Mental Health of Trans and Gender Diverse People in Aotearoa/New Zealand: A Review of the Social Determinants of Inequities

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The effects of health inequities on transgender (or trans) and gender diverse populations have been well documented internationally. Studies that compared the mental health of trans and gender diverse populations to cisgender populations found significant inequities for mental health problems. There has been very little research on this topic, however, from Aotearoa/New Zealand. We conducted database search in the PsycINFO, as well as manual searches for published grey literature in Aotearoa/New Zealand to identify theoretical and empirical literature on social determinants of health and related frameworks to explain the effects of social environments on health inequities experienced by trans and gender diverse people. We also complement international studies by considering Māori and Pacific trans and gender diverse identities and the ramifications of colonisation on the mental health and wellbeing of these populations.

Keywords: Transgender, Gender Diverse, Mental Health, Social Determinants of Health.

Scope of Research

This review examines mental health and wellbeing, and the social determinants that lead to mental health problems among transgender and gender diverse (TGD) people in Aotearoa/New Zealand. We provide an overview of existent transgender and gender diverse health research in Aotearoa/New Zealand and some recommendations for enhancing research design with this population. We used the PsycINFO database to locate relevant mental health research in Aotearoa/New Zealand. Due to the limited amount of local research about indigenous TGD people's health, we searched for international literature that has examined this topic. We also searched the international literature for theories that explain the high prevalence of mental health problems among TGD people.

The database search was based on publications from database inception until June 2019, using the search term keywords, transgender, trans, and gender diverse, and mental health keywords such as depression, anxiety, and mental health problems. Lesbian, gay, bisexual and transgender (LGBT) studies that did not examine TGD people as a separate category were excluded, as previous research has demonstrated TGD and LGB people do not have similar experiences related to gender identity and expression (Tan, Treharne, Ellis, Schmidt, & Veale, 2019). We also explored published grey literature such as reports and conference papers through Google Scholar to provide a comprehensive overview of TGD mental health in Aotearoa/New Zealand.

Introduction

The demographic makeup of Aotearoa/New Zealand is specific to this country, and this has a particular effect on the ways in which mental health is understood. Nearly three-quarters of the Aotearoa/New Zealand population (74.0%) identify with one or more European ethnicity, followed by the indigenous Māori who comprise 14.9% of the national population (Statistics New Zealand, 2015). Aotearoa/New Zealand is also home to Asian people, who comprise 11.8% of the population, and various Pacific people, who make up 7.4% of the population, and are Samoan, Cook Islands Māori, Tongan, Niuean, and other Pacific ethnicities (Statistics New Zealand, 2015). Since the colonisation of Aotearoa/New Zealand by Pākehā (European) settlers during the nineteenth century, the social and cultural status of indigenous Māori have been severely affected, with detrimental impacts on their wellbeing (Hutchings & Aspin, 2007). The process of colonisation has involved degrees of assimilation into Pākehā settings, and a commensurate loss of Māori cultural knowledge. One of the outcomes of colonisation is the marginalisation of the diverse expressions of gender which were specific to Māori culture, but were understood as 'perverse' by many Pākehā missionaries and other colonisers (Hutchings & Aspin, 2007; Kerekere, 2017).

In Aotearoa/New Zealand, there are many ways of understanding gender diversity including Pākehā, Māori, Pacific and Asian ways. Pākehā perspectives of gender diversity are based on the western understandings of gender identity (i.e., the internal sense of individuals toward their experience of gender) and include those who identify under the umbrella terms of transgender or gender diverse. Transgender (or trans) denotes people whose gender identity does not correspond with the gender typically associated with the sex assigned to them at birth (American Psychological Association, 2015). Transgender people may identify as neither men nor women (e.g., non-binary); both men and women (e.g., bigender); as moving between binary genders (e.g., genderfluid); or as no gender (e.g., agender) (Adams et al., 2017; American Psychological Association, 2015).

Gender diverse is a broader term which includes people who identify as transgender or any of the other identities that we describe in the following section. In this review, we use the abbreviation TGD to refer to transgender and gender diverse people.

There is little research into Asian understandings of gender diversity in Aotearoa/New Zealand, but more research has been conducted on Māori and Pacific understandings that are unique to our region.

