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Chris Aiken, MD

Editor-in-Chief

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Learning Objectives

After reading these articles, you should be able to:

1. Describe ways to improve the therapeutic relationship with patients who identify as transgender.
2. Identify the major ways in which ethnic groups can differ in their biological response to psychiatric medications.
3. Summarize some of the current research on psychiatric treatment.

How Ethnicity Influences Medication Response

Donna Lisi, PharmD. Contributing writer to the Carlat Psychiatry Report newsletters. Chris Aiken, MD. Editor-in-Chief of The Carlat Psychiatry Report. Practicing psychiatrist, Winston-Salem, NC.

Drs. Lisi and Aiken have disclosed that they have no relevant financial or other interests in any commercial companies pertaining to this educational activity.

From cultural expectations to genetic variations, ethnicity has a strong effect on medication response. In this article, we'll review five areas where ethnic groups can differ in their biological response to psychiatric medications.

Drug metabolism

Most medications are metabolized in the liver, and patients' liver metabolism varies. Slow metabolism causes medications to back up, resulting in higher serum levels, more side effects, and unexpected efficacy

In Summary

- Certain ethnic groups, particularly Asians, may require lower doses of psychiatric medications because they have high rates of slow metabolizers.
- Genetic testing is required before starting carbamazepine in Asian patients because of the high risk of severe rashes in this population.
- Benign ethnic neutropenia (BEN) is more common in African Americans and should not be a reason to avoid a trial of clozapine.

in the lower dose range. Ultra-rapid metabolism has the opposite effect—drugs are shuttled through so quickly that patients may need high doses to reach therapeutic levels. — Continued on page 2



Working With Transgender Patients

Jack Drescher, MD

Clinical professor of psychiatry at Columbia University, College of Physicians and Surgeons; member of the DSM-5 work group on sexual and gender identity disorders.

Dr. Drescher has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Our profession has a number of obstacles to overcome in gaining the trust of transgender and gender non-conforming patients. We turn to this month's expert, Jack Drescher, to better understand how to work with this population.

TCPR: Tell us about this new diagnosis, gender dysphoria, and what it means for patients.

Dr. Drescher: In DSM-IV, identification with the other gender was itself a mental disorder: gender identity disorder. That added stigma to a group that already experiences a stigmatized identity. That part is changed in DSM-5. The manual explicitly states that gender nonconformity in itself is not a mental disorder, but it retains a diagnosis for those for who experience distress and dysfunction due to incongruence between their experienced and assigned gender: gender dysphoria, without the word "disorder." — Continued on page 4



How Ethnicity Influences Medication Response

Continued from page 1

Genes play a major role in the rate of metabolism, and those genes vary by ethnicity. In commercially available pharmacogenetic tests, slow metabolizers are called “intermediate,” normal are “extensive,” and fast metabolizers are “ultra-rapid.” There’s also a fourth category, “poor metabolizers,” whose enzymes are practically blocked, causing very high medication levels and significant adverse effects.

Poor metabolism is 2–3 times more common among Caucasians (7%–10%) at the pathway that most psychiatric medications pass through: CYP2D6. However, non-Caucasians have much higher rates of *slow metabolism* at this pathway,

particularly East Asians. East Asians from China, Korea, and Japan have high rates (20%–40%) of slow metabolism at several pathways that are important in psychiatry: CYP2D6, CYP3A4, or CYP2C19.

Hispanics and African Americans have higher numbers of both slow and ultra-rapid metabolizers, depending on the country of origin. For example, a third of all African Americans are slow metabolizers at CYP2D6, but among the subset from Ethiopia, a third are ultra-rapid metabolizers at this pathway (Henderson DC et al, Ch 11 in *Clinical Manual of Cultural Psychiatry*, editor Lim RF, 2015). Variations in CYP2D6 metabolism have caused enough problems that in the 1990s, pharmaceutical companies began screening out drugs that pass through this enzyme (de Leon J et al, *J Am Acad Child Adolesc Psychiatry* 2015;54:532–534).

