

Care Considerations for LGBTQ Patients in Acute Psychiatric Settings

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Caring for any patient in psychiatric crisis in an acute care setting requires a keen understanding of risk assessment as well as creation and maintenance of a safe and therapeutic treatment environment. The long-term success of acute psychiatric care is also dependent on competent discharge planning. Yet, current psychiatric practices in acute care settings often fail to account for the unique barriers faced by lesbian, gay, bisexual, transgender, and queer (LGBTQ) patients, starting from the moment of

arrival in the emergency room and continuing through discharge from the hospital. This article highlights best practices to address the needs of LGBTQ patients in acute psychiatric settings, including inclusive and affirming communication and culturally competent history taking, risk assessment, treatment environments, and discharge considerations.

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Psychiatric emergencies and inpatient hospitalizations can be periods of significant vulnerability for all patients, but particularly for members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community (1). In acute care settings, interactions that patients have with their care team and their treatment environment can significantly affect their health outcomes and attitudes toward future treatment. Unfortunately, knowledge about how to care for LGBTQ patients has been identified as an area of weakness among clinicians, particularly in acute care settings (1–4).

Patients who identify as LGBTQ have unique needs and circumstances that clinicians must consider in acute psychiatric settings in order to facilitate therapeutic relationships and improve patient outcomes. For many patients in crisis, a visit to the emergency room or an acute psychiatric facility may be their first encounter with the mental health system. Emergency psychiatrists therefore have a unique opportunity to help improve the negative perceptions of health care providers that many members of the LGBTQ community may harbor because of suboptimal or discriminatory treatment in the past (5). This article aims to serve as a resource by providing multiple techniques clinicians can use to improve the care of LGBTQ patients in acute psychiatric settings, including inclusive and affirming communication and culturally competent history taking, risk assessment, treatment environments, and discharge considerations.

CASE EXAMPLE

The following fictionalized case has been written on the basis of the authors' cumulative experience to illustrate

considerations for care of LGBTQ patients in acute psychiatric settings.

Aiden is a 22-year-old who identifies as queer. He first came out to himself as a lesbian when he was 13 and then as transgender at 17. He began to transition his gender presentation and to use male pronouns during his senior year of high school. His family was hostile throughout his coming out process, and when he began to transition, they threw him out of the house. He spent 2 years homeless and living intermittently on the street, where he was physically assaulted several times and sexually assaulted once. Starting at age 14, he had numerous suicide attempts, including an acetaminophen overdose that resulted in admission to an intensive care unit. At age 20, he attempted to jump off an overpass onto a highway but was stopped and wrestled to the ground by a passing bicyclist. He had numerous admissions to several different psychiatric hospitals, however, he never attended any follow-up appointments. He smokes tobacco and marijuana daily and recently started using synthetic cannabinoids. He was most recently brought to the emergency department by the police when law enforcement officers found him standing next to train tracks, refusing to answer any questions.

Inclusive and Affirming Communication Skills

Aiden arrives to triage at an emergency room where he had been seen prior to transitioning. The nurse greets him with his previously given name of Autumn. Aiden also overhears the nurse discussing his case with the emergency room physician using female pronouns. Aiden asks that his name

and gender be updated in the electronic health record but is told that his information must match the identity delineated on his identification card. A few hours later, the consulting psychiatrist, Dr. Jones, enters the room and again addresses Aiden as “Autumn.” Aiden becomes visibly upset and asks again to be called by his preferred name. Dr. Jones apologizes for her mistake and affirms Aiden’s identity by asking for his preferred pronouns. Dr. Jones reassures Aiden that his gender identity and preferred name will be used appropriately throughout the rest of the hospitalization, and that her team will communicate this information to the other physicians and clinicians involved in his care through documentation in Aiden’s medical record and discussion of his case.

Acute psychiatric settings, such as the emergency department, can be tumultuous environments for both caregivers and patients. Often the pace and volume of clinical care lead clinicians to communicate with each other by referring to patients by their room numbers or their presenting symptoms, contributing to a culture where preferred names and pronouns can be easily overlooked (6). Additionally, when clinicians communicate with patients using language that assumes partners, pronouns, or other forms of sexual and gender identity consistent only with the dominant culture of cisgender heterosexuality, LGBTQ patients may not believe that their physician is committed to them and their individual needs (7). Although practitioners may not be aware of some of these mishaps, they can be damaging to the diagnostic and treatment process, because these mistakes often leave LGBTQ individuals feeling invalidated and reluctant to seek care in the future. This disruption in the relationship between clinicians and patients may also lead some LGBTQ patients be less open and forthcoming in the acute care setting regarding their safety and the symptoms they may be experiencing.

