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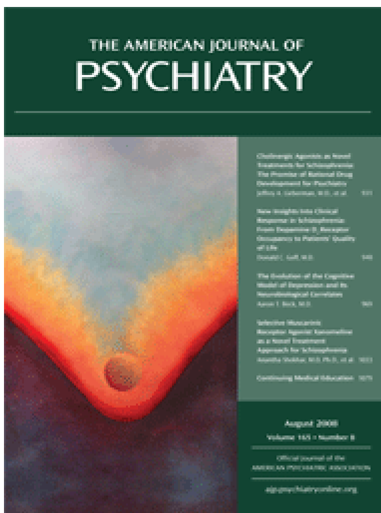

The following is an interview with Nancy Rappaport, M.D., on "School-Based Psychiatry and the Treatment of High-Risk Youth," conducted by Ruth Gerson, M.D. Dr. Rappaport is Director of School Based Programs and Mental Health Director of the Teen Health Center at Cambridge Health Alliance, as well as Assistant Professor of Psychiatry at Harvard Medical School. Dr. Gerson is a second year psychiatry resident at Cambridge Health Alliance and the Resident Editor for this issue.

Dr. Gerson: **What motivated you to become involved with school psychiatry?**

Dr. Rappaport: Between college and medical school, I taught elementary school in Harlem. I initially planned to be a pediatrician. When teaching, however, I realized that while the students' basic needs were being met, they were experiencing all these different kinds of heartbreak, from dissolution of the family, experiencing abuse, or being witness to violence.

Dr. Gerson: **You conduct assessments of violent and aggressive children who are at risk of suspension or expulsion from school. When working with these high-risk youth, how do you manage to balance patient confidentiality versus the needs of school officials?**

Dr. Rappaport: There is a delicate balance between providing the best possible care to young people and working within the demands of a school-based system. The ruling in *Tarasoff v. Regents of the University of California* is very specific in stating that mental health professionals have a duty to protect individuals who are being threatened with bodily harm by a patient, but there are always gray areas and gradations in how you think about safety. For example, if a therapy patient reports that peers are using oxycodone at school, do you notify the school officials, because it is a health risk? What about a patient who reports to his therapist that he has access to weapons and has been feeling "like he could do a Columbine"? There you would have a very low threshold for informing the school. I saw a young man recently at the school-based clinic who was involved with a gang and said, "when I leave here, either I'm going to get shot or someone else will get shot." For him, we made the decision to hospitalize him to help him work through this crisis.

Dr. Gerson: **How do you discuss confidentiality with teen patients?**

Dr. Rappaport: Teenagers are remarkably sensitive to feeling betrayed. The best approach is to be as transparent about your decision-making as possible, very matter-of-fact and neutral: "this is our protocol, how we do things." It is similar when working with parents; the more you can normalize the process and get them on board, the better.

Dr. Gerson: **How do you approach school consultations for violence assessments? What factors influence your assessment of risk of future violence?**

Dr. Rappaport: There is not much research on the accuracy of clinical prediction of violence in adolescents. So remember that this is not a prediction, but an assessment of how we can respond to risk and what services we can put into place. I draw from the FBI guidelines, which emphasize the importance of getting multiple informants and describe how to distinguish high, medium, or low levels of threat. You'll see a wide range of behaviors, from a student making a list of students he's mad at and making vague threats toward them; to aggressive behavior toward teachers; to bad impulsivity, disruptiveness, or hypersexual behavior. It is also important to assess how organized the student's thinking and behavior is, and to ask if the student has at least one anchor, a trusted adult they can go to for help. If not, it is a much more dangerous situation.

Another important consideration is whether the student is demonstrating proactive or reactive aggression. The response to the two is very different. Proactive aggression is predatory. Reactive aggression occurs when the child feels trapped or attacked; it is impulsive and defensive. In reactive cases you look for ways to help the student form a connection with a trusted adult and to use other nonverbal signs to express what is going on inside. It is also important to assess whether the aggression is due to an underlying neuropsychiatric problem that could respond to medication. Finally, it is crucial to ask about suicidal ideation, because when children and adolescents are oppositional, depression is often underneath.

