Understanding Mental Health

Mental Health, Self-Harm, Substance Use, and Eating Disorders in Trans Communities

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To best prevent suicide and promote positive mental health in trans communities, we must understand other common mental health issues and risk factors that disproportionally impact trans people. Issues like self-harm, substance use, and eating disorders are more common among trans people. By better understanding other key risk factors, service providers, family members, peers, colleagues and trans people themselves can better understand their experiences, take steps to better maintain their mental well-being, and support themselves and each other.

Overall Mental Health

The 2020 Trans Pulse Survey found that 56% of respondents rated their mental health as fair or poor, followed by 28% who rated their mental health as good, and 16% who rated their mental health as excellence. Racialized trans people were slightly more likely to report fair or poor mental health at 58%. Trans Pulse also found high rates of unmet healthcare needs, high rates of homelessness, poverty, food insecurity and public harassment within trans communities.

Being Safe Being Me found that trans youth often did not receive needed mental health services, with 71% of survey respondents reporting that did not get mental health services when they needed them. A significant portion of survey respondents (88%) also identified having a chronic mental health condition such as depression or anxiety. Within their survey, no youth rated their mental health as excellent, while 96% reported their mental health as poor or fair.

Self-Harm and Injury

Self-harm has been defined as “a preoccupation with deliberately hurting oneself without conscious suicidal intent, often resulting in damage to body tissue.” Self-harm does not include tattooing or piercing, or indirect injury such as substance abuse or eating disorders. In research, self-harm is also commonly known as self-injurious behaviour (SIB), self-mutilation, non-suicidal self-injury (NSSI), parasuicide, deliberate self-harm (DSH), self- abuse, and self-inflicted violence.

Self-harm does not always translate in to suicide attempts, or even suicidal ideation, actually the majority of those who self-injure do not have suicidal thoughts when self-injuring, at the same time however, self-harm can escalate into suicidal behaviours. One study found that almost half of people who self-harm reported at least one suicide attempt. When we look at hospitalizations, even just here in Canada we can more clearly see the significant impacts self-harm has in relation to suicide.

In 2018, there were 13438 hospitalizations in Canada (excluding Quebec) associated with self-inflicted injuries–over three times the number of suicides. The hospitalization rates in Canada associated with self-inflicted injury have consistently been the highest among the 10-25 age group, compared to all other age groups. While suicide rates are higher in men and boys, women and girls have higher rates of self-harm, with rates of hospitalization for self-inflicted injury among females ages 15 to 19 at almost 3.5 times more than any other age category.

The rate of hospital stays in 2018 were twice as high for Canadians living in the lowest-income neighbourhoods as for those living in the highest-income neighbourhoods. Individuals living in rural or remote areas were more likely to have a hospital stay for self-harm compared with those in urban areas, partly because there may be fewer community services in rural areas.

Compared to studies on suicidality, there is far less research on patterns of self-harm in transgender populations, but what data exists shows that there are many parallels between the two. One Australian study found that 63% of their transgender participants had a lifetime history of self-harm, as compared to the baseline rate of 8.1%.

Transmasculine people are at specific risk of self-harm, with the literature estimating the risk of self-harm as high as twice as likely for transmasculine people as compared to transfeminine people, while other studies have shown that the inverse is true for suicidality, with transfeminine people being more susceptible to suicide.

It is important to note that research in this area is far from complete and there remains much work to be done before definitive conclusions can be drawn. Clinicians should be aware of these general trends, but they should not be taken as the final word, given the limited nature of the existing datasets.

Eating Disorders

Approximately, one million people in Canada are living with an eating disorder at any given point. Eating disorders have the highest mortality rate of all mental illnesses. Eating disorders are often defined under three main categories: anorexia nervosa, bulimia nervosa, and binge-eating disorder. Additional diagnosis labels exist under eating disorders, however, it is also important to understand that not everyone who may be dealing with disordered eating has been diagnosed as such. The absence of fitting into one of these main categories or any diagnosis, does not undermine the seriousness or disordered eating. Too many people with an eating disorder are never diagnosed but suffer significant personal and family distress. The social and economic costs of untreated eating disorders are like those of depression and anxiety, with debilitating physical and mental health effects comparable to psychosis and schizophrenia.