Culturally Competent History Taking and Risk Assessment

Dr. Smith, an inpatient psychiatrist, continues Aiden’s assessment and treatment. In addition to her standard psychiatric assessment, she asks about epidemiologic risk factors that disproportionately affect the LGBTQ community, such as prior suicide attempts, substance use, homelessness, and unemployment. She also explores individual psychological risk factors unique to LGBTQ individuals, such as Aiden’s experience of coming out, family and religious community acceptance, and of formal and informal attempts by others to change Aiden’s gender identity and sexual orientation, recognizing that these experiences can be associated with a greatly elevated risk of suicide and other adverse health outcomes.

One of the most important aspects of care to consider in a risk assessment with LGBTQ patients is the patient’s experience of “coming out of the closet,” particularly the accepting and/or rejecting behaviors of the patient’s family and community (see Drescher and Fadus in this issue [8]). It

is critical to assess safety and acceptance in the home and the potential for violence and harassment from family members (9). This assessment is particularly important because LGBTQ identity is one of the strongest risk factors for homelessness among youths. Family rejection may lead to youths running away or being expelled from the home (10). Additionally, understanding a patient’s support or lack thereof from religious and cultural institutions is important in determining risk in an LGBTQ individual, because religion can have significant impacts on the mental health and stress of an LGBTQ patient, particularly if the individual has been subjected to so-called conversion therapies (11, 12). For example, LGBTQ youth who have undergone such conversion therapy have more than twice the rate of attempted suicide (13). Young LGBTQ people who have undergone attempts by their families to change their sexual orientation are also at higher risk for depression, less educational attainment, lower income, and a threefold-higher rate of suicide attempts than youths of more accepting families (13, 14).

To ensure continuity of care, admitting inpatient psychiatrists must also ask patients if they are currently taking or have previously taken gender-affirming hormonal treatments. Professionals who wish to learn more about best practices on continuing hormonal treatment for transgender patients can view the clinical practice guidelines from the Endocrine Society (15) and can learn more broadly about transgender care through the guidelines of the World Professional Association for Transgender Health (16). Psychiatrists should also inquire about non-pharmacological gender-affirming approaches patients may use to help them feel more comfortable, such as chest binders (for hiding breasts), packers (for simulating male genitalia under clothing), cosmetics (for feminizing the patient’s face), or shaving accessories (for unwanted facial or body hair). Loss of access to gender-affirming care may be a driver of despair and suicidal thoughts and helping patients regain access to these products may provide immense relief and help patients feel respected and understood during their inpatient hospitalization.

An important component of the initial assessment is to gain an understanding of the patient’s social support system, particularly if the patient’s family has been rejecting. It is necessary to inquire about friendship groups, romantic relationships, and other sources of support to determine who can best provide corroborative information during the assessment and to evaluate how much help the patient’s community can provide once the patient is discharged. Isolated individuals, or those whose relationship networks are strained, will need more intensive care management after discharge.

Clinicians must also inquire into employment when conducting a social history. Employment often equates to insurance coverage. LGBTQ individuals are more than twice as likely to be unemployed, and therefore uninsured, compared with their heterosexual counterparts (17). This unemployment is often a result of discriminatory hiring

practices; for example, transgender individuals have reported being fired or denied a promotion because of their gender identity (18). Losing employment or not being hired as a result of sexual or gender identity cannot only have profound psychological effects, it can lead to loss of insurance coverage for gender-affirming treatments (i.e., hormone therapy or gender-affirming surgery). For those members of the LGBTQ community who are employed, harassment and discrimination in the workplace are common, including for LGBTQ physicians (18, 19). Studies have found that one in four LGBTQ employees reported workplace discrimination based on their sexual identity (20).

Culturally Competent Treatment Environments

During a team meeting, Dr. Smith ensures that all the staff on the unit understand how important it is to address Aiden by his chosen name and to use male pronouns. She also explains to the staff that it is not appropriate for Aiden to be housed alone in the seclusion room or in a room with only female peers. She also determines that Aiden's chest binder is not a ligature risk and makes sure staff understand that Aiden can wear it on the unit.

There are institutional practices that can be implemented to support a culturally competent treatment environment for LGBTQ patients. Ensuring that intake and registration forms include options outside of the typical gender binary or heteronormative context (i.e., male or female and married or single) can convey openness and inclusivity toward LGBTQ individuals, who may be apprehensive about their visit in the first place.

