NATIONAL LGBT HEALTH EDUCATION CENTER

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# Minority Stress and Trauma-informed Approaches

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- Current Position: Director of Education and Training Programs, The Fenway Institute
- Disclosure: No relevant financial relationships. Presentation does not include discussion of off-label products.

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# Learning Objectives

This module will enable participants to:

- Discuss the concept of minority stress and the impacts on individuals and communities
- Name three ways that organizations can minimize or prevent the impacts of trauma from minority stress
- Describe a trauma-informed organizational approach in managing and mitigating minority stress

# Polling Question 1

- What is your current role at your organization?
  - Health center provider
  - Health center administrator
  - Government official
  - Non-health center service provider
  - Policy/advocacy professional
  - Consumer

# Polling Question 2

- What is your familiarity level regarding trauma-informed principles?
  - No work with trauma-informed approaches
  - Some understanding of trauma-informed principles and models
  - Regular practice of trauma-informed approaches

# Minority Stress Framework

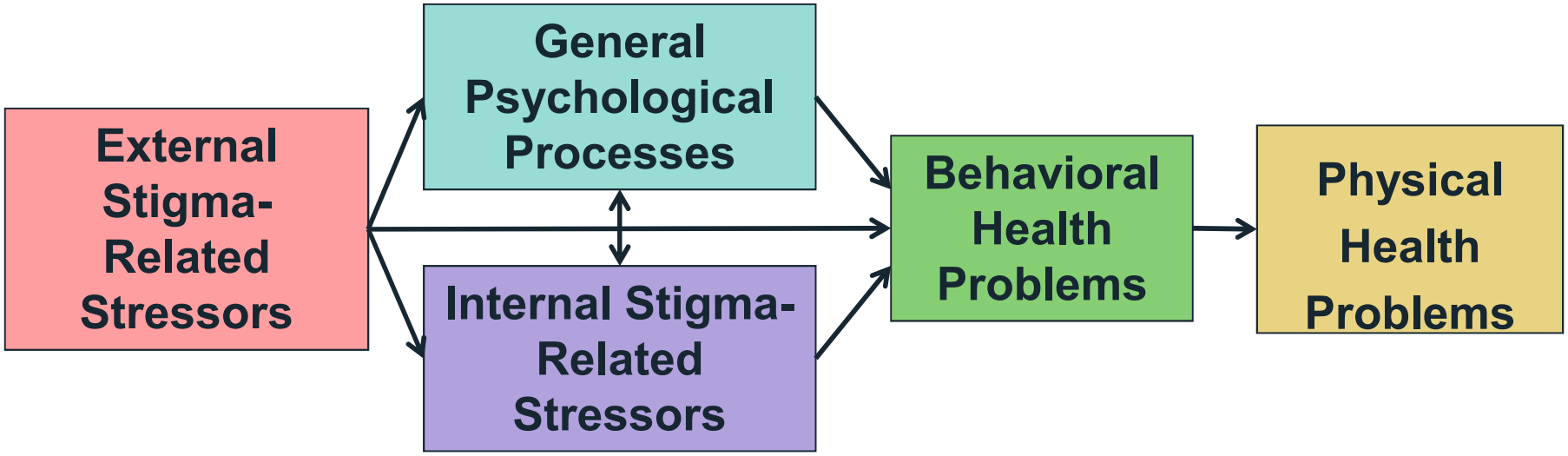
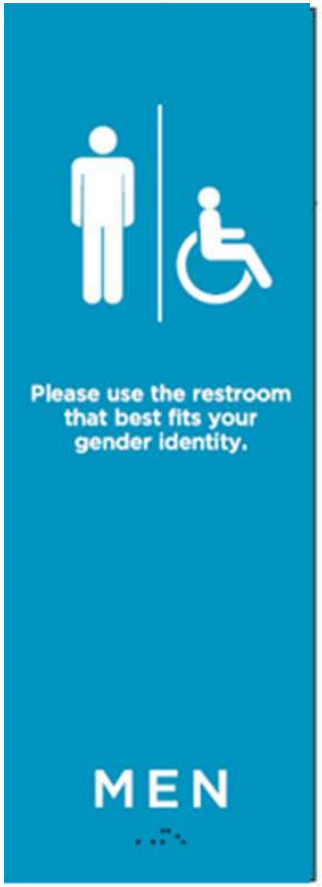



