NATIONAL LGBT HEALTH EDUCATION CENTER

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Behavioral Health Care for Transgender Adults

Alex Keuroghlian, MD, MPH

The National LGBT Health Education Center

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- Independent 501(c)(3) FQHC
- Founded 1971
- Mission: To enhance the wellbeing of the LGBT community as well as people in our neighborhoods and beyond through access to the highest quality health care, education, research and advocacy
- Integrated Primary Care Model, including HIV services

The Fenway Institute

- Research, Education, Policy

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Today's Faculty

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Assistant Professor of Psychiatry, Harvard Medical School

Continuing Medical Education Disclosure

- Program Faculty: Alex S. Keuroghlian, MD, MPH
- Current Position: Psychiatrist, Massachusetts General Hospital; Director, The National LGBT Health Education Center; Assistant Professor of Psychiatry, Harvard Medical School
- Disclosure: No relevant financial relationships. Presentation does not include discussion of off-label products.

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Learning objectives

- Describe behavioral health disparities and risk factors among transgender adults
- Explain how the stresses and challenges associated with stigma can affect behavioral health outcomes
- Describe strategies to address behavioral health issues in transgender adults

Minority Stress Framework

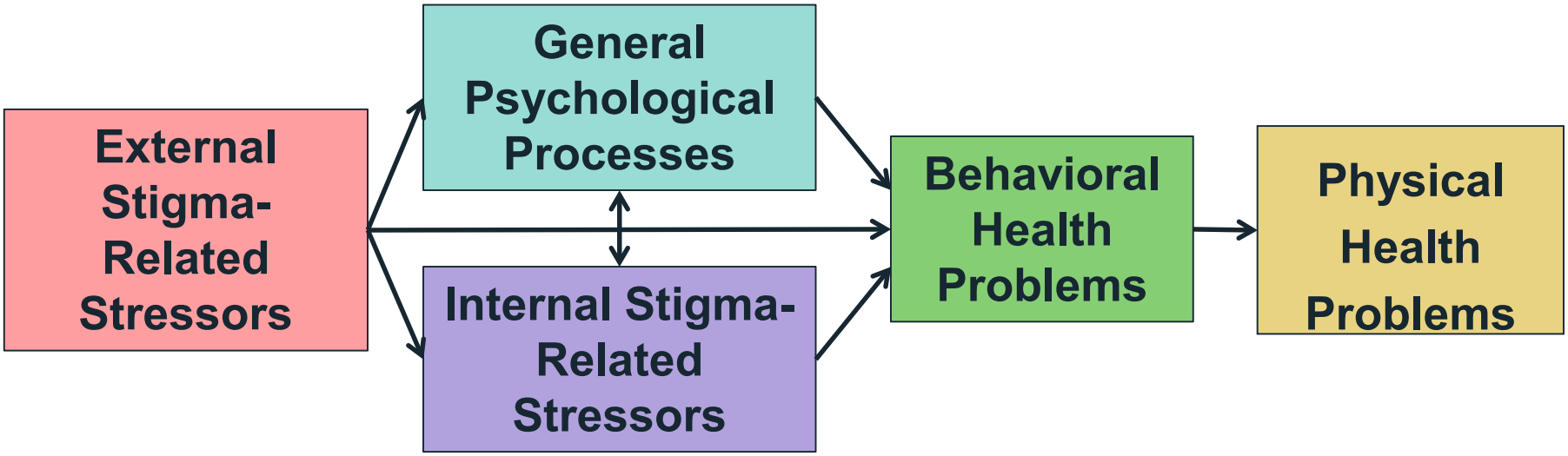


Fig. 1. Diagram adapted from "How does sexual minority stigma get "under the skin?" (Hatzenbuehler, 2009)

Interpersonal Stigma

Structural Stigma

- Structural, or institutional discrimination includes the policies of private and governmental institutions that intentionally restrict the opportunities of certain people, as well as policies that unintentionally restrict these opportunities.

