ARTICLES AND ESSAYS

Transgender and Gender Nonbinary Persons' Health and Well-Being: Reducing Minority Stress to Improve Well-Being

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This article describes minority stress theory as applied to health disparities and health-care experiences of transgender and gender nonbinary (TGNB) persons. The combination of stigma, social and structural inequalities, and actual discrimination events result in mutually reinforcing dynamics that drive persistent and stubborn disparities in physical and mental health for TGNB persons (Halkitis, Kapadia, Ompad, & Perez-Figueroa, 2015). Together with distrust of the medical system and discomfort of health-care providers in caring for TGNB persons (Smith & Turell, 2017), minority stress contributes to poorer health outcomes and reduced quality of care for sexual and gender minority populations. Ways to reduce health-care-related minority stress for TGNB persons are proposed, with the goal of improving TGNB health and well-being.

Keywords: LGBTQ health; transgender health; minority stress; health disparities; patient-provider relationships

Large health disparities for transgender and gender nonbinary (TGNB) persons have been well documented (Department of Health and Human Services, 2016; Healthy People 2020, 2014; Institute of Medicine, 2011) and are often attributed to widespread stigmatization and discrimination against lesbian, gay, bisexual, transgender, queer/questioning, plus (LGBTQ+) individuals (Institute of Medicine [IOM], 2011; Kelleher, 2009; Williams & Mann, 2017). A complex combination of stigma, pervasive social and structural inequalities, and actual discrimination events results in mutually reinforcing dynamics that drive persistent and stubborn disparities in physical and mental health (Halkitis et al., 2015). These same dynamics, together with medical system distrust and health-care provider discomfort (Jaiswal & Halkitis, 2019; Smith & Turell, 2017), impact health care for TGNB persons and reduce the quality of health care they receive.

One explanation for these dynamics is minority stress theory, which defines minority stress as the excess and cumulative impact of prejudice, stigma, and discrimination experienced by members of socially disadvantaged groups, resulting in significant distress as well as negative social, economic, and health implications (Meyer, 2003; Williams, Mann, & Frederick, 2017). Minority stress theory helps to

explain the compromised psychosocial and cognitive-affective resources linking minority stress with poor health outcomes (Siconolfi, Halkitis, & Moeller, 2015; Williams et al., 2017). Examples among TGNB persons include being refused treatment, failure to recognize family members and relationships, lack of legal status, overt experiences of assault, pervasive microaggressions, and failure to honor identity and personhood (IOM, 2011; Platt & Lenzen, 2013; Pounds McGrath, & Walsh, 2013; Smith & Turell, 2017). The experience of minority status in situations of differences in social power can lead to unfair assumptions; stereotype threat; devalued identity; internalized stigma; hypervigilance; marginalization; concealment; unhealthy behaviors; toxic levels of anger, anxiety, and distress; and a host of other deleterious consequences (IOM, 2011; Mereish & Poteat, 2015; Puckett, Levitt, Horne, & Hayes-Skelton, 2015; Schrimshaw, Siegel, Downing, & Parsons, 2013). Fostering health-care providers' improved understanding of sexual and gender minority persons' (e.g., LGBTQ+ individuals') health disparities and the role of minority stress has been shown to contribute positive change in health-care providers' sexual and gender minority (SGM) health-care knowledge, skills, and attitudes (Kelley, Chou, Dibble, & Robertson, 2008; Ziegler, Valaitis, Yost, Carter, & Risdon, 2019).

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This article describes minority stress theory as applied to health-care provider relations and its role in perpetuating TGNB health disparities in particular. While smaller numbers of studies have been conducted with TGNB persons specifically, conclusions from the broader research on sexual and gender minority individuals and minority stress can be applied to TGNB health and health disparities. This article then suggests ways to reduce health-care-related minority stress for TGNB persons, with a goal of improving TGNB health and well-being, and proposes standards for quality care of TGNB persons.

BACKGROUND

An estimated one million or more adults in the United States are transgender, having a current gender identity that differs from their gender assigned at birth (Meerwijk & Sevelius, 2017). The term *gender nonbinary* refers to transgender people who identify outside the traditional male–female gender binary, using descriptors such as genderqueer, gender fluid, or gender nonconforming. Persons who identify as gender nonbinary may comprise up to 35% of transgender persons (Reisner & Hughto, 2019), making more nuanced knowledge of gender diversity important for health-care providers, allowing for care to a wide array of patients of varying gender identities and expressions (Bass, Gonzalez, Colpi, Sharon, & Conklin, 2018). A broader term, sexual and gender minority (SGM), refers to persons of either diverse sexual orientation (gay, lesbian, and bisexual) or gender (transgender, gender nonbinary) identities, and is thus a more inclusive term. Understanding of these distinctions is important,

as the terms and the people they refer to are not interchangeable.