Dr. Gerson: **How do you build rapport with young adolescents, who are often wary of mental health professionals and skeptical of therapy?**

Dr. Rappaport: The important thing in working with young people is to bring a certain amount of humility. You acknowledge the power dynamic, but give them a choice to participate in the relationship. I often say, "You'll meet with me the first time, and you may discover that I am the stupidest doctor in the world; if so, you can fire me." Saying this puts them in charge. I also find it is important to do my homework before I talk to the student. I start by telling him a bit about myself and what my understanding is of what has been going on. It is like being with a wild animal—you let them size you up.

Self-deprecation often helps. Ask them for help

with something, like a cell phone; it lets them be the expert. Be interested in their world. It is so important to figure out why the adolescent is doing what they are doing—what is the thrill and why are they still doing it?

Also, you cannot go in with an agenda. Adolescents will spend session after session talking about their iPod or the contents of their purse, and then the next time they come in and talk about the abuse they've experienced. So patience is crucial. I was talking about this with a patient I have been seeing for years, who helped teach me this, and she said, "that is what I didn't like about my last therapist; she'd sit down and just go for the jugular."

Dr. Gerson: **Residents often feel anxious and intimidated when approaching adolescent patients, particularly by the population you work with: inner city teens who may have gang involvement or a history of violence. What advice do you have to manage this anxiety?**

Dr. Rappaport: It can be anxiety provoking to sit with young people who are making decisions that can derail their lives. And if you are feeling helpless, it's projective identification—this child must be feeling helpless too. But it is important never to sit alone with your anxiety. Trainees often feel that they need to be able to handle it, but swallow your pride and ask for help, share responsibility.

Dr. Gerson: **What advice do you have for residents looking to go into child and adolescent psychiatry?**

Dr. Rappaport: The key ingredient I think is a passion for young people and families. It is also crucial for residents to realize that with children and adolescents, diagnosis is an ongoing process. It can be hard to become comfortable with the evolving nature of the diagnosis and treatment, but a lot is trial and error. And it is so important to avoid the blame game. There is a tendency to look for a villain when bad things happen to children. I have seen a few villains, but most of the time people are just doing the best they can.

Considering Gender

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The term "transgender" is a relatively recent addition to the Western cultural and medical lexicon, though variable gender expressions beyond the binary of male and female have existed for quite some time (1). Medicine, more than other disciplines, has been wed to traditional conceptions of "male" and "female." Gender-focused scholarship within the disciplines of sociology, anthropology, literature, and history has far outpaced the medical and psychiatric literature in thinking critically about gender expression and gender identity (2). As Western culture's concept of gender evolves, and our understanding of mental illness simultaneously expands and is refined, the terms "male" and "female" as the sole descriptors of healthy forms of gender expression and gender identity have become increasingly problematic.

Terminology

Gender theorists have found the terms "sex" and "gender" challenging to define. These terms continue to develop—medically, psychologically, and socially—as our understanding of sex and gender and their complex interplay within our society matures. For the purposes of this article, gender identity is used to describe the subjective sense of oneself as male, female, or "other." Gender identity may or may not coincide with the objective categorization of one's "sex." One's sex is typically described using the biological language of chromosomal makeup and the anatomy of one's internal and external genitalia. Sex is restricted to "male" or "female" (disorders of sexual development, formerly known as "intersex" conditions, are beyond the scope of this article).

The term "transgender," in its broadest sense, describes gender identities and expressions that lie beyond male and female. Subsumed within this term are other expressions of gender variation, including "transsexual" and "androgyne" (refer to Table 1 for a more comprehensive, but by no means exhaustive, list of terms and definitions). A transgender gender identity is typically experienced from a very early age and persists throughout adolescence and adulthood. It should be made clear that variable gender expression is a subjective sense of one's gender identity, and is in no way associated with delusions or psychoses. Moreover, a transgender gender identity is independent of one's sexual orientation.

