Hackensack Meridian Health's Response to the Mental Health Crisis: Advancing the Science of Behavioral Health

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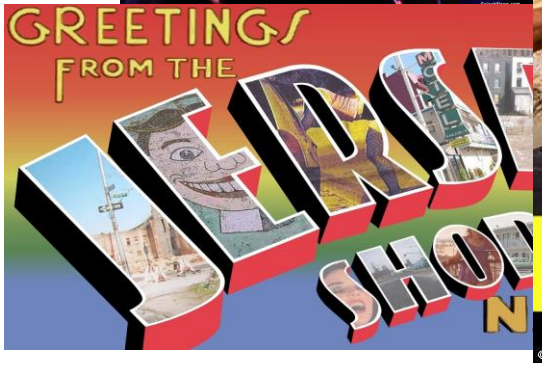
Greetings from the Jersey Shore…



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Acknowledgements

Vice Chair: Adriana Fitzsimmons, MD

Vice Chair (Academics): Stacy Doumas, MD, MBA

Vice Chair (Operations): Eric Alcera, MD

Thank You Front Line Heroes!

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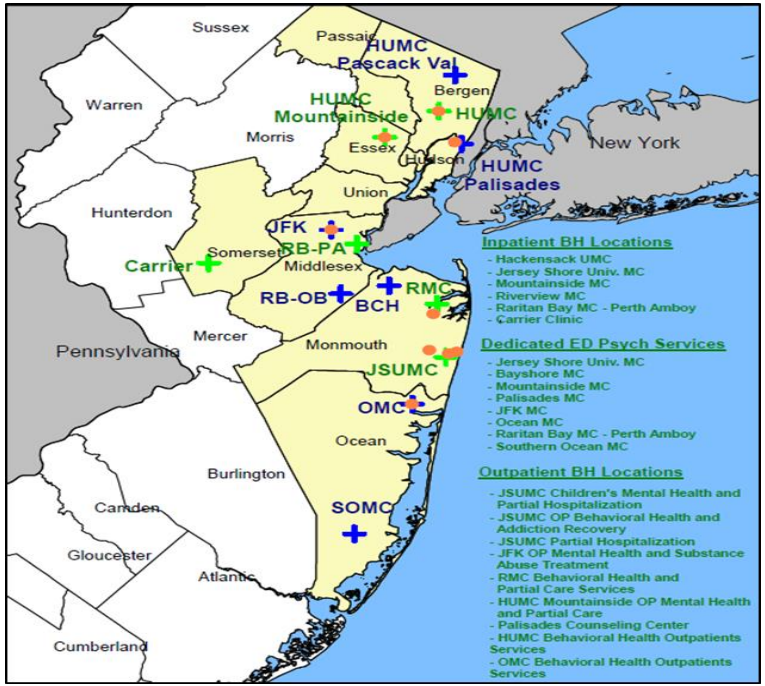
HMH Behavioral Health Continuum of Care



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HMH Strategy for Psychiatry/Behavioral Health

1. Support our current workforce.
    a. Team Member wellbeing
    b. WeCare - try to avoid 2nd Victim phenomenon
    c. Coping with COVID
    d. Physician/Executive concierge experience
    e. Circle of Compassion
2. Use of Technology
    a. Telepsychiatry
    b. Digital Hub
3. Increase access to ambulatory care

HMH Strategy for Psychiatry/Behavioral Health *cont.*

4. Increase workforce, particularly psychiatrists.
    a. HMSOM (UME)
    b. Psychiatric Residencies (GME)
    c. Psychiatric Fellowships (GME)
5. Scientific and Academic programs
    a. Psychiatric Biorepository
    b. Neuromodulation/"Interventional Psychiatry"
    c. Other areas of interest

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HMH NEWS

Network News

Team Member Well-Being

- Social and Emotional Well-Being
- Physical Well-Being
- Spiritual Well-Being
- Financial Well-Being
- Community
- Integrative Health and Medicine: Bringing It All Together

Be a Flu Fighter!

Recognize a Team Member

HMH Maestro

HealthU

https://hackensackmeridianhealth.org/recharge

Team Member Support and Navigation Line

- 24/7 crisis support
- Connection to longer term mental health resources
- Behavioral health navigation program

WeCare: Peer Support Program

"Emotional first aid" for a stressful event, unexpected outcome or other challenge at work

Peer support in a non-judgmental, caring and supportive environment

Provides a "safe zone" to express thoughts and reactions and facilitate effective coping

Provides assurance that emotions and reactions being experienced are normal

Access WeCare through the 24/7 Support and Navigation Line: **844-642-2665**

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Coping With COVID Groups

- Focused on building resiliency and protecting health care providers
- Led by licensed mental healthcare providers
- Conducted at a day/time that works best for the team
- Tailored to the needs of the team
- copingwithcovid@hmhn.org

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Physician/Executive Employee Assistance Program

PHYSICIAN & EXECUTIVE CONCIERGE EXPERIENCE

Dedicated Toll-free Number-
877-445-6880

Priority Call Handling

One-on-one, High-touch
Confidential Support

Thorough assessment of needs
and referrals to all resources
available within the program

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Concierge Work-Life Resources:

Taking the stress out of everyday challenges

- Childcare and parenting support services: Assistance with researching & locating daycare resources
- Convenience services; Personal household needs, pet care resources, home repair referrals, etc.
- Eldercare resources to assist with caring for aging parent. Medical alert services
- Family activities and entertainment referrals
- Life Learning and community education resources, career consulting, and college selection support.

