



# Identify, Engage, Understand: Supporting Transgender Youth in an Inpatient Psychiatric Hospital

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## Abstract

Transgender adolescents may require for inpatient psychiatric care, and have unique healthcare needs and can face barriers to quality care. This study sought to address limited understanding of the inpatient experience of transgender adolescents. This study uses qualitative methods to gain insight into the experience of transgender adolescents and psychiatric care providers on an adolescent inpatient psychiatric unit in the northeast United States. Semi-structured interviews were conducted with patients (9 total, ages 13–17) and unit care providers (18 total). These interviews were recorded, transcribed, and analyzed using inductive thematic analysis. Patients and providers generally reported a supportive inpatient environment. Factors that contributed to this environment were efforts by care providers to respect patients regardless of gender identity, to use patient's preferred identifiers, and to acknowledge mistakes in identifier use. Barriers to consistently supportive interactions were also identified, including a lack of consistent identification of a patient's transgender identity in a supportive manner during the admission intake, challenges associated with the presence of birth-assigned name and gender within the care system (e.g. in the electronic medical record, identifying wristbands, attendance rosters), and a lack of formal training of care providers in transgender cultural competency. Interviews also provided insight into how providers grapple with understanding the complexities of gender identity. Findings suggest that gender-affirming approaches by providers are experienced as supportive and respectful by transgender adolescent patients, while also identifying barriers to consistently supportive interactions that can be addressed to optimize care.

**Keywords** Transgender · Gender identity · Affirmative model · Inpatient experience · Adolescents

## Introduction

Transgender adolescents are individuals who experience marked incongruence between their gender assigned at birth and their gender identity [1]. Adolescents who experience

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dysphoria related to this incongruence may meet criteria for the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis of “gender dysphoria in adolescents and adults” [2].

Recent studies suggest that approximately 0.6% of the US population identifies as transgender, with younger individuals being more likely to self-identify as such [3]. Among adolescents, prevalence of transgender identity is roughly 1% [4, 5].

Transgender adolescents suffer high rates of internalizing psychopathology [6–9], thought to be secondary to minority stress and dysphoria associated with one’s body developing incongruently to one’s gender identity [1]. Up to 80% of transgender adolescents are victims of bullying [10], and poor peer relations have been identified as one of the greatest predictors of internalizing problems [11]. Family nonacceptance has been found to be a significant correlate of suicidality [12–14]. Due to high rates of anxiety and depression, transgender adolescents may present for inpatient psychiatric care. Despite an exponential increase in research regarding transgender adolescents [1], limited literature exists on their experiences on inpatient psychiatric units [15, 16].

Understanding the experience of transgender adolescents in inpatient settings is important given their specific minority status. The challenges of racial minorities in mental health settings has been described in detail [17, 18], and more recently for LGBT individuals [19]. Transgender adolescents would on the face of it appear to be at particularly high risk of encountering challenges in systems that are not optimized to recognize, validate and support their identities. This study seeks to address the need for better understanding of the experiences of transgender adolescents and psychiatric care providers, utilizing qualitative research methods to identify areas where existing approaches are both adequately supporting, but also failing to meet the clinical needs of this vulnerable population.

## Methods

To better understand the inpatient experience of transgender adolescents, we undertook an in-depth, multi-informant qualitative study. Our choice of qualitative methodology was informed by research aims, which sought to define the dimensions of the inpatient experience seen as salient for transgender adolescents. A qualitative approach allowed for obtaining such data and the description of themes not well-defined in the current literature, and which could not have been defined and assessed a priori. A multi-informant perspective was utilized to understand the experience of transgender adolescents and to understand how care providers perceive and work to support these experiences. This approach allowed for the description of multiple perspectives regarding the same aspect of the inpatient experience, and the opportunity to highlight areas of concordance and divergence in care provider and patient perspectives.

## Population and Setting

Participants were patients who self-disclosed a transgender identity at any time during their admission to the 23-bed adolescent inpatient psychiatric unit at a major academic hospital in the northeast US. All patients initially presented to the emergency room prior to admission. Admissions were both voluntary and involuntary. Participants also included unit registered nurses, milieu counselors, and social workers. Unit psychiatrists were not interviewed because of limited number and their role in study implementation.

