Socioecological Factors Implicated in Suicide Ideation among Transgender and Gender Diverse Adults

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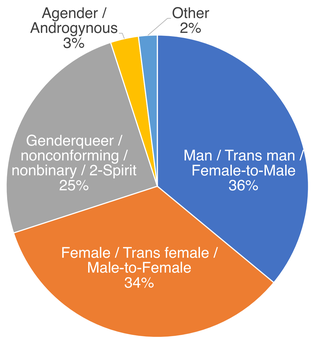
Background

- Individuals identifying as transgender and gender diverse (TGD) are at greater risk for experiencing suicidal thoughts and behaviors (STBs; e.g., suicide ideation [SI], suicide attempts [SA]) compared to their non-TGD peers,[1] in part due to the impact of minority-group-specific stress across core socioecological levels (including (1) individual-, (2) interpersonal-, (3) community-, & (4) societal-levels).[2,3,4]
- Additionally, consistent physical health care is essential to support any adult managing increased stress and/or STBs;[5] however, TGD individuals are often underserved and have difficulty obtaining culturally competent health care.[5,6]
- The current study examines the relationship between SI and a range of factors spanning the four core socioecological levels among TGD adults. Further, barriers to physical health care for TGD adults are described.

Method

Participants

- 118 TGD adults ($M[SD]_{age}$ = 36.0[16.5] years) living in Western New York State:



- **Demographic Information:**
  Sex assigned at birth: 44% male, 56% female
  87% identified as White/European American, 5% bi/multiracial, 4% Black/African American, 3% Latinx/Hispanic, <1% Asian/Asian American
  51% report an annual, individual income < $20,000
  (31% report an annual, household income < $20,000)
- **Physical Health:**
  46% report a chronic illness requiring regular medical care
  20% report being dissatisfied with their PCP/care
- **Mental Health**:
  37% report SI in the past 2-weeks (67% lifetime SI)
  46% report 1+ lifetime SA (26% report 2+ SA, lifetime)
  43% current, moderate-severe depressive symptoms (PHQ-9[7])

Procedures

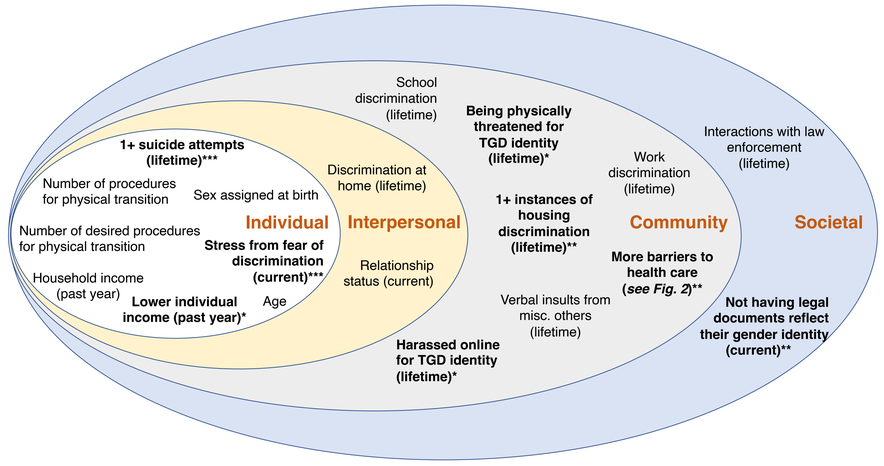
- In 2017, participants completed a one-time, anonymous survey via REDCap assessing constructs that span the four core socioecological levels and barriers to care.

Data Analytic Plan

- Bivariate correlations denote the relationship between SI and socioecological factors. Descriptive frequencies highlight notable barriers to care in our sample.

