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Heavy episodic drinking among transgender persons: Disparities and predictors



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ABSTRACT

Background: Drawing on a survey of transgender people in Canada's most populous province, we estimate the frequency of heavy episodic drinking (HED), compare HED prevalence to the age-standardized background population, and examine associations with socio-demographics, gender transition, and social exclusion.

Methods: 433 transgender persons aged 16+ completed a respondent-driven sampling survey in 2009–2010. Analyses were weighted using RDS II methods, including frequencies and prevalence ratios. Overall and sex-specific estimates of HED among Ontario residents in the 2009–2010 Canadian Community Health Survey (n = 39,980) were standardized to the overall and gender-specific transgender age distributions.

Results: Estimated prevalence of HED at least monthly among transgender Ontarians was 33.2% (95% CI: 26.3, 40.1), 1.5 times greater than expected based on the age-standardized Ontario population. Trans-masculine (female-to-male spectrum) persons were more likely than transfeminine persons to report HED (42.2% versus 22.7%), an effect robust to covariate adjustment. Current sex work was associated with greater HED, but gender transition and social exclusion factors were not.

Conclusion: Gendered pathways to alcohol misuse, particularly among transmasculine persons, warrant further research and intervention development.

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1. Introduction

Hazardous alcohol consumption contributes substantially to the global burden of morbidity and mortality (Rehm et al., 2009). Negative health consequences of alcohol use disproportionately impact poor and socially marginalized groups (Rehm et al., 2009), some of whom (e.g., sexual minorities; Keyes et al., 2011) also have higher rates of disordered and non-disordered use. Less is known about alcohol use among transgender (trans) people, those with a gender identity that differs from their birth-assigned sex. Trans people represent an estimated 0.6% of the adult population in the United States (Flores et al., 2016). In a random sample of substance use research published in 2007 and 2012, only 1.3% of articles reported data on transgender identities (Flentje et al., 2015). Population-based estimates of alcohol use are particularly scarce due to the lack of measures to identify trans respondents in most population

health surveys. Understanding of the epidemiology of alcohol use among trans people is further challenged by the limited and non-validated substance use measures often included in trans surveys, and absence of comparison groups (Keuroghlian et al., 2015).

Much trans substance use research has focused on urban trans women living with or at high risk for HIV, who frequently report heavy alcohol use (Nuttbrock et al., 2014; Santos et al., 2014). Findings from broader trans populations in the United States have been more mixed. In a population-based sample of Massachusetts adults including 131 transgender persons, no difference was found in the prevalence of past-month heavy episodic drinking (HED) by transgender status (Conron et al., 2012). Other studies have been limited to national samples of U.S. adolescents and college students. Reisner et al. (2014) found that trans youth reported higher past-year alcohol use than their cisgender (non-trans) peers, while Coulter et al. (2015) found that trans students were less likely to report HED than cisgender (non-trans) males, but had a greater number of recent HED days.

Disparities in alcohol misuse between cisgender and trans populations may be mediated by social stigma (Reisner et al., 2014). Associations between stigma and alcohol misuse are well-

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documented in non-trans minority populations (Keyes et al., 2011). Among trans people, problematic substance use has been conceptualized as a consequence of minority stress processes that result from a stigmatizing social environment. These processes include external, stigma-related stressors (e.g., violence), anticipation of such stressors, internalized stigma, and concealment of gender identity (Hendricks and Testa, 2012; Meyer, 1995). For example, anti-transgender violence and discrimination have been associated with increased risk of problematic alcohol use (Bradford et al., 2013; Coulter et al., 2015; Nuttbrock et al., 2014; Rowe et al., 2015).

Trans people face systemic barriers to employment, and may rely on sex work for income (Hoffman, 2014). Trans sex workers have reported higher levels of substance use than other trans people (Keuroghlian et al., 2015; Nuttbrock et al., 2014), perhaps due to greater minority stress (Nuttbrock et al., 2014), exposure to violence, and social network norms (Hoffman, 2014). In addition to enacted stigma in adulthood, sexual and gender minority populations disproportionately experience childhood sexual abuse. Such abuse is linked to increased risk of problematic alcohol use later in life (Schneeberger et al., 2014). However, while most trans people encounter some degree of stigma, negative coping responses are by no means inevitable. Potentially protective factors against alcohol misuse include family support (Newcomb et al., 2012).

Gender transition, including social, medical, psychological, and legal processes of gender affirmation (Reisner et al., 2016), is associated with improved mental health for trans people (Bauer et al., 2015) and could also be protective against alcohol misuse. However, findings regarding gender transition and alcohol use have been inconsistent, which may reflect countervailing impacts of heightened exposure to stigma resulting from transition. Among trans women in San Francisco, hormone therapy and breast augmentation were associated with lower odds of past-year HED (Wilson et al., 2014). Conversely, in a cohort of trans women in New York, heavy alcohol use was higher among those living full-time as women or taking hormones (Nuttbrock et al., 2014).