## Recruitment and Data Gathering

Approval was obtained from the Institutional Review Board of the participating hospital system. Informed assent was obtained from patient participants, explaining study procedures and the voluntary nature of their participation. Patients who agreed to participate were then asked for permission to contact their legal guardian for informed consent. Informed consent was also obtained from care providers who participated voluntarily.

Data was gathered using one-on-one open-ended interviews, with separate questions for provider and patient participants. Patients were interviewed at various points during their admission. After being asked the initial question, participants were encouraged to elaborate using simple prompts and occasional follow-up questions. Interviews were recorded electronically and transcribed.

## Analysis

Analysis was conducted in a preliminary way in parallel with data gathering. As new interviews were conducted and transcribed, this material was compared with existing interviews, and recruitment continued until no new themes were emerging amongst care providers or patients, and saturation appeared to have been achieved. For patient interviews, 9 were completed, which represent the total consenting sample over the 1 year recruitment period. Formal analysis involved a process of reading each transcript, and coding responses with descriptive labels using QSR NVivo 9 software. Using an iterative process, labels were organized into overarching themes, and labels describing similar content were merged. A hierarchy was established describing emergent relationships between various themes. After a final thematic hierarchy was established, validity of the overall narrative was assessed by reviewing results with a non-participant, gender diverse individual who would otherwise have met inclusion criteria for the study.

## Results

A total of 18 interviews were conducted with care providers: 8 registered nurses (RN), 6 milieu counselors (MC), and 4 social workers (SW). Nine patient (PT) interviews were conducted. Patients endorsed a range of gender identities, and reasons for admission also varied (see Table 1).

Several themes emerged during data analysis, broadly grouped into three overarching categories. First is matters of identification, including how care providers approach identifying transgender patients and how patients approach identifying themselves. Second is matters of engagement, including how care providers and patients interact, and barriers to consistently supportive interaction. Third is matters of understanding, including how care providers grapple with understanding the complexity of gender identity and the role patients play in helping providers understand. The results were reviewed with a non-participant gender diverse adolescent, who considered the overall structure to be plausible and largely consistent with their own experience of inpatient care, and no changes to the overall structure were suggested.

## Identification of Patients with a Gender Non-conforming Identity

Care providers generally felt patients' transgender identities were consistently identified during the admission nursing intake, either conveyed in charted notes from the emergency room or

**Table 1** Patient participants demographic information, including age, birth-assigned gender, gender identity as stated by the patient, preferred identifiers, and presenting reason for psychiatric admission

	Age	Birth-assigned gender	Identified gender (as stated by patient)	Preferred name / pronouns	Reason for admission
PT1	17	Male	“Somewhat in the middle”	Female / she, her	Schizoaffective disorder, command auditory hallucinations to harm self
PT2	13	Female	“I’m a trans man”	States “I don’t really think names have gender” / he, him	Mood disorder, unspecified; suicide attempt by overdose
PT3	17	Female	“A boy”	Male name / he, him	Major depressive disorder, gender dysphoria; suicidal threat in setting of argument with parents
PT4	16	Female	“Male”	Gender neutral name, notes “can be both” / male or neutral	Major depressive disorder, gender dysphoria; behavioral outbursts following altercation with grandmother
PT5	15	Male	“A woman”	Gender neutral / she, her	Major depressive disorder, gender dysphoria; suicide attempt by overdose
PT6	16	Female	“Male”	Gender neutral name, though notes “more males use it than females” / he, him	Mood disorder, unspecified; behavioral outburst following altercation with parents
PT7	17	Male	“Female”	Female / she, her	Self-inflicted cutting due to gender dissatisfaction with body
PT8	17	Male	“Gender fluid, currently female”	Gender neutral name, which is same as given name / no preference	Suicidal ideation related to gender dysphoria
PT9	15	Female	“Trans Male”	Gender neutral nickname derived from given name, notes “I think it’s more masculine” / he, him on the unit but at home she, her	Suicidal ideation related to gender dysphoria

communicated directly by patients during the intake. While all nursing participants indicated asking patients about their gender identity was not a standardized question during the intake, all felt there was ample opportunity for patients to independently express their identity during the intake, and that patients felt comfortable doing so:

RN3: “...we try to make them feel as comfortable as possible when they first come on the unit...usually they’re in private with a nurse...they have time to do that, they just tell you”

