Mental Health Outcomes Among Transgender & Gender Diverse Survivors of Violence: A Literature Review

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Abstract

This thesis is a literature review of current articles and data available on mental health outcomes among transgender and gender-diverse (TGD) survivors of victimization. The objective of this research is to critically examine and synthesize the literature describing the relationship between victimization and mental health outcomes among TGD people. This literature review includes data from sixteen articles gathered through The Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PubMed (MEDLINE) and utilized search terms related to TGD people, mental health, and violence. This research focuses on four key types of mental health outcomes: depressive symptoms, post traumatic stress disorder (PTSD) symptoms, self-injurious thoughts, and self-injurious behaviors. The research shows that high rates of minority stressors including gender-based victimization and discrimination can negatively impact TGD people's mental health outcomes. The objectives of the research are met and this thesis provides an overview of what is in the current literature for mental health outcomes among the TGD violence survivors population.

Keywords: Transgender, Violence, Mental Health

Mental Health Outcomes Among Transgender & Gender Diverse Survivors of Violence: A Literature Review

Transgender and gender diverse (TGD) people have widely been reported as having worse health outcomes than their cisgender counterparts. TGD people have higher instances of risk factors for cardiovascular diseases and higher instances of cardiovascular disease outcomes than cisgender people (Streed et al., 2021). In a study conducted by Guo et al. (2022), TGD people also have significantly higher rates of risk factors for developing Alzheimer's and dementia related diseases. However, it is important to note that TGD people do not inherently have worse mental health outcomes than their cisgender counterparts (Gus et al., 2019). These poor mental health outcomes can broadly be attributed to experiences of discrimination, victimization, lack of access to gender-affirming care, and lack of social support systems.

The current literature discussing TGD violence survivors and mental health primarily focuses on determining the rates of violence experienced and resulting mental health outcomes. There is also research outlining specific examples of gender-based discrimination and violence against TGD people (Sherman et al., 2022). Sherman et al. (2022) gives direct quotes from TGD violence survivors outlining their experiences of abuse and subsequent health seeking behaviors. The mental health outcomes primarily discussed in the literature are depressive symptoms, post traumatic stress disorder (PTSD) symptoms, self-injurious thoughts, and self-injurious behaviors. In this literature review these four categories will be utilized to assess mental health outcomes among TGD people.

The populations primarily included in the literature discuss lesbian, gay, bisexual (LGB), and transgender people as one population, failing to distinguish between the experiences of LGB people and TGD people. This is seen in the research conducted by Parr (2020) where he

discusses mental health outcomes among cisgender and transgender college-aged sexual assault survivors, and in research conducted by Kassing et al. (2021) where she discusses the effects of polyvictimization on mental health outcomes among LGBTQ+ people. Discussing LGBTQ+ people as a monolith can fail to assess the ways in which gender expression and gender nonconformity put TGD people at risk for additional discrimination and violence. The research that does focus solely on TGD people often fails to distinguish between the experiences of binary transgender people and gender-diverse people. For instance, in a study conducted by Henry et al. (2021) the influence of intimate partner violence (IPV) on mental health outcomes in transgender and gender non-conforming adults was discussed, but the research combined the experiences of all TGD people together. This research would have been enhanced by clarifying the differences in experiences between transgender women, transgender men, and gender-diverse individuals.

This thesis will focus on collecting data on mental health outcomes specific to TGD people, which will help to differentiate between the experiences of TGD and LGB people. Additionally the majority racial group represented in each article will be reviewed to assess for racial diversity in the literature. The data will be synthesized to allow for larger and more impactful assessments of TGD populations and findings will be discussed in the context of real world nursing interventions. This literature review will seek to synthesize data on mental health outcomes among TGD people by combining the data from 16 articles to determine associations between violence exposure and mental health outcomes among TGD people.

The TGD Population & Healthcare Workers

As understood by the minority stress perspective, developed by Dr. Michael P. Dentato, TGD patients experience health disparities largely because of stressors from a transphobic and discriminatory culture. This culture results in negative biases, violence, and victimization of

TGD people which can negatively impact access to healthcare, social support systems, support resources, and resiliency coping skills. In a study by Griffin et al. (2019) barriers to psychosocial needs, barriers to resources, and perceived lack of safety for LGBTQ+ people were indicators of poorer health perceptions, which could relate to health disparities. TGD people have seen the pathologization of TGD identities in medical settings. Due to a history of mistreatment of TGD people from healthcare providers, they tend to have greater distrust of medical establishments, which ultimately lead to delayed healthcare. Delaying healthcare, can result in late interventions and worse prognosis than cisgender people who do not have this mistrust of medical establishments.

