Trauma-informed approaches to sexual and gender stigma at different stages of development

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she/her/hers

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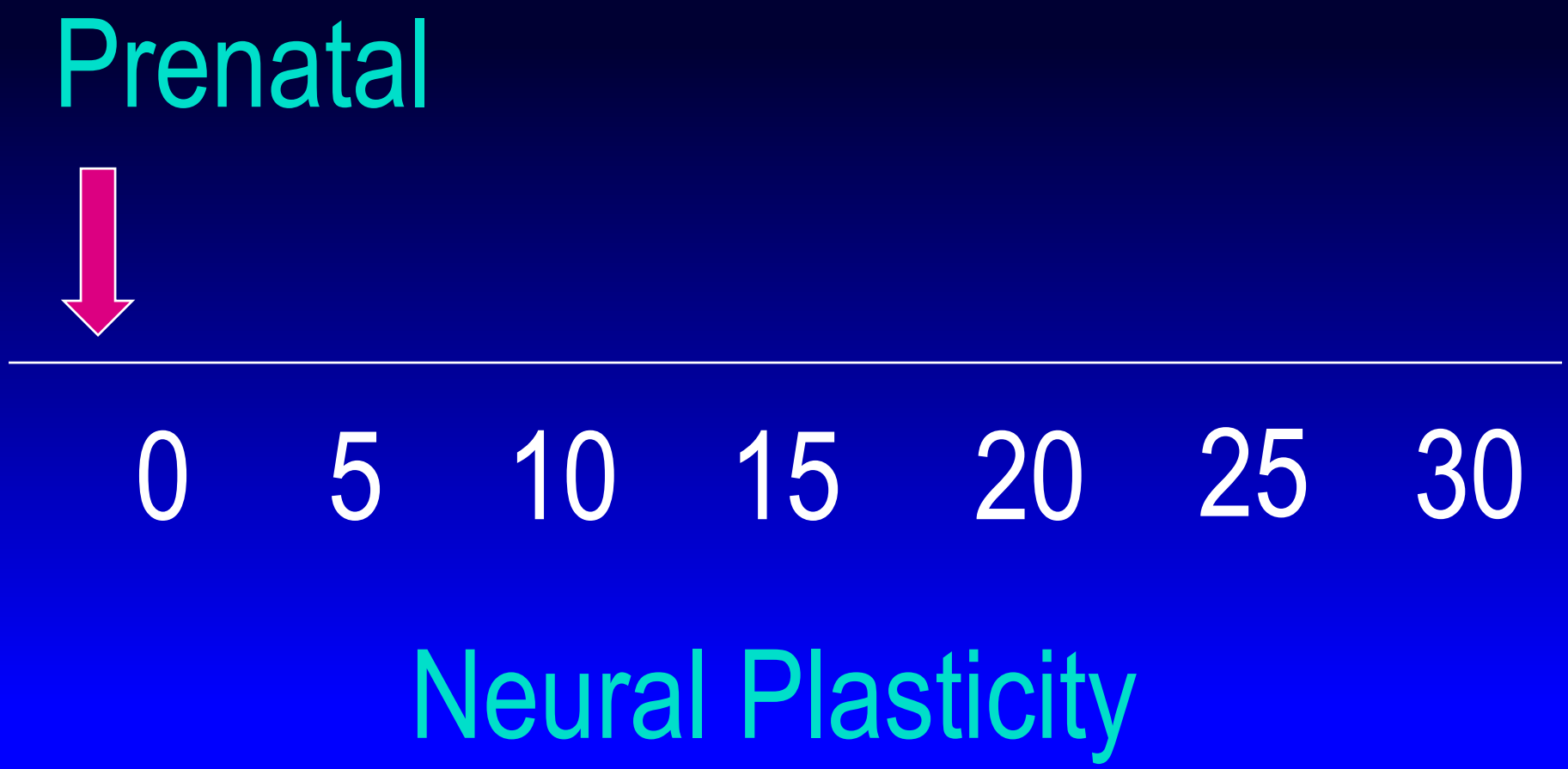
Lessons from Covid


Prenatal
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Neural Plasticity

First year

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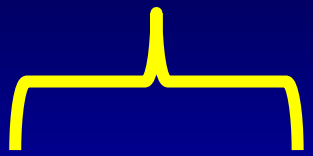
First 5 yrs



