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**Examining Personal and Structural Mental Healthcare Disparities
in Transgender and Gender Non-conforming Individuals**

An Honors Thesis submitted in partial fulfillment of the requirements for Honors in
Psychology.

By
Aiden Mintah-Jumbo

Under the mentorship of *Dr. Brandon Weiss*

ABSTRACT

The current research evaluates the mental healthcare barriers that exist for transgender/ gender non-conforming individuals versus cisgender individuals in the context of anxiety and depression. We hypothesized that non-cisgender people would have greater healthcare disparities than compared to cisgender people. The importance of this research is to further understand the healthcare gap between transgender/ gender non-conforming communities and cisgender communities. Participants (n = 532) took an online survey where they were asked a series of questions relating to how barriers to care impact mental health domains. Data was analyzed using a one-way between groups multivariate analysis of data (MANOVA) which assessed each group's levels of social anxiety, worry, and depression. We found a significant difference in depression when comparing the cisgender and non-cisgender individuals; however, in contrast to previous literature, results also showed that there was no significant difference in social anxiety or worry between the groups. These findings further expand on the ways that mental healthcare disparities impact non-cisgender individuals and provide a basis to develop clinical programming for these people. Nonetheless, more research is needed to pinpoint the needs of this community and how the healthcare field can provide them with the most effective care.

Keywords: Transgender, gender non-conforming, healthcare, disparities, barriers

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**Examining Personal and Structural Mental Healthcare Disparities
in Transgender and Gender Non-conforming Individuals**

Transgender and Gender Non-Conforming (TGNC) individuals are faced with a disproportionate amount of harassment, childhood abuse, discrimination, and violence relative to cisgender individuals (Institute of Medicine [IOM], 2011; Su et al., 2016). These aspects contribute to a greater number of mental and physical health problems within this community, yet, few studies have examined the health disparities present for this vulnerable group of people. TGNC individuals may encounter personal and structural factors that limit their ability to obtain proper, personalized physical and mental care (IOM, 2011). The current study aims to define these factors and examine differences in access to care within the TGNC community.

In this study, the term *transgender* is defined as an individual whose assigned sex at birth is incongruent with their gender identity. Many transgender people choose to medically transition in order for their outward appearance to match their gender identity. These methods may include taking prescribed hormones and undergoing surgery; however, many choose not to undergo these procedures (IOM, 2011). A person who identifies as *gender non-conforming* may express behaviors and appearances that do not align with their perceived gender in society based on the traditional male/female binary. These individuals may also choose to use the term transgender to describe themselves, but many do not. The term *cisgender* will be used to describe individuals who identify with the sex assigned to them at birth, meaning their biological sex is congruent with their gender identity.

Structural-level barriers are defined as “barriers that occur regardless of the attitudes of individuals” as they correspond to the health care system at the institutional level (IOM, 2011, p. 64). For example, TGNC individuals are less likely to have health insurance which, in turn, makes them less likely to utilize healthcare services (Carter et al., 2019; IOM, 2011; Grant et al., 2010). This community, especially those of color, often experiences high levels of joblessness and poverty which contribute to the lack of access to health insurance and healthcare services (IOM, 2011; Grant et al., 2010). Transgender individuals also experience structural barriers with health insurance utilization, as many public and private insurance options severely limit or explicitly exclude the services that they would wish to receive to affirm their gender identity (IOM, 2011). Many individuals report postponing medical care when they were sick or injured due to an inability to afford it (Grant et al., 2010). Healthcare providers have identified insurance as a substantial barrier for TGNC clients accessing care (Holt et al., 2019). Insurance companies have been shown to ask providers for strict diagnostic requirements to cover gender-affirming surgeries, more detailed progress notes, and decide which services that TGNC patients can access (Holt et al., 2019). These factors greatly increase the chances for negative health outcomes in this community.

