Mental Health Disparities in Trans Populations: Minority Stress, Discrimination, and Intersectional Oppression

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Conflict of interest slide

Faculty:

- Pierre-Paul Tellier - no conflicts to declare
- Chérie Moody – no conflicts to declare

Objectives

Learning Objective 1: Define minority stress, transphobia, racism, misogyny, and intersectional oppression and their effects on mental health in gender minority patients.

Learning Objective 2: List rates of mental health problems, including depression, anxiety, self-harm, and suicidal ideation and attempts.

Learning Objective 3: Explain the relationship between suicidality and transition-related care from the perspective of the patient and health care provider.

Who are trans individuals?

Trans individuals are individuals whose gender identities are different from the gender identities typically associated with their sexes assigned at birth (ASTT(e)Q, 2011)

- Trans, transgender, transexual/transsexual, Two-Spirit, genderqueer, genderfluid, a person who has transitioned (socially, medically and/or surgically)

Who are trans individuals?

Estimated trans population

- 1 in 9,000 to 1 in 100,000 (Chope & Strom, 2008)
- 0.3-0.5% (nearly 700,000) of Americans (Gates, 2011)

Diversity within the trans community

- Intersecting social identities
- Not all trans people transition (Istar-Lev, 2004; Tom Waddell Health Center Transgender Team, 2013)
  - Of those who do transition, some transition socially, some transition medically, some surgically and some do various combination of this

Definitions

Gender identity

- is each person's internal and individual experience of gender. It is their sense of being a woman, a man, both, neither, or anywhere along the gender spectrum. A person's gender identity may be the same as or different from their birth-assigned sex. Gender identity is fundamentally different from a person's sexual orientation.
  - In the predominant binary Euro-American culture this translate to "male" and "female"
  - In other cultures terms exist to describe a "third" gender, e.g. Indigenous individuals in Canada may use the term "Two Spirit"

Gender expression

- is how a person publicly presents their gender. This can include behaviour and outward appearance such as dress, hair, make-up, body language and voice. A person's chosen name and pronoun are also common ways of expressing gender.

Definition

Genderqueer (or non-binary)

- Individuals living outside the male-female binary.

Agender

- Describes a person who does not identify as having a gender identity that can be categorized as man or woman or who identifies as not having a gender identity

Cisgender (gender assigned at birth/natal)

- A term to describe a person whose gender identity matches the biological sex they were assigned at birth
- Of note:
  - The sex assigned at birth is usually determined on the genital appearance (e.g., AFAB, AMAB) (Winter et al, 2016)
  - AFAB = Assigned Female At Birth, AMAB = Assigned Mail At Birth
  - The Endocrine Society states that the actual appearance of the genitalia may not accurately reflect the person's genetic make-up, hence discourage the use of such terms as "biological sex", or "biological male or female" (Vance et al, 2014)

Definitions

Two-Spirit

- Evolved from northern Algonquin word nizhh manitoag (Anguksuar, 1997)
- Originally referred more to an identity determined less by genital contact or physical sexual activities than by culturally prescribed spiritual powers and social roles, such as dreamer, mediator, and name-giver (Jacobs, 1997)
- A new term that has been chosen to reflect traditional Indigenous gender diversity, which includes the fluid nature of sexual and gender identity and its interconnectedness with spirituality and traditional views. (Walters, Evans-Campbell, Simoni, Ronquillo, & Bhuyan 2006)
- Not adopted by all GLBT Indigenous peoples

Definitions

Queer

- Reclaimed word includes anyone targeted by heterosexism and homophobia/biphobia
- An umbrella term for a range of people who are not heterosexual and/or cisgender. It has been historically used as a slur; some have reclaimed it as affirming, while other still consider it derogatory.