In practice, slow metabolism is a greater problem than ultra-rapid metabolism, as the side effects it creates can be dangerous or lead patients to drop out of treatment. One solution is to titrate slowly and aim for a low dose, but just how low? Exact figures aren’t known, and they depend on many other factors including age, diet, and drug interactions. Among Asians, most studies arrive at doses that are 30%–50% lower than those used for Caucasians, but that’s the average; the actual dose may be normal for some and significantly lower for those who are slow metabolizers (Henderson DC et al, Ch 11 in *Cultural Psychiatry*, editor Lim RF, 2015).

Pharmacogenetic testing and the SERT gene

Genetic testing can clarify whether a patient is an ultra-rapid or slow metabolizer, but its value continues to be debated. A recent task force weighed in against the routine use of these tests, but also concluded that the metabolic portion of the test is the most useful, particularly for CYP2D6 (Zeier Z et al, *Am J Psychiatry* 2018; appiajp201817111282). The pharmacodynamic section of these tests, which includes genes that are involved in the brain’s response to medications, is considerably less reliable, and its interpretation may depend on ethnicity.

The serotonin transporter (SERT) gene is the most widely studied of these genes.

It comes in two alleles, a short-arm (S) and long-arm (L), and the short-arm is associated with a poor response to serotonergic antidepressants—or at least that’s what the commercial tests report. In actuality, that finding has only held up among Caucasian men. Studies in Asian populations show the opposite trend, with the short-arm predicting a more favorable response to serotonergic antidepressants (Bousman CA et al, *J Clin Psychopharmacol* 2014;34(5):645–648). The frequency of this short allele also varies by ethnicity: 50% in Caucasians, 30% in Africans, and 70% in Asians (Gelernter J et al, *Hum Genet* 1997;101:243–246). The exact role of this allele probably depends on factors beyond the reach of a single-gene test, including ethnicity, environment, and interactions with other genes.

Adverse effects

Some adverse effects occur more frequently in certain ethnic groups even at normal drug levels. Two to watch for with antipsychotics are hyperprolactinemia in Asians, and metabolic and cardiac problems in African Americans (Kim KM, *J Clin Psychopharmacol* 1988;8(3):195–201). In fact, nearly half of the published case reports of new-onset diabetes on atypical antipsychotics have occurred in African Americans (Jin H et al, *Ann Clin Psychiatry* 2002;14(1):59–64).

Carbamazepine hypersensitivity in Asians

Several anticonvulsants carry a risk of severe rashes like Stevens-Johnson syndrome, including carbamazepine, lamotrigine, oxcarbazepine, phenytoin, and zonisamide. In the case of carbamazepine, these rashes are 10 times more common among Asians, and a genetic test can identify Asian patients who have an elevated risk. FDA labeling recommends testing for this gene (HLA-B*1502) before prescribing carbamazepine in Asian patients, and the drug is relatively contraindicated if the test is positive. The test is not recommended among non-Asians, where the HLA-B*1502 gene is almost absent.

What about oxcarbazepine? A recent meta-analysis found that Asians with HLA-B*1502 were 30 times more likely to have ——— *Continued on page 6*

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Behavioral Strategies for Suicide Prevention

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What can you do—beyond prescribing medications—to help your patients who have suicidal ideation? There are many strategies that you can teach your patients, even in the context of brief psychopharm visits. In this article, I'll describe eight behavioral strategies that your patients are likely to find helpful. They are adapted from cognitive behavioral therapy for suicide prevention (CBT-SP), a modified form of CBT designed for patients who've made a recent suicide attempt, regardless of their diagnosis. CBT lowers the risk of repeated attempts by 50% compared to treatment as usual, according to a meta-analysis of 12 controlled trials. That's impressive, though the caveat is that most of those "treatment as usual" groups did not receive comparable levels of regular psychotherapy (Gøtzsche PC et al, *J R Soc Med* 2017;110:404–410).