Table 1: A Sample of Definitions of Transgender Terms

Term	Definition
MTF: male to female (+/− transsexual)	A person born biologically male whose gender identity is female, who presents socially as a woman, and who often, but not always, physically changes their body through the use of hormones or surgery.
FTM: female to male (+/− transsexual)	A person born biologically female whose gender identity is male, who presents socially as a man, and who often, but not always, physically changes their body through the use of hormones or surgery.
Cross-dresser	A person who dresses in clothing not associated with their assigned sex; generally refers to a man who dresses as a woman and who may or may not want to change his gender; considered more politically correct than "transvestite."
Transvestite	A person born biologically male who dresses as a woman, often for sexual gratification. This term tends to be viewed as pathologizing and disparaging (much like the inclusion of transvestic fetishism in DSM-IV).
Disorders of sexual development (formerly known as "intersex")	A person who is born with genitalia that is neither exclusively male or female or that is inconsistent with chromosomal sex (e.g., congenital adrenal hyperplasia, complete androgen insensitivity, etc.). NOT considered a subcategory of transgender, though people born with certain intersex conditions may be more likely to feel that their gender assignment at birth is incorrect.
Androgyne	A person whose gender identity is both male and female, or neither male nor female, or variable over time.
Adapted from Makadon HJ, Mayer K, Potter J, Goldhammer H (eds): The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health. Philadelphia, American College of Physicians, 2007	

Transgenderism and DSM

Since *The Daily News* headline "Ex-GI Becomes Blonde Bombshell" in 1952, which reported on the genital-altering surgery of Christine Jorgensen, born George Jorgensen, and Harry Benjamin's 1966 book *The Transsexual Phenomenon*, alternative gender identities have been a part of the public and medical consciousness, if only on the periphery. Gender identity continues to be a topic fraught with controversy, and psychiatry has often found itself at the center.

Psychiatry generally considers transgender patients in the context of the diagnosis of gender identity disorder. The diagnostic criteria in DSM-IV for gender identity disorder are:

A) A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
B) Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
C) The disturbance is not concurrent with a physical intersex condition (also known as a disorder of sexual development).
D) The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Conceivably, a person could meet the first three criteria without experiencing "clinically significant distress or impairment," as described in criterion D. When considering criterion D, however, one should consider the source of the "clinically significant distress or impairment." Does the cross-gender

identification itself cause distress? Or does a transgender person experience distress as a result of a society that is tolerant of only two gender identities and gender expressions? If the distress arises from the latter, then according to DSM-IV's definition of a "mental disorder" and its stipulation that "neither deviant behavior…nor conflicts that are primarily between the individual and society are mental disorders," gender identity disorder would not be considered a mental disorder.

While the research is not clear as to whether transgender individuals suffer more from mental illness compared with nontransgender persons, transgender individuals are certainly at increased risk of emotional distress because of their often marginalized place within society. It has been reported that transgender persons suffer from a disproportionate amount of intolerance and nonacceptance in the forms of verbal and physical abuse, housing and job discrimination, and poor access to adequate health care (3). By pathologizing gender atypicality, we may increase the distress and marginalization of the very patients we hope to treat. De-pathologizing variable gender identities and expression would place the onus on society and medical professionals to reconceptualize the current understanding and acceptance of gender differences. It is a task worthy of consideration.

Conclusion

Gender identity and gender expression are complex components of a person's sense of self, and their acceptance—both by the self and by society—is critical to one's health. One of the psychiatrist's roles in taking care of a patient is to first do no harm. To treat transgender patients with respect and dignity—which includes the use of the patient's preferred name and pronoun, cognizance of transgender-specific medical and mental health concerns, and sensitivity to a patient's particular experience of the world—is the first step in fulfilling that role.

Many transgender patients and gender specialists view the diagnosis of gender identity disorder as pejorative and intolerant of variable gender expression (2). Moreover, there is compelling scholarship outside the field of medicine that challenges and, at times, rejects the binary model of gender identity currently espoused by the majority of the medical community. Within the field of medicine, there have been case reports and early prospective studies revealing that transgender patients experience less emotional distress when in contact with supportive medical providers and parents (4, 5). First and foremost as healers, but also as researchers and scholars, physicians should be among the first to think critically about gender conventions whose relevance is challenged by the patients we treat.

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Caught Between My Rock and a Hard Place: A Boundary Dilemma for a Christian Psychiatrist-in-Training

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It was the final day of my community psychiatry rotation and I was exchanging goodbyes with "Rita," one of the chronically mentally ill patients I had come to know over the course of the month. Together, we exited the treatment center, a voluntary community-based program with social, rehabilitative, and treatment components.

We were chatting outside in the warm spring weather when she asked me a wholly unexpected question: "What church do you go to?"

