



# Transcending Barriers in Working with Gender Dysphoric Youth on an Inpatient Psychiatric Unit: Case Report

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## Introduction

- Over the past several years, there has been an influx of gender diverse youth with/without gender dysphoria admitted to inpatient psychiatric units.
- This population have **higher risks** of developing depression, anxiety, and trauma which **correlates to an increased risk of suicide and self-injurious behavior** as compared to their cisgender counterparts.<sup>1</sup>
- In the past year, it has been reported that **1 in 3 transgender youth have attempted suicide** with at least **1/2 reporting a two week period of depressive symptoms**.<sup>2</sup>
- 27% of Transgender and 8% of Lesbian-Gay-Bisexual patients report **being refused needed mental health care**, including inpatient hospitalization.<sup>3</sup>
- Demands have increased** to aid needs of gender diverse youth including but not limited to
  - exploration of gender identity
  - coming out and social transitioning
  - treating comorbid mental health conditions related or unrelated to gender.<sup>4,5</sup>

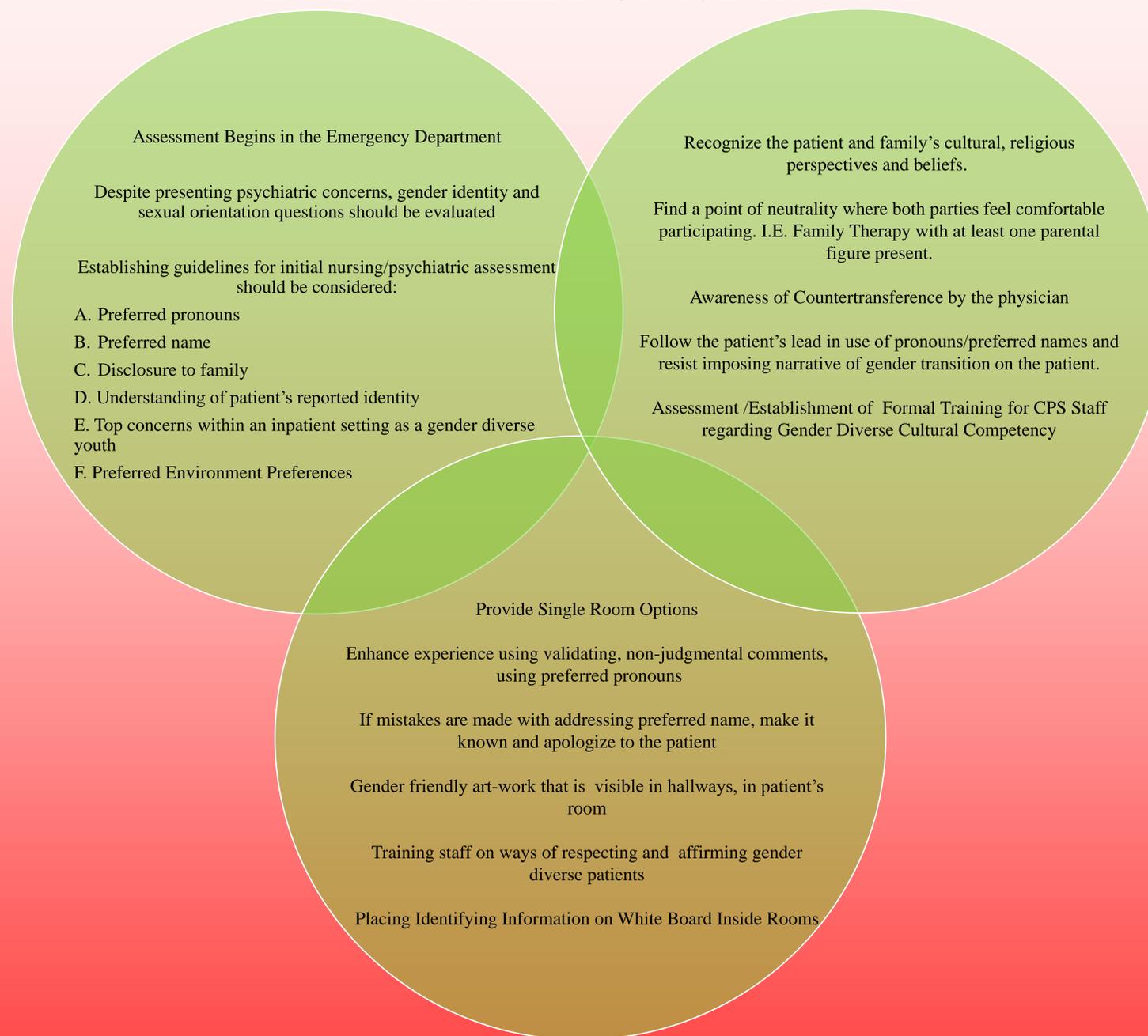
## Purpose

- To add to the growing literature** in inpatient work with gender diverse youth.
- Discuss obstacles faced; techniques utilized to improve problem solving, and provide future considerations** when treating gender diverse youth with gender dysphoria admitted to inpatient psychiatric units.