In a study by Seelman et al. (2017) 31.1% of the sample of TGD people (N = 417) reported delaying healthcare due to a fear of discrimination. Those participants who delayed accessing healthcare because of a fear of discrimination had significantly poorer general health ($p<0.05$), with self-reported general health being 0.26 points lower than TGD people who did not delay healthcare or delayed healthcare for other reasons (Seelman et al., 2017). Those who delayed healthcare because of a fear of discrimination had approximately three times greater rates of current depression and almost four times greater rates of suicidal attempts in the past year than TGD people who did not delay healthcare or delayed healthcare for other reasons (Seelman et al., 2017).

Respondents to the 2015 United States Transgender Survey (USTS) reported delaying care due to fear of being mistreated as a transgender person (23%). Additionally, 33% of respondents who had seen a healthcare provider in the year before the survey reported that they had at least one negative experience because of their transgender status. Experiences described included verbal harassment, refusal of treatment, or having to teach their provider about

transgender people to receive the appropriate care. Nurses, and all healthcare workers, need to make a concerted effort to expand their knowledge and promote acceptance of TGD people, only then will TGD people begin to feel safe seeking out healthcare. Violence survivors specifically report revictimization while attempting to seek out supportive care. Black, Indigenous, and People of Color (BIPOC) may have additional mistrust of medical establishments due to a history of BIPOC people being mistreated and exploited by medical providers for unethical research and personal gain.

Physiological Mechanisms of Violence Exposure

In a study by Pico-Alfonso et al. (2004) a sample of women who were survivors of IPV had more severe symptoms of depression and PTSD than a control group of women who had not experienced IPV. Additionally they had higher levels of morning and evening cortisol when compared with the control group (Picot-Alfonso et al, 2004). Cortisol is the primary stress hormone in the body, demonstrating that instances of victimization in the short term can result in higher stress hormone levels over the long term. Interestingly, mental health status did not have a mediating effect on the impact of hormone levels (Picot-Alfonso et al, 2004).

In a study by Halpern et al. (2013) a nationally representative group of adolescent females (N = 8,531) were surveyed regarding sexual and non-sexual violence exposure and the presence of 16 somatic symptoms, including headache, feeling very tired, and waking up tired. Girls who experienced both sexual and non-sexual violence had highest incidence of somatic symptoms presence, followed by the sexual violence only group, then the non-sexual violence only group (Halpern et al, 2013). This pattern suggests that there is an interaction between the effects of violence, as well as an exposure-response association between cumulative violence exposure and somatic symptoms present (Halpern et al, 2013).

Stressors prompt adaptation from a person's sympathetic nervous system resulting in physiological, cognitive, and behavioral mechanisms to confront or avoid the threat. Threats trigger physiological response patterns resulting in a release of catecholamines from the adrenal glands, including epinephrine, norepinephrine, and cortisol. In the short term these catecholamines are beneficial, helping to increase heart rate, respiratory rate, blood pressure, muscle strength, and cognitive awareness. However, in the long term, increased catecholamines can result in cardiovascular disease, respiratory disease, anxiety disorders, depression, headaches, sleep problems, obesity, and more health issues. A literature review completed by Lannert (2015) highlights the affective, cognitive, and physiological responses of LGB people upon exposure to biased crime information. Exposure to information on biased crimes results in periodic and chronic stress for TGD people (Lannert, 2015). These issues are particularly relevant when discussions of biased crime dominate public discussion, and when local, state, and federal laws seek to restrict the rights of TGD people.

Mental Health Assessment Tools

One difficulty when synthesizing many articles of differing methodologies is determining how the mental health outcomes were assessed. In all research articles the data on these mental health outcomes was collected by individuals reporting their experiences, and some included records of hospital admittances for self-injurious thoughts or behaviors. When assessing depression some articles looked for a clinical diagnosis of depression, whereas others performed assessments to determine the presence of symptoms of depression, such as sleep disturbances, changes in appetite, decreased energy, decreased concentration, and decreased self esteem, among other symptoms. Some specific assessment tools for depressive symptoms include Patient Health Questionnaire-9, Beck Depression Inventory II, Beck Hopelessness Scale,

Hamilton-Depression Scale, and MINIDEP Assessment Tool. The same is true for PTSD, some articles looked for a medical diagnosis of PTSD, whereas others looked for the presence of PTSD symptoms, such as hypervigilance, flashbacks, nightmares, and heightened reactions, among other symptoms. Some examples of assessments for PTSD symptoms include the PTSD CheckList – Civilian Version, Short Post-Traumatic Stress Disorder Rating Interview, and SPAN Self-Report Screen.