Actively prevent dropouts

Premature dropout is a significant risk for suicidal patients. Many decline outpatient care (30%–50%), and over a third who attend treatment drop out within 3 months (Michel K et al, *Int J Environ Res Public Health* 2017;14:243). Unstable social supports, poverty, younger age, impulsivity, and substance abuse are among the factors contributing to these high rates. This risk needs to be addressed early, with an open discussion of obstacles that could prevent the patient from returning. Find out the best ways to reach patients if they miss an appointment, and try to conduct missed sessions by phone.

Communicate hope

Even when the patient's struggles seem insurmountable, maintain an attitude of hope. However, there's no need to be a Pollyanna. Instead of convincing patients that a positive outlook is more realistic, which can be invalidating, focus on the pragmatic value of hope. Patients are more likely to find solutions when they approach problems from an optimistic stance.

A safety plan

In working with suicidal patients, it helps to assume that they won't be able to think clearly when a crisis strikes. Thus, written reminders are critical, particularly a safety plan. At a minimum, the plan should include phone numbers of social supports, emergency numbers for mental health providers, and contacts for a 24-hour emergency behavioral health center and a suicide hotline. For a downloadable safety plan template, see: <https://tinyurl.com/yd65jrt8>

Empathic assessment

Successful therapies for suicide evaluate the risk collaboratively, inviting the patient to weigh in on the assessment and problem-solve methods of risk reduction. Avoid controlling and judgmental attitudes; approach the assessment with a wish to understand how it feels to walk in the patient's shoes. When patients feel understood, their connection to therapy grows, often forming a counterweight to suicidal impulses.

Problem solving

People who attempt suicide tend to have poor problem-solving skills. In CBT-SP, suicide is viewed as an understandable but ultimately harmful attempt to solve a problem. A major focus of CBT-SP is to improve problem-solving skills. For example, patients can list their problems and prioritize those that are most amenable to change. From there, the pros and cons of different solutions are weighed—with an emphasis on flexibility and acceptance, as the available solutions are usually less than perfect.

Distress tolerance

Suicidal impulses are surprisingly brief. Most pass after minutes or hours, and very few continue beyond a day (Hawton K, *Crisis* 2007;28:4–9). Distress tolerance skills can help patients ride out these painful waves unharmed. Cognitive abilities are distorted during a suicidal crisis, so the best skills are simple, easy, and physical: deep breathing, guided meditation, aromatherapy, exercise, a warm bath, music, engaging a pet, or being in nature. Distraction techniques also work, like puzzles or word games. Apps to teach these skills include *Stress Free*, *Panic Relief*, and *Breathe2Relax*. Practice is critical. By using distress tolerance skills in

everyday life, patients gain confidence that they can endure suffering without resorting to suicide.

Coping cards

During a suicidal crisis, thoughts are forceful, quick, and extreme. Coping cards help patients slow down and consider alternatives. On the front of the card is a negative thought that tends to come up in a crisis, such as "This will never get better." On the other side is a more adaptive response, like "I've made it through situations that seemed hopeless before." Patients make these cards when they are thinking clearly, and refer to them when a major stress has narrowed their perspective.

Hope box

This final tool wraps everything up in one place. It's an actual box that patients make to store all of the life-saving information they've gained in therapy but are likely to forget in a crisis. Coping cards, emergency plans, names and numbers of supportive people, and reminders of distress tolerance skills are all inside. Also in the box is a list of reasons to live and sensory reminders of those reasons, like pictures of family or pets, sentimental gifts, letters from friends, or spiritual texts. Reminders of past achievements, like awards, can counter thoughts of helplessness. A free app that keeps all this together is called *Virtual Hope Box*—I recommend patients use both the virtual and the real option.