Intrapersonal Stigma:

"…And to the degree that the individual maintains a show before others that they themselves does not believe, they can come to experience a special kind of alienation from self and a special kind of wariness of others."[4]

DSM-5 Gender Dysphoria (F64._)

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration …

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning, or with a significantly increased risk of suffering, such as distress or disability

.1 adolescence & adulthood .8 other gender identity disorders .9 unspecified

APA (2013)

Gender Minority Stress Treatment Principles for Behavioral Health Clinicians

- Normalize adverse impact of gender minority stress
- Facilitate emotional awareness, regulation, and acceptance
- Empower assertive communication
- Restructure minority stress cognitions
- Validate unique strengths of transgender people
- Foster supportive relationships and community
- Affirm healthy, rewarding expressions of gender

Depression and Anxiety among Transgender Adults

- Prevalence of clinically significant depressive symptoms:
  - 51% of transgender women
  - 48% of transgender men
- Prevalence of clinically significant anxiety symptoms:
  - 40% of transgender women
  - 48% of transgender men

Budge, Adelson and Howard (2016)

Health Disparities (2015 U.S. Transgender Survey)

- 39% of respondents experienced **serious psychological distress** in the month prior (compared to 5% of the U.S. population)

- 40% had **lifetime suicide attempt** (compared to 4.6% of US population)

James *et al.* (2016)

Suicidality: Transgender and LGBQ Adults

- Lifetime prevalence of suicide attempts in the United States:
  - General adult population: 4%
  - LGBQ adults: 11-20%
  - Transgender adults: 41%

Kann *et al.* (2011); Perou and Bitsko (2013)

Suicidality (2015 U.S. Transgender Survey)

In the preceding 12 months:

- 48% had seriously thought about suicide
- 24% made a plan to kill themselves
- 7% had attempted suicide

- 40% had attempted suicide at one point in their lives
- 34% had first attempt by age 13
- 92% had first attempt by age 25

James *et al.* (2016)

Adverse Impact of Lifetime Conversion Therapy Exposure

- Survey of 27,715 transgender adults in the U.S.
- 14% reported gender identity conversion therapy
- Lifetime exposure associated with:
  - lifetime suicidal attempt (aOR 2.14, 99.9% CI 1.47 to 3.10; *P*<.0001)
  - greater than 20 suicide attempts (aOR 2.52, 99.9% CI 1.11 to 5.27; P=.0002)
- No difference in outcomes between conversion therapy by religious advisor versus secular-type professionals

Turban *et al.*, *under review*

Adverse Impact of Conversion Therapy Exposure Before Age 10

- Exposure before age 10 associated with:
  - Unemployment and lower household income in adulthood
  - lifetime suicide attempt (aOR 4.98, 99.9% CI 2.39 to 10.42; *P*<.0001)
  - more than 20 suicide attempts (aOR 5.99, 99.9% CI 1.49 to 23.81; *P*<.0001)

Turban *et al.*, *under review*

Factors Associated with Higher PTSD Severity in Transgender Adults

- Higher everyday discrimination
- Greater number of attributed reasons for discrimination
- High visual gender non-conformity
- Unstable housing

Reisner *et al*. (2016)

Factors Associated with Lower PTSD Severity in Transgender Adults

- Younger age
- Trans masculine gender identity
- Medical gender affirmation

Reisner *et al*. (2016)

Addictions among Transgender People

- Studies examining substance use disorders (SUDs) among transgender people are rare
- Reporting of gender identity data (e.g., transgender status) in SUD-related research is limited
- In the few studies that exist, transgender people have elevated prevalence of alcohol and illicit drug use compared with the general population

Flentje *et al*. (2015); Benotsch *et al*. (2013); Santos *et al*. (2014)

Gender Minority Stress and Substance Use among Transgender People

- Psychological abuse among transgender women as a result of non-conforming gender identity or expression is associated with:
  - **3-4x higher odds** of alcohol, marijuana, or cocaine use
  - **8x higher odds** of any drug use
- Among transfeminine youth, gender-related discrimination is associated with increased odds of alcohol and drug use

Nuttbrock *et al*., (2014b); Rowe *et al*., (2015)

Gender Minority Stress and Substance Use among Transgender People

- 35% of transgender people who experienced school-related verbal harassment, physical assault, sexual assault, or expulsion reported **using substances** to cope with transgender- or gender nonconformity-related mistreatment
- Psychological stress of health care access disparities faced by transgender people is believed to contribute to worse mental health, including **disproportionate substance use as a coping strategy**

Grant *et al*. (2015); Poteat *et al*. (2013); Wilson *et al*. (2015)