Self-injurious thoughts include suicidal thoughts, as well as thoughts of self harm (i.e. cutting, scratching, or burning oneself, carving words or symbols into one's skin, hitting or causing blunt trauma to oneself, piercing one's skin with sharp objects, picking at existing injurious, among other behaviors). Self-injurious thoughts are assessed by participant's self reporting, and assessment tools like The Columbia-Suicide Severity Rating Scale, Beck Scale for Suicide Ideation, and The Ask Suicide Screening Questions (ASQ) Toolkit. Self-injurious behaviors can include suicide attempts and acting on thoughts of self harm. Self-injurious thoughts are assessed by self reports of suicide attempts and self-injurious behaviors. Tools to assess for self injurious behaviors include The Brief Non-Suicidal Self-Injury Assessment Tool, The Non-Suicidal Self-Injury Assessment Tool, and Inventory of Statements About Self-Injury.

A Review of 2017-2022 Literature

Methods

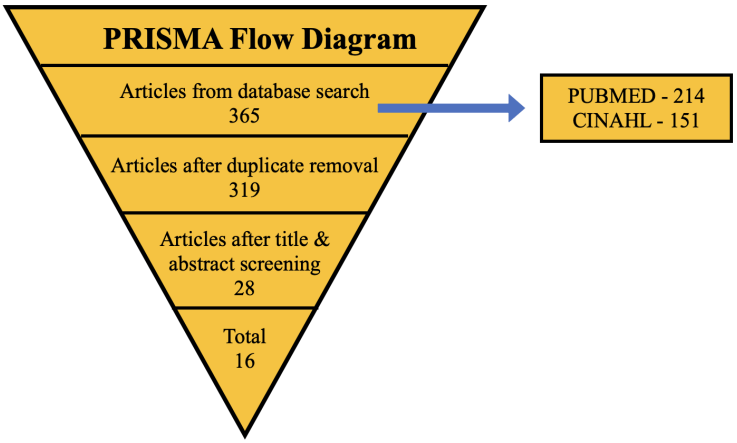
This review of the current nursing literature regarding mental health outcomes among TGD violence survivors utilized the Cumulative Index of Nursing and Allied Health Literature (CINAHL) and PubMed (MEDLINE) databases. Key search terms used in both databases were transgender, violence, and mental health. In CINAHL's advanced search, the filters included English language, human participants, with publication dates set between the years of 2017 and 2022. In PubMed, additional filters included English language, with publication years between 2017 and 2022. With these filters in place CINAHL had 214 articles and PubMed had 151 articles, for 365 total articles. After removing duplicates between databases there were 319 articles. Title and abstract screening narrowed down the relevant literature to 28 articles. After thorough readings of the remaining 28 articles, 16 articles were found to meet all inclusion criteria. The inclusion criteria consisted of:

1. Containing data specific to TGD participants
2. Adult participants (18 years of age and older)
3. Participants were survivors of victimization
4. Data related to mental health outcomes

Exclusion criteria consisted of:

1. Not presenting mental health data specific to TGD people
2. Not presenting data specific to adults
3. Sample not being survivors of victimization
4. Not presenting data with one of the following mental health outcomes: PTSD symptoms, depressive symptoms, self-injurious thoughts, and self-injurious behaviors

Figure 1: Prisma Flow Diagram



Mental Health Outcomes Findings

PTSD Symptoms

Six of the 16 articles reviewed had data discussing PTSD symptoms among TGD people, and the sum of the sample sizes was 2,529 people. All six articles discussing PTSD symptoms found that victimization was associated with a higher severity of PTSD symptoms among TGD people.

Depressive Symptoms

Twelve of the 16 articles reviewed had data discussing depressive symptoms among TGD people, and the sum of the sample sizes was 4,390 people. All twelve articles found that victimization was associated with a higher prevalence of depressive symptoms among TGD people.

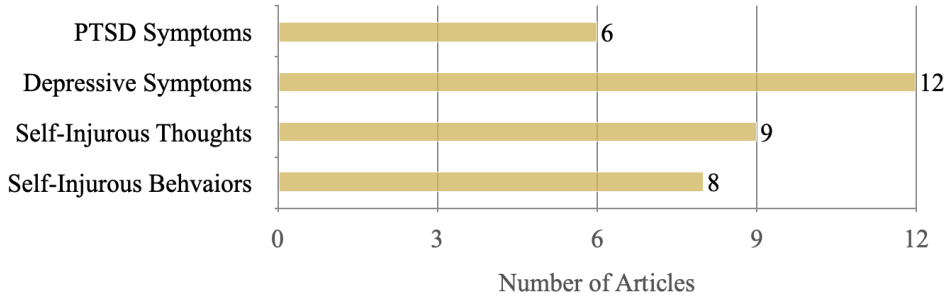
Self-Injurious Thoughts

Nine of the 16 articles reviewed the data discussing self-injurious thoughts among TGD people, and the sum of the sample sizes was 33,727 people. All nine articles discussing self-injurious thoughts found that victimization was associated with a higher prevalence of self injurious thoughts among TGD people.

