Gender Minority Care in Psychosis Treatment: Minority Stress and the Role of Affirming Care in Conceptualizing Symptoms

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Acknowledgment

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At the time of this publication, Miriam E. Delphin-Rittmon, Ph.D, served as Assistant Secretary for Mental Health and Substance Use in the U.S. Department of Health and Human Services and the Administrator of the Substance Abuse and Mental Health Services Administration.

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Presented 2022

The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

Strengths-based and hopeful

Inclusive and accepting of diverse cultures, genders, perspectives, and experiences

Healing-centered and trauma-responsive

Inviting to individuals participating in their own journeys

Person-first and free of labels

Non-judgmental and avoiding assumptions

Respectful, clear and understandable

Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

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Agenda

- Reviewing psychosis models.
- Minority Stress Theory
- Gender Identity: A Primer on Terms
- Gender Expansive Patients and Psychiatric Care
- Psychosis/CHR/Gender Expansive Clients: An Intersection of Clinical Profiles.
- Recommendations for Gender Affirming Treatment
  - Reducing stigma and pathologizing
  - Promoting Wellbeing for gender minority clients within medical care models.
- A Case Study from my internship

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Who I am

- PhD candidate in counseling psychology at Boston College and psychology intern at NYU/Bellevue.
- A post-doctoral fellow (to be!) at Weill Cornell Medicine, Westchester campus, Psychotic Disorders Division.
- Former CEDAR trainee from 2019 to 2021. At Bellevue, my primary clinical focus has been psychosis/suicide risk. Rotations in CPEP and several inpatient units.
- Interested in the intersection of a number of areas.
  - Promoting wellbeing in SGM youth/young adults. Interplay of context and health.
  - Role of family in both exacerbating risk and mitigating concerns around SMI.
  - Role of stigma in developing psychosis.

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Who I am (not)

- I identify as a cis-man; I identify with my gender assigned at birth. I am NOT a gender expansive individual.
- I do not speak on behalf of any gender expansive individuals or the gender expansive community.
- These recommendations come from research and clinical experiences since 2017.

Psychosis: A Developmental Perspective

- Psychiatric research and care models are moving away from a categorical approach to psychosis – schizophrenia vs. psychosis.
- Multidimensional approach to psychosis symptoms.
  - Symptoms occur within a range (tools like the SIPS-5).
  - Symptoms co-occur alongside or as a feature of other diagnoses.

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Psychosis: A Developmental Perspective