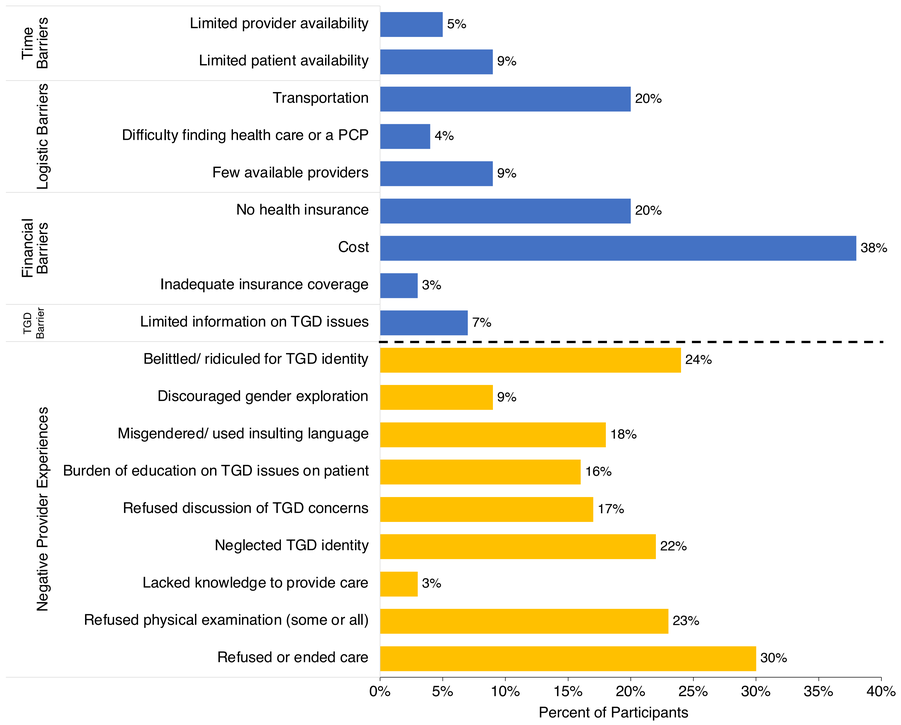
Results

Figure 1. Bivariate relationships between recent suicide ideation & factors across socioecological levels



Note. TGD = transgender or gender diverse. Suicide ideation (SI) was measured as a dichotomous variable (presence/absence) in the past two-weeks. Bolded factors indicate significant bivariate relationship with the presence of SI at $p < .05$. *$p < .05$, **$p < .01$, ***$p < .001$. For significant factors, $.202 \leq r \leq .480$.

Figure 2. Lifetime barriers to health care among TGD adults



Note. PCP = Primary Care Provider; TGD = transgender or gender diverse. N = 118. $M(SD)$ = 1.62(1.80) barriers/person, range: 0-7, with 20 participants (17%) denying any health care barriers. Participants wrote in additional, "other" negative provider experiences, including encouraging conversion therapy, having loud conversations about the participant's gender identity with other staff, and calling in trainees to perform multiple exams for the trainees' "exposure".

Notable Impact

"I'd circled 'transgender' in the 'other issues you'd like to talk about' section … my long-time doctor saw it, said, 'do you really think your transgender?' and I immediately backpedaled because I felt so ashamed … the tone really stuck with me … ***I haven't had a physical in almost 3 years."***

"I was repeatedly misgendered by clinical staff …one of which ***led to my suicide attempt****…"*

"I have had providers be confused and dismissive, making a token effort to treat me properly until the first moment of confusion, at which point regard for ***my comfort was abandoned for their convenience****."*

"There was a time I went in for a neck muscle spasm and the provider asked me if I'd had any 'transgender surgery. Not applicable! ***That was the last time I went to that provider****."*

Implications & Discussion

- Lifetime TGD discrimination across socioecological levels impacts TGD adult suicidal thinking.
- Anecdotally, one-to-one experiences between a TGD individual and their health care provider can have a profound impact on their relationship with the larger health care system and their mental health. Formal and ongoing training for emerging and current providers on TGD health issues is necessary to minimize the burden of education on the patient and improve provider competency. Training in supportive and affirming communication across medical specialties (i.e., not just internal medicine / TGD-specific clinics) is also warranted.
- Results suggest future, longitudinal research with larger samples is needed to identify how general and TGD-specific healthcare barriers and negative provider experiences impact specific physical and mental health outcomes with this vulnerable population.

Selected References

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