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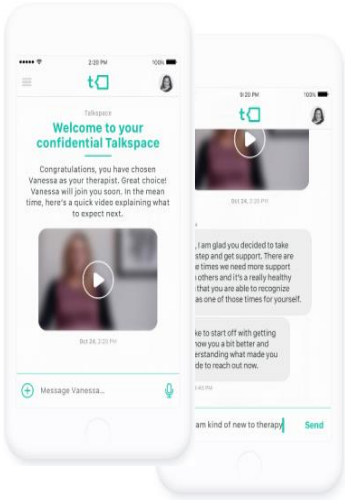
Stress Reduction, Mindfulness and Resiliency Resources: On Demand Access, Digital and Clinically Validated

at the *RIGHT TIME*

talkspace

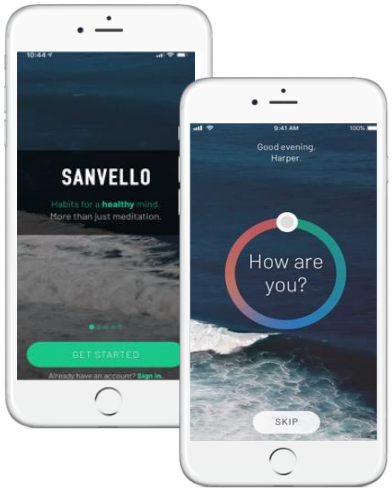
- 5000 licensed therapists across all 50 states.
- Digital provider matching tool.
- Ability to schedule real time video sessions as needed.
- Schedule therapy within hours of selecting a provider – no appointment needed.
- Care engagement and monitoring
- Text, telephonic and video sessions



in the *RIGHT SETTING*

SANVELLO

- On-demand Self Help
- Cognitive Behavioral Therapy (CBT
- Relaxation Techniques and Coping Tools
- Goal Setting & Progress Assessment
- Mindfulness and Meditation Support
- Integrated Goal-setting & Progress Assessments
- Mood & Health Data Tracking Over Time



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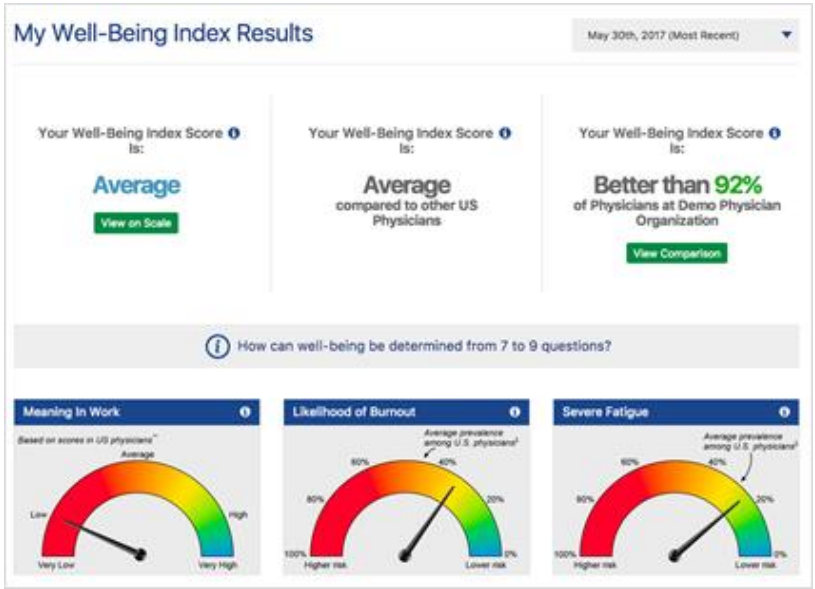
Take the Well-Being Index Survey: *There is Value In This For You*

- Raise your self-awareness
- Get connected to resources to support you and your family
- Compare yourself to your peers, and watch your progress over time
- Provide your input
- Design programming to improve the clinician experience



