See article by Oka et al

Psychiatric Care Considerations for Sexually and Gender Diverse Populations

Alex S. Keuroghlian, MD, MPH[a,b,c,*]

In their newly published study, Oka et al[1] conducted a retrospective chart review of patients who received acute electroconvulsive therapy (ECT) for treatment-resistant psychiatric illness. The investigators sought to understand differences in ECT treatment response between "lesbian, gay, bisexual, transgender, or queer (LGBTQ)" and "non-LGBTQ" patients. They hypothesized that LGBTQ patients would be more likely to have clinical features thought to be associated with less favorable response to ECT, such as posttraumatic stress disorder (PTSD), substance use disorders, personality disorders, and self-injurious behaviors. By extension, they hypothesized that LGBTQ patients may therefore not experience as much clinical improvement from ECT. While the authors reported differences between the two patient samples regarding age, suicidal ideation and attempts, self-injury, PTSD, personality disorders, substance use disorders, and experiencing sexual abuse, they did not observe any differences in clinical responsiveness to ECT.

It stands to reason that there is no a priori basis upon which sexually and gender diverse people would be intrinsically more vulnerable to psychiatric illness than their cisgender straight counterparts, or that psychiatric illness would be less responsive to a given treatment modality based on patient gender identity or sexual orientation. Rather, it is important to emphasize, as the study authors mention in their introduction, that sexually and gender diverse populations experience mental health disparities in the context of minority stress.[2,3] Developmentally, sexually and gender diverse people incur chronic microaggressions, discrimination, and often violence victimization related to their gender identities, gender expressions, or sexual orientations. Over time, these external stigma-related stressors may cause disruptions in general psychological processes, such as coping skills, emotional regulation, interpersonal functioning, and beliefs pertaining to safety and acceptance in society. External stigma can also lead to internalized homophobia and transphobia, expectations of rejection, and identity concealment to prevent mistreatment and abuse. Within the minority stress framework, external and internal stigma-related stressors are associated with increased risk of depressive, anxiety, posttraumatic stress, and substance use disorders, as well as decreased self-care, decreased engagement in health care, and a higher prevalence of physical health problems.

For decades, psychiatry has conceptualized and categorized sexual and gender diversity as psychopathology, including various *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) heuristics that have created, amplified, or perpetuated stigma and discrimination toward sexually and gender diverse people within mental health care, and even throughout society.[4] Advocacy efforts to uncouple oppressed and minoritized communities from the harm of identity-related diagnostic classification continue to this day, with efforts to remove the diagnosis of gender dysphoria from the *DSM-5* altogether.

Importantly, our field has continually wrestled with 2 diametrically opposed conceptual frameworks driving psychiatric practice for sexually and gender diverse people. These consist of identity conversion, erasure, or assimilation to varying degrees on the one hand, and identity affirmation on the other. For example, research indicates that gender identity conversion efforts, or psychological attempts to change a person's gender identity based on societal expectations, are highly prevalent and harmful, including a strong association with suicide attempts.[5,6] In contrast, psychological, social, medical, and surgical gender affirmation are associated with improved mental health outcomes, including decreased odds of suicidal ideation or attempts.[7–11] Health policy debates grounded in this fundamental contest of ideas have reached a boiling point in the United States,[12] with life-and-death implications for sexually and gender diverse populations.

In the context of escalating governmental attacks on the basic rights and health care access of sexually and gender diverse people, attribution of any psychopathology to sexually and gender diverse populations requires more analytic rigor, cautious deliberation, and nuanced contextualization than ever before. We must respond critically to assumptions and statements that sexually and gender diverse people have a greater predisposition to psychiatric illnesses, by diligently examining and naming the basis for such claims. For example, Oka et al report a higher prevalence of personality disorders among sexually and gender diverse people in both the extant literature and their own study sample. A close examination of research on personality disorders among

[a]Department of Psychiatry, Massachusetts General Hospital, Boston, Massachusetts
[b]Department of Psychiatry, Harvard Medical School, Boston, Massachusetts
[c]The Fenway Institute, Fenway Health, Boston, Massachusetts
*Corresponding author: Alex S. Keuroghlian, MD, MPH, 55 Fruit St, Wang Bldg 8th Floor, Boston, MA 02114 (akeuroghlian@partners.org).

J Clin Psychiatry 2022;83(4):22com14579

To cite: Keuroghlian AS. Psychiatric care considerations for sexually and gender diverse populations. *J Clin Psychiatry.* 2022;83(4):22com14579.