When TGNC people are able to access medical services, they are often put in the position to explain their health needs to providers leading to a decreased quality of care (IOM, 2011; Grant et al., 2010). According to Grant’s (2010) survey report, 50% of the sample reported having to educate their providers on transgender-specific medical care. Many individuals also report harassment and violence in medical settings, or an outright refusal of care, both attributed to the “manifestation of stigma within the institutions of

society” (IOM, 2011, p. 64; Grant et al., 2010; Sperber et al., 2005). Most providers lack the available knowledge needed to treat the healthcare needs of TGNC people as related to hormone use, HIV/AIDS counseling, and gynecological care which significantly decreases the quality of care they receive (Sperber et al., 2005; IOM, 2011); however, poor patient-provider communication has been shown to be directly related to decreased levels of patient satisfaction and adherence to physician advice (IOM, 2011). Future training and policies should be dedicated to increasing cultural competency and provider knowledge on transgender care. It is imperative for providers to be knowledgeable about these topics in order to help alleviate the healthcare disparities seen in the transgender and gender non-conforming population.

Currently, research is lacking on the physical health status of TGNC individuals; however, the limited research available has shown that feminizing hormone therapy increases risk for venous thromboembolic diseases and elevated levels of prolactin as well as loss of bone mineral density, elevated liver enzymes, and increased risk for ovarian cancer with masculinizing hormone therapy (IOM, 2011). Another major factor in the physical health status of transgender persons is HIV/AIDS (Grant et al., 2011; IOM, 2011). It has been shown that this community experiences elevated rates of HIV/AIDS infections as compared to the general population. In the study completed by Grant et al. (2011), transgender respondents reported an HIV infection rate of 2.64% placing them at over four times the rate of the national average (0.6%) in the United States. This number significantly increases when examining transgender groups of color, especially African Americans who reported rates of 24.90% as compared to the national rate of 2.4% (Grant et al., 2011). These substantially high rates are related to the

comparatively high unemployment rates seen in the community that lead many to sex work practices, with 61% of respondents who were HIV-positive had reported doing sex work for income (Grant et al., 2011).

Physical health problems can also manifest because of an individual's attempts to avoid discrimination. Herman (2013) reported that 54% of transgender respondents had indicated some sort of physical problem from holding their bladder in order to avoid using public restrooms because of prior experiences of discrimination and/or harassment. Respondents reported health problems including kidney infections, urinary tract infections, dehydration, and other kidney related problems as a result of public restroom avoidance. They also reported avoiding going to the hospital, doctor's office, or other healthcare facilities (and in turn delaying the receipt of necessary healthcare) because of the avoidance of gender-segregated restrooms (Herman, 2013).

Personal-level barriers to healthcare are identified as individual internalized, felt, or enacted stigma that manifests as an acceptance to the negative attitudes about transgender persons in society (IOM, 2011). TGNC individuals may internalize the discrimination, felt or enacted, against them leading them to feel less deserving of the same types of medical services or respect from healthcare providers as their cisgender counterparts (IOM, 2011). This community has been shown to be more likely to experience depression symptoms, attempted suicides, suicidal ideation, substance abuse, and anxiety disorders when compared to the general population (Su et al., 2016; Valentine & Shipherd, 2018). These disorders are elevated by the social stressors that TGNC people experience on a day-to-day basis; moreover, carrying around internalized stigma leads to the greater mental health problems seen in this population. (IOM, 2011;

Valentine & Shipherd, 2018). In the study done by Su et al. (2016), over 40% of the transgender respondents reported facing discrimination. The high rates of discrimination against this community heavily influence the presence of depression symptoms and suicide attempts seen (Grant et al., 2010; Su et al., 2016; Valentine & Shipherd, 2018). Internalized transphobia brought on by societal rejection, non-affirmation, and victimization has been shown to act as both a mediator and moderator in the relationship between trans stress and suicidal ideation (Staples et al., 2017). When individuals internalize the blame for discrimination, they may be more likely to use substances or alcohol to cope with their feelings which can quickly lead to their abuse (Puckett et al., 2019). All of these factors categorize this population as high-risk for psychosocial issues.

TGNC individuals have been shown to use detachment/ withdrawal strategies as a reaction to discrimination (Puckett et al., 2019). These strategies may include isolation from others, avoiding potentially hostile environments, and emotional detachment (Mizock & Mueser, 2014). In the sample collected by Puckett et al. (2019), participants who reported using detachment/ withdrawal strategies reported higher levels of depression and anxiety symptoms than those who reported low usage of these strategies. It is also important to note that those who experienced discrimination over the past year showed a positive correlation with anxiety and depression which aligns with previous research that emphasizes the negative mental health impact of facing discrimination for the TGNC population (Grant et al., 2010; Puckett et al., 2019; Su et al., 2016; Valentine & Shipherd, 2018).