TCPR VERDICT: Suicidal patients can evoke strong emotions, from anxiety to aversion. Clinicians may feel they are charged with an impossible task: to predict and prevent a self-inflicted death. CBT-SP shifts the focus toward matters that are more within the therapist's—and patient's—control. It empowers patients to manage their problems more effectively. Instead of using safety contracts to dissuade them from what they shouldn't do, it emphasizes what they can do during a crisis. To learn more, a good text is *Brief Cognitive-Behavioral Therapy for Suicide Prevention* by Craig Bryan and David Rudd. For patients, the standard workbook is *Choosing to Live* by Thomas Ellis.

Expert Interview
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TCPR: Why not take out the diagnosis altogether?

Dr. Drescher: The challenge we faced in the DSM-5 work group was to reduce stigma while maintaining access to care for patients who have a diagnosis of gender dysphoria. Removing the diagnosis completely would limit access to care for these patients, which includes access to endocrinology consultation and gender reassignment surgery. A different approach would be to remove the diagnosis from the manual of mental disorders but still include it as a medical condition. The World Health Organization has moved in that direction with ICD-11. There, the diagnosis is called “gender incongruence.” I am on the WHO work group that recommended moving that diagnosis from the chapter on mental disorders into a new chapter called “Conditions Related to Sexual Health.” The World Health Organization Assembly will vote on the entire ICD-11 revision in 2019.

TCPR: That makes sense, as the treatment for gender dysphoria has shifted into the medical realm with our endocrine and surgical colleagues. Those colleagues are also calling on us to screen patients before gender reassignment surgery. How should we fulfill that role?

Dr. Drescher: Historically, the role of psychiatrists and other mental health professionals in the treatment of transitioning patients was that of gatekeepers; that is, to make the determination about whether or not a patient should have access to care related to their gender identity. That is no longer the case regarding access to hormone therapy. However, there are many surgeons, for example, who are unwilling to accept a request for reassignment surgery without a mental health professional writing a letter. Many times, the surgeon may require that the letter be from a psychiatrist or mental health professional who knows the patient, has been working with the patient for some time, and can attest to the diagnosis of gender dysphoria. A surgeon might also request a second letter from an expert, who may not know the patient very well but has seen the patient in consultation. Today, it is the surgeons and some insurance companies who want mental health professionals to act as gatekeepers.

TCPR: What factors would steer you away from endorsing a patient’s request for gender reassignment surgery?

Dr. Drescher: It’s a challenging question. The issues are whether there seems to be a stable state of mind, whether the patient meets diagnostic criteria for gender dysphoria, and whether it seems reasonable to assume that the gender dysphoria would be improved with surgical treatment. For example, if a patient presents with psychosis, does gender dysphoria still persist when the patient is not in a psychotic state? One way to make that assessment is through treatment. For

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Ask the Editor

Each month, Editor-in-Chief Chris Aiken, MD, gives advice on a different practice challenge.

If you have a question you’d like Dr. Aiken to answer, please send an email to AskTheEditor@thecarlatreport.com. Dr. Aiken won’t be able to answer all questions received but will pick one each month that is of general interest.



ADHD medications: Three significant food interactions

Dear Dr. Aiken: Patients often ask how their stimulant medication interacts with food. Can you tell us more about this?

Dr. Aiken: The main issues are with extended release amphetamine salts and guanfacine ER (Intuniv). Outside of that, there are a number of minor interactions that may impact some patients.

1. Food delays the effects of some extended release amphetamine salts.

A high-fat meal delays the time to peak concentration (T_{max}) of some extended release versions of mixed amphetamine salts, in particular the following: Mydayis (delayed by 4.5–5 hours), Adderall XR (2.5 hours), and Adzenys XR-ODT (2–2.5 hours). In one study, a heavy breakfast caused levels of Adderall XR to drop 50% during the first 6 hours of the day. Lunch has no known effects. This food delay is minimal (1 hour or less) for lisdexamfetamine dimesylate (Vyvanse), Dyanavel XR liquid, and the extended release

methylphenidates such as methylphenidate ER (Concerta) and dexamethylphenidate (Focalin XR).