Intersectionality

- Intersectionality theory was borne from critical race and feminist theories' (Crenshaw, 1989, 1991)
  - Gradually being incorporated into psychological research and practice
- Two or more social identities shaped through mutual constitution (Hancock, 2007)
  - One is more than the sum of their parts
- A nuanced conceptualization of cultural considerations/individual differences
  - E.g., racialized gender; experiences of racist homophobia (Walcott)
- Video: https://www.youtube.com/watch?v=qM3YKmnvYjQ

Person walking in Toronto Pride Parade
The Atlantic, 2012

Coming Out as a Developmental Process

Multiple stage models for both the development of homosexual identity and for transgender coming out

Apply same principles as Erikson's concept of social development

Identity development

- Greatly influenced by social interaction
- Shaped according to nature of interpersonal relationship
- Altered by physical disease, genetic disorders, psychiatric conditions
- Assisted through medical interventions (hormones, and surgery)
- Reflect North American/Western European culture
  - Includes a binary definition of sex and gender
  - Social stigmatization of gender non-conformity

Not necessarily linear

Bockting/Coleman Model

Five Stages

- Pre-Coming out
  - Time when experiencing cross-gender or trans-gender feelings, but not naming them as such
- Coming out
  - Acknowledgment to oneself and then to others of persistent cross-gender or transgender feelings
- Exploration
  - Learning as much as possible about expressing one's transgender identity now that the "true self" has been revealed
- Intimacy
  - Desire for intimacy
  - Facing the fear of being unlovable as a crucial developmental task
- Identity integration
  - Incorporation of public and private self into an integrated and positive self-image

Minority Stress

- Unique accumulation of distal and proximal short- and long-term stressors due to minority identities
- "Unique, chronic, and social" (Brooks, as quoted in Meyer, 1995)
- LGB individuals (Brooks, 1981; Meyer, 1995, 2003)
- Trans individuals (Hendricks & Testa, 2012)
- Five processes
  - Prejudice events
  - Internalized trans/bi/queer/homophobia
  - Anticipated rejection/vigilance
  - Concealment (non-disclosure)
  - Group coping
  - Would add: Intersectional stress

Sexual Minority Stress

(Brooks, 1981; Meyers, 1995, 2003)

Prejudice events – any negative events such as violence, name-calling, harassment, being discriminated against at school or work, negative remarks and behaviors from family, friends, or from peers.

NEWS

Why 2018 could be the 'deadliest' year yet for transgender women of color

by Anna Orso, Posted: September 6, 2018

Opinions

Persistent homophobia plagues the city

by David Easey | August 30, 2016

Why it's still not safe for same-sex couples in Montreal

Sexual Minority Stress Cont'd

Internalized trans/bi/queer/homophobia

- Internalization of society's anti-gay/bi/queer/trans attitudes in LGBTQ people.

Sexual orientation non-disclosure (formerly concealment)

- choosing to not disclose that one is LGBTQIA2S+, which is often used as a coping strategy aimed at avoiding negative consequences of phobia.
- It is a coping strategy that can sometimes become stressful.

Anticipated rejection

- LGBTQ people sometimes expect negative attitudes and reactions from members of the dominant culture.
- To fight against negative attitudes, discrimination, and violence they often maintain **vigilance**.

Sexual Minority Stress Cont'd

Coping

- Being LGBTQ is associated not only with stress but with important resources such as group solidarity and cohesiveness that protect minority members from the adverse mental health effects of minority stress.
- Coping is also seen in individual ways: LGBTQ people learn to cope both emotionally and by addressing bi/queer/trans/homophobia.

In addition, we would add

- **intersectional stress** (e.g., Professor Rinaldo Walcott at UofT talks about racist homophobia)
- and there is a conceptual model specific to trans folks called **Gender Minority Stress**, developed by Hendricks and Testa.