Self-Injurious Behaviors

Eight of the 16 articles reviewed had data discussing self-injurious behaviors among TGD people, and the sum of the sample sizes was 30,700 people. All eight articles found that victimization was associated with a higher prevalence of self injurious behaviors among TGD people.

Figure 2: Included Articles with Mental Health Outcomes



Literature Assessment Findings

Types of Violence Assessed in the Literature

In the six articles discussing PTSD symptoms: four articles included physical violence, four articles included sexual violence, two articles included IPV, and three articles included psychological violence. In the 12 articles discussing depressive symptoms: nine articles included physical violence, six articles included sexual violence, four articles included IPV, and four articles included psychological violence. In the nine articles discussing self-injurious thoughts: eight articles included physical violence, five articles included sexual violence, four articles included IPV, and four articles included psychological violence. In the eight articles discussing self-injurious behaviors: six articles included physical violence, three articles included sexual violence, three articles included IPV, and two articles included psychological violence. The mode

in every case was physical violence (not including sexual violence) with scarce inclusion of emotional and psychological violence in the literature.

Figure 3: PTSD Symptoms

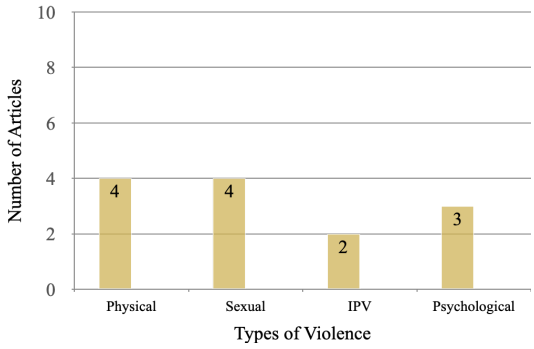


Figure 4: Depressive Symptoms

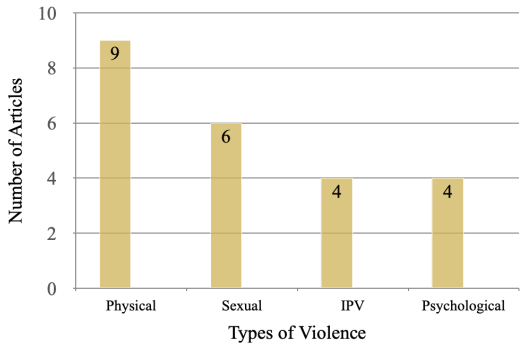


Figure 5: Self-Injurious Thoughts

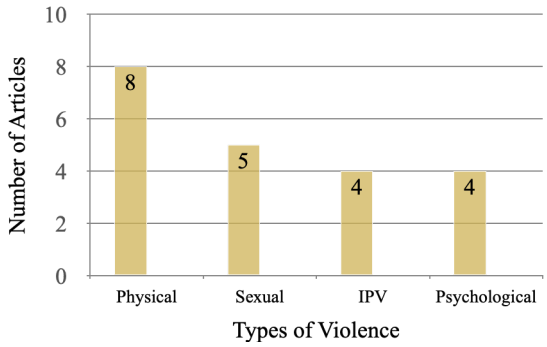
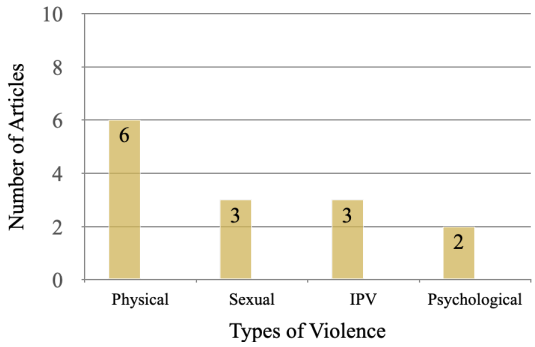


Figure 6: Self-Injurious Behaviors



Gender Identities Assessed in the Literature

In the articles discussing PTSD symptoms: 55% of participants identify as transgender women, 12% of participants identify as transgender men, and 33% of participants identify with a different gender identity. In the articles discussing depressive symptoms: 36% of participants identify as transgender women, 45% of participants identify as transgender men, and 19% of participants identify with a different gender identity. In the articles discussing self-injurious thoughts: 37% of participants identify as transgender women, 27% of participants identify as transgender men, and 36% of participants identify with a different gender identity. In the articles discussing self-injurious behaviors: 33% of participants identify as transgender women, 29% of

participants identify as transgender men, and 38% of participants identify with a different gender identity.