Fig. 1. Diagram from "How does sexual minority stigma get "under the skin"?"[1]

# Interpersonal Stigma

# Structural Stigma

- Structural, or institutional discrimination includes the policies of private and governmental institutions that intentionally restrict the opportunities of certain people, as well as policies that unintentionally restrict these opportunities.

# Intrapersonal Stigma:

"…And to the degree that the individual maintains a show before others that they themselves does not believe, they can come to experience a special kind of alienation from self and a special kind of wariness of others."[4]

# Anti-Transgender Discrimination and Victimization

- The 2015 U.S. Transgender Survey found that:[5]
  - 10% reported that a family member was violent towards them because they were transgender
  - 8% were kicked out of the house because they were transgender
  - Many experienced serious mistreatment in school, including being verbally harassed (54%), physically attacked (24%), and sexually assaulted (13%) because they were transgender
  - 17% experienced such severe mistreatment that they left a school

# Vulnerability to Poverty

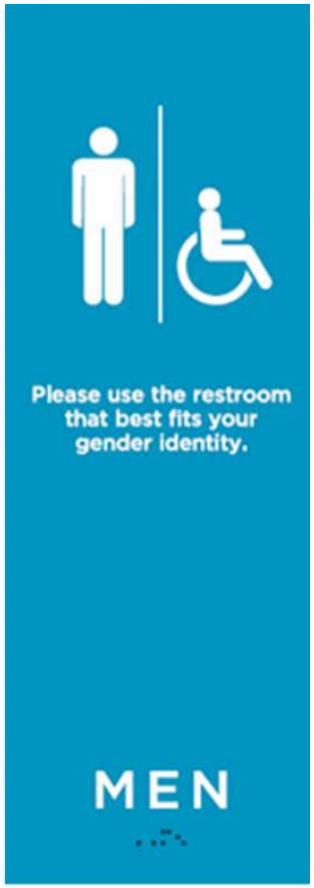
- Children of LGB parents are especially vulnerable to poverty.[6]
  - African American children in gay male households have the highest poverty rate (52.3%) of any children in any household type.
  - The rate for children living with lesbian couples is 37.7%.

# Vulnerability to Poverty

- The 2015 U.S. Transgender Survey found that:[7]
  - 29% of transgender people live in poverty, compared to 14% in the U.S. population
  - Transgender people have a 15% unemployment rate (compared with 5% in the U.S. population)
  - 16% of transgender people report homeownership, compared to 63% of the U.S. population
  - Nearly 30% of transgender people experienced homelessness in their lifetime
  - 12% report past-year homelessness due to being transgender

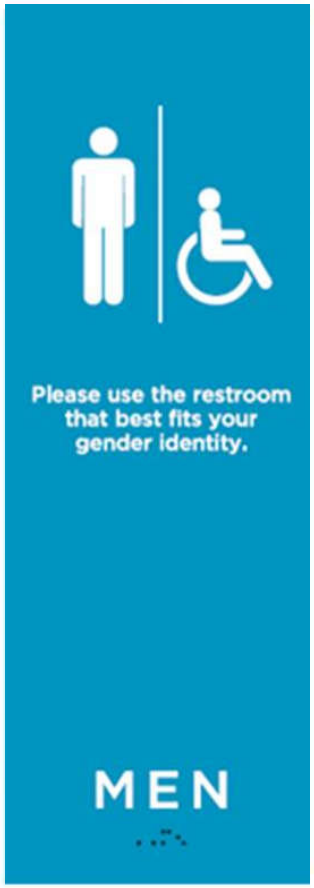
# Factors Associated with Higher PTSD Severity in Transgender Adults

- Higher everyday discrimination[4]
- Greater number of attributed reasons for discrimination
- Social gender transition
- High visual gender non-conformity

