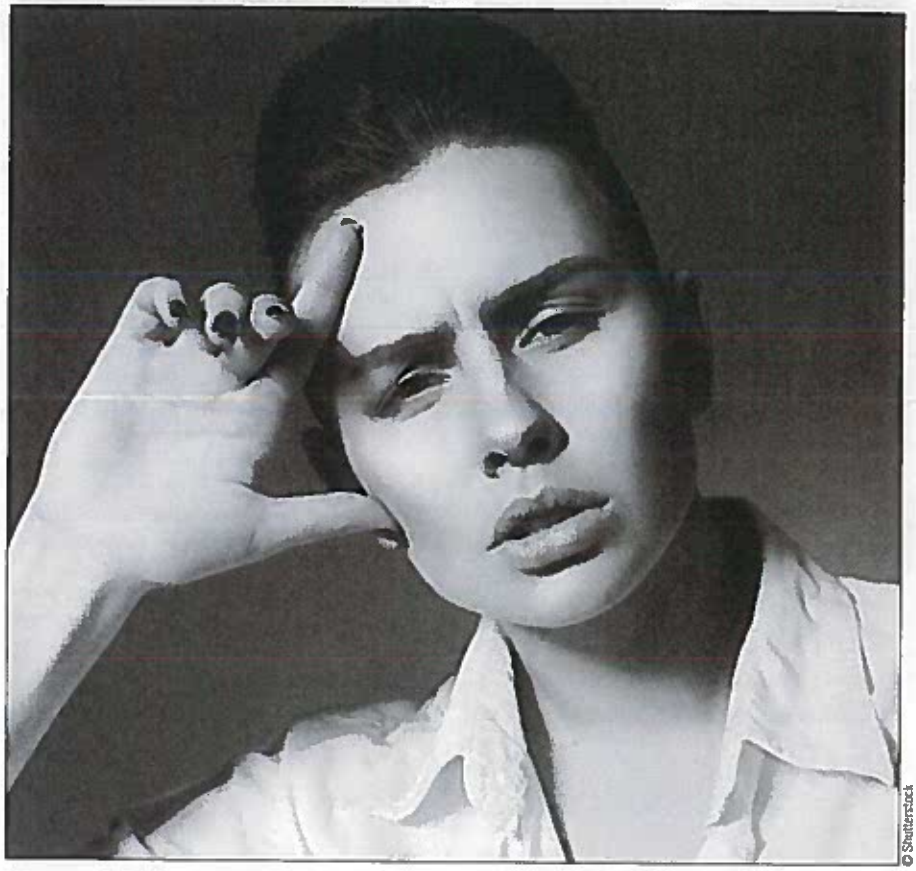
Mental Health and the Transgender Population

Tamar C. Carmel, MD; and Laura Erickson-Schroth, MD, MA

ABSTRACT

Although research has increased remarkably in recent years, exploration of mental health disparities faced by transgender and gender nonconforming (TGNC) populations has historically been limited. TGNC people experience disproportionate rates of discrimination, harassment, violence, and sexual assault, precipitating negative mental health outcomes, as explained by the Minority Stress Model. Further research substantiates an increased risk of depression, substance use disorders, self-injury, and suicidal ideation/attempts in transgender populations. Studies are less conclusive with regard to rates of anxiety disorders, posttraumatic stress disorder, bipolar disorder, psychotic disorders, eating disorders, body dysmorphic disorders, autism spectrum disorders, and personality disorders. Social and familial support are protective factors in this population. **[*Psychiatr Ann.* 2016;46(6):346-349.]**



© Shutterstock

Tamar C. Carmel, MD, is an Assertive Community Treatment Psychiatrist, Family Services of Western Pennsylvania. Laura Erickson-Schroth, MD, MA, is a Psychosomatic Medicine Fellow, Mount Sinai Icahn School of Medicine.

Address correspondence to Tamar C. Carmel, MD, Family Services of Western Pennsylvania, 211 Huff Avenue, Greensburg, PA 15601; email: carmelt@fswp.org.