Figure 7: PTSD Symptoms

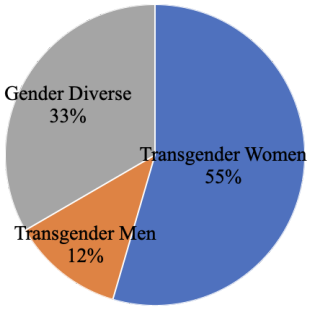


Figure 8: Depressive Symptoms

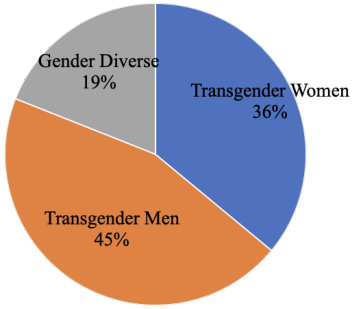


Figure 9: Self-Injurious Thoughts

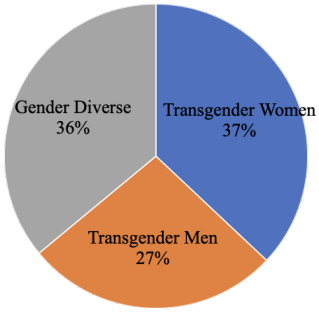
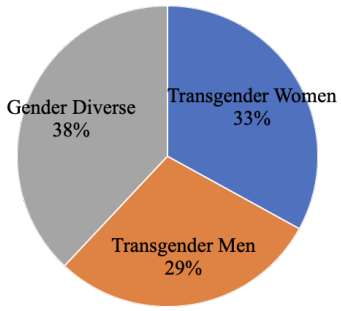


Figure 10: Self-Injurious Behaviors



Races of Participants Assessed in the Literature

Five of the six articles discussing PTSD symptoms collected data on the race of the participants. Of those, three of the five articles had a majority of white participants, and two articles had a majority of Black participants. Eleven of the twelve articles discussing depressive symptoms collected data on the race of the participants. Of those, six out of eleven articles had a plurality of white participants, three had a majority of Black participants, and in one article by Luz et al. (2020) the majority of participants reported being a race "other" than Black. Seven of the nine articles discussing self-injurious thoughts collected data on the race of participants. Of those, six out of seven articles had a plurality of white participants, one of the articles had a majority of Black participants. Seven out of eight articles discussing self-injurious behaviors

collected data on the race of the participants. Of those, six out of seven had a plurality of white participants, one article had a majority of Black participants. The figures below show the racial majority in each mental health outcomes. This data demonstrates a lack of racial diversity in the participants included in the literature. After white participants, Black participants are the second most included in the literature with other races being sparsely included.

Figure 11: PTSD Symptoms

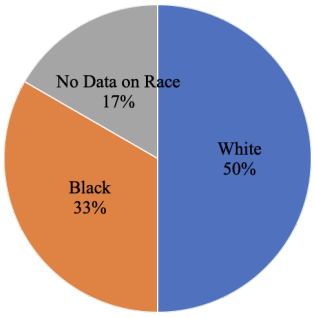


Figure 12: Depressive Symptoms

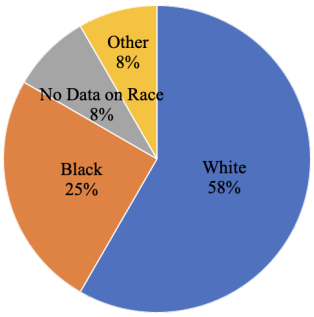


Figure 13: Self-Injurious Thoughts

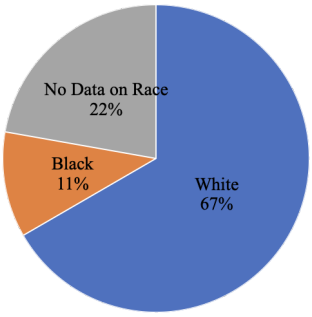
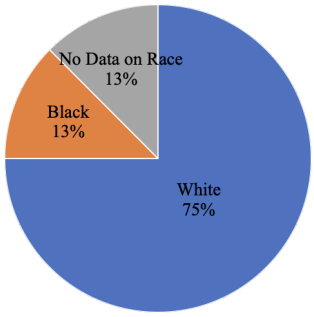


