

## Psychiatric admission in adolescent transgender patients: A case series

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### Abstract

Gender dysphoria is defined as a marked incongruence between one's natal gender and gender identity that causes significant distress. It may be present in children but often fades prior to puberty. Gender dysphoria is more likely to persist into adulthood when present in adolescents. Due to the common occurrence of psychiatric comorbidities, gender dysphoria is a contributing factor leading to outpatient and inpatient psychiatric care in children and adolescents. There is currently limited available literature on psychiatric hospitalization and management in transgender adolescents. A PubMed search revealed no case reports regarding psychiatric admission for transgender adolescents with comorbid anxiety, depression, or suicidal ideation. Due to the lack of literature related to psychiatric management of transgender adolescent patients, this case series briefly describes the past medical history, pharmacotherapy, and discharge diagnoses of 5 transgender adolescents admitted to an inpatient psychiatry unit. In this case series, 4 of the 5 patients identified as female to male and ages ranged from 13 to 17 years. All patients had a history of depressive symptoms with suicidal ideation as the key factor prompting admission. All patients were managed on psychotropic pharmacotherapy, and 3 of the 5 patients were on pharmacotherapy related to gender transition. Anxiety, depression, and suicidal ideation were common comorbidities leading to psychiatric hospitalization of adolescent transgender patients in various stages of gender transitioning in this case series.

**Keywords:** gender dysphoria, transgender, adolescents, anxiety, depression, suicidal ideation

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### Background

Gender dysphoria is defined as a marked incongruence between one's experienced gender and gender assigned at birth that causes significant distress.<sup>1</sup> The diagnostic criteria for gender dysphoria for children is different from that for adolescents and adults. To meet diagnos-

tic criteria, at least 2 of the criteria listed in Table 1 must be present for at least 6 months and cause the individual significant distress.<sup>1</sup> Gender dysphoria may be present in children but disappear prior to puberty. An estimated 2.2% to 50% of children with gender dysphoria have symptoms that persist into adulthood, and rates of persistence are higher in natal females compared with natal males.<sup>1-3</sup> Persistence into adulthood is more likely when present in adolescence, and ages 10 to 13 years are crucial for long-term gender identity development.<sup>2,4,5</sup>

Pharmacotherapy and surgery may be utilized during gender transition. Puberty-suppressing therapy is a reversible pharmacotherapy option that delays body changes associated with females and males. Hormone replacement therapy produces physical changes consis-

**TABLE 1: Diagnostic criteria for gender dysphoria in adolescents and adults<sup>1</sup>**

Symptoms
Marked incongruence between one's experienced gender and anticipated or developed sex characteristics
Strong desire to prevent development or be rid of one's sex characteristics
Strong desire for sex characteristics of the opposite gender
Strong desire to be the opposite gender
Strong desire to be treated as the opposite gender
Strong certainty that one has feelings and reactions typical of the opposite gender

tent with the identified gender. Available puberty-suppressing and hormone replacement therapy is listed in Table 2.<sup>6</sup> Sex reassignment surgery is irreversible and not recommended for children and adolescents.<sup>3</sup>

Patients with gender dysphoria have a greater incidence of psychiatric comorbidities that may be socially induced (eg, bullying, lack of friends, minimal family support).<sup>3,7</sup> Internalizing comorbidities, such as anxiety and depression, are more common than externalizing comorbidities, such as oppositional defiant disorder and conduct disorder.<sup>3,7</sup> Adolescents and adults with gender dysphoria have a higher risk for suicidal ideation (SI), suicide attempts, and completed suicide prior to gender reassignment.<sup>1</sup> Due to the common occurrence of psychiatric comorbidities, gender dysphoria is a contributing factor leading to psychiatric care in adolescents.<sup>1</sup> To address the issue of the lack of literature related to psychiatric management of transgender adolescents, this case series describes 5 transgender adolescents admitted to an inpatient psychiatry unit over a 5-week pharmacy resident rotation in child and adolescent psychiatry.