# Factors Associated with Lower PTSD Severity in Transgender Adults

- Younger age
- FTM spectrum gender identity
- Medical gender affirmation

# Minority Stress and Substance Use Disorders

- LGBTQ people have disproportionate substance use disorder (SUD) prevalence as a downstream effect of minority stress.[10-12]
- Substance use mediates the relationship between life stress and sexual risk.[13]

# Minority Stress and Substance Use Disorders

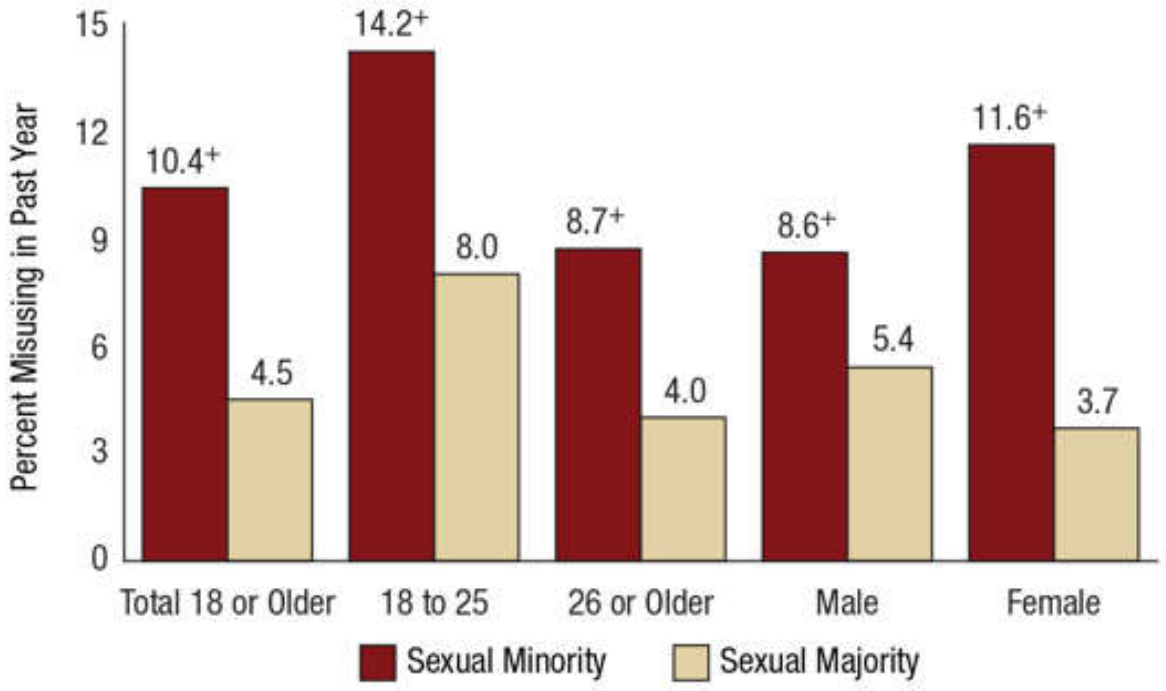
- SUDs are associated with condom-less intercourse and HIV infection.[14,15]
- SUDs are barriers to HIV pre-exposure prophylaxis (PrEP) adherence in populations at high risk for HIV.[16]

# Substance Use among LGBQ People

- LGBQ-identified youth initiate alcohol and illicit drug use earlier than non-LGB identified youth.[17]
- Lesbian and bisexual women are at greater risk for alcohol and drug use disorders.[18]
- Gay and bisexual men are at greater risk of drug use disorders.
- Bisexual people are at higher risk for substance use disorders.

# 2015 National Survey on Drug Use and Mental Health

**Figure 5. Past Year Misuse of Prescription Pain Relievers among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015**




D

+ Difference between this estimate and the sexual majority estimate is statistically signi cant at the .05 level.
Note: Sexual minority adults identi ed as being lesbian, gay, or bisexual. Sexual majority adults identi ed as being heterosexual or straight.