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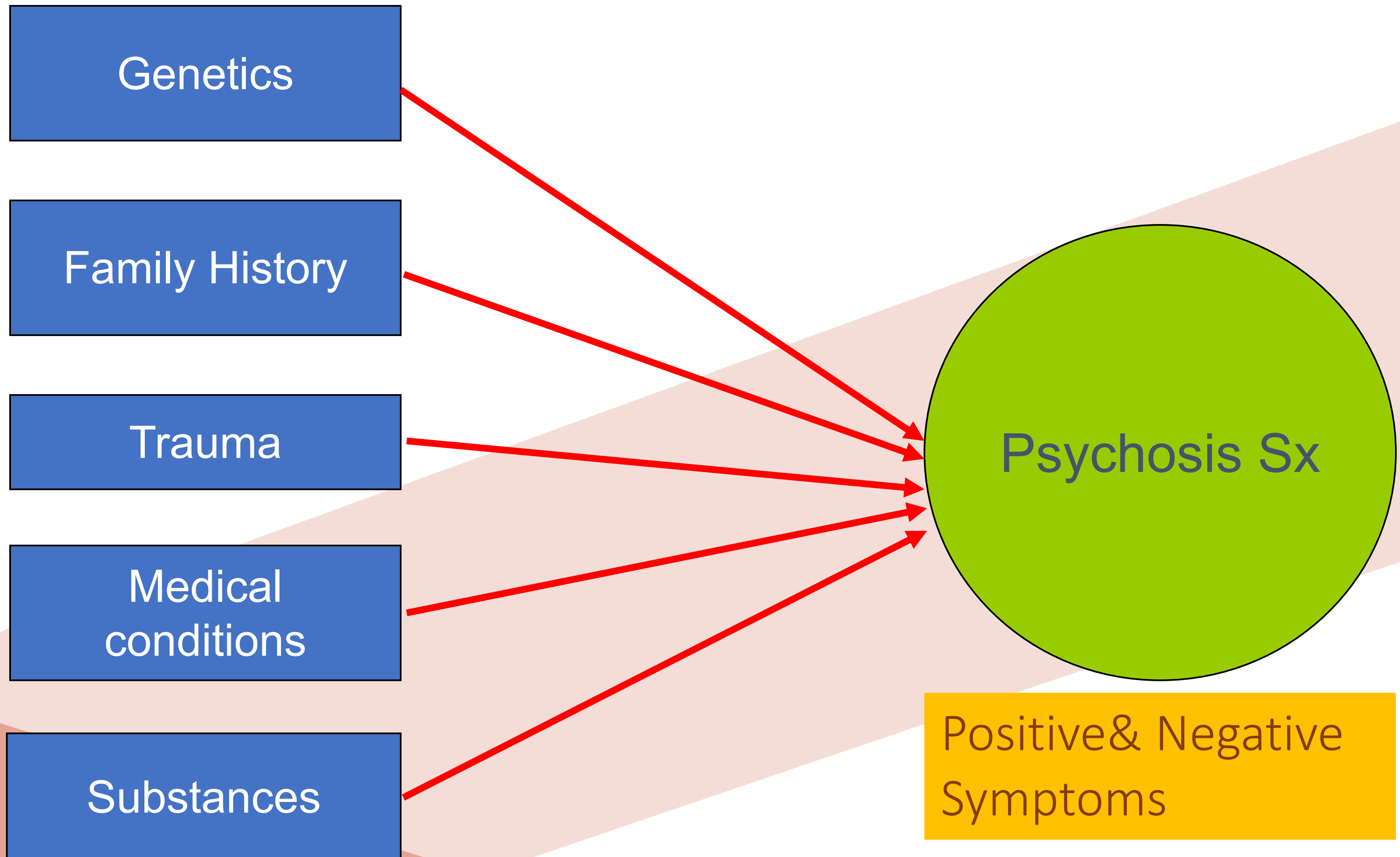
Factors Contributing to Symptoms



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Clinical High Risk for Psychosis

- Supports clinicians in identifying possible signs of early psychosis
- Importance of nuanced assessment; symptoms on a range.
- Lower risk of conversion to FEP for those who receive early intervention

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Minority Stress

- Marginalized social identity associated with negative health outcomes.
  - Static factors
  - Distal stressors (objective/external)
  - Proximal stressors (internal/subjective)
- Role of distal stressors mediated by social trauma, stigma and discrimination
- Increasing evidence underscores the role of minority stress in psychosis development

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Distal Risk Factors

Proximal Stressors

Discrimination

Physical victimization

Structural Policies

Aforementioned static factors

Concealment

Internalized stigma

Anticipated rejection

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MACROSYSTEM
Attitudes and ideologies of the culture

EXOSYSTEM

MESOSYSTEM

MICROSYSTEM

Industry

Social services

Family

Peers

INDIVIDUAL
(sex, age, health, etc.)

School

Church

Mass media

Health services

Neighbors

Local politics

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Moderators
- -Stable characteristics (sex, race/ethnicity)
- -Developmental influences
- -Identity characteristics
- -Stigma-related processes

Distal Stigma-Related Stressors
- -Objective prejudice events (discrimination, violence)

General Psychological Processes
- -Coping/emotion regulation
- -Social/interpersonal
- -Cognitive

Group-Specific Processes
- -Proximal stressors (expectations of rejection, concealment, internalized stigma)

Mental Health Outcomes
- -Internalizing and externalizing psychopathology

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Minority Stress & Psychosis

- Greater prevalence of psychosis-spectrum diagnoses in racial and sexual minority populations (Schwartz, 2014; Meyer, 2003).
  - African Americans four times more likely to be diagnosed with schizophrenia/psychosis in USA.
  - Latinx populations three times as likely to receive psychosis diagnosis.
  - Sexual minority (LGB) individuals exhibit more symptoms of psychosis.
- Emerging evidence linking these disparities to minority stress.

