Reduction in anxiety, depression, psychopathology and suicidal ideation for people from sex and/or gender diverse (SGD) groups from lower socio-economic backgrounds

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Abstract

This paper reviews the current situation of poor mental health outcomes in lower socio-economic sex and/or gender diverse populations in Australia. It further analyses the situation whereby government giving money to projects to improve the wellbeing and circumstances of that population is reducing its effectiveness whilst still perpetuating a lack of basic human rights and discrimination. The author posits that improvement in these populations' mental health must be accompanied by legal equality and protection.

Introduction

Sex and/or gender diverse (SGD) people are made up from many differing groups including people who are intersex, transexed, transsexual, transgendered, androgynous, without sex and gender identity, cross-dressers and people with sex and gender culturally specific differences. They are people who experience variations in physical presentation and social behaviour that is other than stereotypically male or female. Each group may have its own physical, psychological, social, legal and political issues that may not necessarily relate to any of the other groups. Around one 100 people in the general population experience some kind of sex and/or gender diversity (O'Keefe, 1999).

Sex is the physical manifestation of primary and secondary sex characterises including genital, ancillary reproductive structures, gonads, breasts, secondary physical characteristics, hormonal levels and brain structure. Most people are largely male or female and many people manifest between the two. Gender is the behavioural interpretation of sex types in the characterisation of masculine, feminine or neutral (O'Keefe, 1999).

The paper suggests that positive mental health outcomes for people from sex and/or gender diverse groups with lower socio-economic status must be accompanied by legal protection and equal human rights.

Background

Since the commencement of colonisation in Australia, different Eurocentric cultures have imbued society with overly artificial binary concepts of male and female, and masculine and feminine. Those were often born out of religious machismoism and misogyny. The Australian government is still trying to dispel those stereotypes in heteronomative society in other countries through foreign aid programs but often ignores the extent of those inequalities within Australia (Australian Aid Programme, 2011). At the present time no school in Australia has a policy to teach about sex and/or gender diversity.

In May 2010 the World Professional Association of Transgender Health (WPATH) put out a statement urging the de-psychopathologisation of gender variance worldwide. In the launch

of the WPATH Standards of Care (SOC) Version 7 in late 2011WPATH stated: “WPATH is a professional organization devoted to the understanding and treatment of gender identity disorders.” In those new SOC WPATH also referred to intersex people as having Disorders of Sexual Development (DSD). It seems that what WPATH gives with one hand it takes away dignity with another.

There are sex and/or gender diverse people who celebrate their differences and do not see themselves as having a pathology of any kind. Also there are people who suffer sex dysphoria about the sex of their body and people who suffer gender dypshoria and are unhappy with their gender presentation; both are subjective and culturally related experiences (O’Keefe, 1999). Some people may change their bodies or gender role to relieve sex and/or gender dysphoria and other people may not need to do that. Being sex and/or gender diverse, however, is not a pathology in and of itself.

Many transexed, transsexual and transgendered people pass as their destination sex in public with other people being unaware of their transitioning history, therefore they often do not suffer high levels of discrimination in their everyday life, apart from difficulties arising from legal anomalies (O’Keefe, 1997). This also include cross-dressers, many of whom lead heteronormative lives. It is also true for many intersex people whose intersex manifestation is not publicly obvious and pass into ordinary socioeconomic norms, unless their sex physically outwardly presents as different.

Since the mid 1990s, ‘passing’ for many people from sex and/or gender diverse groups has become less important to a wide variety of those groups as they have become more publicly visible in Western societies (Bornstein, 1994) (O’Keefe and Fox, 2003). This is also accompanied with the change in more liberal societal attitudes to less stereotypically sexed and gendered people. However, it can be said that appearing in public as a person from a sex and/or gender diverse group is not without its perils, prejudicial encounters, discrimination and possible exposure to abuse and violence; therefore for some of those people high levels of stress originate from their everyday encounters in society.