When attempting to utilize mental healthcare services TGNC populations encounter a variety of barriers that inhibit their access to proper care (Shipherd et al.,

2010; IOM, 2011). In the sample collected by Shipherd et al. (2010), 52% of respondents had shown symptoms of psychological distress but had not received mental health treatment in the past year. TGNC individuals report problems with cost of treatment (related to lack of health insurance for many), stigma concerns, fear of treatment, and previous bad experiences with healthcare providers (Shipherd et al., 2010; IOM, 2011; Valentine & Shipherd 2018). Previous research has shown that insensitivity to transgender issues and provider ignorance are prominent in the mental health care system (Shipherd et al., 2010; Sperber, 2005); however, as providers attempt to increase their cultural competence for TGNC clients, barriers for this community could be reduced. An interesting finding by Green (2008) showed similar concerns among cisgender populations that have also been seen in TGNC populations. 60% of respondents in that study reported one or more concerns (e.g., not knowing what would happen to them or someone they know having a previous bad experience) that prevented them from receiving mental health treatment (Green, 2008; Green & McCrady, 2009). These findings suggest that cisgender and TGNC populations may both experience similar concerns when seeking services and that it is important for providers to make efforts to minimize stigma concerns around mental healthcare (Shipherd et al., 2010). By creating a more competent and inclusive space, TGNC individuals could receive quality mental healthcare in a culturally informed manner.

Holt et al. (2019) found, by talking with providers, that TGNC clients have many negative emotions (fear, depression, anxiety, shame, suicidal thoughts) that were directly related to societal stigma about gender identity. TGNC patients often experience fear in health care settings, such as being scared to trust a provider, anxiety from hiding their

gender identity, and depression made worse by not having a support system (Holt et al., 2019). Concurrently, it is incredibly difficult for TGNC clients to find TGNC-affirmative healthcare providers, especially for those in rural areas (Holt et al., 2019). These patients are more likely to have to cycle through providers until they can find a therapist who is knowledgeable and a match for them (Holt et al., 2019). The barriers presented complicate the experience between provider and patient; however, because of these barriers, it is even more important that providers are able to serve as advocates and caseworkers to aid their patients (Holt et al., 2019; Hope et al., 2016). Providers should be willing to meet clients where they are in order to give them the best type of care for their situation. This would require them to obtain a deeper understanding of trans stigma, its relation to society, and how societal expectations about gender can contribute to these mental health issues (Holt et al., 2019; Hope et al., 2016).

Rates of anxiety disorders are consistently higher for TGNC persons than they are for cisgender populations (Butler et al., 2019). The elevated rates of anxiety disorders are driven by gender-related stress in the population (Testa et al., 2015). Testa et al. (2015) found that gender-related discrimination, internalized transphobia, nondisclosure, non-affirmation of gender identity, rejection, and negative expectations for the future were all associated with social anxiety for TGNC individuals. It was also found that non-affirmation of one's gender identity may be shaming, embarrassing, or a threat to safety which can lead to the avoidance of social situations therefore heightening the effects of social anxiety for this community (Testa et al., 2015). Internalized transphobia is linked with expectations of rejection and can worsen an individual's self-perception leading to greater mental health problems (Rood et al., 2016). In the survey conducted by Butler et

al. (2019), it was found that transgender people who had completed a gender-affirming medical intervention (chest surgery genital surgery, speech therapy, hormone use, hair removal, or tracheal shave) reported lower levels of social anxiety as compared to people who were either planning or considering an intervention in the future. This relationship may stem from a decrease in rejection, discrimination, gender nonaffirmation, and victimization that comes from the resultant physical characteristics that place them in line with the gender binary (Butler et al., 2019). Medical interventions may also increase body satisfaction which could contribute to higher levels of self-esteem, decreased negative expectations with social interactions, lessened gender minority stressors, and increased social engagement; therefore, reducing the effects of social anxiety for this population (Butler et al., 2019).