Figure 14: Self-Injurious Behaviors



Discussion

The goal of this literature review is to synthesize the data on mental health outcomes among TGD survivors of violence. Findings were consistent among all mental health outcomes that TGD survivors of violence have worse mental health outcomes than TGD people who have not endured violence exposure. Violence exposure was associated with increased severity of PTSD symptoms, and increased prevalence of depressive symptoms, self-injurious thoughts, and self injurious behaviors among TGD people. To those familiar with the literature surrounding

mental health and violence exposure, the findings of this review are likely not surprising. According to the 2015 USTS, 47% of respondents have been sexually assaulted at some point in their life, and 54% of respondents experienced some form of IPV in their life. Given the staggering rates of violence exposure among TGD people, it is clear that interventions are needed to decrease the victimization of TGD people and to support TGD violence survivors.

Types of Violence Exposure

Articles which were surveyed primarily collected data from survivors of physical violence resulting in an under-representation of psychological abuse and IPV. In the 2015 USTS, 54% of TGD people reported experiencing verbal harassment in the past year, compared to 13% of TGD people who reported experiencing a physical attack in the past year. While more TGD people experience psychological abuse, the literature prioritizes physical abuse. This is a limitation of the review as it may be more readily applied to survivors of physical victimization than psychological victimization and IPV. Additionally, more articles collected data on depressive symptoms than other mental health outcomes, with PTSD symptoms being the least represented in the literature. Thus, the sample size of data for depressive symptoms is much larger than that of the PTSD symptoms.

Gender Identities

In this literature review, of the data collected regarding PTSD symptoms, 55% of the sample identified as transgender women. Therefore, PTSD in transgender men is underrepresented in the data at only 12% of the sample. This means the data for PTSD symptoms may be more readily applied to transgender women and gender diverse people, than to transgender men. In depressive symptoms, 45% of the data collected was from transgender men, with 36% from transgender women, and only 19% from gender diverse people. Therefore,

depressive symptoms in gender diverse people are underrepresented in the data. In self-injurious thoughts and self-injurious behaviors the data is more evenly distributed between transgender men, transgender women, and gender-diverse people.

Racial Identities

This literature review also found that in all four mental health outcomes at least 50% of the articles had a plurality of white participants, with Black participants being the second most represented racial group in the research. This demonstrates a need for data specific to other racial groups. For PTSD symptoms 50% of articles had a plurality of white participants, in depressive symptoms 58% of articles had a plurality of white participants, in self injurious thoughts 67% of articles had a plurality of white participants, and in self injurious behaviors 75% of articles had a plurality of white participants. Two articles did not collect data on race at all. This calls to attention a lack of understanding in the literature regarding the nuances of race and its influence on victimization and mental health.

Limitations

There were limitations regarding the distribution of types of violence, gender identities, and racial groups included in the literature. Despite the limitations discussed, this literature review is still a collection of data from 37,053 TGD people which demonstrates associations between violence exposure and mental health outcomes. This literature review should serve as a starting point to understand the associations within the data we have now, and to determine what needs to be done differently in future data collection to make the literature more representative of the TGD community.

Nursing Implications

Clinical Practice

It is important for nurses to increase screening for exposure to violence and adverse mental health symptoms among TGD people. This will allow nurses to recognize survivors of violence and intervene early to provide survivors with resources to help minimize mental health outcomes. Additionally, in clinical nursing practice it is important that nurses are aware of how to avoid potentially triggering language regarding gender identity for their TGD patients and physical assessments that could re-traumatize violence survivors. It is vital that all nurses be trained in trauma informed care and be intentional about obtaining consent before touching patients or performing any procedures. Obtaining consent is a simple way that nurses can promote autonomy and a sense of control in their patients. By asking for permission before entering the room, and before touching patients, we can avoid re-triggering patients during their appointments. Retraumatizing patients, especially TGD patients and violence survivors, can minimize the likelihood that they will seek out healthcare when they need it in the future, and can cut off a line of support for them. It is also important that nurses clearly communicate to patients what assessments will occur and why they are clinically necessary.

Community Health

The expansion of mental health resources that are specific to violence survivors is necessary to promote community and support among TGD violence survivors. A sense of community can help to minimize feelings of isolation and loneliness, which are common in TGD people and can contribute to negative mental health outcomes. Community spaces for TGD people and violence survivors should focus on increasing self empowerment and advocacy, which have been shown to have an effect on promoting a sense of belonging and minimizing

negative mental health outcomes. In a survey conducted by the National Center for Transgender Equality (NCTE) and the National Gay and Lesbian Task Force, 55% of Black respondents, in a sample of 6,456 transgender people, reported that their family was as strong today as it was before they came out. This degree of family acceptance is higher than in any other racial group, and this speaks to the resiliency of Black communities (NCTE, 2011). Family acceptance was correlated with lower rates of negative outcomes, including lower rates of homelessness, suicide, and HIV-positive status (NCTE, 2011). Of other respondents, 49% of Asian-American families, 48% of American Indian families, 47% of Latinx families, and only 45% of white families reported being "as strong today" as before they came out (NCTE, 2011). This data demonstrates a need for resources, not only for TGD people, but also for their families to promote acceptance and understanding of TGD people.