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- Coping/emotion regulation
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Group-Specific Processes
- Proximal stressors (expectations of rejection, concealment, internalized stigma)

Mental Health Outcomes
- Internalizing and externalizing psychopathology

Static Risk Factors

Genetics

Family History

Medical conditions

Substances

Distal Stressors

Discrimination

Physical victimization

Structural Policies

Proximal Stressors

Concealment

Internalized stigma

Anticipated rejection

Psychosis Sx

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Stigma

Alienation from medical system

Obstacles To Early Intervention

Lack of Insight ct and/or family

Clinician reluctance/ lack of info

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Gender Identity: Language Primer

- Sex vs. Gender Identity
  - Also vs. Gender Expression
- Cis → when one's gender aligns with sex assigned at birth
- Trans vs. Non-binary

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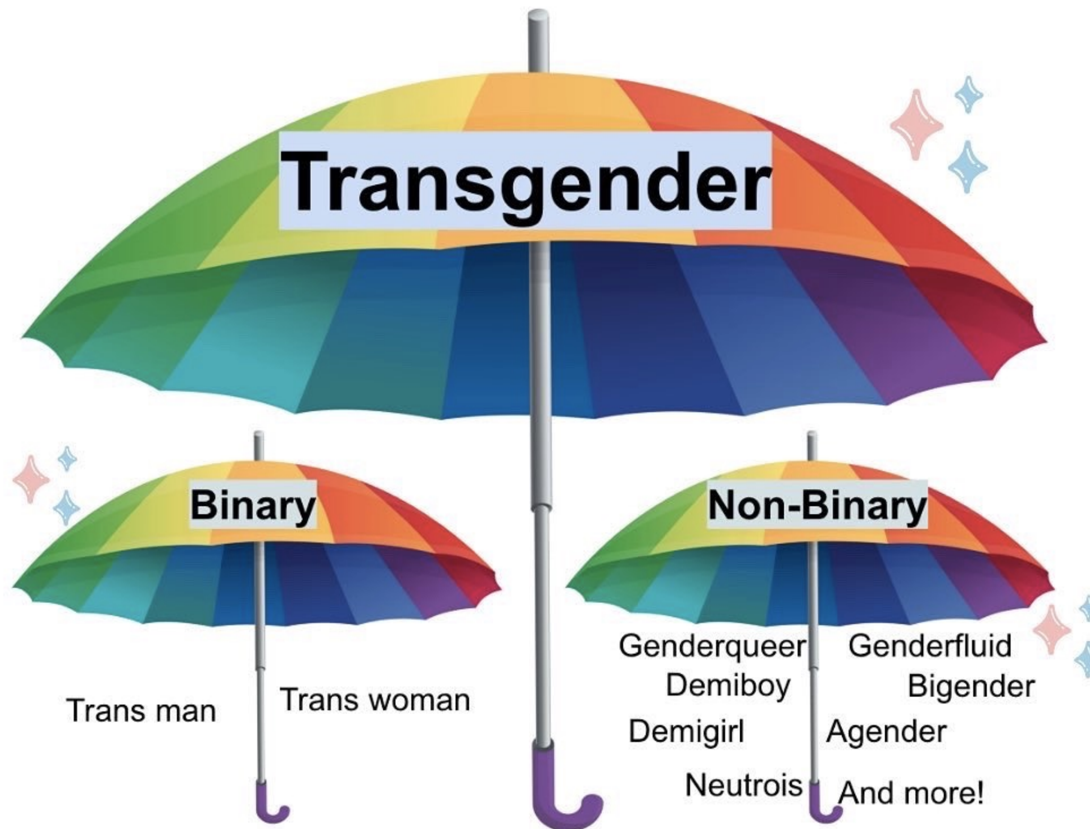

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Trans Health and Risk

- Trans folks at heightened risk for physical harm and discrimination compared to cis populations.
- Trans youth 2.7 times as likely to attempt suicide, compared to cis youth. Similarly elevated risk for NSSI and symptoms of Major Depression.
- Limited research examining psychosis risk
  - One study found more frequent psychosis diagnoses in gender expansive adults (Barr et al., 2021).