Similar aspects seen for anxiety disorders have been shown for the diagnosis of depression in TGNC populations. TGNC persons are particularly vulnerable to “proximal” stressors (e.g., stress of concealment and fear of future discrimination) associated with the minority stress model (Chodzen et al., 2019; I. Meyer, 2003; Testa et al., 2015). The likelihood of being diagnosed with major depressive disorder (MDD) were linked to several factors related to gender minority stress (Chodzen et al., 2019). In the sample collected by Chodzen (2019), transgender youth who experienced a misalignment with their gender identity and physical appearance were more likely to meet the diagnostic criteria for MDD; moreover, internalized transphobic beliefs were shown to be closely related with having both MDD and general anxiety disorder.

Although research has documented health factors for transgender individuals, limited studies exist to properly define the barriers to healthcare that TGNC populations

face. The current study attempts to analyze the barriers to mental healthcare experienced by TGNC individuals as it relates to anxiety and depression. The aim is to contribute to the existing literature and increase the knowledge base about these healthcare barriers. A comparison of these aspects will be made for cisgender and TGNC populations in order to assess the differences between the two communities.

Method

Participants

Participants were all 18 years of age or older and were required to identify as a sexual minority in order to participate in the study. Participants were recruited using MTurk. All participants received a small monetary incentive (1 dollar). Participants were provided with an informed consent form and background information for the study.

Procedure

Potential participants first expressed interest to take the survey via MTurk. After signing up, participants were sent a link that directed them to Qualtrics in order to take the survey. Once reaching the website, they were required to read the informed consent form and consent to participation in the study by electronically signing the form. Then, the participant completed the questions and was directed to a debriefing page.

Measures

The study required a computer with an internet connection in order to access the survey. MTurk was used to recruit participants who were given the link to the survey on Qualtrics after signing up to participate. Participants used a keyboard and mouse to respond to survey prompts on the screen. The items chosen for this study were extracted from part of a larger needs assessment survey.

To measure social anxiety, we used the Brief Fear of Negative Evaluation Scale (BFNE; Leary, 1983). The Brief Fear of Negative Evaluation Scale is the abbreviated version of the Fear of Negative Evaluation Scale (Watson & Friend, 1969). The BFNE includes 12 items that assess fear and worry on a Likert scale from 1 (Not at all characteristic of me) to 5 (Extremely characteristic of me). Eight of the items are related to the presence of fear or worry, while the remaining four items assess the absence of fear or worrying. Although it is shorter in length, this scale has been shown to have high correlation with the original scale and demonstrates nearly identical psychometric properties; similarly, this measure has demonstrated a high internal consistency and validity (Leary, 1983).

In order to measure worry in participants, we utilized the Penn State Worry Questionnaire (PSWQ; T. Meyer et al., 1990). The PSWQ is a 16-item instrument that measures the worry phenomenon. Each item is ranked on a Likert scale that ranges from 1 (Not at all typical of me) to 5 (Very typical of me). The total score is found by averaging all of the participants' scores from each item. Total scores range from 16-39 (low worry), 40-59 (moderate worry), and 60-80 (high worry). The PSWQ has been shown to possess high internal consistency, and good test-retest reliability (Meyer et al., 1990).

Lastly, to measure depression, we used the Center for Epidemiologic Studies – Depression Scale (CES-D; Radloff, 1977). The CES-D is a brief self-report scale used to measure depressive symptoms in the general population. This measure contains 20 items with responses ranging from rarely or none of the time (less than 1 day) to most or all of the time (5-7 days). Items on the scale assess symptoms associated with depression that

have been utilized in previously validated longer scales (Radloff, 1977). The CES-D has demonstrated high internal consistency and adequate test-retest reliability; furthermore, validity, reliability, and factor structure have been similar across a wide variety of demographic characteristics in the general population (Radloff, 1977).

Results

Preliminary Analysis. Analyses focused on participants who correctly responded to the survey prompts. Four participants were excluded from the data because of unclear responses. Descriptive statistics for each variable are shown in Table 1. A one-way between groups multivariate analysis of variance (MANOVA) was conducted to analyze the data, at an alpha level of $\alpha = .05$, with cisgender and transgender as the independent groups and social anxiety (BFNE), worry (PSWQ), and depression (CES-D) as the dependent variables.