Policy Changes

Nurses should advocate for the development of federal legal protections for TGD survivors of hate crimes. Developing federal legislation to protect TGD people from discrimination can help to minimize the instances of discrimination which can result in feelings of social isolation for TGD people. The National Violent Death Reporting System should include accurate capturing of gender identity in their data collection for proper identification of disparities among TGD people. Nurses can advocate on a local level for inclusive bathroom policies, which can protect transgender women from violence in men's bathrooms. Within their hospital systems nurses can advocate for easier ways to correct transgender patients names and list pronouns in their charts.

Insurance Policy

In a study by Gonzales and Henning-Smith (2017), of a sample of 315,893 people, 9.7% of cisgender women and 12.6% of cisgender men were uninsured, whereas 18.9% of transgender women, 28.9% of transgender men, and 13.9% of gender non-conforming people reported being uninsured (Gonzales & Henning-Smith 2017). These insurance disparities are present despite Section 1557 of the Affordable Care Act, which prohibits sex discrimination, including discrimination against TGD people, by most insurance companies and healthcare providers. In June 2020 these protections were threatened by the Trump Administrations ruling that Section 1557 did not protect against TGD discrimination. The protections were reinstated in July 2022 by the Biden-Harris administration, however there is a need for federal legislative protections that cannot be overturned simply based on the political party in power. Additionally expanding insurance policies to include gender affirming care is vital to decrease the gender dysphoria that can compound these mental health outcomes.

Access to Gender Affirming Healthcare

In a study by Bränström and Pachankis (2019), in a sample of 2,679 TGD people, those receiving gender-affirming surgical treatment had a significantly reduced likelihood of being hospitalized compared to hospitalization rates before gender-affirming surgical treatment (adjusted odds ratio = 0.92, 95% CI = 0.87, 0.97). The likelihood of being hospitalized for an anxiety disorder or suicide attempt were also reduced as a function of time since the last surgical treatment.

Researchers have long reported that gender-affirming care results in improved mental health outcomes among TGD people. In a study by Tordoff and Wanta (2022), in a population of 104 TGD youth prior to starting puberty blockers or gender-affirming hormones, 56.7% had

moderate to severe depression and 43.3% reported suicidal thoughts in the last two weeks. In a 12 month period after starting gender-affirming care, researchers observed a 60% decrease in depression (aOR ¼ 0.40; 95% CI = 0.17-0.95) and a 73% decrease in suicidality in TGD youth. Among TGD youth that did not receive gender-affirming care, depressive symptoms and suicidality were two to three times higher than their baseline rates. Government policies should reflect these findings, and gender-affirming healthcare should be accessible to all TGD people. Gender-affirming care is a vital part of improving TGD people's self image and self esteem, and it should be seen as a tool to fight poor mental health outcomes.

Racial Justice

It is also important to discuss the association between race and violence exposure. In a study conducted by Kravitz-Wirtz et al. (2022), it was found that nearly 3 out of 4 Black youth in low-poverty households resided in moderate (47.3%; 95% CI = 33.7−61.2) or high (26.7%; 95% CI = 16.1−40.8) disadvantaged neighborhoods, in comparison to 1 out of 4 white youth in moderate disadvantaged neighborhoods (25.7%; 95% CI = 16.5−37.7) and only 0.9% in high disadvantaged neighborhoods [95% CI = 0.1−7.0]. Community exposure to gun homicides was more frequent in the lives of Black and Latinx youth than their white peers. Kravitz-Wirtz et al. (2022) found that 56% of Black youth (56.3%; 95% CI = 48.1−64.2) and nearly half of Latinx youth (48.6%; 95% CI = 35.7−61.7) lived within 1300 meters of a gun homicide in the past year, with 1 in 4 Black youth (26.0%; 95% CI = 18.8−34.8) and 1 in 5 Latinx youth (19.2%; 95% CI = 10.5−32.6) experiencing 3 or more incidents in the past year. White youth had only 16.8% [95% CI = 9.9−27.0] lived within 1300 meters of a gun homicide in the past year and less than 1% had 3 or more incidents (0.6%; 95% CI = 0.1−2.2).