While health care for TGNB persons has improved dramatically over the past several decades, they continue to express concern about their quality of care (IOM, 2011; Snelgrove, Jasudavicius, Rowe, Head, & Bauer, 2012). Smith and Turell (2017) characterized SGM health-care concerns as a combination of mistrust of the health-care system and SGM persons' insecurity in relationships with health-care providers. More specifically, these authors identified deficiencies in health-care providers' level of receptivity regarding gender identity, the extra burden of needing to disclose identity, breaks in confidentiality, microaggressions, provider discomfort with sexual minority health, and worries about whether appropriate health care would be provided (Smith & Turell, 2017). Considerable literature on LGBTQ+ health describes experiences of both subtle and overt egregious transphobia and homophobia toward SGM individuals, ranging from care refusal to voyeurism, sexual objectification, othering, dismissal, or depersonalization (Reisner & Hughto, 2019; Smith & Turell, 2017). Determinants of quality care are lacking, as noted in the apparent lack of attention to LGBTQ+ health needs across health-care systems and providers, as well as pervasive failure to take SGM health-care needs seriously. Persistent heteronormativity and homo- or transphobic experiences in health care become added to the broader experience of sexual and gender minority stress, comprising an extra burden for TGNB persons that has frequently been unrecognized by health-care providers.

TGNB HEALTH CARE DISCRIMINATION AND HEALTH DISPARITIES

TGNB health disparities include the startling figures that almost 56% of lesbian, gay, or bisexual persons, 70% of TGNB persons, and 63% of persons living with HIV illness have experienced overt discrimination in health care (Lambda Legal, 2010). In almost every category surveyed, TGNB people reported experiencing very high rates of discrimination, barriers to care, and anticipation that they would face discriminatory treatment. Reports of overt discrimination in health care include being refused needed care, health-care professionals refusing to touch them or using excessive precautions, using harsh or abusive language, being blamed for their health status, or being treated with physical roughness (Lambda Legal, 2010). Similar overt discrimination was found by Smith and Turell (2017) and also included less overt forms of discrimination such as microaggressions, perceived

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health-care provider discomfort, insufficient health-care provider knowledge of sexual minority health needs, misgendering, and failure to establish an engaged patient-provider relationship. These failures to provide respectful, culturally appropriate health care for TGNB individuals combine with structural inequalities to exacerbate a myriad of health disparities: increased levels of violence and victimization across the life span, higher rates of unemployment and homelessness, higher lifetime prevalence of depression, extremely high rates of suicidality among transgender youth, significantly higher rates of HIV illness among transgender women, and increased risk for substance abuse (IOM, 2011).

Because many of the studies on SGM health disparities fail to adequately differentiate TGNB identity categories, it is reasonable to assume that multiple additional SGM health disparities may also apply to TGNB individuals. Finally, intersectionalities of TGNB identity and ethnicity, socioeconomic status, geographic location, social supports, and other social determinants of health are known to differentially affect both health risks and protective factors (Conran, Mimiaga, & Landers, 2010; Hatzenbuehler, Phelan, & Link, 2013), making it imperative to identify health needs and approaches in an individualized, patient-centered manner.

IMPACT OF MINORITY STRESS

Experiences of stigma contribute to minority stress for LGBTQ+ persons (Kelleher, 2009; Meyer, 2003; Williams & Mann, 2017) and apply to health-care experiences (e.g., Fingerhut & Abdou, 2017; Smith & Turell, 2017). The additive effects of excess stress and negative life events due to social stigma and marginalization contribute to worsened physical and mental health outcomes from both internal and external stress

processes. According to Meyer's minority stress theory, the differential distribution of social stressors (e.g., stigma-related prejudice, discrimination, victimization) constitutes unique, chronic, and additive psychosocial stressors that can lead to poor health outcomes (Meyer, 2003; Williams & Mann, 2017). Stigma, whether due to nonheterosexual or gender minority identity, has been deemed a fundamental cause of health disparities due to its links with a wide array of social, structural, and interpersonal mechanisms that put people at risk for negative health outcomes beyond those of their non-SGM peers (Balsam, Molina, Beadnell, Simoni, & Walters, 2011; Hatzenbuehler et al., 2013).