Of the 9 patients interviewed, 8 stated care providers were aware of their transgender identity because they had independently spoken up to communicate their identity. The most common time was during the admission nursing intake, in the context of correcting care providers not using preferred names/pronouns (identifiers):

PT2: “...I didn’t tell them I was trans straight up, I was like my name is this, and then they messed up pronouns. I just tried to correct them”

Some patients did not speak up during the nursing intake, contrasting with the generally held view of care providers that all patients would do so. Most patients did eventually speak up, some during their initial evaluation with the psychiatrist, and some a few days into their hospital stay when they felt more comfortable with their providers.

Most patients felt it would be helpful for nursing to have asked them directly during the intake, expressing that it is difficult to speak up for themselves:

PT3: "...it's hard to start saying something when they've referred to you as a girl and as your assigned name"

## **Engagement Between Care Providers and Gender Non-conforming Patients**

### **Respecting Identity**

All care providers felt the inpatient environment was welcoming and supportive. In general, providers expressed the importance of treating all patients equally regardless of demographics, including gender identity:

RN6: "...to me it's a person who needs my help and care...it doesn't matter who they are, what they are, what they look like...I'm here to care for them."

Some also conveyed that while some might have a religious perspective not permissive of varied gender identity, these views do not impact their approach to patient care:

MC2: "...some staff...when they go to church they believe this is against their religion...they don't agree with it, but they don't try to bring their beliefs on them, they just do their job."

All patients agreed that care providers were generally respectful and supportive, conveying a sense of acceptance:

PT4: "...you can tell it's an accepting place the way everyone is...it just feels like an accepting environment"

### **Using Preferred Names and Pronouns**

Pronoun usage is identified by most care providers as the most challenging aspect of working with transgender patients. In general, providers felt there was consistent effort to use patient's preferred identifiers; however, despite this effort, consistent use was challenging. The most common challenge was with patients who were not outwardly expressing their identified gender, and an automatic use of identifiers associated with patient's appearance:

RN1: "...with the pronouns, I know I slip up...it really isn't intentional but it's learned...when you see someone who looks like a girl or a boy...for my whole life I've used the pronoun associated with that gender."

All patients agreed pronoun usage was challenging for care providers. In general, patients felt providers tried to use their preferred identifiers, and this effort was appreciated, but mistakes

were common. Mistakes were upsetting, but patients reported care providers generally apologized for mistakes which helped ease distress some:

PT6: "...I get really anxious...if they know my gender identity and say it wrong, it pisses me off like really bad...when they fix themselves it makes me feel better"

### **Legal Name in the Electronic Medical Record as a Barrier to Engagement**

Some care providers felt the presence of the patient's legal name in various places within the care system made it difficult to be consistent with the use of patient's preferred identifiers:

RN2: "...people get upset when we called them by the wrong name on admission, because they're admitted by their legal name, and you call them up for meds on the first day, and it's the name on their arm band."

Patients also identified the presence of their legal name in the care system as a major stressor, describing scenarios where mistakes were most common. Instances included roll call for group:

PT6: "...during group they always mess up my name...it bothers me because they like wrote it on the paper too, so how do you mess up if it's on the paper"

Medication administration:

PT2: "...if it's a staff member that hasn't met me before and they have the roster they say it out loud and I have to answer to it, which means the other patients think that's my name...It's not a good situation"

And the presence of their legal name on their wristband:

PT9: "...some people have asked to see it because they couldn't tell if I was a boy or a girl, so they would check it and then check the gender too"

## **Understanding the Complexities of Gender Identity**

### **Care Provider Uncertainty Regarding the Authenticity of Patient's Gender Identity**

Several care providers described two categories of patients identifying as transgender. Some patients are consistent in their transgender identity and have taken steps towards transitioning in their affirmed gender. These patients were easier for providers to conceptualize:

RN2: "...the ones who dress the way...it's easier to use those pronouns, it's easier to address them in that manner."

There is a second grouping of patients who are less consistent in their identity and more challenging for care providers. Some providers described patients who had been admitted several times, and had variable gender identity with each admission:

MC4: "...it's confusing ...one admission they'll want to be called this and the next admission they'll go by a different name and gender...that was hard to get used to."