Link to the Well-Being Index:
https://mywbi.org/hmh

Invitation Code:
HMHWellBeing

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Circle of Compassion

program has raised more than

$2.7 million

Financial assistance provided to more than **1,500 team members**

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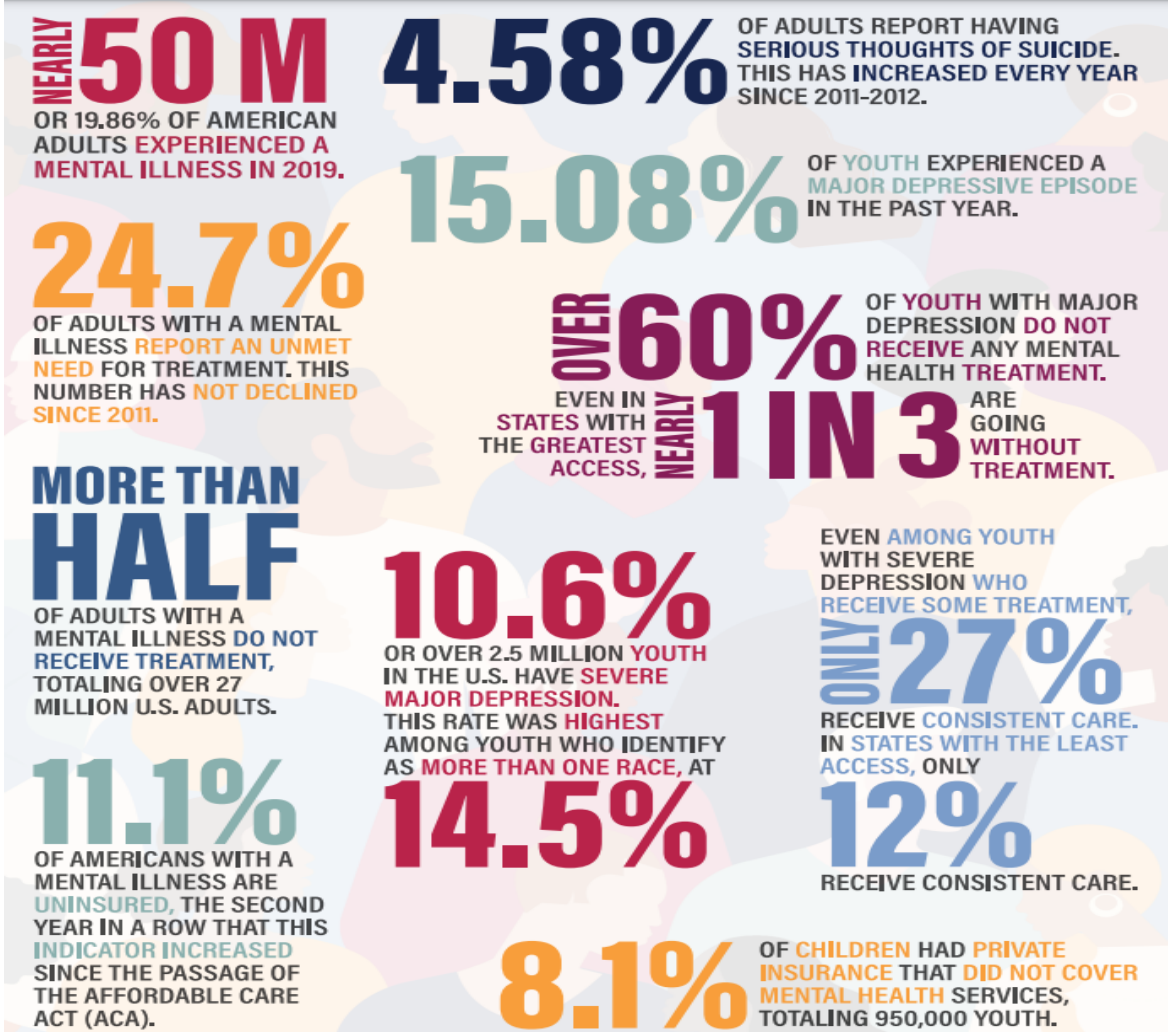

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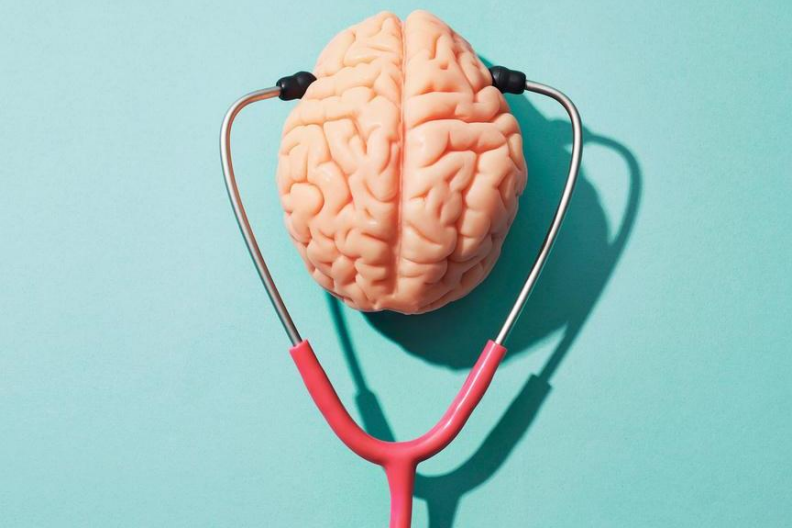
Emergency pediatric behavioral health visits at HMH increased by 47% in the last two years