SAMHSA, 2015

# Opioid Use Disorders among Sexual Minority Groups

- Sexual minority youth aged 16 to 25 are more likely to initiate prescription opioid misuse early in life compared with their sexual majority counterparts (Kecojevic et al., 2012).

- Among young men who have sex with men (MSM) aged 18 to 29, higher perceived stress is associated with higher opioid misuse (Kecojevic et al., 2015).

# Opioid Use Disorders among Sexual Minority Groups

- Higher life stress among young Black MSM in Chicago was associated with greater odds of prescription opioid use (Voisin et al., 2017).

- Nonmedical opioid use among MSM is associated with increased risk of condomless sexual intercourse and sharing syringes (Zule et al., 2016).

# A Closer Look: Addictions among Transgender People

- Studies examining substance use disorders (SUDs) among transgender people are rare.[19]
- Reporting of gender identity data (e.g., transgender status) in SUD-related research is limited.
- In the few studies that exist, transgender people have elevated prevalence of alcohol and illicit drug use compared with the general population.[20,21]

# Gender Minority Stress and Substance Use among Transgender People

- Psychological abuse among transgender women as a result of nonconforming gender identity or expression is associated with:[22]
  - 3-4x higher odds of alcohol, marijuana, or cocaine use
  - 8x higher odds of any drug use
- Among transfeminine youth, gender-related discrimination is associated with increased odds of alcohol and drug use.[23]

# Gender Minority Stress and Substance Use among Transgender People

- 35% of transgender people who experienced school-related verbal harassment, physical assault, sexual assault, or expulsion reported using substances to cope with transgender- or gender nonconformity-related mistreatment.[24]
- Psychological stress of health care access disparities faced by transgender people is believed to contribute to worse mental health, including disproportionate substance use as a coping strategy.

# Substance Use Disorders among Transgender Adults

- Among 452 transgender adults, increased odds of SUD treatment history plus recent substance use were associated with:[25]
  - intimate partner violence
  - PTSD
  - public accommodations discrimination
  - low income
  - unstable housing
  - sex work
- SUDs increasingly viewed as downstream effects of chronic gender minority stress

# Substance Use and Posttraumatic Stress

- Co-occurrence of SUDs with posttraumatic stress symptoms is highly prevalent:[26]
  - Associated with increased treatment costs, decreased treatment adherence, and worse physical and mental health outcomes
- Substance use is a common avoidance strategy for posttraumatic stress

# Definition of Trauma-informed Care

- According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), a trauma-informed service organization:
  - Realizes widespread impact of trauma and understands potential paths for recovery;
  - Recognizes signs and symptoms of trauma in clients, staff, and others involved with the system;
  - Responds by fully integrating knowledge about trauma into policies, procedures, and practices;
  - Seeks to actively resist re-traumatization.

# Trauma-informed Care: An Emerging National Priority

- Emergence of several evidence-informed treatments designed to improve posttraumatic stress symptoms (Brezing and Freudenreich, 2015).
- Implementation of these strategies to target effects of trauma on health has been inconsistent.
- This issue has recently gained more national prioritization with increasing concerns about consequences of posttraumatic stress among veterans.

# Trauma-informed Care

- Trauma-informed approach should incorporate the following (Brezing and Freudenreich, 2015):
  - A trauma-sensitive practice environment
    - Trainings to ensure a sense of safety in all patient interactions with staff members, including clinical and administrative staff
  - Identification of trauma and its mediators
    - Sequelae of posttraumatic stress, including poor adherence to treatment and high-risk behaviors
  - Education for patients about connection between trauma and its negative behavioral and physical health outcomes
  - Linkage to suitable resources and referrals for more specialized treatment as needed

# National Center for Trauma-informed Care

- In 2005, SAMHSA developed the National Center for Trauma Informed Care:
  - Promotes awareness and implementation of best practices
  - Disseminates resources for and referrals for trauma-focused treatments
  - Defines trauma-informed care as an organizational approach rooted in principles that focus on being mindful of and responding to people who have experienced or may be at risk of trauma; rather than a particular set of rigid procedures

SAMHSA, 2014

# Integrated Treatment for Addictions and Trauma

- Recent shift in focus toward trauma-informed care created a favorable environment in community SUD treatment settings for evidence-based integrated therapies that also target trauma and stress.[27-30]
- Integrated treatments for SUDs and posttraumatic stress are well tolerated and improve both SUDs and PTSD.