Historically, eating disorders have been believed to primarily afflict heterosexual, affluent, cisgender, thin, white women. However, we know that this is not the case, and misinformation around eating disorders such as this has resulted in many individuals at these intersections outside of this definition to receive inadequate diagnosis and care. In 2018, a survey of LGBTQ youth in the United States, from the Trevor Project in partnership with the National Eating Disorder Association, found that 54% of LGBTQ youth had been diagnosed with an eating disorder, with an additional 21% suspected they had an eating disorder.[7]

Eating Disorders in the Trans Community

Both trans populations and people with eating disorders have elevated rates of suicide, which means the combination of transgender identity and disordered eating must be taken very seriously. Trans folks have identified that some of the contributing factors around the prevalence of eating disorders within the community are: cisgender and heteronormative body ideals, prevalence of discrimination within the healthcare system and the eating disorder support system, and internet representation and support.

> "Gender dysphoria and body dissatisfaction in transgender individuals is often cited as a key link to eating disorders. It is often hypothesized and reported that transgender individuals may attempt to suppress features of their assigned gender. Or they may try to accentuate features of their gender identity specifically to present gender identity in ways that are understandable to the world around them. However, it is dangerous to generalize. We know that eating disorders are complex and stem from a combination of factors. While some transgender folks with eating disorders may attempt to change their bodies to conform to their gender identity, others may feel that their eating disorder is not related to their physical body."

A study from McMaster University, *Trans(cending) Recovery: Discussions with Trans and Non-binary Folks Around Recovery in the Context of Eating Disorders*, found a strong connection between transgender identity and the development of eating disorder behaviours that create an experience vastly different than the cisgendered reality in which the treatment programs are based. In general, trans folks often cite a lack of trans specific care around eating disorders even if they are able to access services. A lack of adequate care in this area intersects with other healthcare inadequacies and injustices that trans folks are faced with. Recent studies have highlighted the lack of education and training on trans issues for healthcare providers,[9] biases and stereotypes held by healthcare providers towards trans individuals[10] and the pathologization of trans individuals by healthcare providers.[9]

Substance Use

Alcohol is included here since the Canadian Center on Substance Use includes this in their definition.

Alcohol:

- Alcohol is by far the most common drug used by Canadians and use has increased significantly among females since 2013.
- In 2017, the rate of hospitalizations entirely caused by alcohol (249 per 100000) was comparable to the rate of hospitalizations for heart attacks (243 per 100000) and the rate was thirteen times higher than for opioids.

Opioids:

- There were at least 15393 opioid-related deaths in Canada between January 2016 and December 2019, with the highest number of deaths occurring in 2018.
- In Ontario, opioid-related deaths have increased four-fold in Ontario between 2003 and 2018 (from 366 to 1473), increasing by about 17% from 2017 to 2018 alone. Between July 2017 and June 2018, there were 1337 opioid-related deaths, a rate of about 9.3 per 100000. Among these deaths, the non-opioid substances that most often directly contributed to death were cocaine (33.9%), methamphetamine (14.6%), alcohol (13.2%) and benzodiazepines (11.0%). One study suggested that as of 2013, one in five fatal opioid overdoses involved alcohol.

Harm Reduction:

- Harm reduction is an evidence-based, client-centered approach that seeks to reduce the health and social harms associated with addic-

tion and substance use, without necessarily requiring people who use substances to abstain or stop.

- Harm reduction approaches such as overdose prevention sites or safe consumption sites, naloxone distribution programs, and other non-abstinence-based programs have been rolling out across Canada increasingly.
- Harm reduction is historically rooted in work from Black and Queer communities. In the US, harm reduction work can be seen in the 60s, 70s, and 80s in the work of The Young Lords' launch of an acupuncture program for heroin users in the South Bronx, and the grassroots and activist response to the AIDS crisis in the 1980s and beyond.

2SLGBTQ+ Folks and Substance Use:

- Evidence suggests that members of the 2SLGBTQ+ community experience substance use issues at a higher rate than those who do not identify with this community.
- Some research suggests that use of alcohol, tobacco and other substances may be two to four times higher among LGBT people than heterosexual people.
- A 2017 study found that, an estimated 12.3% of transgender Ontarians had used at least one of the specified drugs in the past year, with no significant difference by gender identity.