2. Acidic foods can reduce the absorption of immediate release amphetamines.

Potential offenders include fruit juice, coffee, carbonated beverages, energy drinks, sports drinks (such as Gatorade), and vitamin C supplements. Though often quoted, this effect is understudied, and it’s not known how significant it is. While it applies to the IR amphetamines (Adderall, Evekeo, and Dexedrine), it is not thought to occur with extended release amphetamines or with methylphenidate derivatives.

3. A high-fat meal raises guanfacine levels.

This last interaction is significant and occurs when extended release guanfacine is taken with a high-fat meal. There’s a 75% rise in peak levels (C_{max}) and a 40% increase in total exposure (AUC), which can lead to fatigue and hypotension. The other non-stimulants such as clonidine ER (Kapvay) and atomoxetine (Strattera) are free of food interactions.

Sources: Markowitz JS et al, *J Child Adolesc Psychopharmacol* 2017;27(8):678–689; Auiler JF et al, *Curr Med Res Opin* 2002;18(5):311–316; www.pdr.net.

Expert Interview
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example, before recommending surgery, does something such as testosterone treatment relieve their anxiety and make them less dysphoric? And if so, does the patient still want a double mastectomy as part of the transitioning process?

TCPR: So, it sounds like a big part of the assessment is providing some reassurance to our surgical colleagues that this procedure is actually going to help the patient, and that the patient won't be worse after the procedure and will be happy they had it?

Dr. Drescher: Right. The major preoccupation in this area is concern about regrets, but psychiatrists are not always very accurate at predicting whether or not someone will regret transition. Yet the whole gatekeeping system is set up to try and prevent regrets. However, it's not a perfect process, and serious questions have been raised over whether everyone should go through the psychiatric evaluation process.

TCPR: Do we have research on what outcomes look like after surgery in terms of regrets?

Dr. Drescher: There's not a lot of research in the U.S. A study in the Netherlands looked at outcomes in over 6,000 patients who underwent reassignment surgery. The rate of regret was very low: 0.6% for transwomen and 0.3% for transmen (Wiepjes CM et al, *J Sex Med* 2018;15:582–590).

TCPR: At what age does the medical field now consider it acceptable for a patient to undergo either surgical or hormonal transition?

Dr. Drescher: Well, it varies from country to country. I think in the U.S. nobody will perform surgery before age 18. In some countries it might be younger. It really depends on what the age of consent is for adulthood. In the U.S. now, some physicians are providing hormones for gender transition as young as 12. I don't think that is the case everywhere. I think most physicians are waiting maybe until age 15 or 16 before they will give hormones.

TCPR: Can you tell us about using hormones to delay puberty in someone with gender dysphoria?

Dr. Drescher: Puberty suppression or puberty blocking is an intervention that was perfected by the Dutch at the gender clinic in Amsterdam. It was based upon the clinical observation that some kids become panicky and suicidal about developing secondary sex characteristics as puberty approaches. So, children assigned female at birth—who identify as male—might not want to have menstrual periods start or to develop breasts. Children assigned male at birth might not want to have the typical male growth spurt, develop an Adam's apple or beard, or have their penises grow. So, the Dutch introduced puberty suppression medications more than 20 years ago, and now it's being done everywhere around the world. Puberty suppression prevents those changes related to assigned gender from happening.

TCPR: What are some of the benefits to puberty suppression?

Dr. Drescher: It's not always clear which prepubescent children will continue to be gender dysphoric as they age into adolescence and which ones will not. The children whose gender dysphoria persists are called persisters, and the ones whose gender dysphoria goes away are called desisters (Steensma TD et al, *J Am Acad Child Adolesc Psychiatry* 2013;52:582–590). The Dutch have done studies in which they followed up with the kids that did get puberty suppression, who are now in their 20s or older, and they found that psychologically these people are doing great—maybe even better than the control groups that they compared them against.