Disclosure: The authors have no relevant financial relationships to disclose.

doi: 10.3928/00485713-20160419-02

Although research into the physical and mental health disparities faced by transgender and gender nonconforming (TGNC) populations is becoming more popular, historically it has been limited. It is now recognized that TGNC people experience disproportionate rates of negative mental health outcomes relative to both their gender-normative, heterosexual peers, as well as their gender-normative lesbian, gay, and bisexual (LGB) peers. The theoretical basis of current transgender mental health research is rooted in the Minority Stress Model, which postulates that we live in a hetero-centric, gender-normative society that stigmatizes and discriminates against lesbian, gay, bisexual, and transgender (LGBT) people, subjecting them to chronic stress.[1,2] This chronic, potentially compounding stress, is responsible for the increased risk of negative mental health outcomes in LGBT populations. TGNC people, in particular, may experience more adverse outcomes than

their LGB peers due to rejection and discrimination within society at large as well as within the LGB community.

TGNC people experience societal micro-aggressions on a daily basis, and a majority experience more overt discrimination, and even violence, in any number of life domains. TGNC people are at increased risk of verbal harassment, physical abuse, and sexual violence. It is well understood within psychiatry that discrimination and violence put people at increased risk of negative mental health outcomes. It can be further postulated that the severity and chronicity of stressors, as experienced by many TGNC people, would put them at even higher risk of negative mental health outcomes. This has been shown in studies of transgender populations, with higher rates of depression, substance use disorders, self-injury, and suicidal ideation (SI) and attempts.

TRAUMA, DISCRIMINATION, AND VIOLENCE

Despite the increasing number of out transgender celebrities and incremental governmental protections for the community, it is still difficult to be transgender-identified in the US,[3] particularly so for TGNC youth. Gender nonconforming children, trans-identified or not, are at increased risk of bullying and physical violence, and things do not necessarily improve as they grow older. TGNC teens and adults are at heightened risk of harassment, violence, and institutionalized discrimination, such as loss of housing or employment, with few legal protections. Transgender people are twice as likely to be unemployed, and 90% report either being harassed or mistreated at work, or taking steps to avoid workplace mistreatment.[4] Thirty-two states have no state law prohibiting discrimination against transgender people.[5] The lack of legal protection leaves TGNC people even more vulnerable to discrimination, including within health care settings. In a recent study of transgender people in Massachusetts, 24% reported discrimination in health care settings in the prior year. Health care discrimination was associated with a 31% to 81% increased risk of adverse emotional and physical symptoms, and a 2- to 3-fold increased risk of postponement of needed care.[6]

In various studies, 50% to 80% of transgender participants report having experienced harassment, discrimination, victimization, violence, or forced sex.[7-9] In one study,[7] gender discrimination and victimization was associated with increased suicide attempts. Murder rates of TGNC people are high, although likely underestimated, as the exact prevalence of TGNC people is uncertain and gender identity of murder victims is often not reported.[10] Certain groups within the TGNC community are at even higher risk than others. According to the National Coalition of Anti-Violence Programs, 67% of LGBTQ (lesbian, gay, bisexual, transgender, and queer) homicide victims are transgender women of color.[11]

MOOD DISORDERS

The lifetime prevalence of depression in the TGNC community may be as high as 50% to 67%.[7,12-14] This increased risk is believed to be the result of gender discrimination, transphobia, abuse, and victimization.[8,13,15,16] Use of exogenous feminizing hormones conveys a theoretical risk of inducing depressive symptoms; however, clinically this is not typically seen in trans women. In fact, there is some evidence to suggest that hormonal and surgical interventions for transgender people who desire such can improve quality of life and decrease depression and anxiety symptoms.[17]

Additionally, there is a theoretical risk of mania or aggression with use of exogenous testosterone; however, this is not seen clinically in trans men with testosterone levels within a physiologic male range. There is no corroborating research to convey any increased risk of bipolar symptoms or disorder in TGNC people, with or without gender-affirming hormone treatment.

It is not appropriate to initiate hormone treatment in an acutely decompensated person, nor to abruptly discontinue hormones solely because of an acute decompensation or hospitalization. If a TGNC person on hormones comes into the hospital in an acute depressive or manic episode, their gender-affirming hormones should be continued. Discontinuing a person's hormones risks worsening the person's mood symptoms, damaging the therapeutic alliance, and sets up the person for bullying and violence on the inpatient unit. It is reasonable to check hormone levels if there is concern for misuse of prescribed hormones. Transgender patients should be allowed to have room accommodations and restroom access consistent with their identified gender.