# Co-occurring Opioid Use and Psychiatric Disorders: Fenway's Model

- Fenway's model: Addictions and Wellness Program (800 patients) within Behavioral Health (BH) Department, integrated with Violence Recovery Program

- Individual and group therapy programs rooted in a minority stress framework

- Leveraging LGBTQ community solidarity as a source of resilience and self-efficacy

# Minority Stress Treatment Principles for Clinicians

- Normalize adverse impact of minority stress[31]
- Facilitate emotional awareness, regulation, and acceptance
- Empower assertive communication
- Restructure minority stress cognitions
- Validate unique strengths of LGBTQ people
- Foster supportive relationships and community
- Affirm healthy, rewarding expressions of sexuality and gender

# Cognitive-behavioral Therapy for Substance Use Disorders

- Adapting selected topics and practice exercises from the manual by Carroll[32]
- Focus:
  - Coping With Craving (triggers, managing cues, craving control)
  - Shoring Up Motivation and Commitment (clarifying and prioritizing goals, addressing ambivalence)
  - Refusal Skills and Assertiveness (substance refusal skills, passive/aggressive/assertive responding)
  - All-Purpose Coping Plan (anticipating high-risk situations, personal coping plan)
  - HIV Risk Reduction

# Cognitive-behavioral Therapy for Substance Use Disorders

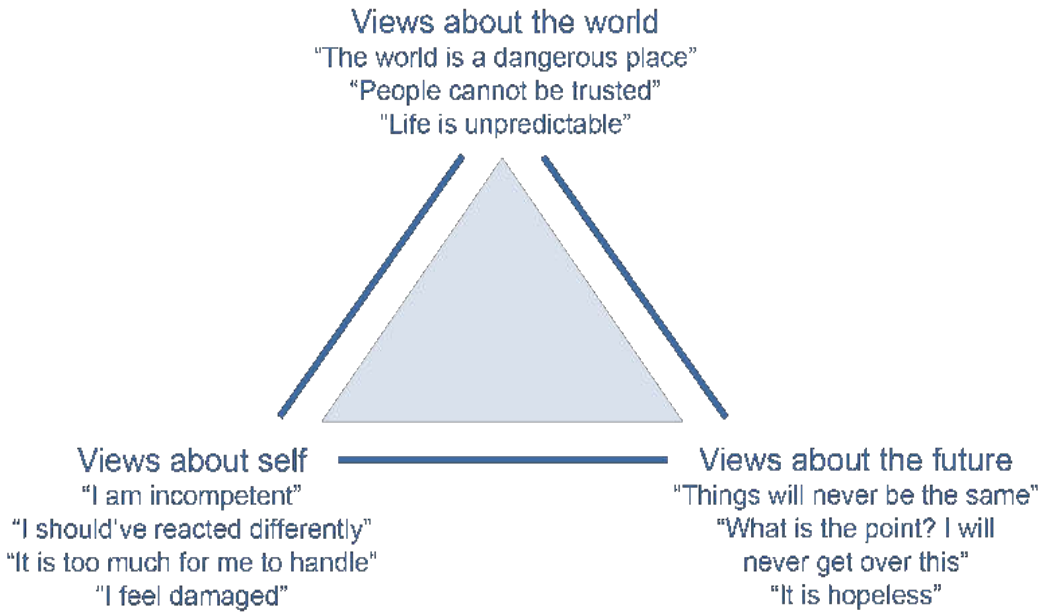
- Tailoring for LGBTQ patients:
  - Minority stress-specific triggers for cravings (e.g. nonconformity-related discrimination and victimization, expectations of rejection, identity concealment, and internalized homophobia/transphobia)
  - SUDs as barriers to personalized goals of adequate PrEP adherence or consistent condom use
  - For transgender patients: assertive substance refusal with non-transgender sex partners; HIV risk from hormone and silicone self-injections; SUDs as barriers to personalized goal of successful gender affirmation

# Cognitive Processing Therapy for PTSD

- Adapting selected components of cognitive processing therapy for PTSD
- Focus:
  - Education about posttraumatic stress;
  - Writing an Impact Statement to help understand how trauma influences beliefs;
  - Identifying maladaptive thoughts about trauma linked to emotional distress;
  - Decreasing avoidance and increasing resilient coping.