In summary, findings regarding both disparities and predictors of HED in trans communities have been somewhat inconsistent. To date, no published research has investigated alcohol use among trans people in Canada, where the social and health context for trans people varies from the United States by virtue of greater human rights protections and a universal health care system. The objectives of the current study were (1) to describe the prevalence of HED among trans people in Ontario, Canada; (2) to compare HED prevalence to the age-standardized cisgender population of Ontario; and (3) to assess the impacts of socio-demographic characteristics, gender transition, and social exclusion on HED.

2. Methods

The Trans PULSE community-based participatory research project recruited 433 trans Ontarians via respondent-driven sampling (RDS) in 2009–2010, including 404 who completed alcohol use measures. Eligible participants needed to be 16 years of age or older; live, work, or receive health care in Ontario; and indicate that they identified as transgender, transsexual, or transitioned. This definition included individuals who identified as genderqueer or another non-binary gender identity, and participants were not required to have undergone any social or medical gender transition.

RDS is a chain-referral sampling and analysis method for hidden populations (Heckathorn, 1997). Beginning with 16 seed participants selected for maximum diversity, each respondent was provided with three tracked recruitment coupons for recruiting their peers. Twenty-two additional seeds were added after 4–5 waves of recruitment. Maximum chain length was ten waves beyond the seeds. Respondents completed a 60–90-min survey

online or by visually-identical paper copy. They were compensated with a \$20 gift card, or could opt to donate the honorarium to a trans-related charity. Secondary incentives for recruitment of peers (\$5 gift cards) were added in the final months of the study, with no perceptible impact on recruitment. Research ethics boards at The University of Western Ontario and Wilfrid Laurier University approved this study. Research procedures and demographic characteristics pertaining to the Trans PULSE study population have been described in greater detail previously (Bauer et al., 2012).

A portion of this analysis used data from the Canadian Community Health Survey (CCHS) from Ontarians aged 16+ ($n = 39,980$). The 2009–2010 data cycles were used to match the time of recruitment of Trans PULSE data. CCHS is an ongoing cross-sectional survey of Canadians aged 12 and above employing a multi-stage, stratified, cluster sampling approach, with coverage of over 97% of the Canadian population (excluding institutionalized persons and those living on First Nations reserves). Additional information about the survey methodology is available from Statistics Canada (2010). CCHS estimates describe the assumed cisgender population because the survey did not include measures to identify trans respondents. Under the reasonable assumption that the population prevalence of trans people in Ontario, Canada is relatively similar to that of the United States (about 0.6%; Flores et al., 2016), the inclusion of trans persons within the assumed cisgender comparison group would not have a significant impact on results.

2.1. Measures

2.1.1. Heavy episodic drinking. Trans PULSE and CCHS participants were asked how often they consumed five or more alcoholic drinks on one occasion in the past year. Response options ranged from “never” to “more than once a week”. For comparisons between the two populations and regression analyses, HED was defined as reporting consuming five or more alcoholic drinks on one occasion at least monthly in the past year.

2.1.2. Sociodemographic factors. Socio-demographic characteristics included age, gender spectrum (transfeminine or transmasculine, i.e., natal male or female respectively, including those who identify as neither men nor women), Toronto residence (Ontario's capital and largest urban center, based on postal code), ethno-racial group (Aboriginal, white, or non-Aboriginal person of color), educational attainment, and sexual minority identity (coded as yes if the respondent endorsed any non-heterosexual identity). Reported childhood physical or sexual abuse was included as a background factor.

2.1.3. Transition. Participants indicated how often they lived in their felt gender (dichotomized as full-time versus part-time or less) and described their medical transition status as not planning, unsure, or not applicable; planning but not begun; in process; or complete based on self-perceived needs.

2.1.4. Social exclusion and inclusion, sex work, and depression. The research team developed an 11-item scale measuring the frequency of lifetime experiences of both external and internalized anti-trans stigma (Cronbach's $a = 0.81$; Marcellin et al., 2013), adapted from a measure of homophobia (Diaz et al., 2001). Other social exclusion and inclusion variables included lifetime experience of physical or sexual assault related to being trans (yes versus no), Medical Outcomes Study social support scale scores (Sherbourne and Stewart, 1991; Cronbach's a in our data = 0.97), employment status (full-time, part-time, student, or other), and low income status (Statistics Canada low-income cut-off; LICO; Health Canada, 2009). Underhousing was defined as current homelessness, living in sub-standard or temporary housing, or trouble meeting housing costs

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