Pediatric Behavioral Health Summit

Bringing together leading experts to create a roadmap forward for HMH

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More children need emergent (and urgent) mental health

HMH received $5 million in state funding for the planned Pediatric Behavioral Health Expansion Project at the Carrier Campus

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Significant Increases in Behavioral Health Visits Occurring via Telemedicine

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Improving Access to Services

- NJ Pediatric Psychiatry Collaborative (NJPPC) Project - restored full funding from NJ DCF
- Urgent Care Center with Behavioral Health (Pilot)
- Renovating Medical Psychiatry Unit @ HUMC
- Plan to expand, renovate and consolidate our adult inpatient units in the Central Region; Move from general psychiatry to specialized behavioral health units - “We need to centralize to specialize”

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Increased Addiction Recovery Resources

- New outpatient services in Northern Region
- New 48 bed Inpatient Addiction Recovery Unit under construction in Northern Region
- Recovery coaches in three University Medical Center Emergency Departments
- Mental Health First Aid Training for first responders
- Programs to increase availability of Suboxone to patients

Retreat & Recovery at Ramapo Valley

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Expansion of Outpatient Services

- Strategy to Expand with Lower Cost Structure
- Manage services for government (county) run Behavioral Health Services
- Provide contracted psychiatric leadership to community mental health centers
- Explore unique partnerships with mental health centers without increasing administrative/overhead expenses

Improving Access to Psychiatrists

- Telepsychiatry Hubs
- Increased medical student rotations
- Increased Residencies
- Increased Fellowships

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Department of Psychiatry

- Organized as a consolidated Department of Psychiatry across the Central and Southern Regions.
- Central academic hub is JSUMC
- Our physicians are credentialed at all 8 campuses and take a shared regional call

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Sections of the Department of Psychiatry @ JSUMC

- Child & Adolescent Psychiatry - Stacy Doumas, MD, MBA
- Outpatient & Community Psychiatry - Patrick Kane, MD
- **Neuromodulation/Interventional Psychiatry** - Muhammad Abbas, MD
- Geriatric Psychiatry - Robert Stern, MD
- Inpatient Psychiatry - Syed Tirmazi, MD
- Emergency Psychiatry - Ihab Ibrahim, MD
- Addiction Psychiatry - Hugo Franco, MD
- Addiction Medicine - (Aakash Shah, MD)
- Forensic Psychiatry - Adam Sagot, DO
- **Digital Psychiatry** - Daniel Weiner, MD

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Undergraduate Medical Education (UME)

Phase 1 Course - Neurosciences & Behavior (NB)

- 8 weeks

Phase 2 - Psychiatry Clerkship:

- Rotate to JSUMC, OMC, RBMC, or HUMC
- 6 weeks; 12 students per block, increasing to 18-20

Phase 3:

- 2 pathways:
  - P3R - “fast track” into HMH Residency
  - P3 Experiences - electives, research, Masters Degree, etc.

Match Day - March 18, 2022
P3R Track

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Graduate Medical Education (GME) - Residencies

General Psychiatry Residency @ JSUMC

- ACGME-accredited for 18 residents (**now 24**)
- Developed a HUMC “track” which has 8 residents total (2 per year).

General Psychiatry Residency @ OMC (and RBMC)

- ACGME-accredited for 32 residents (**actually, 40**)
- Working on an expansion to add another 8 residents as part of the Reimaging RBMC-Perth Amboy plan.

Graduate Medical Education (GME) - Fellowships

Child & Adolescent Psychiatry Fellowship @ JSUMC

- ACGME-accredited for 6 fellows (3 per year)
- Currently rotating at East Mountain Youth Lodge and the East Mountain School
- Adolescent Inpatient Unit @ Jefferson-Cherry Hill

Addiction Medicine Fellowship @ JSUMC

- ACGME-accredited for 2 fellows
- Currently rotating at Blake Recovery Center
- Rotating at RBMC-PA for Dual Diagnosis

Graduate Medical Education (GME) - Fellowships (cont.)

Geriatric Psychiatry Fellowship @ JSUMC

- ACGME-accredited for 2 fellows
- Planned to start July 1, 2022

Forensic Psychiatry Fellowship @ OUMC

- Submitted to ACGME - accreditation expected April 2022

Future Plans:

- Consultation-Liaison Fellowship? (ACGME Accredited)
- Integrative Psychiatry Fellowship? (non-ACGME Accredited)

Advancing the Science of Behavioral Health

- Continue to expand genetic biorepository (BioR) for patients with psychiatric disorders in partnership with the Center for Discovery and Innovation
  - Also use of commercial genomics - Tempus
- Create partnerships with health systems and universities conducting clinical trials in psychedelics
- Expand Social Determinants of Health initiatives for Behavioral Health