A Tranznation self-reporting survey carried out at the Australian Research Centre in Sex, Health & Society (ARCSHS) at La Trobe University found that 87.4% of transgender, and presumably transexed and transsexual persons experienced at least one form of discrimination on the basis of their gender presentation (Couch, Pitts, Mulcare, Croy, Mitchell, Patell, 2007). A third had been threatened with violence. The general health of participants was also considerably lower than the national average. The survey seemed to be confused around terminology at it was unclear if this included sex and/or gender diverse people who did not identify as transgendered or transsexual.

The City of Sydney’s Lord Mayor launched the Transgender Anti violence Project (TAVP, 2011) to protect what it called transgender people, presumably meaning all non-normative sex and/or gender diverse individuals, whether they be transgender or not. Many incidences of violence against people from non-normative sex and/or gender diverse groups have not in the past been reported to the police out of fear of ridicule, not being taken seriously or an absence of many not being covered under anti-discrimination laws.

Sociologist Max Weber talked about “life chances” directly linking opportunity in life to social status. Life chances not only include social status but economic status, access to shelter, food and work opportunities. Reduction in life chances is not solely dependent on

subjective perceptions of one's own agency but opportunities open within the structure of society (Julian, 2009). Many people in Australia who come from sex and/or gender diverse groups lead very ordinary, unnoticed lives and do very well economically; many, however, struggle in society due to prejudice, violence, reduced socio-economic status and reduced life chances.

Various studies over the years have tried to measure whether higher levels of mental disorders are associated with lower socio-economic status. Miech, Avshalom, Wright & Silva (1999) used a longitudinal study to measure incidence of higher levels of mental disorders due to lower socio-economic status. One central measurement was educational status and attainment during adolescent years. In lower socio-economic groups they found higher incidence of four disorders of anxiety, depression, anti-social disorder, and attention deficit disorder.

Colton, Meier, Fitzgerald , Pardo & Babcock (2011) used a self-reporting survey to gauge the levels of satisfaction and reduced anxiety due to testosterone treatment in transsexual and transgendered men registered female at birth. It was found that participants reported reduced depression, anxiety, stress, improved mental health outcomes, higher levels of social support and related quality of life.

In the Australian National Survey of Mental Health and Wellbeing study 2007 (Mental Health Fact Sheet, Australian Government, 2011) it was found that one in five (20%) Australian adults experience some form of mental illness in any one year. The prevalence of mental illness decreased with age. The highest incidence of mental illness was in ages 16 to 24 years (26.4%) and 25 to 34 years (24.8%).

Marmot (Marmot & Wilkinson, 2006) clearly states and shows a causal link between lowered health outcomes and lower socioeconomic status. In Australia it can be seen that groups with lower levels of education, social disadvantage and reduced economic status have high levels of stress and mental distress including the Aboriginal population and first-generation immigrants after immigration (Julian, 2009).

The Gender Centre is a social housing project in Sydney which states it is **"**committed to developing and providing services and activities which enhance the ability of people with gender issues to make informed choices". It is a residential unit and community services project funded by the Department of Community Services under the Supported Accommodation Assistance (SAAP) Program and supported by the New South Wales Health Department through the AIDS and Infectious Diseases Branch. In an interview with the Gender Centre manager a figure of 2% was reported for their client group who suffered mental illness including schizophrenia and bipolar disorder (Gender Centre, 2011). At the time they had 11 residential placements and were working with 178 clients, through residential and outreach, mainly with socio-economically disadvantaged individuals.

Analysis

The government currently has no national education policy on sex and/or gender equality except for a heteronormative model as part of foreign policy (Australian Aid Programme, 2011). People remain largely uneducated about sex and/or gender diversity. Despite international attempts to de-psychopathologise sex and/or gender diversity worldwide, the

Australian government still funds, through Medicare and hospitals, practices that place SGD groups in psychiatric models of psychopathology (WPATH, 2011).