Most of the center's clients suffer from schizophrenia spectrum disorders and have significant negative symptoms. Rita, however, was coping with affective illness and alcohol abuse. Although she had greater than a dozen hospitalizations over a 2-year span and multiple suicide attempts, on "good" days she displayed a range of warmth, humor, creativity, and positive affect that I had difficulty reconciling with the severity of illness reflected in her medical record. In fact, it was a bit difficult distinguishing whether she was client or staff in our first encounter.

Her question left me with a few questions of my own. What is the manner in which a good psychiatry intern would appropriately respond to that question? What is the manner in which a good Christian would do so? Were the two mutually exclusive?

And what prompted her to ask me?

While I am Christian and a member of a local church, I had not discussed my faith or my church membership with anyone, client or colleague, in my time on the rotation. No cross hung from my neck, no "WWJD" bracelet adorned my wrist, and no metal fish appeared on my car.

From my perspective, the only objective clue to my church involvement Rita had was that I, like her, am an African-American woman, a member of a group that has relatively high church attendance rates. Even so, medical doctors tend to be less religious than the general public, and psychiatrists even less so (1). Without realizing it, and despite my efforts to remain professionally neutral, something in our interaction led her to guess, correctly, that I am a Christian.

Though the development of my faith is a continuous work in progress, Christianity is familiar to me. As a neophyte in psychiatric training, my role as a psychiatrist is one that I am far from fully grasping or integrating into my self-concept, which may have been reflected in how I responded to Rita's question.

In that moment, I fell into the familiar. Despite my role as a psychiatric trainee, the boundary issues inherent in the situation, and the often antagonistic relationship between religion and psychiatry, I not only told Rita where I went to church, but also reassured her after she confided that she had been there before and now felt shame about the possibility of coming back after missing so many services. "We'd be happy to see you," I said with a smile.

For years, my church has been my second home, its leaders and members a surrogate family and invaluable source of support and validation, and its lessons a blueprint for forgiveness of others and self. My disclosure and assurance to Rita were in part motivated by the hope that she, as someone who struggled with a history of difficult relationships and severe shame about her alcohol relapses, could find the sense of community and self-worth that I have.

Perhaps this is merely rationalization, bolstered by citations, for the boundary transgression of a naive, inexperienced psychiatry intern, but some research supports my hope. A meta-analysis of 35 studies on religiosity and mental health found a significant positive relationship between the two (2) and a clinical study showed that regular religious practice predicted posttreatment alcohol abstinence in African-Americans (3).

Though the body of literature is far from conclusive and the psychiatric community continues to debate the interplay between religion and mental health, my faith and the overwhelmingly positive effects it has had in my life have been central to shaping my personal identity. Like many residents in psychiatric training, I am in the process of

clarifying where my personal identity ends and my professional identity begins, and if and how the two cannot only coexist but be skillfully integrated in a manner most beneficial to those I serve.

While working through this process, I concede that despite my striving to embody neutrality in the pursuit of professionalism, my patient interactions will continually be colored by personal beliefs and experiences—quite often unwittingly so.

I do not know if the answer I gave Rita was the "right" one, but I suspect that if she happened to end up on one of our pews next Sunday, I would indeed be happy to see her.

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Resident Survey

As the Residents' Journal enters its third year, we hope the publication has proved highly valuable to you in your training. Each year, Dr. Robert Freedman and select *AJP* deputy editors meet annually with residents at the APA Annual Meeting to learn about residents' perspectives on and experiences with the Residents' Journal. Since few residents are able to attend these meetings, we are conducting a national survey, created by **Anna Yusim, M.D.**, to provide us with some evidence-based empirical data on your experience with the Residents' Journal to enable us to better meet your needs in the coming years. Please take 15 minutes to complete this survey. Your responses are confidential. We look forward to hearing your thoughts.

Please answer each of the questions to the best of your ability. Your answers will be kept confidential and will not be shared or used to contact you further. If you would like to leave the survey at any time, just click "Exit this survey." Your answers will be saved.

At the conclusion of the survey you will have a chance to enter a contest for a $50 gift certificate to the American Psychiatric Publishing, Inc., Bookstore. One respondent will be randomly chosen as the winner. This gift certificate can be used in conjunction with your 25% Member-in-Training discount you already receive at www.appi.org.

Are you getting the full story? In addition to this online edition of the Residents' Journal, there is an e-mail portion delivered each month. This month's e-mail highlights the evolution of the cognitive model of depression and a phase 2 trial of a nicotinic agonist in the treatment of schizophrenia.