Social Determinants of Health

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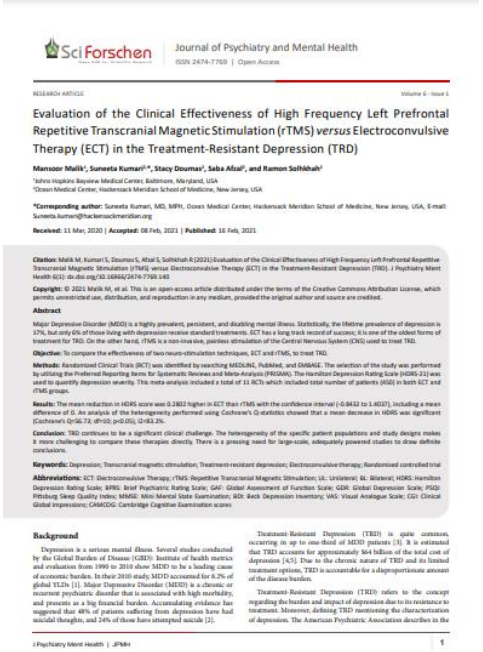
Scientific and Academic Programs

- **Expand Programs in the use of Neuromodulation:**
  - ECT:
    - 3 campuses
    - >6,000 treatments per year
  - Deep Transcranial Magnetic Stimulation (dTMS)
    - 425 patients in 2021
  - IN (and IV) ketamine - 223 patients in 2021



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RESEARCH ARTICLE Volume 6 - Issue 1

Evaluation of the Clinical Effectiveness of High Frequency Left Prefrontal Repetitive Transcranial Magnetic Stimulation (rTMS) *versus* Electroconvulsive Therapy (ECT) in the Treatment-Resistant Depression (TRD)

Mansoor Malik[1], Suneeta Kumari[2,*], Stacy Doumas[2], Saba Afzal[2], and Ramon Solhkhah[2]

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Abstract

Major Depressive Disorder (MDD) is a highly prevalent, persistent, and disabling mental illness. Statistically, the lifetime prevalence of depression is 17%, but only 6% of those living with depression receive standard treatments. ECT has a long track record of success; it is one of the oldest forms of treatment for TRD. On the other hand, rTMS is a non-invasive, painless stimulation of the Central Nervous System (CNS) used to treat TRD.

Objective: To compare the effectiveness of two neuro-stimulation techniques, ECT and rTMS, to treat TRD.

Methods: Randomized Clinical Trials (RCT) was identified by searching MEDLINE, PubMed, and EMBASE. The selection of the study was performed by utilizing the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA). The Hamilton Depression Rating Scale (HDRS-21) was used to quantify depression severity. This meta-analysis included a total of 11 RCTs which included total number of patients (458) in both ECT and rTMS groups.

Results: The mean reduction in HDRS score was 0.2802 higher in ECT than rTMS with the confidence interval (-0.8432 to 1.4037), including a mean difference of 0. An analysis of the heterogeneity performed using Cochrane's Q-statistics showed that a mean decrease in HDRS was significant (Cochrane's Q=56.72; df=10; p=0.05), I2=83.3%.

Conclusion: TRD continues to be a significant clinical challenge. The heterogeneity of the specific patient populations and study designs makes it more challenging to compare these therapies directly. There is a pressing need for large-scale, adequately powered studies to draw definite conclusions.

Keywords: Depression; Transcranial magnetic stimulation; Treatment-resistant depression; Electroconvulsive therapy; Randomised controlled trial

Abbreviations: ECT: Electroconvulsive Therapy; rTMS: Repetitive Transcranial Magnetic Stimulation; UL: Unilateral; BL: Bilateral; HDRS: Hamilton Depression Rating Scale; BPRS: Brief Psychiatric Rating Scale; GAF: Global Assessment of Function Scale; GDR: Global Depression Scale; PSQI: Pittsburg Sleep Quality Index; MMSE: Mini Mental State Examination; BDI: Beck Depression Inventory; VAS: Visual Analogue Scale; CGI: Clinical Global Impression; CAMCOG: Cambridge Cognitive Examination scores

Background

Depression is a serious mental illness. Several studies conducted by the Global Burden of Disease (GBD) Institute of health metrics and evaluation from 1990 to 2010 show MDD to be a leading cause of economic burden. In their 2010 study, MDD accounted for 8.2% of global YLDs [1]. Major Depressive Disorder (MDD) is a chronic or recurrent psychiatric disorder that is associated with high morbidity, and presents as a big financial burden. Accumulating evidence has suggested that 48% of patients suffering from depression have had suicidal thoughts, and 24% of those have attempted suicide [2].

Treatment-Resistant Depression (TRD) is quite common, occurring in up to one-third of MDD patients [3]. It is estimated that TRD accounts for approximately $64 billion of the total cost of depression [4,5]. Due to the chronic nature of TRD and its limited treatment options, TRD is accountable for a disproportionate amount of the disease burden.