Some felt this inconsistency was related to developmental stage, expressing that adolescents are generally less secure in their identity overall:

MC3: "...sometimes it's tricky because some of them don't know who they are yet, and that's normal, they're teenagers."

Other care providers felt this inconsistency was related to a patient's attempts to fit in with peers:

RN7: "...there are a couple of people...it was maybe more prevalent or popular at school and so they were partially going along with the crowd."

Some expressed concern that using the preferred identifiers with patients who were less consistent might have negative consequences, reinforcing an identity still uncertain to the patient:

MC1: "...sometimes maybe the person is confused, or are we feeding into something we're not sure of"

### **Gaining Understanding from Patients**

Some care providers expressed learning about gender identity concepts directly from patients, generally asking patients questions and using these interactions as their primary resource to become more familiar with terminology and process:

MC2: "...they taught me, that's how I learned...we sit down and that's what we talk about...the gender and why they feel the way they feel, and it was great for me...I thank them for educating me."

In general, patients interpreted these questions from their providers as an interest in learning more about terminology and the spectrum of gender identity, and did not mind explaining concepts to them:

PT4: "...I am non-binary, and they didn't know what that meant and I explained it to them...it doesn't bother me, I'm glad they want to know, it's better than them just not wanting to know"

### **Discussion**

Patients and care providers in this study generally reported a supportive and respectful inpatient environment. This contrasts to other studies, which indicate transgender patients experience high levels of discrimination in medical settings [12, 20–22]. One survey found 70% of adult transgender patients had experienced discrimination in interactions with healthcare professionals; 51% believed they received different treatment; and 32% felt they received worse care [21]. The consequence is often a reluctance to seek care, and consequently poorer health outcomes [12, 21, 22]. This is particularly important for adolescents, who are learning to maneuver the healthcare system and could be dissuaded from seeking mental healthcare in the future.

Using accurate identifiers was highlighted by patients as an important contributor to a positive inpatient experience, though both patients and providers agree mistakes were common. The consequence of mistakes has been shown to negatively impact patient satisfaction

and quality of care [22, 23]. Patients in our study agreed mistakes were distressing. Guidelines from various organizations recommend that when mistakes do occur, care providers should acknowledge the mistake and apologize [24–26]. This was the approach taken by most care providers, who reported apologizing immediately after making mistakes, or catching and correcting themselves. This approach was satisfactory to most patients, who felt acknowledgment of mistakes somewhat eased distress.

The approach by care providers in our study incorporates some elements of a gender-affirmative model, whereby adolescents are able to live in the gender that feels most real or comfortable, and are supported in their expression of that gender without rejection or restriction [27]. Several patients expressed this support was unique to their inpatient experience, in contrast to their developmental system outside the hospital (e.g. family, school, peers). This lack of support was often a major contributor to their reason for admission, which echoes various studies showing that adolescents not permitted freedom to live in their identified gender are at increased risk for various psychological adversities [28–31]. While the impact of this supportive approach by care providers was not rigorously studied, patients experienced it positively, and some evidence exists that an opposite approach (i.e. conveying that patients' gender expression must conform to birth-assigned gender) negatively affects patients [32, 33].

Findings also identified several areas that could be improved in the current approach to transgender care. Transgender patients were not being consistently identified during the intake in a supportive manner, in contrast to provider's generally held views. Although questions regarding gender identity were not a standardized part of the intake, care providers felt by creating a comfortable environment in a private setting, patients would independently communicate their gender identity. While most patients did, this occurred in the setting of correcting providers who were unaware of a patient's transgender identity and therefore not using preferred identifiers. This approach is troublesome; not only is the onus on patients to speak up for themselves – which some do not because of fear of judgment or mistreatment – but those that do speak up must overcome the anxiety of having just been referred to by birth-assigned name or pronoun. This can be particularly problematic during psychiatric hospitalization, where gender identity and associated stressors frequently contribute to reason for admission, and where failing to identify patients' unique needs can exacerbate psychiatric symptoms. Several healthcare authorities recommend systems be in place to routinely identify transgender patients from their initial interactions with care providers, and that providers should take initiative in identifying transgender patients [25, 26, 34].