Māori and Pacific Gender Diversity in Aotearoa/New Zealand

All colonised states have a specific and unique history of colonisation, and Aotearoa/New Zealand is no exception. European settlement of Aotearoa/New Zealand occurred throughout the 17th and 18th centuries, and the Treaty of Waitangi was signed between the representatives of the British Crown and some rangatira (chiefs) in 1840 (King, 2003). Given the distinctive colonial context of Aotearoa/New Zealand, Burford, Lucassen, and Hamilton (2017) urged researchers to reflect on the "history of indigenous inhabitation, settler colonisation and the migration of peoples from the islands of the South Pacific, and among other migrant groups" (p. 213). For TGD research to be relevant to Aotearoa/New Zealand, Māori and Pacific understandings of gender diversity need to be central to this work.

Diversity in gender identity, gender role (i.e., social roles associated with gender in a culture), and gender expression (i.e., the presentation of an individual to reflect aspects of gender identity or role) have always been part of Māori society (Hutchings & Aspin, 2007). Although many details were lost as a consequence of colonisation and the imposition of binary western gender frameworks onto indigenous understandings of gender (Feu'u, 2017; Hutchings & Aspin, 2007), there are various sources (e.g., oral accounts, archival material and carvings) that provide evidence of the existence of gender diversity within pre-colonial Māori culture (Kerekere, 2017). For instance, there is a Māori traditional narrative of an ancestor, Tāwhaki who was on a journey when he encountered Tongameha, a tipua (spiritual force who had the ability to change form and gender in remarkable ways). The ability of tipua to embody both female and male, and alter gender provides a sense of cultural resonance for contemporary Māori TGD people (Feu'u, 2017; Kerekere, 2017). Feu'u (2017) also brought up accounts from James Cook's crew members on the Endeavor voyage, who commented on the striking beauty of Māori "maidens", although they soon realised these maidens were whakawahine (Feu'u, 2017), a term that literally translates as "like a woman". Contemporary usage of this term denotes a person assigned male at birth with the wairua (spirituality) of a woman (Kerekere, 2017).

There are many instances of gender diversity among Pacific populations in Aotearoa/New Zealand, such as Samoan fa'afāfine, Cook Islands Māori akava'ine, Tongan fakaleiti, and Niuean fakafifine (Brown-Acton, 2014). As Samoans are the largest population of Pacific origin in Aotearoa/New Zealand (Statistics New Zealand, 2015), the Samoan fa'afāfine are relatively common within Pacific TGD populations. Fa'afafine literally translates as "in the manner of a woman", and fa'afāfine are

traditionally identified by virtue of their propensity for feminine labour (Schmidt, 2017). Contemporary fa'afāfine represent a broad range of gender expressions that sometimes (although not always) encompass more western aspects of trans and gender diversity and/or might be understood as 'gay men', while still aligning themselves with the traditional identity of fa'afafine (Schmidt, 2017). While globalised discourses of gender and sexuality diversity have been actively utilised by fa'afāfine in constructing their identities, they have also led to a range of stereotypical representations of fa'afāfine within both popular and academic texts (Schmidt, 2017), and Farran (2010) noted similar ramifications of colonisation and globalisation on gender diverse people across other Pacific cultural contexts.

Māori and Pacific TGD people ascribe to various identities — some affiliate with terms of their specific cultural context, others align only with Pākehā TGD identities, and others encompass both their own cultural backgrounds and western models within their identities (Adams et al., 2017; Brown-Acton, 2014). Māori and Pacific terms often carry historical, political and social connotations that are not necessarily interchangeable with Pākehā terms, which are reflected in the range of identifications adopted by Māori and Pacific TGD people in Aotearoa/New Zealand (Feu'u, 2017). The uniqueness of Māori and Pacific gender diversity, and the specific social outcomes wrought by colonisation and westernisation mean that considering the mental health and wellbeing of TGD people in Aoteaora/New Zealand necessitates awareness and consideration of the additional marginalisation faced by people with these identities.