Treatment-Resistant Depression (TRD) refers to the concept regarding the burden and impact of depression due to its resistance to treatment. Moreover, defining TRD mentioning the characterization of depression. The American Psychiatric Association describes in the

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Scientific and Academic Programs
(cont.)

- ICARE (SAMHSA grant) - $2.5 million/5 years
- Project HEAL - $1 million/year (NJOAG)
- NJ PPC - $4.2 million/year (NJ DCF)
    - HMH oversees services for 20 of the 21 counties in NJ (8 of the 9 hubs)

INTERDISCIPLINARY REFLECTION ROUNDS: SPIRITUALITY EDUCATION FOR MEDICAL & PHYSICIAN ASSISTANT STUDENTS

Stacy Doumas, MD[1], Ruchika Bhargav, [1,2], Rev. David Cotton[1], David Kountz, MD[1], Ramon Solhkhah, MD [1]
[1] Jersey Shore University Medical Center, [2] Rowan School of Osteopathic Medicine

Hackensack Meridian *Health*

Abstract

- Interdisciplinary reflection rounds (RR) provide spirituality education for psychiatry students at Jersey Shore University Medical Center (JSUMC).
- The aim of this study was to identify whether students from different forms of healthcare training perceived RR differently.
- Results were positive and similar between medical and physician assistant (PA) students.
- Interdisciplinary RR is one well received method of providing spirituality education to PA students.

Introduction

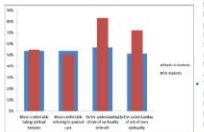
- **Spirituality Education:** Medical students throughout the country receive training to discuss spirituality during patient encounters. 37% of PA Programs do not offer this education.
- **Reflection Rounds:** RR were started at JSUMC in 2014 through a grant from the George Washington Institute for Spirituality and Health to provide this training. RR have since been incorporated into the curriculum of both medical and PA students doing rotations in psychiatry at JSUMC. Education is provided on the role of spirituality in healthcare and health outcomes, the role of pastoral care, and how to take a spiritual history. Through reflection, participants look at how encounters with patients impact them emotionally, spiritually and formatively. Each small group session is co-facilitated by a physician and a chaplain.

Objective

- To identify whether students from different forms of healthcare training (medical vs. PA) perceived interdisciplinary RR differently.

Methods

An anonymous, voluntary online survey is given to medical and PA students who participated in RR at JSUMC via Survey Monkey in order to improve the curriculum. With IRB approval the student surveys from the 2015-2016 and 2016-2017 academic years were retrospectively reviewed.



Results

- Surveys sent to 132 students with 50% response rate including 18 PA and 33 medical students.
- Data from 2015-2016 and 2016-2017 academic years was combined.
- 80% agreed RR was a valuable part of the psychiatry curriculum.
- The majority of both student groups agreed that the frequency and duration were appropriate.
- 79% of medical and 67% of PA students felt that RR should be extended to other rotations.
- The majority of both student groups felt more comfortable taking spiritual histories and referring patients to pastoral care and had a better understanding of the role of spirituality in healthcare outcomes and the role of their own spirituality in the practice of medicine after attending RR.
- They both identified small group format, physician and chaplain facilitator and case presentations as factors that contributed to the usefulness.
- About 50% of each group reported no barriers to participation.
- The greatest barriers reported were time away from clinical duties and discomfort with sharing of personal spiritual history.

Conclusion

- To provide patient centered care, it is imperative to treat the whole person: mind, body and soul.
- The relationship between spirituality/religiosity (S/R) and positive health outcomes is well documented in the literature.
- Research also indicates that patients want to discuss S/R beliefs with their healthcare provider.
- Students must have training on addressing S/R in patient encounters. This is done in a variety of ways in medical schools, but some PA programs have not yet included it in the curriculum.
- The interdisciplinary model of RR studied is one method of providing this training that is well received by both medical and PA students.
- Future research is needed to identify the benefits and best methods for incorporating S/R education into PA programs.

Medical Students	PA Students
"I felt like it was a safe place to reflect on my emotions that came up as we were working with patients."	"I feel that reflection rounds are a good addition to the program."
"Psychiatry is an emotionally difficult rotation and the chance to decompress through group talk was therapeutic."	"I felt it offered greater insight into the psyche of the patient."
"I now offer to pray with patients and will do so if they say they would like that."	"I now consider spiritual preferences when talking to my patients."

Acknowledgement
Thank you to all students who have participated in Reflection Rounds and the survey. Thank you to GWish for spirituality education training.

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Gender Diversity in Psychiatry CME Programs: Are Female Voices Heard?