Sex and/or gender diversity is clearly a part of nature's diversity (O'Keefe, 1999). Some people who need medical assistance and experience sex dysphoria or gender dysphoria should not be burdened with a psychiatric diagnosis, just as people who are pregnant, menopausal or andropausal should not be held to ransom to a psychiatric diagnosis (O'Keefe, 1997). Whether people pass as male, female or other should be immaterial to their right to be treated with dignity (Bornstein, 1994; O'Keefe & Fox, 2004).

Threats of violence, discrimination and denial of basic human rights can be a common feature of the lives of many people from SGD groups (Couch et al, 2007). Despite efforts by government to implement anti-violence projects to protect SGD groups, the lack of basic legal anti-discrimination protection leads to public disorder (TAVP, 2011). This leads to reduction of life chances for these discriminated populations (Julian 2009). What may be therapeutic gains for some members of these populations are often thwarted by lack of legal protection in society, discrimination and exposure to violence (Colton et al, 2011; Couch et al, 2007).

It is clear that those who have less education, lower economic status and reduced life chances are more subject to the vagaries of life and develop higher levels of depression and anxiety in the general population (Miech, Avshalom, Wright & Silva, 1999). In those who are in lower socio-economic groups and from SGD groups it is safe to deduce that they have lower life chances and suffer higher levels of anxiety and depression. The figures of a national average of 20% per annum of general population that experience mental illness can be deduced to be higher in lower socio-economic disadvantaged SGD groups (Australian National Survey of Mental Health and Wellbeing study, 2007). This is borne out by the facilities that the Gender Centre needs to provide to the SGD population, yet fails to record in its figures (Gender Centre, 2011). To be fair, however, it may be beyond the abilities of the Gender Centre staff and resources to distinguish between depression and anxiety suffered through sex and/or gender dysphoria and general depression, which needs long-term follow up.

What this adds up to is a population of sex and/or gender diverse people with lower socio-economic status who are more subject to higher levels of depression, anxiety and certainly suicidal ideation than higher-income people from SGD groups, due to lower life chances than a higher level of psychopathology than the average population.

Discussion

The author runs a private sex therapy practice in Sydney and specialises in sex and/or gender diversity. The author sees around 400 client hours of sex and/or gender diverse clients a year. Over the years the author has seen over 3,000 people from sex and/or gender diverse groups in her clinic and many socially. They come from many socio-economic backgrounds from millionaires to disabled people on state pensions, charged on a sliding scale. Schizoid-type psychopathology is rare as clients in the private sector tend to be A type well-functioning personalities and may be goal-directed in seeking therapeutic outcomes. Bipolar disorder is also rare in this population but major depression is present in most clients who seek transition as it is concurrent with sex and/or gender dysphoria, but not sex and/or gender euphoria.

With psychotherapy and sex and/or gender transition, if applicable, depression is alleviated in the large majority of those clients. Whilst someone may come into the clinic depressed and confused around their sex and/or or gender presentation, once that has been resolved many of those people will go onto to live happy and productive lives. What the author tells clients is that she does not tell them what they are or will be but simply assists them in finding that out for themselves and executing the direction they may wish to proceed.

The author is aware in the public sector in Australia, different benchmarks are often used in that many people from SGD groups are forced into psychiatric interviews and examinations to access state-provided hormone treatment and surgery. There is basically one surgeon in NSW for genital surgery who will not take patients without a psychiatric interview. Any other surgeons working in the public sector can also adopt those kinds of attitudes despite this being contrary to international WPATH guidelines which determine that those referrals for surgery can be carried out by a psychiatrist, psychologist, psychotherapist, counsellor, social workers or other medical professional with experience in sexology, qualified to doctorate standard.

During the organising of this conference, a hospital in Sydney that treats sex and/or gender diverse people told the author that it did not wish the public to know what it did. The hospital – despite providing services – refused an invitation to attend the conference in the service providers' section. It also stated that it would not accept patients without a psychiatric interview. The psychopathologising of sex and/or gender diverse people is contrary to WPATH guidelines for trans people and, in fact, the hospital representative was unaware of the contents of the guidelines.