TCPR: Can you tell us about the terminology we need to know while treating transgender patients?

Dr. Drescher: First, it is very difficult keeping up with the constant change in appropriate language. Terms that were perfectly appropriate just a year or two ago are no longer appropriate for a variety of reasons. One basic thing worth keeping in mind is that it's really important to think about the pronouns and names of the people who are your patients. Ask patients directly how they want to be addressed. Be aware that some people use conventional male and female pronouns, and some people prefer "they." I think Facebook offers about 50 different choices that one can use in terms of pronouns.

TCPR: Can you give us a practical example of how to apply pronouns?

Dr. Drescher: Sure. An easy place to make a change is on our intake forms. Under gender, you could have male, female, or other—and then "please specify." Another example is on the inpatient unit. Let's say there's a transgender patient who is legally male but identifies as female. The chart has to have the legal male name on it. What should one do? I suggest writing a note at the beginning of the chart saying that the patient is legally still male but identifies as female, and going forward in the chart we will use female pronouns. It's not rocket science.

TCPR: Are there transgender individuals who don't want to transition? I'm thinking of people who don't want to conform to either gender, and may view gender transitioning as conforming to binary stereotypes.

Dr. Drescher: That's true. Another change with DSM-5 is that we now talk about the "other" gender instead of talking about genders as binary "opposites." Genders are not necessarily opposite to each other; that's just the

"Terms that were perfectly appropriate just a year or two ago are no longer appropriate for a variety of reasons. It's really important to think about the pronouns and names of the people who are your patients. Ask your patients directly how they want to be addressed."

Jack Drescher, MD

Research Updates IN PSYCHIATRY

ANOREXIA NERVOSA

Are All Psychotherapies for Anorexia Created Equal?

REVIEW OF: Zeeck A et al, *Front Psychiatry* 2018;9:158. doi:10.3389/fpsy.2018.00158

TYPE OF STUDY: Meta-analysis of randomized controlled trials

Psychotherapy is the main treatment for anorexia nervosa, but which type works best? Several therapies have good evidence in this population, but they differ in their models and methods, and head-to-head comparisons among them are rare. To overcome that limitation, this study used a technique called “network meta-analysis,” which evaluates different treatments based on how they measured up against a common comparison group. For example, suppose that CBT and family therapy have never been directly compared to each other but both have been compared to supportive therapy. A network meta-analysis would compare CBT to family therapy based on how each fared relative to supportive therapy.

Only a handful of therapies have good evidence to work in anorexia, and most of them were included in this study. Effective therapies had two common ingredients: a focus on weight restoration

and work on psychosocial factors. It was in the psychosocial focus that the therapies differed, which ranged from skill building (CBT), relationship dynamics (focal psychodynamic therapy, interpersonal psychotherapy), family work, and supportive psychotherapy (specialist supportive clinical management). The family therapies empowered parents to re-feed their child, and then progressed to work on family dynamics (systemic family therapy) or adolescent development (family-based treatment and the Maudsley model) as normal weight was restored.

The result: No single therapy was more effective than the others in this analysis of 18 randomized controlled trials. The authors followed that up with another new-fangled technique, called “standardized mean change analysis,” which compared the degree of weight gain among all of the therapies after 1 year of treatment. This analysis allowed naturalistic studies to be included, bringing the total number of trials to 38. Again, no single therapy stood out, but weight gain was more rapid with inpatient vs outpatient treatment, and overall weight gain was greater in adolescent studies than it was for adults (inpatient: 1.4 lbs/week for adolescents, 1.2 lbs/week for adults;

outpatient: 0.42 lbs/week for adolescents, 0.23 lbs/week for adults).