Primary Analysis. The overall multivariate effect was significant $F(3, 530) = 3.52, p = .015$, Pillai's Trace = .02. For social anxiety, the MANOVA revealed that there was no significant difference between the cisgender and non-cisgender participants $F(1, 532) = .048, p = .827$ for social anxiety. We also found no significant difference $F(1, 532) = .767, p = .382$ for the worry phenomenon when both groups were compared; however, The MANOVA showed that there was a significant difference in depression between the cisgender and TGNC individuals $F(1, 532) = 8.3, p = .004$.

Individual Items Assessment. After completing the main analysis, we assessed individual items to determine whether non-cisgender people had differing experiences with healthcare than those who identified as cisgender. Although the non-cisgender individuals often displayed higher means than the cisgender individuals, the means were

not statistically significant. For example, one item asked participants “Overall, in terms of your experience as an LGBT individual, how often have you had negative experiences with your healthcare provider?” This item was not found to have a significant difference $F(1, 756) = 3.445, p = .064$, however TGNC individuals ($M = 2.67, SD = 1.187$) did rate this item higher than the cisgender participants ($M = 2.06, SD = 1.085$).

Discussion

The current study involved the analysis of the personal and structural mental healthcare disparities that exist between transgender and cisgender individuals. We hypothesized that TGNC people would experience higher levels of social anxiety, worry, and depression than cisgender people. When assessing depression between the two groups, the data was found to be statistically significant (Chodzen et al., 2019; Rood et al., 2016) meaning that transgender people were experiencing higher levels of depression when compared to cisgender people. Concerning social anxiety and worry, the data was not found to be significant; however, these results were inconsistent with previous literature (Butler et al., 2019; Testa et al., 2015) that found rates of anxiety in TGNC communities to be much higher than in cisgender communities. This result was surprising considering that a large number of the previous literature shows higher anxiety levels for transgender people, especially related to the healthcare setting (Holt et al., 2019; IOM, 2011; Shipherd et al., 2010; Valentine & Shipherd 2018).

The implications of the current findings suggest TGNC individuals may not experience higher levels of social anxiety and worry when compared to cisgender individuals, but they do experience a significant difference in depression. Although we found support that TGNC individuals may not experience significantly higher levels of

social anxiety and worry, we cannot conclusively state that the current study invalidates the work done by previous researchers. These results heighten the need for further research to be conducted surrounding these mental health issues and how they affect someone who identifies outside of the gender binary. For the depression factor, our results align with the existing literature stating that the transgender community is more susceptible to higher rates of depression than compared to the cisgender community (Chodzen et al., 2019; Rood et al., 2016). This would imply that TGNC people experience greater mental healthcare disparities, in this context, which could limit their ability to obtain and receive proper care. Previous literature has already shown that transgender individuals are more likely to experience depression and it is often attributed to their internal struggle with gender identity as well as in the larger society (Chodzen et al., 2019). Previous societal rejections and negative expectations in social interactions may lead to even greater mental health problems that contribute to the barriers this community faces in accessing sufficient healthcare (Butler et al., 2019; Holt et al., 2019).

Limitations

The information presented in this study was not assessed without some limitations. Although our results showed that there was no significant difference in social anxiety and worry, for the TGNC community, this study only incorporated sexual minorities; therefore, this could explain the contrast with the literature as many sexual minorities face discrimination that can raise their levels of social anxiety and worry. Consequently, many of the participants may have preexisting heightened levels of mental stress that could have been reflected in our results. Furthermore, due to the sample size, transgender and gender non-conforming identities were grouped in the study. Data was

collected for a larger number of cisgender participants ($n = 481$) than TGNC participants ($n = 53$) which indicated unequal manipulated variables that could have influenced our results. This limitation could be rectified by gathering data from more TGNC individuals to help balance the number of participants. Another limitation was in the use of self-report measures instead of diagnostic measures. For instance, self-report measures are subject to bias as individuals are reporting their own experiences. Questions can be misinterpreted, depending on the wording, or the order of the prompts may influence the individuals' responses. Conversely, the use of self-report measures was beneficial to this study because of the format of data collection. Data was collected via MTurk which provided us with access to a larger number of participants. Interested respondents, who matched the criteria for participation, could easily partake in the study as long as they had an internet connection and a compatible device. Also, due to the nature of the data being collected, it was not possible for the researchers to directly observe the experiences of the individuals as they were receiving care and/or attempting to receive care; therefore, self-report measures allowed us to analyze these experiences, from the individuals themselves, without needing direct access to them.