SELF-HARM

There is literature to suggest that TGNC people are at increased risk of self-injury.[18,19] TGNC youth appear to be particularly vulnerable, with childhood gender nonconformity and victimization being risk factors for self-harm.[20] A large study of LGBT youth[19] found that TGNC youth had increased rates of cutting behaviors, and a smaller study revealed self-injury in 32% of participants.[18] Although concerns about self-injurious behaviors in the transgender population tend to focus on genital mutilation, this type of self-injury is actually quite rare, with only a few case reports published over the last 50 years of transgender research.[21-23]

SUICIDE

Studies have consistently shown an increased rate of SI and suicide attempts (SA) in the TGNC population, ranging anywhere from 25% to 76%.[4,7,8,13,24,25] The wide variation in rates is likely due to different definitions of SI/SA and small sample sizes in many studies. A large community survey by the National Center for Transgender Equality and the National Gay and Lesbian Task Force found a disturbingly high rate of suicide attempts, with 41% of the 6,500 TGNC respondents reporting a history of attempts.[4] Of note, this study did not distinguish between severities of attempts, such as those that required medical treatment versus those that did not. A study of 571 transgender peo-

ple living in New York City found the lifetime prevalence of SI to be 53.5%, suicidal plans 35%, and SAs 28%.[13] Risk factors for suicide in the TGNC population include comorbid depression, substance use, inadequate social supports, and younger age.[4, 7, 8,20,26-28]

ANXIETY DISORDERS AND POSTTRAUMATIC STRESS DISORDER

Given the alarmingly high rates of violence and victimization faced by the TGNC community, increased rates of anxiety disorders and posttraumatic stress disorder would be expected. However, at present, there is limited empirical evidence to support this theory. One study showed the rate of anxiety disorders within the TGNC population to be 26%.[29]

SUBSTANCE USE DISORDERS

Substance use disorders are more common in the TGNC community than the general population.[4,27,30] TGNC people may abuse substances to cope with chronic gender-related stressors and discrimination; alleviate body dysphoria; or self-medicate as a result of underlying mental health issues.[24,31] TGNC people may also use substances of abuse to facilitate sex work, particularly when facing homelessness and unemployment. It is important to note that transgender people may not seek out rehabilitation or other inpatient or residential treatments due to fears of institutional discrimination or victimization, particularly around bathroom use and roommate accommodations.

BODY IMAGE AND EATING DISORDERS

One might assume that TGNC people would be more prone to body image issues and eating disorders due to dysphoria related to a gender identity that does not match their physical body. However, limited evidence does not support this assumption. One study showed that transgender women engage in more body-checking than nontransgender women,[32] but this is not necessarily maladaptive. In fact, body-checking could be a protective factor, helping trans women avoid being recognized as transgender, and thus protecting them from discrimination and violence.

PSYCHOSIS

There are no large-scale studies evaluating the prevalence of schizophrenia or other psychotic disorders in the TGNC population. However, clinical experience and expertise does not suggest any increase in risk. Providers often wonder how to approach cross-gender identification in an acutely psychotic person. The authors recommend evaluating the person for gender dysphoria when their psychosis is cleared, and establishing a timeline of their cross-gender thoughts and identification. If the person has had these thoughts, feelings, and behaviors before, during, and after the psychotic episode, then they most likely have an underlying trans identity, unrelated to the psychotic illness. If a TGNC person who is taking gender-affirming hormones comes into the hospital for an acute psychotic episode, hormones should be continued as prior to hospitalization. Providers may check hormone levels if clinically indicated. However, it is inappropriate to initiate hormone treatment in an acutely psychotic person.

AUTISM SPECTRUM DISORDERS

There has been recent interest in investigating a potential connection between autism spectrum disorders (ASDs) and the TGNC population. Some studies suggest higher rates of ASDs in transgender people and, inversely, higher rates of transgender identity in people with ASDs.[33] This is a new area of interest with small study sizes, and needs to be replicated in large-scale studies.

PERSONALITY DISORDERS

Certain personality disorders (PDs), such as borderline personality disorder, are correlated with early life trauma and abuse. In theory, this would put TGNC people at heightened risk of PDs given the prevalence of violence and victimization experienced by the TGNC population, especially at a young age. Because of the diverse characteristics of PDs and the low prevalence of TGNC-identification, it is extremely difficult to research this area. Thus, research into PDs and TGNC identities is lacking and inconsistent. One study[29] indicated that the majority of transgender people studied did not have PDs, but those who did tended to have multiple mental health disorders and more severe illnesses.