The authors suggested that some therapies may be superior for certain subgroups of anorexia. Most successful therapies for adolescents involved the family, while individual therapy was the mainstay for adults with anorexia. Adolescents with significant obsessive-compulsive symptoms had greater benefit with systemic family therapy than family-based treatment. For severe anorexia, the Maudsley model was more effective than specialist supportive clinical management.

TCPR'S TAKE

While the outcomes for these therapies were similar, this does not mean that any psychotherapy will work for anorexia. These are highly structured therapies with specific behavioral and psychological techniques. When making referrals, psychiatrists should look for therapists that use evidence-based methods, and adolescents may do better with a family approach. Once in therapy, weight gain of 0.23–1.4 lbs/week can be considered a successful outcome.

—Adam Strassberg, MD, and Chris Aiken, MD. Drs. Strassberg and Aiken have disclosed that they have no relevant financial or other interests in any commercial companies pertaining to this educational activity.

How Ethnicity Influences Medication Response

Continued from page 2

Stevens-Johnson syndrome on oxcarbazepine (Tangamornsuksan W et al, *J Pharm Pharm Sci* 2018;21(1):1–18). However, more data is needed to prove this association, and HLA-B*1502 testing is not yet recommended by the FDA in Asians on this relative of carbamazepine.

Other baseline labs (blood count, platelets, liver function, basic chemistry, and thyroid) are recommended before starting carbamazepine, and this test can be added to that list as “HLA-B*1502, carbamazepine sensitivity” (a cheek swab is also available). The test is positive if 1 or 2 alleles are present.

Clozapine and benign neutropenia in African Americans

Certain ethnic groups have lower than average absolute neutrophil counts (ANC).

This condition, benign ethnic neutropenia (BEN), is a normal finding and not a reason to avoid or discontinue clozapine therapy. BEN is most common in persons of African descent (25%–50%), some Middle Eastern ethnic groups (Yemenite Jews, Jordanians), and other non-Caucasian ethnic groups with darker skin (Rajagopal S, *Postgrad Med* 2005;81(59):545–546). A hematology consultation can clarify if a patient's low ANC is due to BEN, and the clozapine guidelines have separate standards for this condition (for more information, see: www.clozapinerems.com).

While BEN is more common in male African Americans, genuine clozapine-induced agranulocytosis occurs more often in women and those of Asian or Ashkenazi Jewish descent (Rajagopal S, *Postgrad Med* 2005;81:545–546).

TCPR VERDICT: With Asian patients, start low and go slow, particularly with meds metabolized by CYP2D6, CYP3A4, and CYP2C19. Hispanics and African Americans may also need modified dosing. Pharmacogenetic testing can clarify some of these problems, but other reasons beyond drug metabolism can make ethnic minorities more prone to side effects. A low white blood count is normal in some populations, particularly African Americans with BEN, and clozapine can still be used in these patients. Before starting carbamazepine, the FDA requires a HLA-B*1502 test in Asians to prevent a potentially life-threatening rash.

CME Post-Test

To earn CME or CE credit, you must read the articles and log on to www.TheCarlatReport.com to take the post-test. You must answer 75% of the questions correctly to earn credit. You will be given two attempts to pass the test. Tests must be completed within a year from each issue's publication date. As a subscriber to *TCPR*, you already have a username and password to log onto www.TheCarlatReport.com. To obtain your username and password, please email info@thecarlatreport.com or call 978-499-0583.

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For those seeking ABPN Self-Assessment (MOC) credit, a pre- and post-test must be taken online at <http://thecarlatcmeinstitute.com/self-assessment/>

Below are the questions for this month's CME/CE post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com. Note: Learning Objectives are listed on page 1.