Substance Use Disorders among Transgender Adults

- Among 452 transgender adults in MA, increased odds of SUD treatment history plus recent substance use were associated with:
  - intimate partner violence
  - PTSD
  - public accommodations discrimination
  - unstable housing
  - sex work
- Higher SUD prevalence increasingly viewed as downstream effects of chronic gender minority stress

Keuroghlian *et al*. (2015)

Alcohol Research with Transgender Populations

- Current definitions of hazardous drinking do not consider complexity of physical sex and gender
  - Doubts regarding validity, applicability and use with these populations
- Systematic review of English language, peer-reviewed journals, published 1990-2017, and extracted key details
  - e.g., sample composition, alcohol measures, results
- 44 studies met all inclusion criteria

Gilbert *et al*. (2018)

Alcohol Research with Transgender Populations

- Recommendations:
  - Being explicit as to whether and how sex assigned at birth, current sex-based physiology, and/or social gender are operationalized and relevant for research questions
  - Expanding repertoire of alcohol measures to include those not contingent on sex or gender
  - Testing psychometric performance of established screening instruments (e.g., AUDIT) with transgender populations
  - Shifting beyond cross-sectional study designs

Gilbert *et al*. (2018)

Opioid Use Disorders among Transgender People

- Transgender middle school and high school students in California more than twice as likely to report recent prescription pain medication use compared to other students
- Transgender adults on Medicare have increased prevalence of chronic pain compared to cisgender (non-transgender) adults.
- Transgender patients may be at increased risk post-operatively of developing an opioid use disorder.

De Pedro *et al.* (2017); Dragon *et al.* (2017)

Opioid Agonists and Gender-affirming hormone therapy

- Co-prescription of opioid agonists (e.g., methadone and buprenorphine) and gender-affirming hormone therapy
  - Safe and feasible with appropriate monitoring and follow-up

Kerridge *et al.* (2017); Dragon *et al.* (2017)

Co-occurring Opioid Use and Psychiatric Disorders

- Dual diagnosis approach to treatment
  - Integration of addictions treatment with behavioral health services
- Individual and group therapy programs rooted in a gender minority stress framework
- Leveraging transgender community solidarity as a source of resilience and self-efficacy

Fenway's Two Models of Buprenorphine Treatment

- Buprenorphine clinic in BH department
  - Weekly clinic with psychiatric prescriber, buprenorphine group meets concurrently
  - Leverages treatment contingencies and behavioral reinforcement paradigms
- Harm reduction model for buprenorphine in primary care
  - Initiated in Fall 2017 in response to opioid epidemic
  - Led by nurse practitioner based in medical department

Cognitive-behavioral Therapy for Substance Use Disorders

- Adapting selected topics and practice exercises from the manual by Carroll
- Focus:
  - Coping With Craving (triggers, managing cues, craving control)
  - Shoring Up Motivation and Commitment (clarifying and prioritizing goals, addressing ambivalence)
  - Refusal Skills and Assertiveness (substance refusal skills, passive/aggressive/assertive responding)
  - All-Purpose Coping Plan (anticipating high-risk situations, personal coping plan)
  - HIV Risk Reduction

Cognitive-behavioral Therapy for Substance Use Disorders

- Possible tailoring for transgender clients:
  - Minority stress-specific triggers for cravings (e.g. nonconformity-related discrimination and victimization, expectations of rejection, identity concealment, and internalized transphobia)
  - SUDs as barriers to personalized goals of adequate ART/PrEP adherence or consistent condom use
  - Assertive substance refusal with non-transgender sex partners; HIV risk from hormone and silicone self-injections; SUDs as barriers to personalized goal of successful gender affirmation

Psychiatric Diagnoses, Acuity and Outpatient Engagement

- Retrospective review of EHR data from:
  - 201 transgender-identified patients,
  - 19-64 years old,
  - presented for one or more health-care visits between July 1, 2010 and June 30, 2015 at an urban community health center in Boston, MA.
- Not being employed associated with **ANY DIAGNOSIS**
- Suicide attempts and older age of hormone therapy initiation associated with **SUBSTANCE USE DISORDERS**
- Alcohol use disorder, MDD, PTSD, and absence of behavioral health integration associated with **ACUITY**
- MDD, anxiety disorders , and case management associated with **OUTPATIENT TREATMENT ENGAGEMENT**

Beckwith *et al*., *under review*

ORIGINAL ARTICLE Open Access

Factors Associated with Gender-Affirming Surgery and Age of Hormone Therapy Initiation Among Transgender Adults