RESILIENCE IN TRANSGENDER POPULATIONS

Resilience is a relatively new area of research in TGNC populations, shifting the focus from risk and illness to positive outcomes. Resilience has been defined in many ways, but is generally equated with the capacity to thrive in the face of adverse life events.[34] Researchers' considerations of adverse events in transgender populations have included experiences of internal or external stigma, subtle or blatant discrimination, as well as simply living life as a transgender person. Outcome measures include self-esteem, mental distress, depression, anxiety, and suicidality. Some resiliency factors in the TGNC population align with existing research on resilience in other populations, specifically LGB populations. These include social connectedness and family support. Other resiliency factors appear to be unique to transgender communities.[14, 35-38] Further research is needed for improved understanding of resilience in TGNC populations, especially to identify factors modifiable by health or social interventions. Clinicians should work with TGNC patients to promote resilience-building through enhancement of self-esteem and encouraging clients to build supportive social networks. If family is important and/or active in the person's life, the clinician should work with them to create a safe and supportive family system.

CONCLUSIONS

TGNC populations are disproportionately affected by discrimination, harassment,

and violence, leading to mental health disparities, such as increased rates of depression, substance use disorders, self-injury, and SI/SA, as predicted by the Minority Stress Model. Other mental health concerns are not as well researched. Despite these disparities, many transgender people are highly resilient, employing internal strengths and using supportive social networks to navigate and thrive in an often hostile world.