# Cognitive Triad of Traumatic Stress

Exhibit 1.3-2: Cognitive Triad of Traumatic Stress




SAMHSA, 2014

# Cognitive Processing Therapy for Minority Stress

- Possible tailoring for LGBTQ People:
  - Focus on how transgender-specific stigma causes posttraumatic stress (e.g. avoidance, mistrust, hypervigilence, low self-esteem);
  - Attributing challenges to minority stress rather than personal failings;
  - Impact Statement on how discrimination and victimization affect beliefs (e.g. expecting rejection, concealment needs, internalized homophobia/transphobia);
  - Decreasing avoidance (e.g. isolation from LGBTQ community or medical care);
  - Impact of minority stress on PrEP adherence or condom use.

# Safe Communities and Spaces

- Encourage clients to utilize peer support resources (online or in-person), and community organizations dedicated to affirming diverse sexual orientations and gender identities[38]
- Provide advocacy within public mental health systems for sexual and gender minority residents of group homes and homeless shelters
- LGBTQ competency training for staff

# Minority Stress Impact on Antiretroviral Adherence

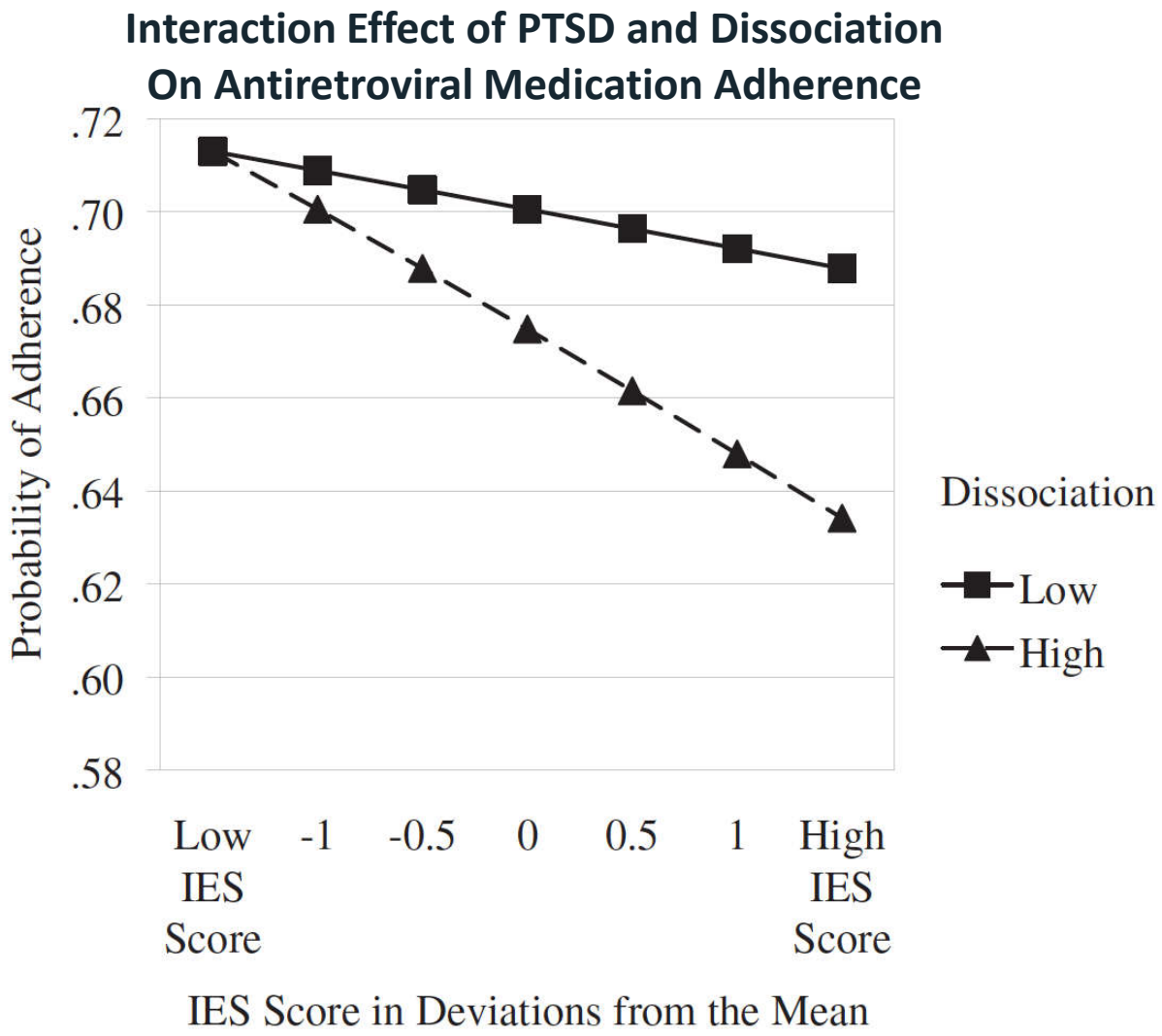
- Transgender women and men who have sex with men are the two subpopulations with the greatest HIV incidence and prevalence in the U.S.[39-41]
- Antiretroviral medications for HIV treatment and pre-exposure prophylaxis require adequate adherence for effectiveness.[42-44]