Mental Health in Aotearoa/New Zealand

Mental health can be defined as a state of wellbeing which allows people to "realise their abilities, deal with life's challenges and stresses, enjoy life, work productively and contribute to their communities" (Brunton, 2018, p. 1). Those who experience mental health problems face psychological and emotional reactions that may affect their ability to perform daily routine activities (Brunton, 2018). Various surveys have been developed to examine the health and wellbeing of Aotearoa/New Zealand populations. The 2015 New Zealand Mental Health Survey is a population-based study of 1,377 adult participants from the general Aotearoa/New Zealand population. It found that 9.3% and 6.5% of Aotearoa/New Zealand population reported symptoms of depression and anxiety respectively (Hudson, Russell, & Holland, 2017). Mental health problems can have life-threatening consequences, with Aotearoa/New Zealand studies (e.g., Beautrais, 2003) finding that mental health problems are associated with an increased risk of developing suicidal ideation and attempting suicide.

The Aotearoa/New Zealand National Health Committee (1998) posited a need to examine upstream factors influencing mental health, which comprise determinants of health that are social (e.g., accessibility to health services), cultural (e.g., connectedness to cultural group) and economic (e.g., socioeconomic status). The Committee highlighted the importance of investigating health within a social context, as social environments

comprise upstream factors that exert predominant influences on health and are often beyond the control of individuals (Blane, 2006; Jayasinghe, 2015). Hence, a holistic health model should contemplate social determinants of health as a collection of intermediary factors that intertwine with social systems (e.g., education system), social norms (e.g., racism), and social structures (e.g., policy) in generating health outcomes (Jayasinghe, 2015).

TGD Mental Health and Social Determinants of Health

Recent published review studies in the Europe and North America found that TGD people manifest higher rates of various mental health problems when compared to general population prevalence figures. For example, Millet, Longworth, and Arcelus (2017) conducted a systematic review of the prevalence of anxiety symptoms and disorders among TGD people across various countries in the regions of Americas, Europe and Asia, and found that the prevalence of anxiety disorders among this population may be as high as 68.0% compared to the 18.1% found in general population surveys. Public health literature correlates the relative susceptibility of minority populations (TGD populations in this instance) in manifesting mental health problems with their marginalised social positions (Brunner & Marmot, 2006).

These review studies have generally not taken into consideration issues of ethnicity and indigenous backgrounds. Burford and colleagues (2017) noted the importance of acknowledging the ramifications of colonisation in taking into account the wellbeing of gender diverse people who are marginalised in contemporary westernised society as well as the ethnic and cultural differences among Aotearoa/New Zealand populations in gender diversity research. Such acknowledgement promotes the inclusivity of Māori and Pacific populations, and this in turn fosters their mana (authority, influence, and power).

Historic colonialism has resulted in destruction of Māori communities and Māori becoming disconnected from their land (Durie, 2011; National Health Committee, 1998). Deleterious effects of colonialism on the wellbeing of indigenous populations are outlined in the Indigenist Stress-Coping Model (Walters & Simoni, 2002). According to this model, indigenous people experience heightened levels of life stressors (e.g., historical trauma) that in turn affect health negatively. Reid and Robson (2007) attributed the high prevalence of mental health problems among indigenous Māori populations to their loss of mana, rangatiratanga (autonomy), and sense of belonging.

When gender diversity is examined in health-related research, it is clear that TGD people are at risk of a range of health inequities when compared to cisgender people (Pega & Veale, 2015). Health inequity refers to those inequalities or disparities in health outcomes, which are "deemed to be unfair or stemming from some form of injustice" (Kawachi, Subramanian, & Almeida-Filho, 2002, p. 647). In order to understand the fundamental causes of mental health inequities for TGD people, we need to examine the circumstances in which people live and work—the social determinants of health (SDHs)

(Brunner & Marmot, 2006) and refer to theoretical frameworks that explain the roles of social determinants in causing health inequities that TGD people experience. Pega and Veale (2015) argued that gender diversity has been neglected as a social determinant of health and that health inequities specifically affecting TGD people arise as the result of cisgenderism. Cisgenderism is a form of structural marginalisation of TGD people through a process that privileges cisgender people by reinforcing the understanding that there are only two valid genders (i.e., woman and man) and that people's gender must align with expectations of their sex assigned at birth (Riggs, Ansara, & Treharne, 2015). Consequently, cisgenderism causes the delegitimising of TGD identities and genders. The privileging of cisgender people situates TGD people in a lower social position and causes TGD-related negative experiences, such as discrimination, rejection, and victimisation at individual, interpersonal, and structural levels (Pega & Veale, 2015; Testa, Habarth, Peta, Balsam, & Bockting, 2015). These negative experiences also limit TGD people's ability to access other determinants of health including education, employment, social programmes, and healthcare services.