## Case Series

### Case 1

A 13-year-old white transgender female to male (FtM) patient with a past medical history of major depressive disorder (MDD) and unspecified anxiety was admitted due to worsening depression and SI in the context of ongoing family strain. He had begun his gender transition 10 months prior to admission and took ethinyl estradiol/norethindrone, 1 tablet daily, for suppression of menses. He preferred male pronouns and clothing, and his family was semisupportive. The only previous medication trial was sertraline, which was ineffective. He was initiated on citalopram, titrated to 30 mg daily, and participated in psychotherapy during admission. Discharge diagnoses

**TABLE 2: Puberty-suppressing and hormone replacement therapy for transgender patients<sup>6</sup>**

Pharmacotherapy Options	
Puberty-Suppressing Therapy	
FtM or MtF	Goserelin, histrelin, leuprolide, triptorelin
FtM	Letrozole, anastrozole, tamoxifen, medroxyprogesterone
MtF	Spironolactone, finasteride
Hormone Replacement Therapy	
FtM	Testosterone (intramuscular, transdermal, subcutaneous <sup>a</sup> )
MtF	Estradiol (oral, intramuscular, transdermal)

FtM = female to male; MtF = male to female.

<sup>a</sup>Subcutaneous route not approved by the Food and Drug Administration for any indication

included MDD, social anxiety disorder, and gender dysphoria.

### Case 2

A 15-year-old white transgender FtM with a past medical history of unspecified depression was admitted due to worsening depression and SI due to bullying at school related to identifying as transgender. He preferred male pronouns and clothing, and his family was supportive. He desired to pursue hormone therapy in the future and had started his transition a few weeks prior to admission. Previous medication trials included aripiprazole and sertraline, which were no longer effective. The patient was continued on his current medication regimen, fluoxetine 40 mg daily, lurasidone 60 mg with dinner, and trazodone 100 mg at bedtime, and he participated in psychotherapy. Discharge diagnoses included unspecified trauma- and stressor-related disorder, MDD, and gender dysphoria.

### Case 3

A 17-year-old white transgender FtM patient with a past medical history of generalized anxiety disorder and MDD was admitted due to worsening depression and anxiety with SI. He had first identified with the male gender approximately 4 years prior to admission and preferred male pronouns and clothing. His brother and friends were supportive, but his parents were not. Past medication trials included sertraline, fluoxetine, and escitalopram, which were not beneficial. Due to multiple unsuccessful selective serotonin reuptake inhibitor trials, he was initiated on venlafaxine extended release 37.5 mg daily and participated in individual and family psychotherapy during admission. Discharge diagnoses included MDD, unspecified anxiety, parent-child relational problem, and phase-of-life problem.

## Case 4

A 16-year-old white transgender FtM patient with a past medical history of MDD and unspecified anxiety was admitted due to worsening depression with SI since school started. He had initiated his gender transition 2 years prior to admission and had begun testosterone therapy 9 months prior to admission. Known past medications included sertraline, buspirone, and vilazodone. During admission he was initiated on lithium, titrated to 600 mg twice daily, due to a history of manic symptoms that had occurred prior to initiating testosterone therapy. He was continued on testosterone 50 mg subcutaneously weekly, after consultation with endocrinology and a testosterone level (322 ng/dL; testosterone level was drawn on day 1 of admission, but did not result until day 8). Throughout admission he wore a compression garment due to significant distress regarding body image, and he desired a mastectomy. Discharge diagnoses included unspecified bipolar disorder, most recent episode depressed; unspecified anxiety; and gender dysphoria.

## Case 5

A 17-year-old white transgender male to female patient with a past medical history of MDD and binge eating disorder was admitted due to SI and self-harm. She had begun her gender transition approximately 2 years prior to admission; her mother was supportive, but her father was not. She was on spironolactone 50 mg twice daily to block the effects of testosterone. She was on citalopram prior to admission but experienced increased SI after a recent dosage increase. During admission, sertraline 25 mg daily was initiated with a planned increase to 50 mg daily after 1 week with close outpatient follow-up to monitor for SI. She expressed the desire to ultimately have gender reassignment surgery. Discharge diagnoses included unspecified depression, unspecified anxiety, gender dysphoria, and parent-child relational problem.