Noor Beckwith,[1,2] Sari L. Reisner,[2–5] Shayne Zaslow,[3,6] Kenneth H. Mayer,[2,3,7] and Alex S. Keuroghlian[1–3,*]

Gender-affirming Surgery and Age of Hormone Therapy Initiation

- Retrospective review of EHR data from:
  - 201 transgender-identified patients,
  - 19-64 years old,
  - presented for one or more health-care visits between July 1, 2010 and June 30, 2015 at an urban community health center in Boston, MA.
- Accessing gender-affirming treatments is associated with **better mental health**, **higher socioeconomic status**, and identifying as **straight/heterosexual**

Beckwith *et al.* (2017)

Body Image Dissatisfaction

- Transgender people have greater body dissatisfaction than control participants
- Trans masculine participants have comparable body dissatisfaction scores to cisgender males with eating disorders
- Drive for thinness greater among trans feminine participants than trans masculine participants
- Trans masculine and trans feminine participants report greater dissatisfaction not only for gender-identifying body parts but also body shape and weight

Witcomb *et al.* (2015); Testa *et al.* (2017)

Body Image Dissatisfaction

- Treating pre-pubertal GM children with gonadotropin-releasing hormone agonists to suppress puberty, then providing them with gender-affirming medical interventions in later adolescence, has been shown to increase body satisfaction and decrease eating disorders and depression
- Pubertal suppression may initially create body dissatisfaction for GM youth who are bothered by looking younger than their peers

De Vries *et al.* (2011)

Weight-related Disparities

- Compared to cisgender peers, transgender students more likely underweight or obese; less likely to meet recommendations for strenuous physical activity, strengthening physical activity, and screen time
- Transgender students may need more tailored interventions to alleviate existing disparity and improve their long-term health
- Providers need to deliver weight loss/weight gain messages sensitive to and affirming of gender needs and gender expression

Vankim *et al.* (2014)

Discussing Body Image

- In discussing weight loss or gain with transgender patients, messages should be framed to affirm a patient's gender identity
- Asking what words people use to describe their body parts and then using those words with them can help improve rapport and enhance engagement in treatment

Treating Eating Disorders

- Enhanced Cognitive Behavioral Therapy for Eating disorders (CBT-E) (Fairburn, 2008)
- Family-based Treatment (FBT) (Courturier *et al*., 2013)
- Interpersonal therapy (IPT) (Rieger *et al*., 2010)
- Dialectical Behavior Therapy (DBT) (Safer *et al*., 2001).
- Clinicians must be attentive to unique sociocultural factors, minority stressors that amplify risk for eating disorders (Calzo *et al*., 2017).

Gender Identity and Psychosis

- Is gender identity derived from, or amplified by, psychosis?
- Alternative hypothesis: during psychiatric decompensation and disinhibition, less concerned about stigmatization, rejection, and abandonment
- Psychotic episodes may involve more unfiltered expression of innate gender identity

Gender Diversity

- Cannot assume fluctuations in gender identity over time could only result from psychiatric instability
- Gender identity often fluid and evolves naturally over time
- Some people live most comfortably part-time in alternating masculine and feminine gender roles

Gender Diversity

- Fluctuating gender presentation may be prolonged process of gender identity exploration until transitioning full time to a single gender expression
- In other cases, people feel most comfortable with fluid gender expression that fluctuates long-term without needing to settle on one permanent gender expression

Gender Diversity

- Inconsistent endorsement of male and female gender identities within single conversation may indicate thought disorganization, or challenge in conceptualizing and communicating core experience of non-binary gender identity
- Important role for mental health clinicians to assist clients in exploring and understanding gender identity (fluid over time, non-binary, etc.)