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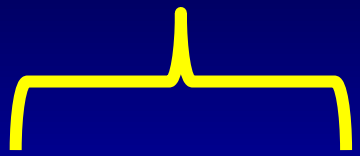
Early/middle childhood



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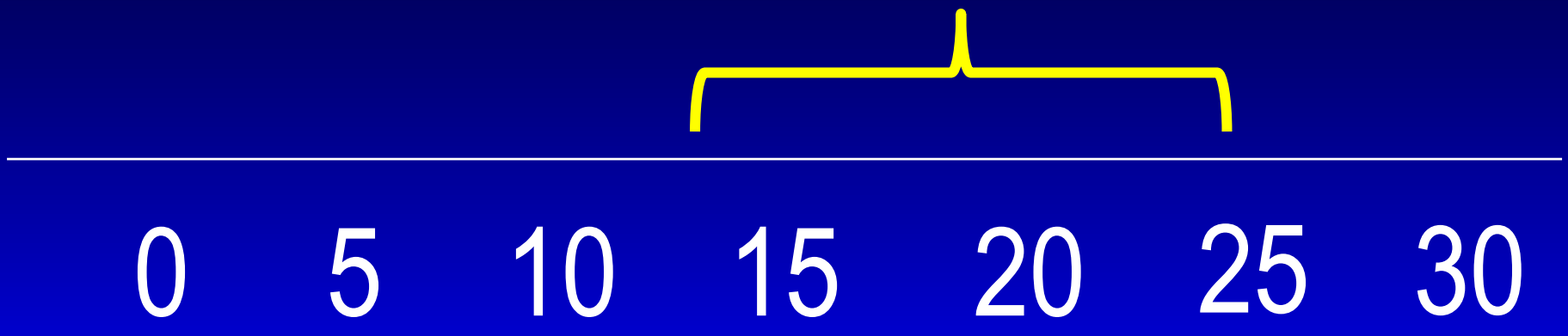
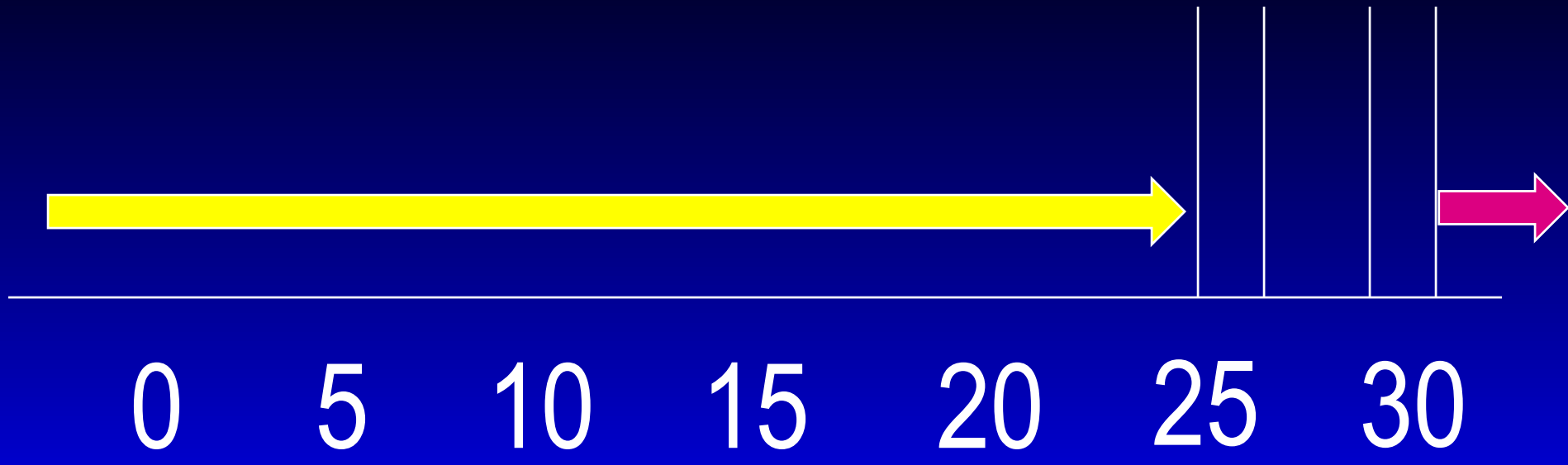
Adolescence, emerging adulthood

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Childhood Adversities (BRFSS data, Austin et al, 2016)

Why?