Stacy Doumas, MD[1], Pooja Shah, MD[1,2], Manali Lodaya, MD[1], Siana Ziemba [3], Ramon Solhkhah, MD [1]
1 Department of Psychiatry, Jersey Shore University Medical Center, 2 S.S.R. Medical College, 3 Rowan School of Osteopathic Medicine

MERIDIAN HEALTH

Background

The American Psychiatric Association created a task force on women in 1972 to explore the concerns of female psychiatrists. In 1979, psychiatrist, Dr. Kenneth Solomon, documented the presence of sexism and professional chauvinism in male psychiatrists (1). Gender roles have evolved since that time with half of medical students and psychiatry residents now female, but still there are fewer women in academic psychiatry and in leadership roles. Data suggests they are also underrepresented at speaking programs and on academic committees (2,3,4). Female faculty members account for 56% of the psychiatric faculty (psychiatrists, psychologists, APNs) employed primarily at Jersey Shore University Medical Center (JSUMC) and 44% of the faculty in psychiatry for the entire Meridian Health System. A sampling of attendance at Grand Rounds and Symposia for the department also showed a female majority. When Rock Health, a digital healthcare initiative, looked at speaker demographics from 11 of the 12 largest medical conferences from 2013 they found that women at best were just 38% of the faces on the stage.

Objective

Our aim was to see to what extent female speakers were represented in Continuing Medical Education (CME) Programs in the Department of Psychiatry at JSUMC between 2011 and 2016.

Methods

CME paperwork from Grand Rounds and Symposia held by the Department of Psychiatry from 2011-2016 was retrospectively reviewed. For each program, the invited speaker's gender and affiliation as either an internal (Meridian) or external (non-Meridian) faculty member were noted. Resident activities such as case presentations and journal club were excluded as these were assigned based on a rotation schedule, not by invitation. No further information was collected. Information was compiled by calendar year.

Results

Results for invited speakers in the Department of Psychiatry at JSUMC.

Year	Total Speakers	Male Speakers	Female Speakers
2011	25	13	12
2012	19	11	8
2013	25	17	8
2014	29	19	10
2015	30	19	11
2016*	18	11	7

*only partial data for 2016 available

Conclusion

Despite the fact that females make up the majority of the Department of Psychiatry at JSUMC and the audience for CME activities, males constitute the majority of speakers, especially speakers from outside institutions. From 2011-2016 there have been an average of 38% female speakers. Although this is far from ideal, we are in line with Medicine X, the most gender diverse of the large international medical conferences looked at by Rock Health in 2013 (2).

There are many contributing factors to this lack of gender diversity that may include the following:

- fewer women in academic positions available to speak
- women being more likely to turn down speaking invitations
- lack of (or perceived lack of) public speaking skills by women
- women being less proactive in seeking speaking opportunities
- women invited to speak less frequently than male colleagues

Further research is needed in this area both in psychiatry and other medical fields as well as solutions to achieving medical speaker gender equality. This should include:

- female speaker databases
- programs to develop presentation skills and keep women engaged as speakers
- engagement of females on conference planning committees

Acknowledgements
Thank you to all of our female speakers!

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Using Inhaled Loxapine to Manage Agitation Induced by Crystal Methamphetamine & GHB

Victoria Pappas-Villafane, APN [1], Stacy Doumas, MD [1], Ramon Solhkhah, MD [1]
[1] Department of Psychiatry, Jersey Shore University Medical Center

Hackensack Meridian *Health*

LEARNING OBJECTIVES

1. Recognize substance induced agitation in patients in the emergency department (ED).
2. Identify the role of inhaled loxapine in managing substance induced agitation.

CASE PRESENTATION

- A homosexual male in his 40s with a history of HIV was brought to the ED overnight by police after he called them multiple times paranoid.
- He had a long history of polysubstance abuse and reported smoking crystal methamphetamine in the afternoon and drinking γ-hydroxybutyrate (GHB) with alcohol in the evening.
- He was agitated and restless with inappropriate disrobing, sexual preoccupation and an inability to follow directions, sleep or eat.
- Initial management involved lorazepam 2mg IV push with minimal effect except to slow pacing.
- Lorazepam PO was given 6 hours later with no impact on his agitation, sleep or mental status.
- Inhaled loxapine (Adasuve) was then given and within 40 minutes he was calm and able to sleep.
- He woke agitated 3 hours later and lorazepam 2mg PO was given with effect.
- He slept 4 more hours and woke amnestic to the described events. He was calm, cooperative with goal directed thoughts and no further psychosis.
- He was discharged home with follow up with Addiction Recovery Services Intensive Outpatient Program and his Primary Care Physician.

GHB: THE FACTS

PHYSICAL EXAMINATION

- **Urine drug screen** positive for amphetamines and benzodiazepines (after lorazepam given in ED)
- **CBC** and **CPK** unremarkable
- **Blood alcohol level** was not checked
- **EKG** unremarkable
- **CT Brain** without contrast unremarkable

LABORATORY DATA

- **Mental Status Exam** showed evidence of pressured speech, increased motor activity, mood lability, flight of ideas and paranoid delusions.
- **Vital Signs** were significant for BP 136/85 and P 115.