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Minority Stress and Gender in Treatment Settings

Due to nascent understandings of trans/non-binary populations, more frequent experiences of microaggressions:

- Breakdown in communication between different staff members. I.e., different staff using different (incorrect) pronouns.
- Use of flattering language around gender expression in notes (e.g., he looks convincingly masculine).
- Changing gender pronouns, either by accident or code switching – though this can be supportive at times for youth.
- Being unable to change client's gender identity in medical files; being forced to use sex as identifier (this is more structural).

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Gender Identity in CHR Treatment

- The CEDAR Clinic at BIDMC/Brookline Center – CHR treatment program
- Observed increase in gender expansive patients.
- We were curious:
  - What has the trend been?
  - Are there any diagnostic/symptomatic differences in these patients? Increased psychotic symptoms? Other trends?

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Table 1: Sample Demographics

	Cis-Gender (n = 110)	Gender Expansive (n = 25)	*T or* χ^2, *P*-value
	Mean (SD) or n (%)		
Age –mean (SD); range	17.79 (3.44) 12-28	20.32 (4.06) 15-29	
Race/Ethnicity			
Asian	8 (7.6%)	0 (0%)	4.05 (p = 0.541)
Black/African American	13 (12.4%)	1 (5.6%)	
Hispanic/Latino/a	12 (11.4%)	1 (5.6%)	
Mixed	14 (13.3%)	2 (11.1%)	
White	52 (49.5%)	13 (72.2%)	
Other	6 (5.7%)	1 (5.6%)	
Gender Identity by year			6.12 (p = 0.106)
2017	32 (94.1%)	2 (5.9%)	
2018	31 (79.5%)	8 (20.5%)	
2019	37 (78.7%)	10 (21.3%)	
2020	10 (66.7%)	5 (33.3%)	

Note:
* $p < 0.05$

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Suicidal and Non-suicidal Self-Injurious Behavior	Cis-gender		Gender Expansive				
	N	%	*N*	%	χ^2	ϕ	*p*
SS Wish to be dead (lifetime)	66	66.0%	20	83.0%	2.736	0.149	0.098
SS Suicidal Thoughts (lifetime)	60	60.0%	20	83.0%	4.603	0.193	0.032*
SS Thoughts w/plan/intent (lifetime)	41	42.3%	15	68.2%	4.834	0.202	0.028*
SS Passive actions (lifetime)	18	18.9%	8	36.4%	3.135	0.164	0.077
SS Intent w/ plan (lifetime)	26	26.5%	9	42.9%	2.220	0.137	0.136
SS Behavior (lifetime)	24	24.7%	7	31.8%	0.661	0.075	0.719
SS Attempts (lifetime)	20	20.6%	4	18.2%	0.066	-0.024	0.797
NSSI Thoughts/Urges (lifetime)	40	41.7%	17	70.8%	6.55	0.234	0.01*
NSSI Self-injurious behaviors (lifetime)	32	33.7%	17	70.8%	10.917	0.303	0.001**
NSSI Other risky behaviors (lifetime)	13	13.8%	6	26.1%	2.041	0.132	0.153

Note: χ^2 Chi-Square co-efficient,
ϕ Phi coefficient, measure of effect size. Higher positive ϕ values indicate greater suicidality as measured per item for the Gender Expansive population.
SS, Suicidality Screener; NSSI; Non-Suicidal Self-Injury
Some missing data for different screening questions; analyses exclude missing data.
* $P < 0.05$

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Findings

- As found in other literature, gender expansive patients endorsed more SI/NSSI compared to cis patients.
- No differences in psychosis risk symptoms, based on SIPS-5 scores
  - Delusions, paranoia, grandiosity, hallucinations, DT
- Trend of increasing proportion of gender expansive patients seeking CHR evaluation.
  - 5.9% (2017); 33.3% (2020).

