and report they are sexually active with a male, cisgender partner. Which of the following is an important consideration when prescribing psychotropic medications for this patient?

1. TGD patients should not be treated concomitantly with gender affirming hormone therapy and psychotropic medications.

2. Gender-affirming hormone therapy with testosterone significantly decreases the likelihood of pregnancy and therefore, additional patient education is not required.

3. A sexual health history which includes documentation of gender-affirming surgeries should be conducted prior to prescribing medications for this patient.

4. Psychiatric mental health providers should not be concerned about their patient’s sexual health or current sexual practices.