Minority Stress

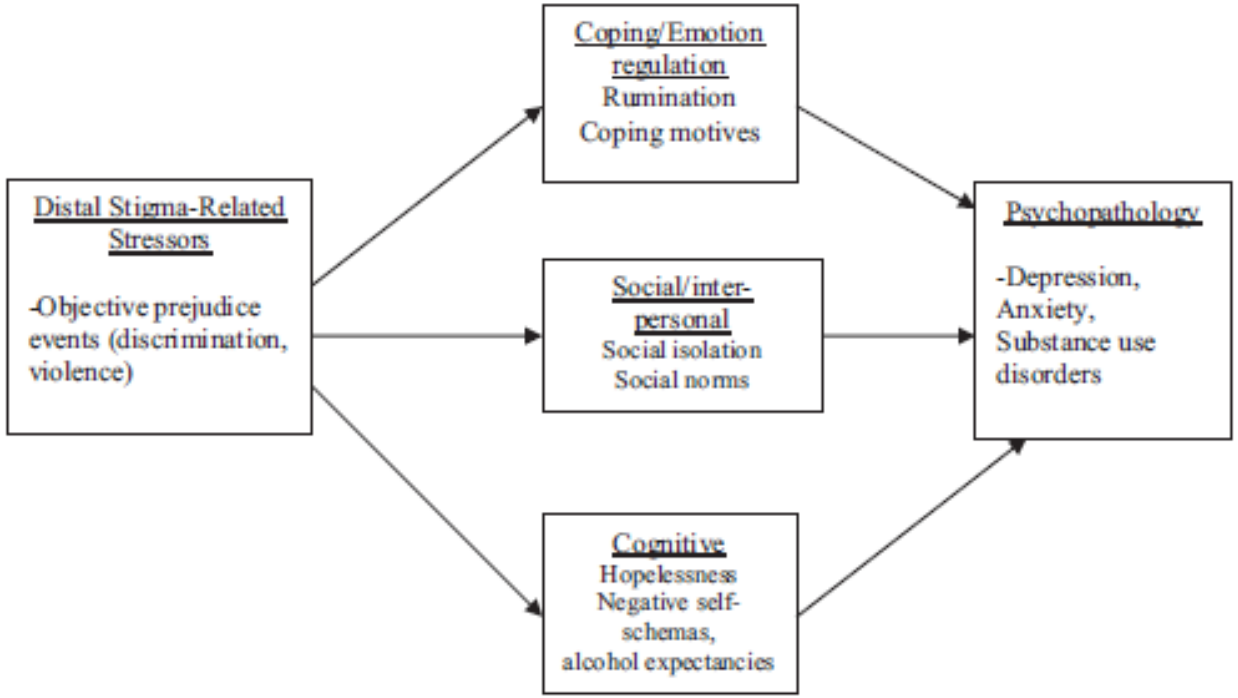


Figure 1. Psychological mediation framework.

Hatzenbuehler, 2009

Minority Stress

Stress-ameliorating factors

- Accepting immediate environment
- Coming out
- Support groups on line or in person
- Gender confirming care (mental health support, access to hormones and surgery)
- Supportive policies that ease change of identity documents
- Resilience

Intersectionality

- Multiple minority stress identities
  - Race, gender, religion, ethnicity, sexual identity, social-economic status, etc.

Effects of MS and Microaggressions

- Physical health effects
  - Smoking
  - Risky sexual behaviour (STIs, including HIV)
- Mental health effects
  - Non Suicidal Self-injury (NSSI)
  - Depression
  - Anxiety
  - PTSD
  - Alcohol and substance use (coping, socializing)
  - Suicidality (ideation and attempts)

Clark et al., 2014; Institute of Medicine, 2011; Liu & Mustanski, 2012; Marshal et al., 2011; Whitbeck et al., 2004

Effects of MS and Microaggressions

Isolation

- Others
- Health professionals
  - Avoidance of care at all levels, transition, acute care, care for chronic diseases, prevention

Anxiety (38%) (Hyde et al, 2014)

Depression (44%) (Bockting et al, 2013)