To share: https://doi.org/10.4088/JCP.22com14579

transgender and gender diverse people, however, revealed wide variability in study settings, eligibility criteria, gender identity data collection, and measurement of personality disorder symptoms, as well as only cross-sectional study designs with inadequate power and substantial variability in findings.[13]

Systematic, sensitive, accurate, and complete collection of gender identity and sexual orientation data with all patients is necessary for clinical research, patient care, and population health management pertaining to sexually and gender diverse communities.[14] Reporting of these data has been a requirement of the Health Resources and Services Administration's Bureau of Primary Health Care since 2016.[15] Patient data completeness in reporting by health centers is related to the strength of local gender identity and sexual orientation nondiscrimination laws.[16] Detailed guidelines exist for effective data collection protocols in electronic health record systems and clinical workflows[17–19]; however, implementation of these protocols across health care organizations continues to lag.[20] The study by Oka et al features a common pitfall in gender identity data collection: the investigators counted patients as broadly transgender or gender diverse if they selected a gender identity option that was not "female" or "male." Many transgender or gender diverse people, however, identify primarily as female/woman or male/man and will therefore select one of these two response options over the additional options that were made available to them in the Oka et al study's clinical setting.[21] Thus, some transgender and gender diverse patients may have been categorized as "non-LGBTQ" in the study's analyses.

In the discussion section, the authors report that, "curiously," no patients whom they categorized as transgender or gender diverse ("non-cisgender") indicated a heterosexual sexual orientation. They speculate that this finding may be "an artifact of the way the question was phrased," that heterosexual transgender or gender diverse people "may be unlikely to select 'straight (not lesbian or gay)' to describe themselves," or that people undergoing gender affirmation may experience changes in, or be uncertain about, their sexual orientation. Questions about the accuracy of the study's gender identity categorization notwithstanding, this finding is consistent with previous studies showing that transgender and gender diverse people are less likely to endorse being straight or heterosexual.[22,23] Moreover, when transgender or gender diverse people are straight or heterosexual, there is no reason to believe that they would indicate otherwise when disclosing their sexual orientation identities.

In light of the main finding by Oka et al that patients have similar clinically significant improvement with acute ECT series regardless of gender identity or sexual orientation, ensuring equitable treatment access for sexually and gender diverse people within welcoming and inclusive mental health care environments is all the more important. If you build it, they will come. Guidelines exist for implementing organizational strategies and affirming language throughout a clinical practice's policies, procedures, and forms.[24] All staff working within psychiatric care settings require training on foundational concepts and terminology, the relationship of minority stress to adverse mental health outcomes, how to mitigate adverse impacts of implicit bias on rapport and decision making, and sensitive and effective communication.[25–27] Psychiatric practices must strive to build and retain a workforce that reflects the full diversity of the communities they seek to serve in terms of race, gender identity, and sexual orientation. Beyond mental health care organizations, legal nondiscrimination protections are critical at municipal, state, and federal government levels to ensure equity in treatment access, quality, and outcomes, free of discrimination and abuse, for all sexually and gender diverse people.[12,14]

The article by Oka et al points us toward exciting future research directions. Psychiatric treatment implications for sexually and gender diverse populations remain largely understudied. Clinical guidance is beginning to emerge for psychopharmacologic considerations with transgender and gender diverse patients, including use of psychiatric medications with gender-affirming hormone therapy.[28] There is also tremendous opportunity for development of culturally tailored manualized psychotherapy protocols, grounded in principles of minority stress and resilience, for specific sexually and gender diverse communities.[29,30] Finally, studies on the mental health impacts of social determinants and of the rapidly evolving rights landscape for sexually and gender diverse populations are necessary to inform public discourse in a manner that advances mental health equity for these communities in society at large.

Published online: July 18, 2022.

Relevant financial relationships: **Dr Keuroghlian** reports royalties as editor of a McGraw Hill textbook on transgender and gender diverse health care. There are no relevant conflicts of interest.

Funding/support: None.

REFERENCES

1. Oka F, Weischedel K, Bakian A, et al. Treatment-resistant mood disorders in LGBTQ people: a retrospective study of clinical features and response to electroconvulsive therapy. *J Clin Psychiatry*. 2022;83(4):21m14321.
2. Hatzenbuehler ML. How does sexual minority stigma "get under the skin"? a psychological mediation framework. *Psychol Bull*. 2009;135(5):707–730.
3. Hendricks ML, Testa RJ. A conceptual framework for clinical work with transgender and gender nonconforming clients: an adaptation of the Minority Stress Model. *Prof Psychol Res Pr*. 2012;43(5):460–467.
4. Perlson JE, Walters OC, Keuroghlian AS. Envisioning a future for transgender and gender-diverse people beyond the *DSM*. *Br J Psychiatry*. 2021;219(3):471–472.
5. Turban JL, King D, Reisner SL, et al. Psychological attempts to change a person's gender identity from transgender to cisgender: estimated prevalence across US states, 2015. *Am J Public Health*. 2019;109(10):1452–1454.
6. Turban JL, Beckwith N, Reisner SL, et al. Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults. *JAMA Psychiatry*. 2020;77(1):68–76.
7. Turban JL, King D, Li JJ, et al. Timing of social transition for transgender and gender diverse youth, K-12 harassment, and adult mental health outcomes. *J Adolesc Health*. 2021;69(6):991–998.
8. Turban JL, King D, Carswell JM, et al. Pubertal