- Differential reporting
- Targeting, eliciting
- Does adversity change youth?
  - Yes – *adaptation*
  - Differential susceptibility
  - Maturational timing, risk/reward processing
- Health implications
  - Mediating, embedding, cascade effects
  - Mechanisms: Systemic inflammation

Psychoneuroendocrinology

journal homepage: www.elsevier.com/locate/psyneuen

Systemic inflammation as a driver of health disparities among sexually-diverse and gender-diverse individuals

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ABSTRACT

Sexually-diverse individuals (those who seek sexual or romantic relationships with the same and/or multiple genders) and gender-diverse individuals (those whose gender identity and/or expression differs from their birth-assigned sex/gender) have disproportionately high physical health problems, but the underlying biological causes for these health disparities remain unclear. Building on the minority stress model linking social stigmatization to health outcomes, we argue that *systemic inflammation* (the body's primary response to both physical and psychological threats, indicated by inflammatory markers such as C-reactive protein and proinflammatory cytokines) is a primary biobehavioral pathway linking sexual and gender stigma to physical health outcomes. Expectations and experiences of *social threat* (i.e., rejection, shame, and isolation) are widespread and chronic among sexually-diverse and gender-diverse individuals, and social threats are particularly potent drivers of inflammation. We review research suggesting that framing "minority stress" in terms of social safety versus threat, and attending specifically to the inflammatory consequences of these experiences, can advance our understanding of the biobehavioral consequences of sexual and gender stigma and can promote the development of health promoting interventions for this population.

Evo-devo perspectives

- Adversity is species-typical
- Type and timing matter
- The Bayesian brain
  - Deprivation
  - Threat
  - Unpredictability
- *No one is broken*
- Trade-offs and mismatches
- The adapted child and the functional adult

Where does trauma fit in?

- Primal threat
- Criteria A events
- "Sticky" adaptations
  - *Memory gaps, disassociation, rumination, avoidance, attention problems, compulsive behavior, hostility, sleep disruption, wariness, vigilance, dread, nightmares, numbing, intolerance of uncertainty, self-soothing*
- Hypervigilance, hyperprotection, hypersubmission
- But….
- cPTSD: Adaptation to chronic uncontrollable fear
  - *Unpredictability*

Fear of What?

- More than just violence
- Humans are altricial and social (Bowlby, Slavich)
- Social rejection as a primal threat
  - "Over" sensitivity? "Micro" aggressions?
  - High priority signals for the social brain
  - Internalization versus fear
- What does this mean for stigma?
- Stigma as social trauma
  - Adaptation to insufficient social safety
  - Hypervigilance, hyperprotection, hypersubmission
  - Systemic inflammation

Neuroscience and Biobehavioral Reviews

journal homepage: www.elsevier.com/locate/neubiorev

Rethinking minority stress: A social safety perspective on the health effects of stigma in sexually-diverse and gender-diverse populations

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A B S T R A C T

For over two decades, the minority stress model has guided research on the health of sexually-diverse individuals (those who are not exclusively heterosexual) and gender-diverse individuals (those whose gender identity/expression differs from their birth-assigned sex/gender). According to this model, the cumulative stress caused by stigma and social marginalization fosters stress-related health problems. Yet studies linking minority stress to physical health outcomes have yielded mixed results, suggesting that something is missing from our understanding of stigma and health. Social safety may be the missing piece. Social safety refers to reliable social connection, inclusion, and protection, which are core human needs that are imperiled by stigma. The *absence* of social safety is just as health-consequential for stigmatized individuals as the *presence* of minority stress, because the chronic threat-vigilance fostered by insufficient safety has negative long-term effects on cognitive, emotional, and immunological functioning, even when exposure to minority stress is low. We argue that *insufficient social safety* is a primary cause of stigma-related health disparities and a key target for intervention.

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Specific Needs

- More specific and comprehensive assessment
  - Deprivation, threat, and unpredictability
  - Availability of social safety
  - Compulsive safety-maintenance (achievement, relationships, eating/body, etc.)
  - Numbing, self-soothing, escape, vigilance, submission
- Trauma-informed research and intervention
  - Safety first (therapist, parent, school, doctor)
  - Mattering matters
  - Secondary trauma: Parents, chosen family
  - Sanctuary trauma
  - Neural remodeling takes time