Suicidality (43% attempted suicide, 77% suicidal ideation) (Grant et al., 2011; Scanlon, Travers, Coleman, Bauer, & Boyce, 2010)

Physical injuries and death from others

HIV and STIs

Effects of MS and Microaggressions

Substance use and misuse

- Excessive drinking (22%)
- Marijuana (24%)
- Other drugs (12%) (Bockting, et al, 2016)

Rejection by family (57%) and family violence (19%) (Grant et al, 2011)

- Throwaways
- Runaways
- Homelessness
- Survival sex

Effects of MS and Microaggressions

Truancy and avoidance of school (Winter et al, 2016)

- Difficulty getting work
- Poor economic security
- Poverty

Health impact of hormone therapy

- Unknown
- Cardiovascular
- Cancers
- Metabolic diseases

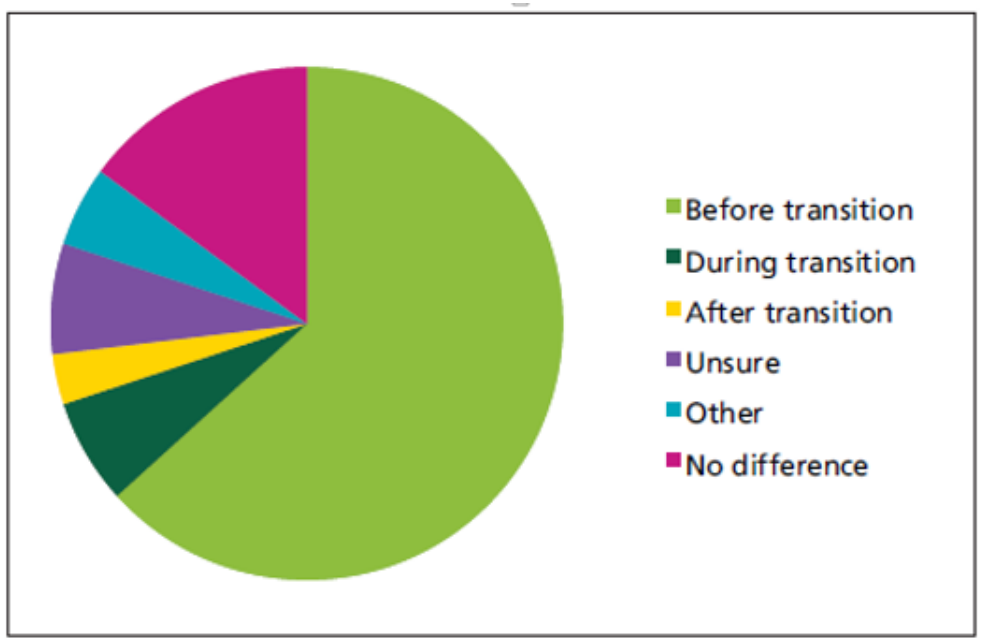
Suicidality in Adults

- Lifetime suicide attempt rates in adults:
  - between 0.4-5.1% worldwide (Nock et al., 2008)
- Adult LGB individuals' suicide attempt rates:
  - between 20%-53% (McDaniel et al., 2001)
- Trans adults
  - 43% of trans individuals report having attempted suicide, and 77% report having experienced suicidal ideation (Grant et al., 2011; Scanlon, Travers, Coleman, Bauer, & Boyce, 2010)
  - three to four times more likely to report suicidal ideation and three times more likely to attempt suicide than cis individuals (Reisner, White, Bradford, & Mimiaga, 2014)

Suicidality and transitioning

Rates of suicidal ideation and behaviour are highest among trans individuals who plan on transitioning but have not yet begun to do so (Bauer, Pyne, Francino, & Hammond, 2013)

- **25% pre-transition compared to 1% post-transition**



(Ellis, Bailey, and McNeil, 2014)