The presence of legal names in various parts of the care system was also problematic for care providers and patients, including the electronic medical record (EMR), patient wristbands, medication administration documentation, and various attendance rosters. While many transgender people officially change their name and/or gender on legal documents and insurance records to match their gender identity, adolescents are less likely to have done so because of age, developmental stage, or lack of support for such a name change by guardians. Care providers reported being unaware of features in the current EMR to input preferred identifiers into relevant forms, and felt this made it more challenging to be consistent. Others have also described such issues within the EMR as problematic [35]. Patients also reported that wearing their birth assigned gender and corresponding name on their wristband was a major stressor and potentially 'outing' to other patients. Guidelines from national organizations highlight the importance of creating a system for recording preferred identifiers within the EMR and possibly a name alert sticker to flag patient's charts [25, 26]. Such a system also has the advantage of conveying transgender identity across a range of treatment settings.

Findings also provided insight into how care providers grapple with understanding gender identity. They described two groups of transgender patients. The first, who providers often find easier to conceptualize, were those who have begun transitioning to their identified gender or are outwardly expressing that gender, and are consistent between hospitalizations. The other group is more challenging for care providers to conceptualize, consisting of those with varied gender identity between hospitalizations. Some providers expressed concern that using preferred identifiers with this less consistent group of patients might exacerbate uncertainty for the patient. However, gender affirmative models suggest that a child's determination of what gender is most comfortable for them can be a fluid process that evolves over time, and that the approach should be to allow this expression to unfold as the child matures, supporting their preferences along the way [27]. Stigmatizing an evolving gender identity and placing limits on these adolescents' gendered behavior can lead to patient shame and damaged therapeutic relationships. It is also important to consider that some adolescents may transition then later de-transition upon entering a new unsupportive social environment; they may later choose to transition again when they return to a more accepting environment [36].

More broadly, this uncertainty described by certain providers could be the result of limited understanding as to the diverse nature of gender development in adolescence and might be a consequence of limited training, as suggested by a recent study [37]. In our study only social workers reported receiving some form of training consisting of an annual online course, whereas nurses and milieu counselors reported no formal training. National guidelines and various studies recommend regular trainings in transgender cultural competency for all care providers [20, 24, 26, 34], and organizations have developed guides for care providers and suggested competencies for working with transgender patients [38–40]. Potentially because of this lack of formal training, some care providers described asking patients directly about gender identity concepts as their primary educational resource. Other studies have found this is commonplace, with one survey reporting that 50% of sample patients had to teach their medical providers about transgender care [12] and another finding lack of practitioner knowledge was strongly tied to negative experiences [22]. Though in our study patients generally did not mind educating care providers, this should not be taken to mean the responsibility for education should fall to the patient in place of formal training.

Several limitations within our findings are important to consider. Our study was performed in an urban setting with generally liberal-leaning views, which brings into question the generalizability of findings to regions where social perspectives and awareness might differ. Further research in these settings would be valuable in comparing across different localities. Second, our findings rely on self-reported data, which is limited as it cannot be independently verified and has the potential for bias, including recall bias, attribution, and exaggeration. To limit risk of bias, only themes that emerged across multiple participants were included, and instances of incongruence were specifically noted. Care providers may also have implicit biases which they are not aware of, and which may not have been identified in interviews.

In conclusion, patients and care providers generally reported a supportive inpatient care environment. The principal factors were efforts by care providers to respect patients regardless of gender identity, to use patient's preferred identifiers, and to acknowledge mistakes. These factors are consistent with a gender-affirmative model of care. Barriers to consistently supportive care were also identified, including a lack of consistent identification of a patient's transgender identity in a supportive manner during the admission intake, challenges associated with the presence of birth-assigned name and gender within the care system, and a lack of formal training in transgender cultural competency.

## Compliance with Ethical Standards

**Conflict of Interest** Authors Turban and van Schalkwyk are currently co-editing a textbook on pediatric gender identity for Springer.

**Informed Consent** Informed assent was obtained from all patient participants, explaining study procedures and the voluntary nature of their participation. Patients who agreed to participate were then asked for permission to contact their legal guardian for informed consent. Informed consent was also obtained from care providers who participated voluntarily.

**Ethical Approval** All procedures performed were in accordance with ethical standards of the institutional research committee of the participating hospital system. Approval was obtained from the Institutional Review Board prior to study initiation.

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