Existing TGD Mental Health Research in Aotearoa/New Zealand

The Youth'12 study (Clark et al., 2014) is the only research based in Aoteaora/New Zealand to investigate TGD people's health inequity with comparisons to cisgender populations. Youth'12 is the third of the Youth2000 series of population-based surveys that focused on the health and well-being of secondary school students in Aotearoa/New Zealand. It included the question "Do you think you are transgender? This is a girl who feels like she should have been a boy, or a boy who feels like he should have been a girl (e.g. Trans, Queen, Fa'faffine, Whakawahine, Tangata ira Tane, Genderqueer)". In response, 1.2% of the sample responded yes to the question, and a further 2.5% reported being not sure about their gender.

Youth'12 found an almost 4-fold increased risk of depression among TGD students (41.3% vs 11.8%), an almost 2-fold increase in non-suicidal self-injury (NSSI) risk (45.5% vs 23.4%), and an almost 5-fold increase in risk of a suicide attempt in past 12 months (19.8% vs 4.1%) when compared to cisgender students (Clark et al., 2014). TGD students were significantly more likely than cisgender students to experience external stressors including being physically harmed (49.9% vs 32.5%) and bullied at school (17.6% vs 5.8%), and internal stressors such as being afraid of someone hurting them at school (53.5% vs 39.8%). TGD students also reported being significantly less likely to experience protective factors, such as getting along with family members (63.9% vs 81.5%), enjoying the school environment (74.1% vs 90.4%), and feeling connected with friends (63.9% vs 81.5%) (Clark et al., 2014). This decreased access to protective factors is important for TGD youth, as studies have shown that family acceptance and social support aid in reducing the risk of manifesting mental health problems (e.g., Veale, Peter, Travers, & Saewyc, 2017).

However, there is a need to interpret the results of Youth'12 on TGD students with caution. Although

Youth'12 was a product of its time, its transgender question defined TGD people based on their sex assigned at birth, referring to TGD youth as a girl who feels like she should have been a boy, or a boy who feels like he should have a girl. This narrow conceptualisation of "transgender" could present TGD identities as arbitrary choices, and fail to include students whose gender is outside the binary of boys and girls. It is unclear what effect, if any, this had on TGD participants' responding.

It is also possible that some cisgender students may have responded yes to the transgender identity question because of misunderstanding of the question or not answering the question seriously, and it would have only taken a small proportion of cisgender students to endorse this question to meaningfully dilute the transgender sample. Pega, Reisner, Sell, and Veale (2017) also raised concern about the usage of the one-question method (i.e., asking if one identifies as transgender) in a population-based survey, because it runs the risks of undercounting TGD people whose gender is different from their sex assigned at birth but who only identify themselves within the gender binary framework. Hence, the current best practice in population-based surveys includes using the two-question method, which involves collecting both sex assigned at birth (i.e., female or male), and current gender identity (in a way that is inclusive of non-binary genders). This allows for the responses for these two items to be cross-classified to determine TGD identity (Pega et al., 2017; The GenIUSS Group, 2014).

TranZnation was an Australian-based TGD health study that has included 24 TGD participants from Aotearoa/New Zealand (Pitts, Couch, Hunter, Croy, & Mitchell, 2009). New Zealand participants in this study comprised less than 10% of the total sample, and the researchers did not report separately on data from this group. TranZnation found an approximate 6-fold increase in depression among TGD people (36.2% vs 6.8%) in comparison to the Australian general population. TGD people who had faced a greater number of different types of stressors (e.g., verbal abuse, physical attack, and sexual assault) were found to be more likely to exhibit depressive symptoms.

Theoretical Frameworks in TGD Mental Health

There are competing theoretical frameworks to explain these mental health inequities, one that suggests that being TGD is psychopathological (i.e., psychologically disordered and inferior) and another that focuses on the stigma and minority stresses that TGD people face.