Connecting stigma to negative health outcomes, minority stress theory describes how identification as a sexual or gender minority leads to greater exposure to social stress related to prejudice and stigma experienced in relation to sexual or gender identity (Frost, Lehavot, & Meyer, 2013; Meyer, 2003; Meyer, Schwartz, & Frost, 2008). Examples of increased social stressors include prejudice-related stressful life events such as being attacked or fired; everyday discrimination including microaggressions and slights; expectations of rejection regardless of actual discriminatory circumstances; the cognitive burden associated with negotiating outness; and the self-devaluation inherent in internalized homophobia (Meyer, 2003). Models of minority stress theory recognize that sexual and gender minority individuals are exposed to greater amounts of social stress as a result of their stigmatized status and have access to fewer coping resources than their heterosexual and cisgender peers.

While most studies of minority stress focus on mental health outcomes, physical health disparities have also been connected to minority stress. In their research with LGB persons, Frost et al. (2013) found that externally rated prejudice events (i.e., events rated by independent external reviewers as to whether or not prejudice was involved in the experience of the event, such as being fired from a job, assault, and homelessness) predicted the onset of physical health problems (including but not limited to influenza, hypertension, HIV and other sexually transmitted infections, tendonitis, and cancer), but self-appraised experiences of minority stress did not. Experiencing a physical health problem within a 1-year period was associated with experiencing a prejudice event, higher expectations of rejection, and more frequent experiences of everyday discrimination. Worse self-rated physical health was associated with higher expectations of rejection, more frequent experiences of everyday discrimination, and higher levels of inter-

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nalized homophobia (Frost et al., 2013). These results, while not uniform, provide evidence for the hypothesized negative effects of minority stress on the physical health of sexual and gender minorities, with prejudice events being more damaging to physical health than general stressful life events that do not involve prejudice.

Gender-affirming hormone therapy, often necessary for gender confirmation, is also associated with health risks, including increased risk of ovarian and prostate cancer, thromboembolic disease, elevated liver enzymes, and loss of bone density (IOM, 2011). In later adulthood, concerns include increased risk of cardiovascular disease, diabetes, osteoporosis, liver disease, and dementias, due to TGNB persons' longer duration of hormone use and lack of clear data on its effects (IOM, 2011).

HEALTH-CARE PROVIDERS' PERPETUATION OF MINORITY STRESS AND HEALTH DISPARITIES

Health-care providers' insufficient knowledge of LGBTQ+ life experiences and health needs is evident (IOM, 2011; Johnson & Nemeth, 2014; Pounds et al., 2013; Rondahl, 2009) and limits the effective exchange of health-care information (Smith & Turell, 2017). Studies have identified health-care providers' biased behaviors, ranging from subtle, covert behaviors and interactions known as microaggressions (Platt & Lenzen, 2013; Shelton & Delgado-Romero, 2011) to blatant homo-, bi-, and transphobic discrimination (Chapman et al., 2012; Durso & Meyer, 2013; Jowett & Peel, 2009; Neville & Hendickson, 2006). It is clear that hetero- and cis-normativity continue to influence health-care communications (Rondahl, Innala, & Carlsson, 2006; Zelle & Arms, 2015). As a result, TGNB-identified persons frequently experience discomfort while accessing health care, withhold personal information, change health-care providers,

or avoid seeking health care altogether (Bonvicini & Perlin, 2003; Cant, 2005; IOM, 2011).

These challenges are perpetuated by health-care educational settings, curricula, and professional guidelines that fail to adequately address knowledge, skills, and attitudes about LGBTQ+ people (De Guzman, Moukoulou, Scott, & Zerwic, 2018; Eliason, DeJoseph, & Dibble, 2010; Fredriksen-Goldsen, Woodford, Luke, & Gutierrez, 2011; Obedin-Maliver et al., 2011). The satisfaction of SGM persons with care and the effectiveness of health outcomes have been shown to be negatively affected by hetero- and cis-normativity in the health-care system (Eliason & Schope, 2001; Mosack, Brouwer, & Petroll, 2013). Counter to this, gender identity disclosure has been positively associated with social integration, resiliency, and psychological well-being (Killian, 2010). Thus, the perceived inability to bring one's full identity to the health-care encounter may further contribute to stress for TGNB persons. Barriers to disclosure can confound health-care decision making when elements of gender identity are important to making the correct diagnosis or to clinical management decisions.