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Lingering Questions

- To what extent did the binary language around gender obscure these trends prior to 2017?
- Are the trends at CEDAR being seen across the country? To what extent does CEDAR's context (location, affiliations, etc) play a role in this trend?
- Are there similar trends in centers focusing on FEP?

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Gender-affirming Care

- Gender affirming treatment of gender-expansive individuals in medical settings is relatively nascent in the field.
- Long history of pathologizing trans/nonbinary identities – gender dysphoria.
- For years, used sex as a housing determinant, not gender. This has changed in some settings (McLean ART, Bellevue adolescent units).
  - Evidences the divide between medical and contextual lenses.

Movements in Clinical Settings

- Beginning in 2017, CEDAR intake form directly asked clients about gender-expansive identities.
- Bellevue Hospital rooms patients with those of their gender identity.
- If name/sex in system cannot be changed, notes reflect gender identity.
- Discussion with underage patients about documentation.

Gender Affirming Practices at CEDAR

Clinic Practices

- Documentation, emails, trainings

Individual Treatment

- Sharing pronouns, explaining documentation procedures – asking for input.

Engaging with Families

- Confirm with patient first, clarify preferences, if warranted provide psychoeducation, connect to community resources

Schools and Employers

- Similarly, confirm with patient first.

Gender Affirming Practices at Bellevue Hospital

Psychiatric Emergency Room

- Documentation notes gender if not correct in system.

Child/Adolescent Inpatient Units

- Documentation for gender is discussed openly with patients.
- Staff alerted if patient's share gender identity that is different from paperwork (often from C-CPEP).
- Staff introduce themselves with pronouns.

Adult Inpatient Units

- Provide patients gender aligned rooms.
- Provide toiletries aligned with gender.
- Openly discuss the role of gender identity in development - intake, group/individual, psychiatry

Concrete Action for Gender Affirming Care

For Supervisors

"Queering" Supervision - Decenter cis/binary identities and narratives as the "norm".

- What is typical is not what is "normal". It is merely the status quo.

Navigating structural forces – recognizing our role in larger systems.

- Report writing
- Clinical notes
- Communication with other providers/family members.
- Explicit affirmation of clients' gender identity.
- Encourage listening. Clinicians have limits to their expertise.
- Continue critical reflection in supervision..

Case Study -

- A is a 30 yo White, transwoman, domiciled in state supported housing, history of physical trauma, history of incarceration, state hospitalization. Multiple partial hospitalizations at a hospital for queer adults. BIB EMS after attempted suicide in public setting.
- Multiple suicide attempts, chronic high suicidal ideation with a specific plan.
- Psychosis symptoms: believed in elaborate spell system and held grandiose delusions (believed she could assassinate a dictator).
- Diagnosis of Borderline Personality Disorder.

Case Study

- Conceptualizing gender and psychosis.
  - Gender-related trauma and psychosis symptoms. Why delusions and grandiosity?
- Role of SI/SA in this interplay.
  - Building up self in response to trauma. Narcissistic injury of interpersonal
- Gender affirming practices during care.
  - Introduced pronouns at intake – asked openly about coming out process and estrogen regiment.
  - Inclusion of gender affirming policies – room aligned with gender. Allowed razor to shave (under supervision).

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Summary

- Minority stress shapes the experiences and mental health trajectories of gender expansive individuals.
- Although no apparent disparity in psychosis symptoms, there is a greater risk of SI/NSSI.
    - Evidence of more psychosis **<u>diagnoses</u>** in gender expansive individuals.
- Gender affirming care in psychosis treatment can improve patient experience engaging in treatment.
    - Affirmation is individual and it is structural.

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The purpose of the MHTTC Network is technology transfer - disseminating and implementing evidence-based practices for mental disorders into the field.

Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the MHTTC Network includes 10 Regional Centers, a National American Indian and Alaska Native Center, a National Hispanic and Latino Center, and a Network Coordinating Office.

Our collaborative network supports resource development and dissemination, training and technical assistance, and workforce development for the mental health field. We work with systems, organizations, and treatment practitioners involved in the delivery of mental health services to strengthen their capacity to deliver effective evidence-based practices to individuals. Our services cover the full continuum spanning mental illness prevention, treatment, and recovery support.

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