Conclusion

Despite these limitations, this study provides necessary data, for the healthcare field, about the disparities that affect those who identify outside of the gender binary. Cultural sensitivity to TGNC individuals is vital to closing the disparity gap. Furthermore, education about these groups is much needed for the expansion of and access to proper care that will best suit them. Importantly, when collecting demographic information, it would behoove healthcare providers to include a broad range of gender

identifications to better understand their patient's identities and the challenges that they may face in obtaining care. Future research should further investigate the healthcare disparities between different transgender and gender non-conforming identities. A masculine-presenting person compared to a feminine-presenting person will face distinct challenges in the healthcare field. More research is needed to assess what these differences are and how they affect the lived experiences of transgender individuals. Future studies could also examine the differences in depression between the cisgender and TGNC community. A more in-depth procedure should be taken to fully evaluate the extent that depression contributes to healthcare disparities and how to minimize its effects. We believe that this study documents mental health factors for the transgender and gender non-conforming community and serves to expand the knowledge base for healthcare providers.

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Table 1

Cisgender vs Non-cisgender Outcome Measures for Social Anxiety, Worry, and Depression

Measure	Cisgender		Transgende		<i>F</i>	<i>df</i>	<i>p</i>
			<i>r</i>				
	<i>n</i>	<i>M (SD)</i>	<i>n</i>	<i>M (SD)</i>			
BFNE	481	37.2 (10.2)	53	36.9 (10.4)	0.048	532	0.827
PSWQ	481	51.8 (13.6)	53	53.5 (14)	0.767	532	0.382
CES-D	481	39.7 (14.4)	53	45.8 (14.9)	8.33	532	0.004

Note. BFNE = *Brief Fear of Negative Evaluation Scale*; PSWQ = *Penn State Worry Questionnaire*; CES-D = *Center for Epidemiologic Studies – Depression Scale*.

Table 2

Descriptive Statistics, t-value, df, and p-value for Individual Items Assessment

Individual Items	Cisgender		Non-cisgender		t-value	df	p-value
	n	M (SD)	n	M (SD)			
Item 1	670	3.03 (1.207)	82	3.23 (1.169)	-1.403	750	0.86
Item 2	674	3.44 (1.200)	79	3.59 (1.104)	-1.121	751	0.176
Item 3	672	2.06 (1.085)	82	2.67 (1.187)	-4.789	752	0.064
Item 4	674	3.49 (1.055)	82	3.27 (1.055)	1.782	754	0.616
Item 5	670	3.25 (1.240)	82	3.07 (1.245)	1.213	750	0.659
Item 6	672	3.50 (1.190)	82	3.43 (1.217)	0.524	752	0.705
Item 7	677	2.36 (1.220)	81	2.51 (1.226)	-1.016	756	0.874

Note. Item 1 = How important do you feel it is for LGBT individuals to disclose their sexual orientation and/or gender identity to medical providers?; Item 2 = How important do you feel it is for LGBT individuals to disclose their sexual orientation and/or gender identity to mental health providers?; Item 3 = Overall, in terms of your experience as a LGBT individual, how often have you had negative experiences with your healthcare provider?; Item 4 = Overall, in terms of your experience as a lesbian/gay/bisexual/transgender (LGBT) individual, how often have you had positive experiences with your healthcare provider?; Item 5 = How comfortable do you feel disclosing your sexual orientation and/or gender identity to medical providers?; Item 6 = How comfortable do you feel disclosing your sexual orientation and/or gender identity to mental health providers?; Item 7 = How concerned are you about concealing your LGBT identity when at your primary healthcare facility now/currently?.