REDUCING HEALTH-CARE-ASSOCIATED MINORITY STRESS FOR TGNB PERSONS

A number of approaches have been identified in the literature that can reduce health-care-associated minority stress for TGNB persons. These can be categorized as health-care system approaches; health-care provider knowledge, skills and attitudes; and support for TGNB persons' individualized health-care needs and concerns.

Health-Care System Approaches

In health-care systems, ensuring the safety of the environment for TGNB persons and their family members is paramount. This can be fostered by creating welcoming and inclusive environments with attention to staff education, nondiscrimination policies, intake forms that represent sexual and gender diversity, and informed and inclusive communications across all levels.

Health-Care Provider Dimensions

Health-care provider education programs need improved content and competency evaluation about care for sexual and gender minorities, including both basic and advanced skills that address the nuanced

needs of TGNB persons across spectrums and intersectionalities. Building skill in the application of this knowledge requires direct interaction with TGNB persons, both in practice and in broader social settings.

Supporting TGNB Person's Individualized Health-Care Needs and Concerns

Recognizing the impacts of minority stress in combination with the individual's specific health risks and protective factors across the life span is necessary for effective and comprehensive care. An example is provided by Castillo III (2019), enumerating inclusive practices in the areas of communication and care on first encounter, phases of transition, consultation with mental health providers, contour shaping for physical gender expression, and medication management across hormones and coexisting disease. Engaging the TGNB person fully in partnership for their health-care management and decision-making is necessary for this level of care, an outcome that is less likely to be achieved in the absence of effective health-care system and provider practices. Continued vigilance around broader social policy is also needed, particularly as threats to TGNB human rights and equality have reemerged in the current political climate. Health-care provider support for equitable health-care coverage and access for TGNB persons will remain necessary for many years to come.

TOWARD HEALTH-CARE QUALITY STANDARDS FOR TGNB PERSONS

The above review, and the record of persistent health-care deficits for TGNB persons, suggest the

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need for more specific standards of care to reduce minority stress and improve health and well-being. Such standards would need to be established through consensus and an engaged partnership with TGNB persons. Areas to address include but are not limited to health-care provider education, access to care, care equity and quality, involvement in decision-making, individualized gender-affirming care, improved health promotion and prevention, and improved chronic disease management. Support for improved equity across social determinants of health is also needed.

The development of technical standards for TGNB clinical care by the World Professional Association for Transgender Health (Coleman et al., 2011), University of California—San Francisco (2016), Fenway Institute guidelines (<https://fenwayhealth.org/the-fenway-institute/publications-presentations/>), and the Gay Lesbian Medical Association (GLMA) Handbook on LGBT Health (Schneider, Slinzio, & Eriskson-Schroth, 2019) all provide excellent clinical practice guidelines for providers. More is needed, however, to clearly direct philosophies and standards of care across all care settings, health-care disciplines, geographic locations, and SGM identities. Minority stress theory provides a clear pathway for developing such standards by identifying a wide array of proximal (personal and interpersonal) and distal (structural, system-based, or policy-based) stressors and protective factors that interact with TGNB identity to affect health.

While a national consensus on care standards for TGNB persons is currently lacking, individual health-care providers, educators, and health systems administrators can make an enormous difference through their attention to individual skill-building, systems change, and support for the health-care needs and concerns of TGNB persons. For example, educators can better and more intentionally integrate teaching about TGNB health needs and care provider competencies into the standard health-care curriculum; health-care providers can work to familiarize themselves with existing research and technical standards of care and ensure the normalization of care for TGNB persons through excellent communications and relationship competencies; and health systems administrators can foster improved health outcomes for TGNB persons by ensuring inclusive and welcoming health-care environments, well-educated staff members, and strict no-tolerance policies for discriminatory behaviors.

Progress toward the development of health-care quality standards for TGNB persons is an urgent need and an important part of the equation for reducing health disparities for all SGM persons. Minority

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stress theory can provide an avenue for such standards by significantly increasing the depth of understanding of stigma, pervasive social and structural inequalities, discrimination events, medical system distrust, health-care provider discomfort, and numerous other factors contributing to the cumulative negative effects of minority stress as a barrier to health. By identifying factors that impede health for TGNB persons, their corollary health protective factors (disclosure, positive coping strategies, resilience, family- and systems-level supports, social integration, informed health-care providers, health-care relationship building, accepting attitudes, respect, welcoming environments, and promoting trust) can be employed to reduce health disparities and foster improved TGNB health outcomes. Such approaches would serve well to reduce minority stress and may assist with decreasing TGNB health disparities and improving well-being.

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