## Discussion

This case series describes 5 adolescent transgender patients admitted to an inpatient psychiatry unit. Of the 5 patients, 4 identified as FtM, which is consistent with the higher persistence of gender dysphoria in natal females. All patients had a history of depressive symptoms with SI as the key factor prompting admission, often due to psychosocial stressors. It is important to ensure that additional psychosocial stress is not encountered during hospitalization. Addressing patients by preferred name and pronouns is one way to help decrease potential psychosocial stress encountered during admission.

Psychiatric treatment decisions were based on patients' presenting symptoms, previous medications, and respective guidelines for each diagnosis, as applicable. The World Professional Association for Transgender Health published recommendations for the standard of care for transgender individuals covering numerous topics, including the assessment and treatment of children and adolescents with gender dysphoria.<sup>3</sup> However, specific pharmacotherapy recommendations are not made for the treatment of psychiatric comorbidities experienced by adolescent transgender patients.<sup>3</sup>

Of the 5 patients, 3 were on pharmacotherapy related to gender transition (ethinyl estradiol/norethindrone, testosterone, and spironolactone, respectively). The Endocrine Society guidelines for endocrine treatment of transgender patients includes criteria adolescents should fulfill prior to beginning puberty-suppressing or hormone replacement therapy.<sup>8</sup> In this case series, 1 patient was on hormone replacement therapy; however, he had started testosterone prior to the recommended age of 16 years. Another concern of testosterone therapy in this patient was a history of mania. Testosterone can exacerbate manic symptoms, although this is associated with high doses or supraphysiologic blood levels.<sup>8</sup> In this case the patient's testosterone level was slightly below the recommended target of 350 to 700 ng/dL, and he presented with depressive symptoms; therefore, testosterone was not thought to contribute to his presentation, and therapy was continued.

Of the 5 patients, 3 desired surgery for sex reassignment; however, they did not meet the recommended criteria, including age 18 years or older and use of hormone replacement therapy for 12 consecutive months. In addition, during acute psychiatric hospitalization decisions regarding hormone replacement therapy or surgery should not be made. Psychiatric evaluation is recommended, and symptoms should be stabilized prior to making any treatment decisions.<sup>8</sup>

There is currently limited literature available on the management of transgender adolescents admitted to inpatient psychiatry services. A PubMed search revealed 1 case report<sup>9</sup> of gender dysphoria in an adolescent with autism and a case report<sup>10</sup> of 2 adolescents with anorexia nervosa and gender dysphoria. No patients in this case series were diagnosed with an autism spectrum disorder or anorexia nervosa; however, one patient had a history of binge eating disorder. Psychiatric comorbidities are common, and a retrospective cohort study by Reisner et al<sup>11</sup> found that transgender youth patients were more likely to have depression, anxiety, SI, suicide attempt, and self-harm compared with matched cisgender youth (all  $P < .05$ ). In addition, transgender youth were more likely

to utilize inpatient and outpatient psychiatry services ( $P < .05$ ).<sup>11</sup>

## Conclusion

Based on the number of patients admitted during a 5-week resident rotation and known increased risk of psychiatric comorbidities, there may be an increase in psychiatric admissions in adolescents who identify as transgender and experience gender dysphoria. This case series supports the conclusions of previous literature that anxiety, depression, and SI are common comorbidities leading to psychiatric hospitalization of adolescent transgender patients. In addition, this case series shows that admissions may be prompted due to psychosocial stressors, including lack of family support or bullying. No specific pharmacotherapy recommendations exist for treating psychiatric comorbidities in transgender adolescents. At this time the same approach as treating a cisgender adolescent should be taken.

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