# Minority Stress Impact on Antiretroviral Adherence

- Studies of antiretroviral adherence emphasize population-specific contextual barriers.
- Sexual and gender minority stress (e.g. discrimination, victimization) both adversely impact HIV self-care.[45-49]

# PTSD and Antiretroviral Adherence

Fig. 2: Graph from "Trauma, dissociation and antiretroviral adherence among persons living with HIV/AIDS."[50]






Keuroghlian et al., 2011

# PTSD and Antiretroviral Adherence

- Importance of psychosocial interventions that target posttraumatic stress symptoms to maximize antiretroviral adherence in community populations.[51,52]
- Integration of trauma-focused treatment services into antiretroviral medication management may effectively improve adherence.

# Bio-behavioral HIV Care

- Tailored behavioral interventions exist for antiretroviral adherence (e.g. Life-Steps).[53]
- Combined biomedical and behavioral HIV treatment and prevention strategies are optimal.
- Behavioral health treatments that restructure minority stress cognitions can improve self-care and physical health outcomes.[54]

# Trauma-informed Service Environment

- Priority is to promote a sense of safety
- Prior traumatic experiences influence reaction in subsequent interactions, such as the process of seeking care.
- A history of interpersonal trauma can contribute to mistrust of caretakers and increased likelihood of being re-traumatized.
- Retention in care for patients with trauma histories requires engagement through collaboration, transparency, trust, and consistent supportiveness.

Brezing and Freudenreich, 2015

# Screening for and Identifying Trauma and Its Mediators

- Screening all patients for a trauma history
  - Extra attentiveness for subpopulations with an even higher risk of trauma, who may have heightened sensitivity
  - Screening for intimate partner violence.
- If trauma is identified, care team ought to assess specifically for posttraumatic stress symptoms
  - Hypervigilance; avoidance, numbing, re-experiencing through intrusive thoughts, flashbacks, nightmares; psychological dissociation, including amnesia, depersonalization, and derealization.