General Concepts and Practices for Understanding and Supporting Trans People

This section explores key concepts and practices for supporting and understanding trans people. Touching on key concepts such as transition, non-binary identity and gender pronouns, alongside practical guidance on how to be inclusive of trans people, these resources are an important starting point for service providers, family members and colleagues of trans people, and all cisgender people.

Understanding Transition – What it Is and What it Means

"Transition" is a big and broad word, typically used to describe the social, legal and/or medical processes trans and gender diverse people undertake as they come into themselves as trans and gender diverse people. Transition means something different to every trans person, and there is no single way to transition as a trans and gender diverse person.

Important: The term trans is defined as "identifying with a gender identity different from the gender you were assigned at birth". Being trans or gender diverse is not inherently connected to any specific transition journey. While many trans and gender diverse people access medical support, such as surgical or hormonal interventions, an individual's trans identity is *no more or less* legitimate based on whether or not they access medical transition services.

This resource is intended to help service providers, educators and loved ones of trans people better understand the complexity of

transition, what transition might mean to different people, and how to support trans people in their lives who are in the midst of a transition.

Transition isn't linear, nor is it ever necessarily over. Many trans people, as they explore and seek to better understand themselves, will transition in different ways over the course of their lifetime.

Understanding Different Types of Transition

Transitioning is often described within three interconnected categories – legal transition, social transition and medical transition.

Social transition largely refers to trans people changing their chosen name or pronouns, and/or shifting their gender expression (i.e., changing how they dress to better align with their gender identity). Social transition also includes changing mannerisms, voices and other behaviours.

Medical transition largely refers to either surgical or hormonal interventions that trans people may undertake to better align their bodies with their gender identity. Medical transition is different for every trans person, but may include breast removal or augmentation, permanent hair removal, removal of the adam's apple or trachea, taking estrogen or testosterone, and/or undertaking surgery to reconfigure genitals to better match a person's gender identity. These are but a few examples of processes that *may* be included in an individual's medical transition.

Legal transition generally describes the process of changing your legal name and/or designated sex/gender markers to better align with your gender identity.

Common Misconceptions of Transition

Many misconceptions persist about transition that negatively impact trans and gender diverse people. These misconceptions are important to avoid and unpack, in order to better understand and support trans people in your life.

Misconception #1: "Trans people aren't trans unless they have had the surgery."

Many, but not all, trans people access medical interventions to align their bodies with their gender identity. However, not all trans people want or need to undertake medical procedures. Many trans people are content with their bodies or may only seek certain interventions over others. A trans person's specific transition journey has no bearing on if they are or are not trans.

Misconception #2: "I have the right to know about a trans person's transition journey."

Many people presume that trans people's experiences and stories should be readily available for discussion and debate. Trans people, like all people, have the right to privacy, agency, and autonomy. It is disrespectful to pry into an individual's transition journey or medical histories. You should not ask a trans person about their transition unless they have explicitly provided consent.

Misconception #3: "All trans people are seeking to match binary norms."

While many trans people identify as either male or female and should be treated like any other man or woman, some trans people are non-binary. It is important to note that not all trans people are seeking to fit into gender binary norms and should not be forced to subscribe to or identify by binary terms. The way a trans person wishes to identify has no bearing on the fact that they should be treated with respect and given the space to identify as they chose.

Supporting Trans and Gender Diverse People's Transitions as a Loved One or Care Provider

If a trans friend, client, loved one or colleague is soliciting your support with their transition, there are some simple steps you can take to best support them.

Thank them for trusting you enough to discuss this: Transition is fundamentally a personal and private issue, and one that can be difficult or emotionally charged for a trans person to discuss. By thanking them for trusting you in these moments, you demonstrate that you understand the importance of this conversation and recognize the trust they have afforded to you.

Managing your own reactions: Feelings of uncertainty, loss or fear are entirely legitimate and, in many cases, predictable responses to an individual disclosing their transition plans to you. While you have every right to your response, it is important to center and prioritize the needs of the trans person, rather than your own insecurities and curiosity in the moment. Trans people are not looking for a debate on their identities or their intended transition journeys. Rather, they are looking for support, and for a trusted person they can discuss their own feelings and plans with.

Do your own research: If you are new to supporting trans loved ones or clients, consider doing additional research, on your own time, to understand how best to support them. Connect with your local 2SLGBTQ+ community organizations (like SPECTRUM), or explore trustworthy, trans-inclusive websites for more information.