BIPOC people are more likely to have violence exposure incidents, including severe exposures, when compared with white people. These violence exposures contribute to mental health disparities. As discussed by Compton and Shim (2015), social factors like discrimination and racial bias work in congruence with inequitable public policies resulting in uneven distribution of opportunities for BIPOC people. This can be seen in income inequality, rates of poverty, housing insecurity, food insecurity, underemployment, poor education, and increased rates of adverse childhood experiences (ACEs) in BIPOC people compared to white people (Compton & Shim, 2015). All of these are risk factors for developing poor mental health outcomes. When BIPOC people also hold a TGD identity they meet at the intersection of racism and transphobia, which compound each other for significantly worse mental health outcomes.

Future Research

Researchers should focus on expanding their definitions of violence to include emotional and psychological victimization, as well as determining the differences in mental health outcomes between physical and psychological victimization. Future research should also strive to better understand the differences between the victimization experiences of binary transgender people and gender diverse people. Future research should also prioritize including the narratives and experiences of BIPOC people. This will highlight the differences in mental health outcomes between white TGD people and BIPOC TGD people, as well as recognize cultural differences in victimization experiences. Future research should evaluate the appropriateness of known modifiers of the relationship between violence exposure and mental health symptoms (e.g. coping skills, social support systems, community centers). Additionally, research databases should allow researchers to list participants as additional sexes and gender identities. Both CINAHL and PubMed, which were used in this literature review, only have male and female

listed as options for participants sex. This is exclusionary of intersex participants, who do not fall neatly into the male-female binary, as well as making it more challenging to search for research specific to the intersex population. Research databases should also include gender identity in search filters to allow people to search for articles specific to TGD people.

Nursing Education

Nursing educators need to develop curriculum to adequately support nurses and nursing students in learning about TGD people and how to support TGD patients. Nursing professionals need to expand discussions of TGD patient's needs in nursing school curricula and continuing education for nurses. By integrating TGD health, trauma-informed care, and bias and prejudice training into the nursing curricula we can better prepare nurses to support TGD people. Registered nurses should also have continuing education on bias and prejudice identification and response. Nurses need to continue to develop information and resources for families of TGD people. By providing resources to the families of TGD people we can help to promote family acceptance and minimize instances of domestic victimization, TGD homelessness, and social isolation in TGD people.

For LGBTQ+ youth there is no factor with greater significance on physical and mental health outcomes than family acceptance (McCormick & Balrdgrige, 2019). McCormick and Baldridge describe family acceptance as including behaviors such as: affirming a child's LGBTQ+ identity, advocating for their child when they have been mistreated for their identity, and avoiding double standards regarding interests and relationships (2019). McCormick and Baldridge found that among LGBTQ+ youth those with accepting families were 8.4 times less likely to make a suicide attempt than those with rejecting family experiences, and six times less likely to have depressive symptoms than those with rejecting families (2019). Additionally,

LGBTQ+ youth with accepting families were 3.4 times less likely to abuse substances and 3.4 times less likely to engage in risky sexual behaviors than those with rejecting families (2019). These statistics highlight the need to develop comprehensive resources and support groups for the families of TGD youth to promote acceptance of TGD people.

Nursing schools need to create a culture of safety and support for TGD nursing students. Schools can support their TGD students by implementing compulsory staff and faculty training on LGBTQ+ issues, teaching staff and faculty on how to use TGD peoples' pronouns correctly, and developing resources for TGD nursing students. By having more TGD nurses and healthcare professionals TGD people will see themselves reflected within the workforce and will feel safer seeking out care. Nursing schools should have anti-bullying and anti-discrimination policies protecting TGD students and programs focused on the retention of TGD students. Nursing schools should host educational sessions on LGBTQ+ issues for students to promote acceptance and decrease victimization of TGD students within their classes.

Conclusion

Victimization has significant implications for the health and wellbeing of survivors, this is especially true among the TGD community. Nurses need to take a personal responsibility to stand up for this highly vulnerable population. Based on the findings of this literature review survivors of victimization had higher rates of PTSD symptoms, depressive symptoms, and self-injurious thoughts and behaviors. Primary interventions to prevent TGD victimization, secondary interventions for early interference of victimization, and tertiary interventions to support TGD survivors are needed. Community nurses should advocate for the creation of spaces that allow TGD people to form connections, educate their families on how to support them, and advocate for policy changes to create a more inclusive community for TGD people. Nurses in

acute care settings should advocate for interventions to support TGD patients on their units and in their communities. Such interventions could decrease victimization and subsequent mental health disparities among TGD people. Developing resources for survivors can help to mitigate these disparities and promote survivors' health and wellness.

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