- Many psychiatric medications are metabolized through hepatic enzymes. Which ethnic groups have higher numbers of *both* slow and rapid metabolizers at these enzymes? (LO #1)

<input type="checkbox"/> a. Hispanics and African Americans	<input type="checkbox"/> c. East Asians from China, Korea, and Japan
<input type="checkbox"/> b. Caucasians	<input type="checkbox"/> d. Yemenite Jews and Jordanians
- According to Dr. Drescher, which of the following terms applies to children whose gender dysphoria does not continue through adolescence? (LO #2)

<input type="checkbox"/> a. Persisters	<input type="checkbox"/> c. Gender nonconformists
<input type="checkbox"/> b. Agenders	<input type="checkbox"/> d. Desisters
- African American patients may have an elevated risk of developing diabetes while taking atypical antipsychotics. (LO #1)

<input type="checkbox"/> a. True	<input type="checkbox"/> b. False
----------------------------------	-----------------------------------
- A 2018 study completed in the Netherlands found that the rate of regret for patients who underwent gender reassignment surgery was _____. (LO #2)

<input type="checkbox"/> a. Under 1%	<input type="checkbox"/> b. 3%	<input type="checkbox"/> c. 5%	<input type="checkbox"/> d. 7%
--------------------------------------	--------------------------------	--------------------------------	--------------------------------
- According to a 2018 meta-analysis, the most successful therapies for adolescents with anorexia nervosa involved individual versus family-based treatment. (LO #3)

<input type="checkbox"/> a. True	<input type="checkbox"/> b. False
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Expert Interview

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conventional way it's been conceptualized. It's possible for people to meet diagnostic criteria for the diagnosis of gender dysphoria who are not thinking in male/female binaries, but who may be presenting themselves with some other representation of gender. Another thing to keep in mind is that not all transgender people have gender dysphoria. Many are secure and happy with their gender identity. People who identify as transgender are all different from each other. They don't all want the same thing, and they are not all moving in the same direction. So, one of the things that is helpful in dealing with patients is to not make assumptions, to listen to their story, to develop tactful skills for questioning them about where they are in their life right now, what their goals are overall, and what their goals are in regard to gender. What are their thoughts about their gender? I do have patients who are very sensitive about being misgendered. They'll say, "If I identify as female, I'm dressed in a female way, and you call me 'sir,' you are misgendering me." Or, a more common thing is the patient who is preoccupied about whether everybody they pass on the street identifies them as the gender they consider themselves to be.

TCPR: On the last point, can you give us a specific patient example and share how you dealt with it?

Dr. Drescher: I had a patient come in complaining that people were looking at her on the street, and she felt that they were "tagging her as male." I was very direct and said, "Look, if your level of self-esteem is going to depend on everybody getting your gender right, you are going to be in a lot of trouble. And if your self-esteem is going to depend on everyone getting your pronouns right, you're not going to be able to withstand some of the things that will happen in life. That's not to dismiss your hurt feelings, but to say that the reality is that you will have to develop a certain amount of resilience."

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Working With Transgender Patients

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Drug Metabolism**

Expert Interview

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TCPR: That really is putting it right out there, but how do you get to the point where you can speak to the patient in such a direct way?

Dr. Drescher: It's a very important question. I think it takes a relationship where the patient feels that you understand what they are going through. That happens over time and goes back to what I said earlier about being able to talk with them and understand where they're at while being able to listen to their story. Once they are comfortable knowing that you understand them, it's been my experience that you can talk frankly with them about getting over being misgendered by people.

TCPR: What are some good resources for psychiatrists working with this population?

Dr. Drescher: One really good resource is the World Professional Association for Transgender Health (WPATH). They have published guidelines, including standards of care for evaluating patients prior to surgery, and those are free at wpath.org/publications/soc. I think that's a great starting point. There are also resources available through groups such as the Association of Gay and Lesbian Psychiatrists (AGLP) at www.aglp.org. A great book is *Transgender Mental Health* by Eric Yarbrough, which was released last March by APA Press and has sample letters for patients seeking surgical reassignment.

TCPR: Thank you for your time, Dr. Drescher.

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