This continual psychopathologising of people on account of their sex and/or gender diversity going through state Medicare services disempowers them. Being sex and/or gender diverse is not an illness in itself. What it also does is take away people's sense of agency over their own destiny. This in itself can lead to depression, anger, resentment against the medical profession and lack of promoting agency within the therapeutic environment.

Being an adult or young adult can be a difficult enough time for many people as they find their direction and confidence in the world. Add to that having to cope with sex and/or gender dysphoria or being a sex and/or gender exploring person in an often hostile society can interfere with education and lower those people's life chances. Add to that the burden of an unreal, biomedical, reductionist, artificially constructed, psychiatric diagnosis and that can severely disable people's sense of ego, self-efficacy and agency, and the practice becomes dangerous.

The figures from the Gender Centre show that many sex and/or gender diverse people struggle socially, economically and psychologically in society. However, that is only the tip of the iceberg because many people from lower socio-economic groups that the author and other clinics see do not use the Gender Centre and do not show up in their figures. Many of those people may be homeless, sleeping on friends' couches or floors for years at time. The author constantly encounters outside of her clinic those people who update her of their latest struggles with accommodation and trying to get work. For many of them accommodation in what are considered safe areas is often out of their economic reach.

The accumulating life stressors, lower level of education, accommodation difficulties, difficulty finding work, being under threat of insult, mistreatment or violence, encumbered with an unnecessary psychiatric diagnosis leads to higher levels of depression and anxiety in lower socio-economic people from SGD groups.

This scenario is not new and the author has witnessed it several times over the years. In London in the 1970s, groups of SGD people would gather in Earls Court where they would sleep four in a single hotel room. Many of those people died prematurely due to drug addiction, alcoholism or suicide. In New York in the 1980s Rusty Mae Moore and her partner Chelsea Goodwin ran Transi House where they opened up their homes to those from SGD groups who were struggling economically and socially. In the 1990s the author saw the hijra of Mumbai approaching people asking for money in exchange for blessings in the street to survive as they could not get work. The phenomenon of people from sex and/or gender diverse groups struggling economically and socially is common to nearly all major cities in the world. This fight for survival in lower socio-economic groups leads to higher levels of depression and anxiety and suicide. It is not as common in economically advantaged people from SGD groups who have much higher life chances.

Conclusion

Many people from sex and/or gender diverse groups with lower economic circumstances struggle to survive on day-to-day basis. This adds to the stress they experience in life, as rising levels of anxiety and depression makes them more vulnerable to added psychological or psychiatric complications. They experience lower levels of life changes in society by the very nature of them being publicly identified as being from those groups. Laws that prohibit them living their lives peacefully and fully recognised in society add to their stress levels, and in the Western world is likely to lead to the inability to work, higher anxiety, depression, psychopathology, suicidal ideation and state economic support dependency in older years.

Improved legal, social, medical and psychological support for lower socio-economic people from SGD groups is likely to lead to a higher level of life satisfaction and lower level of anxiety, depression, psychopathology, suicide, drug addiction, alcoholism, early death and lower level of long-term welfare dependency.

Recommendations

Australasian clinics need to stop using out-of-date psychiatric medical models that classify sex and/or gender diverse people as having a psychiatric illness due to their SGD status.

Medicare needs to give full Medicare rebates for the treatment that many sex and/or gender diverse people may need if they are from lower socio-economic groups determined by means testing. This leads to lower stress levels and ability to rejoin the workforce.

Medicare needs to make more available points of source of information about treatment rebates for assisting sex and/or gender diverse populations.

Australian state governments need to remove legal obstacles for sex and/or gender diverse people being recognised in society.

The federal government needs to give full anti-discrimination protection to all sex and/or gender diverse people.

Australian governments need to embark upon a positive discrimination strategy for raising the status of sex and/or gender diverse people in society by allocating a certain number of government jobs to that population.

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