Suicidality and transition-related care

Lack of or withholding of treatment can have detrimental effects on trans individuals' physical and mental health (WPATH, 2011)

Hormone treatment and surgery

- lower rates of depression, social anxiety, general anxiety, and suicidality (Davis & Meier, 2014; Gomez-Gil et al., 2012; Keo-Meier et al., 2014; McNeil et al., 2012)
- significantly improved ratings of one's quality of life (Murad et al., 2010)

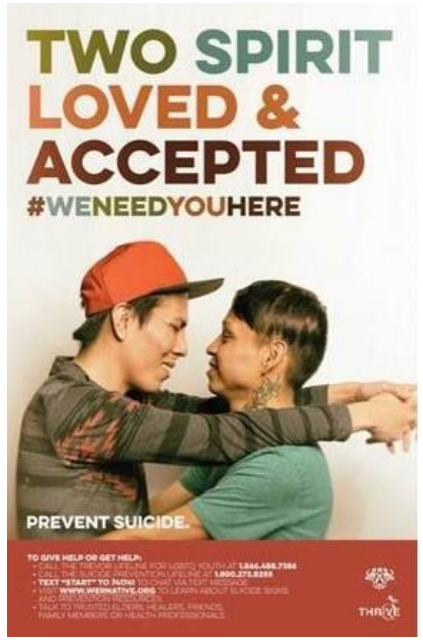
Suicide ideation and attempts – Intersectional lens

Race/ethnicity (racism, transphobia, colonization)

- White trans people experience the lowest rates of lifetime suicide attempts (38%), while trans individuals of colour experience the highest rates of lifetime suicide attempts (39%-56%) (Haas, Rodgers, & Herman, 2014)

Income and formal education (class privilege)

- Lower-income trans individuals and trans individuals with lower levels of completed formal education were significantly more likely to have attempted suicide, compared to their higher income and more formally-educated counterparts (Haas, Rodgers, & Herman, 2014)



Suicide Risk and Protective Factors among Trans Adults

Risk factors

- Victimization and transphobia (Clements-Nolle, Marx, & Katz, 2006; Nuttbrock et al., 2010; Xavier, Bobbin, Singer, & Budd, 2005)
- Physical and sexual violence (Testa, Sciacca, Wang, Hendricks, Goldblum, Bradford, et. al., 2012)

Protective factors

- Social support, reduced transphobia, and identification documents with correct sex marker (Bauer, Scheim, Pyne, Travers, & Hammond, 2015)
- Suicide resilience, child-related concerns, family support (Moody & Smith, 2013)
- Social support, acceptance, and transition-related care (Moody, Fuks, Peláez, & Smith, 2013)
- Hormone treatment and surgery
  - lower rates of depression, social anxiety, general anxiety, and suicidality (Bauer, Scheim, Pyne, Travers, & Hammond, 2015; Davis & Meier, 2014; Gomez-Gil et al., 2012; Keo-Meier et al., 2014; McNeil et al., 2012)
  - significantly improved ratings of one's quality of life (Murad et al., 2010)

Preliminary Findings

Suicidality before access to transition-related care was understood as being related to:

-Dysphoria

-Bullying and trauma

-Family factors – Not being mirrored, and experiencing rejection and abuse

-Societal factors – Not being seen, not seeing self represented

From a provider participant: “It’s [suicidal ideation] a very, very common experience because the world that we live often rejects and renders invisible folks with a trans experience. Isolation and rejection are the two harshest thing that a human being can experience, right? When we don’t see ourselves, when we don’t hear ourselves, when we don’t learn about ourselves, or see people with the same experiences as us in history or in literature or in media, how can we know that we exist and deserve to exist?”

