

# Adolescent identity: The importance of the social history

SAGE Open Medical Case Reports  
Volume 8: 1–3  
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DOI: 10.1177/2050313X20952980  
journals.sagepub.com/home/sco



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## Abstract

This is a unique case of a patient with trichotillomania, depression, and anxiety for 2 years, serving as coping strategies for underlying gender dysphoria. To our knowledge, a case of a patient presenting with this unique constellation of comorbid conditions has not previously been reported. This case stresses the importance of providers obtaining a full social history consistently and repeatedly while providing a nonjudgmental environment for patients to disclose sensitive and potentially fluid information related to gender identity and sexuality.

## Keywords

Gender dysphoria, gender identity, anxiety, trichotillomania, adolescent medicine

Date received: 23 April 2020; accepted: 3 August 2020

## Introduction

Depression and anxiety are common diagnoses among adolescents; per the Centers for Disease Control and Prevention, 7.1% and 3.2% of children aged 3 to 17 years have been diagnosed with anxiety and depression, respectively.<sup>1</sup> The etiology of these mental health diagnoses are multifactorial and complex. Gender dysphoria is a relatively newly recognized diagnosis among adolescents; it is estimated that approximately 2.7% of adolescents experience gender identity concerns.<sup>2</sup> Many adolescents with gender dysphoria initially present with unexplained and clinically significant comorbid mental health conditions. It is important for medical providers to obtain a thorough psychosocial history from adolescent patients using a nonjudgmental and open stance so patients can safely explore the context and potential etiology of their distress. This case emphasizes the further value in repeated screening to identify potential stressors related to the fluid nature of gender identity among this age group.

## Case report

This patient is a 14-year-old female assigned at birth who presented to the adolescent medicine clinic with her father after being referred by her counselor for refractory anxiety, depression, trichotillomania, and, in the previous few weeks, puncturing herself superficially with pens. She was diagnosed with depression at 12 years of age and had been seeing a therapist weekly for approximately 2 years. Dad was

concerned that her mental health issues were related to her estranged mother's alcoholism. The patient attributed her depression and anxiety to deteriorating grades and poor sleep. Past medical history, surgical history, and review of systems were unremarkable at the initial visit. Per the social history obtained without the parent present, the patient was previously a straight-A student and was now failing multiple classes. She reported trouble with sleep and decreased physical activity. She denied substance use and had never been sexually active. She was unsure whether or not she was attracted to males or females. She did not have suicidal ideation but rated her depression as 5 on a scale of 0 to 10 with 0 representing "no depression" and 10 representing "suicidal thoughts." On physical exam, she had mild hair thinning with a patch of short hair on the crown of her head. Labs were within normal limits, including a normal thyroid panel. Due to worsening anxiety, increased trichotillomania, and clinical depression impairing daily function, fluoxetine was prescribed at 10 mg daily and increased to 20 mg daily after

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7 days. She transitioned to a therapist within the adolescent medicine clinic.

At a follow-up visit 2 months later, the patient's trichotillomania, anxiety, and depression had improved. She rated her depression and anxiety both at a 2 out of 10. She stated that she felt her most relaxed at her Thursday night church group. Five months after presentation, when again asked screening questions, the patient added to her previous disclosure about her sexual orientation by stating she was not attracted to males or females and by describing herself as gender neutral.

Eleven months after the initial visit, the fluoxetine appeared to be less effective despite an increased dose during the interim to 40 mg daily. The patient and father felt as though the anxiety and depression had worsened, both now at a 6 out of 10, which contributed to a decline in school performance and difficulty interacting with peers. The trichotillomania had worsened, resulting in a large bald spot on top of the head to the point that the patient felt the need to wear a hat in public. During psychosocial screening/review, when asked for preferred pronouns, the patient indicated a preference for they/them pronouns and again reported feeling "better" at church group on Thursday evenings. The patient reported recently wearing a binder they borrowed from a friend. They stated they were not sure where they were "going with gender." Due to the increased severity of the depression, anxiety, and trichotillomania, recommendations included increased frequency of therapy and an increase in the dose of fluoxetine to 60 mg daily.

At medication follow-up approximately 1 year after the initial visit and 1 month after increasing the dose of fluoxetine, the patient reported the trichotillomania had resolved and the anxiety and depression had improved significantly. When asked directly why they felt more comfortable specifically in the Thursday evening church group, the patient shared that the group they were attending was an LGBTQ (lesbian, gay, bisexual, transgender, and queer or questioning) support group conducted in the church hall. The patient revealed that they had been uncomfortable with their gender for a long time and that they had begun to think they wanted to become a man. The patient now preferred he or him pronouns at the church group where he felt most at ease. He expressed interest in taking medication to stop menses and in disclosing his gender dysphoria to his father. Within days of this visit, the patient's father contacted the medical team to share the discussion that he had had with the patient and to report that he was supportive of his son's transition. The patient began using male pronouns and a male name at school and at home. The patient had several visits for medication follow-up and further discussions regarding his specific path to transition. Twenty-five months after his first visit to the adolescent medicine clinic, the father and patient reviewed and signed informed consent for testosterone therapy. The patient received his first dose of testosterone 4 months after consent was obtained.