REFERENCES

1. Meyer IH. Minority stress and mental health in gay men. *J Health Soc Behav*. 1995;36:38-56.
2. Hendricks ML, Testa RJ. A conceptual framework for clinical work with transgender and gender nonconforming clients: an adaptation of the Minority Stress Model. *Prof Psychol Res Pr*. 2012;43(5):460-467.
3. White Hughto JM, Reisner SL, Pachankis JE. Transgender stigma and health: a critical review of stigma determinants, mechanisms, and interventions. *Soc Sci Med*. 2015;147:222-231.
4. Grant JM, Mottet LA, Tanis J. National Center for Transgender Equality. National Gay and Lesbian Task Force. Injustice at every turn: a report of the national transgender discrimination survey. http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf. Accessed April 19, 2016.
5. American Civil Liberties Union. Know your rights: transgender people and the law. https://www.aclu.org/know-your-rights/transgender-people-and-law. Accessed April 19, 2016.
6. Reisner SL, Hughto JM, Dunham EE, et al. Legal protections in public accommodations settings: a critical public health issue for transgender and gender-nonconforming people. *Milbank Q*. 2015;93(3):484-515.
7. Clements-Nolle K, Marx R, Katz M. Attempted suicide among transgender persons: the influence of gender-based discrimination and victimization. *J Homosex*. 2006;51(3):53-69.
8. Kenagy GP. Transgender health: findings from two needs assessment studies in Philadelphia. *Health Soc Work*. 2005;30(1):19-26.
9. Lombardi EL, Wilchins RA, Priesing D, Malouf D. Gender violence: transgender experiences with violence and discrimination. *J Homosex*. 2001;42(1):89-101.
10. Gates GJ. The Williams Institute. How many people are lesbian, gay, bisexual, and transgender? http://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-Many-People-LGBT-Apr-2011.pdf. Accessed April 19, 2016.
11. Ahmed O, Jindasurat C. National Coalition of Anti-Violence Programs. Lesbian, gay, bisexual, transgender, queer, and HIV affected hate violence in 2013. http://www.avp.org/storage/documents/2013_ncavp_hvreport_final.pdf. Accessed April 19, 2016.
12. Kim TS, Cheon YH, Pae CU, et al. Psychological burdens are associated with young male transsexuals in Korea. *Psychiatry Clin Neurosci*. 2006;60(4):417-421.
13. Nuttbrock L, Hwahng S, Bockting W, et al. Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons. *J Sex Res*. 2010;47(1):12-23.
14. Rotondi NK, Bauer GR, Scanlon K, Kaay M, Travers R, Travers A. Prevalence of and risk and protective factors for depression in female-to-male transgender ontarians: trans PULSE Project. *Can J Commun Ment Health*. 2012;30(2):135-155.
15. Bontempo DE, D'Augelli AR. Effects of at-school victimization and sexual orientation on lesbian, gay, or bisexual youths' health risk behavior. *J Adoles Health*. 2002;30(5):364-374.
16. Roberts AL, Rosario M, Corliss HL, Koenen KC, Austin SB. Childhood gender nonconformity: a risk indicator for childhood abuse and posttraumatic stress in youth. *Pediatrics*. 2012;129(3):410-417.
17. Gómez-Gil E, Zubiaurre-Elorza L, Esteva I, et al. Hormone-treated transsexuals report less social distress, anxiety and depression. *Psychoneuroendocrinology*. 2012;37(5):662-670.
18. Hoshiai M, Matsumoto Y, Sato T, et al. Psychiatric comorbidity among patients with gender identity disorder. *Psychiatry Clin Neurosci*. 2010;64(5):514-519.
19. Walls NE, Laser J, Nickels SJ, Wisneski H. Correlates of cutting behavior among sexual minority youths and young adults. *Soc Work Res*. 2010;34(4):213-226.
20. Liu RT, Mustanski B. Suicidal ideation and self-harm in lesbian, gay, bisexual, and transgender youth. *Am J Prev Med*. 2012;42(3):221-228.
21. McGovern SJ. Self castration in a transsexual. *J Accid Emerg Med*. 1995;12(1):57-58.
22. Baltieri DA, de Andrade AG. Transsexual genital self-mutilation. *Am J Forensic Med Pathol*. 2005;26(3):268-270.
23. St Peter M, Trinidad A, Irwig MS. Self-castration by a transsexual woman: financial and psychological costs: a case report. *J Sex Med*. 2012;9(4):1216-1219.
24. Xavier J, Honnold JA, Bradford JB. The health, health-related needs, and lifecourse experiences of transgender Virginians. Virginia Department of Health. http://www.vdh.virginia.gov/epidemiology/diseaseprevention/documents/pdf/THISFINALREPORT-Vol1.pdf. Accessed April 19, 2016.
25. Krehely J. How to close the LGBT health disparities gap. Center for American Progress. https://cdn.americanprogress.org/wp-content/uploads/issues/2009/12/pdf/lgbt_health_disparities.pdf. Accessed April 19, 2016.
26. Grossman AH, D'Augelli AR. Transgender youth and life-threatening behaviors. *Suicide Life Threat Behav*. 2007;37(5):527-537.
27. Risser JM, Shelton A, McCurdy S, et al. Sex, drugs, violence, and HIV status among male-to-female transgender persons in Houston, Texas. *Int J Transgend*. 2005;8(2-3):67-74.
28. Terada S, Matsumoto Y, Sato T, Okabe N, Kishimoto Y, Uchitomi Y. Suicidal ideation among patients with gender identity disorder. *Psychiatry Res*. 2011;190(1):159-162.
29. Hepp U, Kraemer B, Schnyder U, Miller N, Delsignore A. Psychiatric comorbidity in gender identity disorder. *J Psychosom Res*. 2005;58(3):259-261.
30. Leslie DR, Perina BA, Maqueda MC. Clinical issues with transgender individuals. A provider's introduction to substance abuse treatment for lesbian, gay, bisexual and transgender individuals. In: Messinger L, Morrow DF, eds. *Case Studies On Sexual Orientation & Gender Expression in Social Work Practice*. New York, NY: Columbia University Press; 2001:93-100.
31. Scourfield J, Roen K, McDermott L. Lesbian, gay, bisexual and transgender young people's experiences of distress: resilience, ambivalence and self-destructive behavior. *Health Soc Care Community*. 2008;16(3):329-336.
32. Vocks S, Stahn C, Loenser K, Legenbauer T. Eating and body image disturbances in male-to-female and female-to-male transsexuals. *Arch Sex Behav*. 2009;38(3):364-377.
33. Shumer DE, Reisner SL, Edwards-Leeper L, Tishelman A. Evaluation of Asperger syndrome in youth presenting to a gender dysphoria clinic. *LGBT Health*. 2015; doi:10.1089/lgbt.2015.0070. [epub ahead of print]
34. Masten AS. Ordinary magic: resilience processes in development. *Am Psychol*. 2001;56(3):227-238.
35. Bariola E, Lyons A, Leonard W, Pitts M, Badcock P, Couch M. Demographic and psychosocial factors associated with psychological distress and resilience among transgender individuals. *Am J Public Health*. 2015;105(10):2108-2116.
36. Breslow AS, Brewster ME, Velez BL, Wong S, Geiger E, Soderstrom B. Resilience and collective action: exploring buffers against minority stress for transgender individuals. *Psychol Sex Orientat Gend Divers*. 2015;2(3):253.
37. Singh AA, Hays DG, Watson LS. Strength in the face of adversity: resilience strategies of transgender individuals. *J Couns Dev*. 2011;89(1):20-27.
38. Testa RJ, Jimenez CL, Rankin S. Risk and resilience during transgender identity development: the effects of awareness and engagement with other transgender people on affect. *J Gay Lesbian Ment Health*. 2014;18(1):31-46.