Preliminary Findings

Suicidality while accessing or trying to access transition-related care was understood as being related to:

-Barriers: Financial, lack of competent providers, waitlists, multiple complex steps
-Dysphoria
-Family rejection
-Intersectional factors (e.g., racism and transphobia)
-Feeling violated, disempowered, and/or dehumanized by care providers/process (e.g., providers disregarding bodily autonomy)

From a trans participant: “It’s [suicidal ideation] because of all those things… Trying to access transition-related care and trying to access other resources in my life follow kind of the same pattern of not feeling legitimacy, feeling shamed, feeling like you don’t deserve those things, or feeling that it can be taken away at any moment. The feeling that other people have power over you.”

Preliminary Findings

Suicidality post-access to transition-related care was understood as being related to:

-Family rejection

-Post-surgery depression

-Transphobia (e.g., violence, lack of employment)

-Intersectional aspects (e.g., transmisogyny, ageism, poverty, racism)

From a provider participant: “The number of trans women in their 40s or 50s who have never found another job even though they were professionals with impressive CVs… I mean, it’s very, very serious transphobia out there.”

Role of Health Care Practitioners

Be open, non judgmental and supportive

Screen, diagnose, treat

- Anxiety
- Depression
- Suicidality
- Chemical dependency
- Autism spectrum disorder
- Non suicidal self-injury
- Other mental health problems

Role of Health Care Practitioners

Counselling issues can be address as per identity development stage

- Pre-Coming out
  - Children
    - Usually addressed in a specialized center by a multidisciplinary team providing support to child and family, may offer puberty blocker when patient reaches Tanner 2 in pubertal development, hormonotherapy when reaches Tanner 5 if still experiencing gender dysphoria
    - Parents may bring child due to concern about gender non-conformity
    - Isolation
    - Difficulties in academic performances for multiple reasons including teasing at school
  - Adults
    - May present for other problems such as depression, chemical dependency, anxiety
    - Manage above
    - Create an environment to allow the client to move to next stage of development (coming out), by acknowledging transgender feelings, first to oneself and then to others

Role of Health Care Practitioners

Coming out

- May be first person to whom a client discloses transgender feelings or a transgender identity
  - Remember a clinical stage
  - Open and accepting attitude
  - Encourage to take calculated risks
    - Disclosing feelings first to those most likely to accept
    - Assist in deciding who this may be
    - Help anticipate reactions explaining that immediate acceptance cannot be expected, especially from family and peers
    - Assist in rehearsing script, should be done in person, prepare answers to questions that may arise, have some resources to give family and peers
    - Explain that family and peers will have to do their own coming out to others and will need support, a therapist may offer to meet with family and peers and with patient.
    - A good place to start is transgender peers, suggest groups if feel at ease.

Role of Health Care Practitioners

Exploration

- Provide resources so as to connect with peers and community
- Encourage experimentation with gender roles and expressions
  - Explore client's desire to socially, medically or surgically transition and provide resources
  - Facilitate access to this
  - Explore how client can develop sense of attractiveness and sexual competence (assess readiness for this first)
  - Help pace process and encourage exploration of aspects of identity management
  - Provide guidance on how to come out to others, e.g. at work and manage feelings of rejection
  - Assist in confront clients inner transphobia
  - Facilitate the grieving process of fantasies that client may have had about transition process and affirming a transgender identity

Role of Health Care Practitioner

Intimacy

- Address lack of trust and fear of abandonment as one transitions
- Normalize the struggles, provide information on how to develop intimate relationships
- As chooses to become intimate if the chosen partner is of the same gender then may need to come out as gay, lesbian or bisexual
- Counsel about STIs and contraception

Identity Integration

- Assist in dealing with normal life process, midlife, ageing, managing relationships.
- Offer help in managing crises or difficulties with growing confidence, self esteem and pride.

Resources

Provincial

- Rainbow Health Ontario (for providers)
  - **RHO Trans Care Mentorship Program**
  - Directory
  - Bi-Annual Conference

Canadian

- CPATH

North American

- WPATH

For Trans patients: Trans Lifeline (Canadian number: 1-877-330-6366)

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Thank you!

QUESTIONS?