## Discussion

The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*) defines gender dysphoria as at least 6 months of a "marked difference between the individual's expressed/experienced gender and the gender others would assign him or her."<sup>3</sup> In the past, social stigma associated with gender dysphoria prevented equal access to quality health care to gender-nonconforming patients, or patients that do not conform to the social construct of a two-gender (binary) society. In a large survey done by the National Center for Transgender Equality (NCTE), people who are transgender or nonbinary report they often find themselves teaching their medical providers how to give them appropriate health care.<sup>4</sup> Many of these patients are treated poorly by the health care system, including refusal of care by medical providers.

A study by Olson et al.<sup>5</sup> reveals that many adolescents seeking care for gender dysphoria initially present in a medical setting with clinically significant depression. The NCTE survey further notes that patients with gender issues also suffer more often than the general population from suicidal ideation, suicide attempts, and drug and alcohol abuse, making screening for health risk behaviors imperative among those with gender dysphoria, and equally necessitating screening for gender dysphoria among those with mental health care diagnoses. In the case of our patient, there were two additional comorbid diagnoses presenting with depression: anxiety and trichotillomania. Whether presenting simply as clinical depression or with other mental health diagnoses, the diagnosis of gender dysphoria may not be clear at the time of presentation. Notably, per our literature review, trichotillomania has not previously been reported as a concomitant condition with gender dysphoria. Although medication alone initially ameliorated the symptoms related to his comorbid conditions, it was not until our patient's gender dysphoria was addressed directly that sustained symptomatic improvement was seen with the treatment regimen.

When assessing adolescents, it is critical to ask all social history questions in a nonjudgmental way to elicit potentially important historical elements that can add understanding to the etiology of otherwise common symptoms or diagnoses. For adolescents, providers can use a screening tool of which there are many versions of many names (e.g. HEADDSV), most of which include questions related to the general categories of Home, Education, Activities, Depression/suicide/anxiety, Drugs, Sexual behavior/gender, and Violence. Providers should screen all adolescents at least annually and when indicated by presenting symptoms, using the same questions for all patients to avoid making or conveying assumptions about patient information, and after explaining and offering minor patients conditional confidentiality. When exploring gender identity specifically, providers need to use simple, unbiased language, such as "What name would you like me to call you? What gender pronouns do you prefer I use when I talk with you—he/him, she/her, or they/them?"

Do you identify as male, female, non-binary, or other gender?"<sup>6</sup> Tangible ways to foster a nonjudgmental clinical environment include the use of pamphlets featuring same-sex couples, rainbow stickers, gender neutral bathroom signs, and appropriate pronouns for each patient.<sup>2</sup> In addition, it is also helpful to be knowledgeable about community resources such as LGBTQ support groups for patients in the event they reveal a desire to participate.

An additional critical step to supporting LGBTQ youth is offering to aid in the disclosure discussion with parents. Patients often prefer to disclose privately with parents, but providers should offer to be present for the discussion if the patient prefers. The provider can also support the adolescent by providing families (and patients) with literature, access to support groups, and family counseling to enable the family to better support the patient.

Gender dysphoria can present in a variety of ways, but even with annual screening, it may take years for the patient to disclose it to a provider or family member, even if an individual recognizes their gender incongruence from a young age. "Coming out" leads to higher self-esteem and decreased depression in the LGBTQ population,<sup>7</sup> emphasizing the necessity for clinicians to assess gender identity and sexual orientation regularly during adolescence. Our patient revealed his gender dysphoria using progressive disclosure. He originally discussed lack of sexual attraction to others, then that he was "gender neutral," then ultimately disclosed that he was *male*. Despite years of prior therapy, an open environment and routine, sensitive, and repeated questioning about gender identity allowed him to develop the comfort he needed to access the care he ultimately desired and deserved.

## Conclusion

This case demonstrates that patients with gender dysphoria may present with multiple comorbid conditions used to cope with distress that may obfuscate the patient's underlying gender identity confusion. It is critical to obtain a thorough social history from every adolescent patient, especially those presenting with symptoms of anxiety and depression, and to repeat these social history questions in some form at least annually. Potentially sensitive topics such as gender identity may require consistent, repeated, nonjudgmental assessments that convey an open approach in a safe environment. Only when providers fully understand the context of an adolescent patient's distress can they address and optimize their patients' physical and mental health.

## Declaration of conflicting interests

The author(s) declared the following potential conflicts of interest with respect to the research, authorship, and/or publication of this article: Amy B. Middleman receives royalties in her role as Section Editor for UpToDate.com. She is the principal investigator on a grant her institution received from Pfizer Medical Research. She has no other potential conflicts related to this article. Laura Silverstein and Emily Zander have no potential conflicts of interest.

## Ethical approval

Our institution does not require ethical approval for reporting individual cases or case series.

## Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

## Informed consent

Written informed consent was obtained from a legally authorized representative(s) for anonymized patient information to be published in this article.

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