Gender Identity and Psychiatric Disorders

- Often impede gender identity exploration and alleviation of distress
- Need to stabilize psychiatric symptoms for facilitation of gender identity discovery and affirmation
- WPATH guidelines for reasonable control of co-occurring disorders

Role of Behavioral Health Clinician in Gender Affirmation Process

- Fostering gender identity exploration, discovery and affirmation
- Presenting appropriate non-medical and medical strategies for gender affirmation
- Assistance in making fully informed decisions regarding personalized gender affirmation process:
  - relevant options
  - risks/benefits
  - evaluate capacity for medical decision making/informed consent
  - arranging suitable referrals to care

Gender-affirming Behavioral Health Care

- Explore gender identity, expression, and role
- Focus on reducing internalized transphobia
- Help improve body image
- Facilitate adjustment through affirmation process (physical, psychological, social, sexual, reproductive, economic, and legal challenges)

Safe Communities and Spaces

- Encourage clients to utilize peer support resources (online or in-person), and community organizations dedicated to affirming gender diversity
- Provide advocacy within public mental health systems for gender-variant residents of group homes and homeless shelters
- Transgender competency training for staff

Harm Reduction

- In cases where co-occurring psychiatric disorders remain unstable despite full treatment, harm reduction principles must guide clinical management

Definition of Trauma-informed Care

- According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), a trauma-informed service organization:
  - Realizes widespread impact of trauma and understands potential paths for recovery;
  - Recognizes signs and symptoms of trauma in clients, staff, and others involved with the system;
  - Responds by fully integrating knowledge about trauma into policies, procedures, and practices;
  - Seeks to actively resist re-traumatization.

Trauma-informed Service Environment

- Priority is to promote a sense of safety
- Prior traumatic experiences influence reaction in subsequent interactions, such as the process of seeking care.
- A history of interpersonal trauma can contribute to mistrust of caretakers and increased likelihood of being re-traumatized.
- Retention in care for patients with trauma histories requires engagement through collaboration, transparency, trust, and consistent supportiveness.

Brezing and Freudenreich (2015)

Screening for and Identifying Trauma and Its Mediators

- Screening all patients for a trauma history
  - Extra attentiveness for subpopulations with an even higher risk of trauma, who may have heightened sensitivity
  - Screening for intimate partner violence.
- If trauma is identified, care team ought to assess specifically for posttraumatic stress symptoms
  - Hypervigilance; avoidance, numbing, re-experiencing through intrusive thoughts, flashbacks, nightmares; psychological dissociation, including amnesia, depersonalization, and derealization.

Brezing and Freudenreich (2015)

The Primary Care PTSD Screen (PC-PTSD)

Exhibit 1.4-5: PC-PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, *in the past month*, you…

1. Have had nightmares about it or thought about it when you did not want to?
   YES NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
   YES NO
3. Were constantly on guard, watchful, or easily startled?
   YES NO
4. Felt numb or detached from others, activities, or your surroundings?
   YES NO

Source: Prins et al., 2004. Material used is in the public domain.

SAMHSA (2014)

Intimate Partner Violence Screening Tool

Exhibit 1.4-4: STaT Intimate Partner Violence Screening Tool

1. Have you ever been in a relationship where your partner has pushed or Slapped you?
2. Have you ever been in a relationship where your partner Threatened you with violence?
3. Have you ever been in a relationship where your partner has thrown, broken, or punched Things?

Source: Paranjape & Liebschutz, 2003. Used with permission

SAMHSA (2014)

PTSD Checklist

Exhibit 1.4-7: The PTSD Checklist

Instructions to Client: Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully and circle the number that indicates how much you have been bothered by that problem *in the past month*.

1. Repeated, disturbing memories, thoughts, or images of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
2. Repeated, disturbing dreams of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
4. Feeling very upset when something reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
6. Avoiding thinking about or talking about a stressful experience or avoiding having feelings related to it?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
7. Avoiding activities or situations because they reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
8. Trouble remembering important parts of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
9. Loss of interest in activities that you used to enjoy?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
10. Feeling distant or cut off from other people?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
12. Feeling as if your future will somehow be cut short?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
13. Trouble falling or staying asleep?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
14. Feeling irritable or having angry outbursts?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
15. Having difficulty concentrating?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
16. Being "super-alert" or watchful or on guard?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
17. Feeling jumpy or easily startled?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

Source: Weathers et al., 1993. Material used is in the public domain.