Furthermore, both clinical and nonclinical staff should be educated on topics such as implicit and explicit biases toward LGBTQ individuals, the stigma and minority stress of identifying as LGBTQ, and preferred names and pronouns. For patients with preferred names that differ from their legal names in the medical record, treatment teams should be cognizant of the legal name but remain committed to using the patient's preferred name and pronoun in clinical interactions with the patient. Staff members should also be coached in making sure their documentation is respectful and reflects the identity of the patient (21). These practices can be carried out in a multitude of ways. For example, at admission, a note documenting the disparity between the patient's legal name and preferred name can be made: "The patient has a female legal name but prefers to be addressed as Aiden. The patient will be referred to as Aiden, and male pronouns will be used." It is important to convey this information early in the hospitalization, because this information often follows patients in the medical record throughout their hospitalization and beyond. Stigmatizing language can also occur from a lack of knowledge by staff members. For example, a staff member may refer to a *packer* as a *dildo*, which is not only incorrect but invalidating.

In addition to medical record recommendations, culturally competent treatment environments include affirming accommodations. In many acute care settings, private

hospital rooms are not available, and shared patient rooms are common. As a result, patients who identify as transgender or gender nonbinary may be misgendered and subject to embarrassing and uncomfortable situations by being placed in a shared room that is not congruent with their gender identity (22, 23).

Ensuring that individuals who are transgender or gender nonbinary be placed with roommates or shared bathrooms that are congruent with their gender identity can be clinically desirable to convey a message of respect and compassion. However, these considerations of inclusivity must be carefully balanced with the clinical needs and wishes of potential roommates and the benefits and risks of disclosing the transgender patient's gender identity. It is also important to consider the risk of aggression or violence toward the LGBTQ patient on the unit. Blocking a shared room so that it is only occupied by a transgender patient can be isolating and can lead to adversarial relationships with peers in the same setting who are subjected to having a roommate. This issue is not easy to resolve, and hospitals will need to develop policies that prioritize the recovery and comfort of LGBTQ patients and that are sufficiently flexible to consider individual patient characteristics and the dynamics of the unit milieu.

LGBTQ-Specific Discharge Planning

Successful engagement in outpatient care after discharge reduces risk of relapse and readmission during the first 90 days after discharge, a period of particularly high risk for suicide (24, 25). Practitioners should be aware of the additional barriers to effective discharge planning faced by LGBTQ patients, however. As sexual minorities, access to certain programs, housing, or other supportive services may not always be available. Although hospitals may have standard programs to which they refer patients, it is important to ensure that these programs are inclusive of LGBTQ patients. For example, clinicians may unknowingly refer patients to faith-based substance use treatment centers that are not accepting of and possibly hostile toward LGBTQ individuals. Similarly, clinicians may not be aware that certain housing or shelter options may have discriminatory policies that would preclude LGBTQ individuals from staying there, which could further deepen the crisis that led to the patient's initial hospital presentation. Clinicians should be aware of the resources available in their communities and should be familiar with therapists, practitioners, and centers in the area with expertise or interest in supporting the LGBTQ community. At minimum, clinicians need to ensure that LGBTQ patients are not referred to homophobic or transphobic community programs. Referring LGBTQ patients to accepting and affirming outpatient environments is likely to lead to better and faster engagement with ambulatory care. Helpful national resources for LGBTQ-affirming information and services include the GLBT National Resource Database (GLBTNearMe.org), the LGBT National Hotline (GLBTHotline.org), and The Trevor Project (TheTrevorProject.org). PsychologyToday.com also maintains

a search function for LGBTQ-affirming mental health clinicians.

CONCLUSIONS

As frontline caregivers in the mental health system, psychiatrists in emergency departments and inpatient units have an opportunity to recognize and address the disproportionate health care challenges faced by the LGBTQ community. Historically, LGBTQ patients have experienced disrespect and hostility in health care settings; restoring their trust is vital for treatment success. Fostering an environment that is respectful, affirming, and welcoming for LGBTQ patients is the first step toward making that happen.