suppression for transgender youth and risk of suicidal ideation. *Pediatrics*. 2020;145(2):e20191725.
9. Turban JL, King D, Kobe J, et al. Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS One*. 2022;17(1):e0261039.
10. Almazan AN, Keuroghlian AS. Association between gender-affirming surgeries and mental health outcomes. *JAMA Surg*. 2021;156(7):611–618.
11. Lee MS, Almazan AN, Nambudiri VE, et al. Association between gender-affirming hair removal and mental health outcomes. *JAMA Dermatol*. 2021;157(9):1120–1122.
12. Cahill S, Miller AS, Keuroghlian AS. Sexual and gender minority health equity in the Biden administration. *JAMA Health Forum*. 2022;3(2):e214868.
13. Goldhammer H, Crall C, Keuroghlian AS. Distinguishing and addressing gender minority stress and borderline personality symptoms. *Harv Rev Psychiatry*. 2019;27(5):317–325.
14. Keuroghlian AS. Electronic health records as an equity tool for LGBTQIA+ people. *Nat Med*. 2021;27(12):2071–2073.
15. Grasso C, Goldhammer H, Funk D, et al. Required sexual orientation and gender identity reporting by US health centers: first-year data. *Am J Public Health*. 2019;109(8):1111–1118.
16. Almazan AN, King D, Grasso C, et al. Sexual orientation and gender identity data collection at US health centers: impact of city-level structural stigma in 2018. *Am J Public Health*. 2021;111(11):2059–2063.
17. Grasso C, McDowell MJ, Goldhammer H, et al. Planning and implementing sexual orientation and gender identity data collection in electronic health records. *J Am Med Inform Assoc*. 2019;26(1):66–70.
18. Grasso C, Goldhammer H, Thompson J, et al. Optimizing gender-affirming medical care through anatomical inventories, clinical decision support, and population health management in electronic health record systems. *J Am Med Inform Assoc*. 2021;28(11):2531–2535.
19. Goldhammer H, Grasso C, Katz-Wise SL, et al. Pediatric sexual orientation and gender identity data collection in the electronic health record. *J Am Med Inform Assoc*. 2022;29(7):1303–1309.
20. Mayer KH, Peretti M, McBurnie MA, et al. Wide variability in documentation of sexual orientation, gender identity, and preventive health screenings in a diverse sample of US community health centers [published online ahead of print June 30, 2022]. *LGBT Health*. 2022:lgbt.2021.0362.
21. Kronk CA, Everhart AR, Ashley F, et al. Transgender data collection in the electronic health record: current concepts and issues. *J Am Med Inform Assoc*. 2022;29(2):271–284.
22. Kuper LE, Nussbaum R, Mustanski B. Exploring the diversity of gender and sexual orientation identities in an online sample of transgender individuals. *J Sex Res*. 2012;49(2–3):244–254.
23. Katz-Wise SL, Reisner SL, Hughto JW, et al. Differences in sexual orientation diversity and sexual fluidity in attractions among gender minority adults in Massachusetts. *J Sex Res*. 2016;53(1):74–84.
24. Goldhammer H, Smart AC, Kissock LA, et al. Organizational strategies and inclusive language to build culturally responsive health care environments for lesbian, gay, bisexual, transgender, and queer people. *J Health Care Poor Underserved*. 2021;32(1):18–29.
25. Ard KL, Keuroghlian AS. Training in sexual and gender minority health—expanding education to reach all clinicians. *N Engl J Med*. 2018;379(25):2388–2391.
26. McDowell MJ, Goldhammer H, Potter JE, et al. Strategies to mitigate clinician implicit bias against sexual and gender minority patients. *Psychosomatics*. 2020;61(6):655–661.
27. Ard KL, Goldhammer H, Almazan AN, et al. A pilot sexual and gender minority health curriculum for the largest public health care system in the United States [published online ahead of print March 8, 2022]. *Acad Med*. 2022.
28. Turban JL, Kamceva M, Keuroghlian AS. Psychopharmacologic considerations for transgender and gender diverse people. *JAMA Psychiatry*. 2022;79(6):629–630.
29. Pachankis JE. A transdiagnostic minority stress treatment approach for gay and bisexual men's syndemic health conditions. *Arch Sex Behav*. 2015;44(7):1843–1860.
30. Girouard MP, Goldhammer H, Keuroghlian AS. Understanding and treating opioid use disorders in lesbian, gay, bisexual, transgender, and queer populations. *Subst Abus*. 2019;40(3):335–339.