## Initial History

- 15 year old first generation Immigrant Transgender Male**, presenting for the first time in an inpatient psychiatric unit after attempting suicide via overdose.
- Initial Emergency Department intake: Youth **appeared guarded and timid** unwilling to reveal stressors leading to the suicide attempt.
- Inpatient Psychiatry Assessment: The patient revealed **that this was not the first time a suicide attempt** occurred but the third, each time increasing the amount of medication taken with a desire to "end it all."
- Identified Stressors: **Gender identity in the context of family, faith and culture. The youth had "come out" to family one month prior to most recent suicide attempt with overt rejection due to religious and cultural norms.**
- Past Psychiatric History: SIB via cutting arms starting > 1 year ago.
- Trauma History: Bullying throughout middle and now high school.
- Social History:
  - Family originally from Caribbean Islands. Parents separated when patient was 10.
  - Lives with Mother, two older siblings and aunt. Christian Household.
  - No male figure identified in household. Relationship with family is described as "so/so."

## Recommendations on Affirmative Care of Gender Diverse Youth



## Case Presentation In-Depth

Basic questions asked by ED and Psychiatry Social Worker documented that youth was grappling with his identity, confirmed by his parents.

It was difficult to ascertain what questions and depth of conversation were performed surrounding his gender dysphoria which was a causative factor in his suicide attempt.

Initial psychiatric **nursing assessment questions** were asked with documentation **still using she/her pronouns and again, no mention of preferred name.**

Electronic medical record (EMR) **documentation throughout used non-preferred she/her pronouns without mention of his preferred name.**

During Initial psychiatric evaluation the fellow psychiatrist addressed the youth by his birth name, which **was perceived as demoralizing and emotionally triggering**.....

Being a first generation immigrant raised among American values he identified the latter as his primary culture. However, part of **his ideals still stemmed from his family's culture** as within the contained household many traditions were still upheld.

In an attempt to bridge that gap, our team **conducted family meetings without the youth's presence with the goal of learning cultural perspectives.** Once gathered, a subsequent meeting was performed involving the youth to continue the conversation. The arising challenge was to find a common ground where neither felt targeted or blamed.

**Utilizing DBT based strategies (WHAT, HOW and Interpersonal effectiveness skills) helped youth and his family find a ground of neutrality to begin building a positive relationship.** This laid the foundation of an environment where the youth was able to express his preferred gender—through actions such as wearing desired attire and cutting his long hair, culturally symbolizing femininity and beauty-- in a more accepting family environment....

When the youth entered the psychiatric unit for the first time he described **being fearful and frightened.** To aid with inpatient transition, he was placed in an individual room with a private bathroom.

There was an **informal staff assigned to him for the purpose of observing and establishing rapport.** Similar to his peers, he was assimilated to the daily schedule without bias.

After partaking in milieu and group activities with his peers he reported a sense of comradery, even viewing some as friends. Regarding staff, he mentioned having mixed views as he felt "more safe" with certain personnel than others.

When asked what made the difference, **he remarked that those who were "safer" properly addressed him by his preferred name and pronouns.** Even if they made a mistake they apologized and promptly corrected themselves.

## Conclusion

**Inpatient providers must be prepared to expand the scope of care when working with gender diverse youth as it requires support on many relational levels that includes not only individual but family, community, and systemic interventions.**

This case composite highlights the importance of taking a culturally and environmentally informed assessment of the family when working with a transgender adolescent in an inpatient psychiatric setting.

## References

- Hill, Wesley J., and Michael A. Shapiro. "Transgender Youth in the Inpatient Psychiatric Setting." *Journal of Psychiatric Practice*, vol. 23, no. 4, 2017, pp. 290–293., doi:10.1097/pr.0000000000000244.
- Lambda Legal. (2010). *When Health Care Isn't Caring: Transgender and Gender-nonconforming People.* [https://www.lambdalegal.org/sites/default/files/publications/downloads/whic-insert\\_transgender-and-gender-nonconforming-people.pdf](https://www.lambdalegal.org/sites/default/files/publications/downloads/whic-insert_transgender-and-gender-nonconforming-people.pdf)
- Dickey, Lore, et al. "Mental Health Considerations with Transgender and Gender Nonconforming Clients." *Mental Health Considerations with Transgender and Gender Nonconforming Clients*, 28 May 2016, [transcare.ucsf.edu/guidelines/mental-health](https://transcare.ucsf.edu/guidelines/mental-health).
- Green, Amy, et al. "National Estimate of LGBTQ Youth Seriously Considering Suicide." *Trevor Project*, 27 June 2019, [https://www.thetrevorproject.org/trvr\\_press/national-estimate-of-lgbtq-youth-seriously-considering-suicide/](https://www.thetrevorproject.org/trvr_press/national-estimate-of-lgbtq-youth-seriously-considering-suicide/).
- Haider, Adil H., et al. "Emergency Department Query for Patient-Centered Approaches to Sexual Orientation and Gender Identity." *JAMA Internal Medicine*, vol. 177, no. 6, 2017, p. 819., doi:10.1001/jamainternmed.2017.0906.