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REFERENCES

- Samuels EA, Tape C, Garber N, et al: "Sometimes you feel like the freak show": a qualitative assessment of emergency care experiences among transgender and gender-nonconforming patients. *Ann Emerg Med* 2018; 71:170–182.e1
- Moll J, Krieger P, Heron SL, et al: Attitudes, behavior, and comfort of emergency medicine residents in caring for LGBT patients: what do we know? *AEM Educ Train* 2019; 3:129–135
- Rerucha CM, Runser LA, Ee JS, et al: Military healthcare providers' knowledge and comfort regarding the medical care of active duty lesbian, gay, and bisexual patients. *LGBT Health* 2018; 5: 86–90
- Shetty G, Sanchez JA, Lancaster JM, et al: Oncology healthcare providers' knowledge, attitudes, and practice behaviors regarding LGBT health. *Patient Educ Couns* 2016; 99:1676–1684
- Lutwak N: Opportunity also knocks in the emergency room: improved emergency department culture could dramatically impact LGBT perceptions of healthcare. *LGBT Health* 2014; 1:149–150
- Ouyang H: A transgender learning gap in the emergency room. *New York Times*, April 2017. <https://www.nytimes.com/2017/04/13/well/live/a-transgender-learning-gap-in-the-emergency-room.html>. Accessed May 28, 2020
- Hobaica S, Kwon P: "This is how you hetero:" sexual minorities in heteronormative sex education. *Am J Sex Educ* 2017; 12:423–450
- Frescher J, Fadus M: Issues arising in psychotherapy with lesbian, gay, bisexual, and transgender patients. *Focus* 2020; 18:262–267
- Ryan C, Huebner D, Diaz RM, et al: Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics* 2009; 123:346–352
- Morton MH, Dworsky A, Matjasko JL, et al: Prevalence and correlates of youth homelessness in the United States. *J Adolesc Health* 2018; 62:14–21
- Beagan BL, Hattie B: Religion, spirituality, and LGBTQ identity integration. *J LGBT Issues Couns* 2015; 9:92–117
- Drescher J, Schwartz A, Casoy F, et al: The growing regulation of conversion therapy. *J Med Regul* 2016; 102:7–12
- National Survey on LGBTQ Mental Health. New York, The Trevor Project, 2019. <https://www.thetrevorproject.org/wp-content/uploads/2019/06/The-Trevor-Project-National-Survey-Results-2019.pdf>. Accessed on Nov 8, 2019
- Ryan C, Toomey RB, Diaz RM, et al: Parent-initiated sexual orientation change efforts with LGBT adolescents: implications for young adult mental health and adjustment. *J Homosex* 2020; 67:159–173
- Hembree WC, Cohen-Kettenis PT, Gooren L, et al: Endocrine treatment of gender-dysphoric/gender-incongruent persons: an endocrine society clinical practice guideline. *J Clin Endocrinol Metab* 2017; 102:3869–3903
- Coleman E, Bockting W, Botzer M, et al: Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *Int J Transgenderism* 2012; 13:165–232
- Charlton BM, Gordon AR, Reisner SL, et al: Sexual orientation-related disparities in employment, health insurance, healthcare access and health-related quality of life: a cohort study of US male and female adolescents and young adults. *BMJ Open* 2018; 8:e020418.
- United States Transgender Survey 2015. Washington, DC, National Center for Transgender Equality, 2015. <http://www.ustranssurvey.org/reports>. Accessed Nov 8, 2019
- Eliason MJ, Dibble SL, Robertson PA: Lesbian, gay, bisexual, and transgender (LGBT) physicians' experiences in the workplace. *J Homosex* 2011; 58:1355–1371
- Sears B, Mallory C: Documented Evidence of Employment Discrimination and Its Effects on LGBT People. Los Angeles, Williams Institute, 2011. <https://escholarship.org/uc/item/03m1g5sg>. Accessed May 28, 2020
- Lampert M: Say, be like, quote (unquote), and the air-quotes: interactive quotatives and their multimodal implications. *Engl Today* 2013; 29:45–56
- Seelman KL: Transgender adults' access to college bathrooms and housing and the relationship to suicidality. *J Homosex* 2016; 63: 1378–1399
- Wuest J: The scientific gaze in American transgender politics: contesting the meanings of sex, gender, and gender identity in the bathroom rights cases. *Polit Gend* 2019; 15:336–360
- Vigod SN, Kurdyak PA, Dennis CL, et al: Transitional interventions to reduce early psychiatric readmissions in adults: systematic review. *Br J Psychiatry* 2013; 202:187–194
- Olfson M, Wall M, Wang S, et al: Short-term suicide risk after psychiatric hospital discharge. *JAMA Psychiatry* 2016; 73:1119–1126