Brezing and Freudenreich, 2015

# The Primary Care PTSD Screen (PC-PTSD)

Exhibit 1.4-5: PC-PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, *in the past month*, you…

1. Have had nightmares about it or thought about it when you did not want to?
   YES NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
   YES NO
3. Were constantly on guard, watchful, or easily startled?
   YES NO
4. Felt numb or detached from others, activities, or your surroundings?
   YES NO

*Source: Prins et al., 2004. Material used is in the public domain.*

SAMHSA, 2014

# Intimate Partner Violence Screening Tool

## Exhibit 1.4-4: STaT Intimate Partner Violence Screening Tool

1. Have you ever been in a relationship where your partner has pushed or Slapped you?
2. Have you ever been in a relationship where your partner Threatened you with violence?
3. Have you ever been in a relationship where your partner has thrown, broken, or punched Things?

*Source: Paranjape & Liebschutz, 2003. Used with permission*

SAMHSA, 2014

# PTSD Checklist

Exhibit 1.4-7: The PTSD Checklist

Instructions to Client: Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully and circle the number that indicates how much you have been bothered by that problem *in the past month*.

1. Repeated, disturbing memories, thoughts, or images of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
2. Repeated, disturbing dreams of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
4. Feeling very upset when something reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
6. Avoiding thinking about or talking about a stressful experience or avoiding having feelings related to it?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
7. Avoiding activities or situations because they reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
8. Trouble remembering important parts of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
9. Loss of interest in activities that you used to enjoy?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
10. Feeling distant or cut off from other people?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
12. Feeling as if your future will somehow be cut short?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
13. Trouble falling or staying asleep?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
14. Feeling irritable or having angry outbursts?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
15. Having difficulty concentrating?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
16. Being "super-alert" or watchful or on guard?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
17. Feeling jumpy or easily startled?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

*Source: Weathers et al., 1993. Material used is in the public domain.*

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SAMHSA, 2014

# Promoting Resilience in Trauma-Informed Care

**Resilience:** *This term refers to the ability to bounce back or rise above adversity as an individual, family, community, or provider. Well beyond individual characteristics of hardiness, resilience includes the process of using available resources to negotiate hardship and/or the consequences of adverse events.*

SAMHSA, 2014

# Promoting Resilience through Strengths-Oriented Questions

## Potential strengths-oriented questions include:

- The history that you provided suggests that you've accomplished a great deal since the trauma.
- What are some of the accomplishments that give you the most pride?
- What would you say are your strengths?
- How do you manage your stress today?
- What behaviors have helped you survive your traumatic experiences (during and afterward)?
- What are some of the creative ways that you deal with painful feelings?
- You have survived trauma. What characteristics have helped you manage these experiences and the challenges that they have created in your life?
- If we were to ask someone in your life, who knew your history and experience with trauma, to name two positive characteristics that help you survive, what would they be?
- What coping tools have you learned from your _____ (fill in: cultural history, spiritual practices, athletic pursuits, etc.)?
- Imagine for a moment that a group of people are standing behind you showing you support in some way. Who would be standing there? It doesn't matter how briefly or when they showed up in your life, or whether or not they are currently in your life or alive.
- How do you gain support today? (Possible answers include family, friends, activities, coaches, counselors, other supports, etc.)
- What does recovery look like for you?

SAMHSA, 2014

# Promoting Resilience in Trauma-Informed Care

## Resilience: Cultural, Racial, and Ethnic Characteristics

The following list highlights characteristics that often nurture resilience among individuals from diverse cultural, racial, and ethnic groups:

- Strong kinship bonds
- Respect for elders and the importance of extended family
- Spirituality and religious practices (e.g., shrine visitations or the use of traditional healers)
- Value in friendships and warm personal relationships
- Expression of humor and creativity
- Instilling a sense of history, heritage, and historical traditions
- Community orientation, activities, and socialization
- Strong work ethic
- Philosophies and beliefs about life, suffering, and perseverance

*"Fortune owes its existence to misfortune, and misfortune is hidden in fortune."*

–Lao-Tzu teaching, Taoism (Wong & Wong, 2006)

SAMHSA, 2014

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The Education Center is a part of The Fenway Institute, the research, training, and health policy division of Fenway Health, a Federally Qualified Health Center, and one of the world's largest LGBT-focused health centers.

Advice from one health care provider to another.
JANUARY 18, 2017

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