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CONCLUSIONS

- Patients often abuse multiple substances at the same time.
- **GHB:**
  - Intoxication presents with coma 64% of the time (often in alcohol co-users) and agitation 23% of the time.
  - At lower doses it produces mixed stimulant/sedative effects and at higher doses causes sedation and coma.
  - Withdrawal symptoms include anxiety, insomnia, tremors, tachycardia, agitation, hallucinations and delirium.
- **Crystal methamphetamine:**
  - Intoxication can present with psychosis, mania, irritability, insomnia, restlessness and tachycardia.
  - Behaviors are usually self-limited, but if severe they can be managed with behavioral and pharmacological interventions to prevent harm to patient and staff.
- **Management:**
  - Adequate use of benzodiazepines and the addition of an antipsychotic medication as needed will reduce agitation and psychosis and enable patients to sleep.
- **Inhaled loxapine:**
  - Is a rapidly acting antipsychotic medication with a route of administration that is noninvasive and allows the patient to be an active participant in treatment.
  - In clinical trials for agitation it is seen to be effective in patients with bipolar disorder and schizophrenia.
  - One case series was found in the literature describing the use of inhaled loxapine for 14 patients with dual diagnosis. It was effective, rapid, well tolerated.
  - Caution needs to be used in emergencies when patients are refusing medication and when active airway disease is present (contraindication).

SUMMARY

- Inhaled loxapine may be an alternative to other medications for substance induced agitation.

Gender Dysphoria in Adolescents: Addressing the Whole Patient

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LEARNING OBJECTIVES

1. Identify Gender Dysphoria (GD) in Adolescents according to DSM 5 Criteria.
2. Recognize common gender identity terms.
3. Discuss common psychiatric comorbidity associated with GD.
4. Use an integrative approach with patients with GD so you can better address their well-being.

CASE PRESENTATION

- 14 year old adolescent presents for outpatient psychiatric evaluation for depression, anxiety, and gender dysphoria.
- His assigned gender at birth was female but by the age of 12 years he developed gender dysphoria with a strong desire to be male. He is socially living as a male as of 3 months prior to date of presentation. He wears clothing to hide female secondary sexual characteristics and expresses a desire for cross-sex hormone treatment and possible gender reassignment surgery as an adult.
- 2 years ago he developed depression, panic attacks, social anxiety, and generalized worries. He experiences bullying in school. He has had suicidal ideation in the past, but without intent or plan.
- He has had one crisis visit, but no history of hospitalizations, self-harm, or psychotropic medication trials.
- He is engaged in individual cognitive behavioral therapy and is bright with good family support.
- After his evaluation, he was started on a SNRI (selective serotonin reuptake inhibitor) antidepressant for mood and anxiety in addition to therapy.

Gender Identity Term	Definition
Gender Dysphoria	Incongruence between one's experienced gender and assigned gender for at least 6 months.
Gender Fluidity	Shifting physical, mental, and emotional gender expression between masculine, feminine, and other non-binary categories.
Transgender	A person's gender identity is different from the one assigned at birth (i.e. a male at birth identifies as female).
Cisgender	A person's gender identity is the same as the one assigned at birth (i.e. a male at birth identifies as male).
Queer	An umbrella term that includes anyone outside of societal norms of gender or sexuality. Used as discriminatory in the past, but has been reclaimed by those who identify with it.
Genderqueer	Gender non-binary identities that are neither exclusively male nor exclusively female.
Intersex	Conditions of being intermediate between male and female, can be from birth, during development, or during a change of sex.

CONCLUSIONS

- Although the terminology is still evolving, the DSM describes Gender Dysphoria in Adolescents and Adults (GD) as incongruence between one's experienced gender and assigned gender for at least 6 months that includes a desire to be the other gender, be treated as the other gender and have the secondary sexual characteristics of the other gender only. Each of these was experienced by this patient.
- The DSM 5 also recognizes that for some people, gender may be "some alternative gender different from one's assigned gender", recognizing the non-binary nature of gender. This is a change from DSM IV that used the term "Gender Identity Disorder" and ICD 10 which uses "transsexualism".
- Psychiatric comorbidity is commonly seen in GD including depression, anxiety, self-injurious behaviors, behavioral problems, and suicidal thoughts and attempts. This patient suffers from internalizing symptoms (depression, anxiety, suicidal thoughts). Behavioral problems, emotional difficulties and poor peer relationships may be partially related to peer acceptance of gender non-conforming youth.

RECOMMENDATIONS

- Care for adolescents with GD needs to be multidisciplinary. The Affirmative Care Model does not view transgender identity as pathological. The clinician supports the person to live in the gender that is most comfortable to them.
- A comprehensive psychological evaluation is usually conducted to identify/treat underlying mental health concerns or effects of trauma and to explore gender and sexual identity. Group and individual therapeutic programs are often indicated as well as family interventions.
- Medical treatments such as hormone blockers, cross-sex hormones and gender reassignment surgery may be indicated. In this patient, cross-sex hormones are desired and will be explored further with the family.

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Comments & Controversies

Thank You!

Any questions??

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