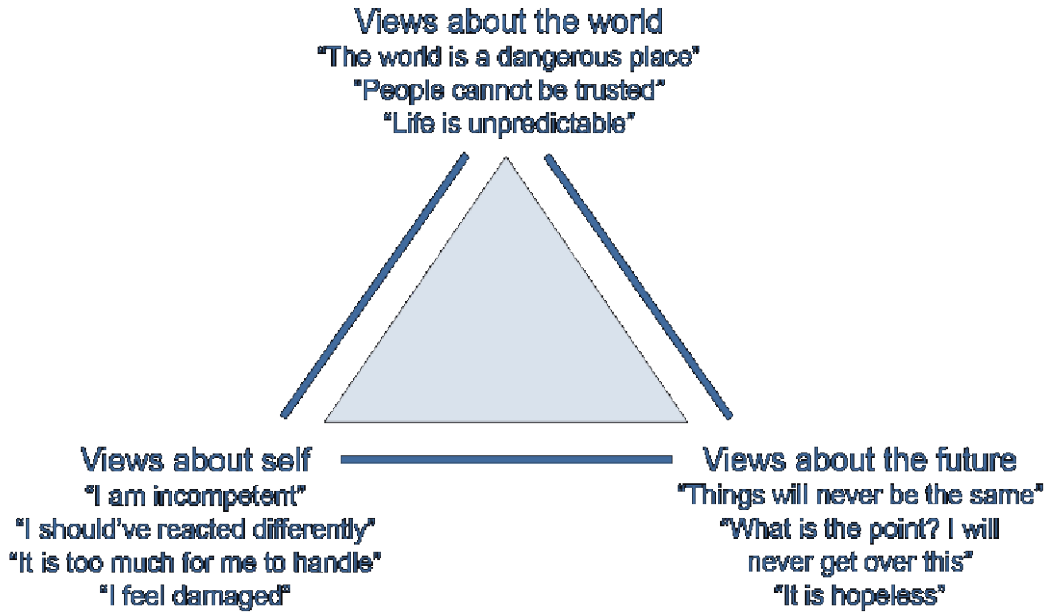
SAMHSA (2014)

Cognitive Processing Therapy for PTSD

- Adapting selected components of cognitive processing therapy for PTSD (Resick, Monson and Chard, 2016)
- Focus:
  - Education about posttraumatic stress;
  - Writing an Impact Statement to help understand how trauma influences beliefs;
  - Identifying maladaptive thoughts about trauma linked to emotional distress;
  - Decreasing avoidance and increasing resilient coping.

Cognitive Triad of Traumatic Stress

Exhibit 1.3-2: Cognitive Triad of Traumatic Stress



SAMHSA (2014)

Cognitive Processing Therapy for Minority Stress

- Possible tailoring for Transgender Clients:
  - Focus on how transgender-specific stigma causes posttraumatic stress (e.g. avoidance, mistrust, hypervigilence, low self-esteem);
  - Attributing challenges to minority stress rather than personal failings;
  - Impact Statement on how discrimination and victimization affect beliefs (e.g. expecting rejection, concealment needs, internalized transphobia);
  - Decreasing avoidance (e.g. isolation from transgender community or medical care);
  - Impact of minority stress on PrEP adherence or condom use.

Systems of Care for Transgender Clients with Severe Mental Illness

- Evidence of effectiveness of Assertive Community Treatment (ACT) teams and wraparound services
- 24-hour coverage by multidisciplinary treatment teams, integration of treatment and rehabilitation, small caseloads and frequent client contact, and close attention to illness management and daily living problems
- Training staff on how to engage in effective, sensitive communication, and how to create gender-inclusive care environments for transgender people

Burns *et al.* (2007)

Promoting Resilience in Trauma-Informed Care

Resilience: *This term refers to the ability to bounce back or rise above adversity as an individual, family, community, or provider. Well beyond individual characteristics of hardiness, resilience includes the process of using available resources to negotiate hardship and/or the consequences of adverse events.*

SAMHSA (2014)

Promoting Resilience through Strengths-oriented Questions

- The history that you provided suggests that you've accomplished a great deal since the trauma.
- What are some of the accomplishments that give you the most pride?
- What would you say are your strengths?
- How do you manage your stress today?
- What behaviors have helped you survive your traumatic experiences (during and afterward)?
- What are some of the creative ways that you deal with painful feelings?

SAMHSA (2014)

Promoting Resilience through Strengths-oriented Questions

- What characteristics have helped you manage these experiences and the challenges that they have created in your life?
- If we were to ask someone in your life, who knew your history and experience, to name two positive characteristics that help you survive, what would they be?
- How do you gain support today? (Possible answers include family, friends, activities, coaches, counselors, other supports, etc.)
- What does recovery look like for you?

SAMHSA (2014)

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