Psychiatric diagnoses related to being TGD have existed in the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) since the 1980s (American Psychiatric Association, 2013; Drescher, 2014), reflecting the idea that being TGD is mentally disordered (Zucker, Lawrence, & Kreukels, 2016). Because mental health problems tend to co-occur, the belief that this pathology can explain the increased prevalence of mental health problems among TGD people was widely taken for granted without much consideration of the role of cisgenderism as a social determinant of mental health inequities (Schulz, 2017). The existence of psychiatric diagnoses is a form of social determinant of inequities affecting TGD people, as these diagnoses serve as gatekeeping criteria and compel this population to undergo extensive assessment and referral prior to obtaining medically necessary healthcare services (Schulz, 2017). During this process, TGD people may risk exposing themselves to mental health professionals who are not equipped with sufficient level of TGD healthcare knowledge, or worse, who utilise the pathologisation perspective to invalidate lived experiences of a TGD person (Schulz, 2017).

TGD populations mobilised to criticise this pathologisation for its lack of conderation of the role of cisgenderism as a social determinant of health; they also noted that this pathologisation leads to harmful stereotypes about TGD people and advocated the end of the pathologisation of TGD people (Suess, Espineira, & Walters, 2014). While the pathologisation explanation for mental health problems in TGD people is still taken seriously by some (Zucker et al., 2016), as more researchers and health professionals listen to the views of TGD people, this approach is becoming less accepted. Professional organisations such as the World Professional Association for Transgender Health (WPATH, 2018) and the American Psychological Association (American Psychological Association, 2015) have publicly affirmed that being TGD is not pathological. In June 2018, the World Health Organization (2018) announced that Gender Incongruence will be moved from the mental health to section of the ICD to a new section called Conditions Related to Sexual Health.

One of the most widely adopted theories to explain health inequities that TGD people experience is the Gender Minority Stress Framework (GMSF; Testa et al., 2015), which is an adaptation of Minority Stress Theory (Meyer, 2003). The GMSF focuses on the impact of cisgenderism on the mental health of TGD people (Tan et al., 2019). This framework proposes that TGD people experience risk factors (that create adverse experiences and increase vulnerability to negative mental health outcomes) and protective factors (that buffer risks and promote health and wellbeing). Risk factors that TGD people face include distal (external) minority stressors (e.g., TGD-related discrimination and non-affirmation of identity), which lead to the development of proximal (internal) minority stressors within TGD people (e.g., internalisation of negative societal attitudes about one's own TGD identity and TGD people as a social group). Testa et al. (2015) proposed that the negative impacts of minority stressors can be mitigated when TGD people are exposed to protective factors, such as education, access to affirmative healthcare services, and social support (e.g., TGD community organisations and family support).

Numerous studies have found correlations between distal and proximal stressors and mental health problems (e.g., Veale et al., 2017). When put together, Testa et al. (2015) postulated a plausible chain: cisgenderism causes TGD people to experience distal stressors; some, or all of these distal stressors lead to proximal stressors that affect TGD people internally, and the accumulation of these stressors contribute to heightened levels of stress among TGD people. In this instance, stress is displayed through the over-activation of fight-or-flight responses. The

physiological changes associated with the dysregulation of flight-or-flight responses resonate with the symptoms of mental health problems (Brunner & Marmot, 2006).

Intersectionality can be used in relation to the Minority Stress Theory to investigate the experiences of TGD people with multiple and intersecting identities, who have distinctive individual and collective experiences (Parent, DeBlaere, and Moradi, 2013). In Aotearoa/New Zealand, this includes understanding the experiences and needs of TGD people of a range of ethnic groups, including Māori and Pacific TGD people. Intersectionality is used to explore how multiple and overlapping structural marginalisations (e.g., racism and cisgenderism) shape the experiences of TGD people with multiple and intersecting marginalised identities (Crenshaw, 1991; Parent et al., 2013). Overlooking intersectionality in mental health research would lead to a lack of a full understanding of the experiences of those most negatively affected by more than one form of marginalisation (Blane, 2006).

TGD Mental Health and Ethnicity

Because no research has yet examined differences in TGD people's mental health in Aotearoa/New Zealand on the basis of ethnicity, here we review international research on this topic. The 2010 U.S. National Transgender Discrimination Survey was a community-based survey that recruited 6,450 TGD people (Grant et al., 2011). A higher prevalence of suicide attempts was reported among non-white TGD people (categorised as aboriginal American Indian, Asian, Latino and Black) when compared to white TGD people (54.0% vs 38.0%). Significance test was not carried out for this comparison, however. The 2009 U.S. National College Health Assessment-II was a population-based survey that recruited 111,415 students, of whom 174 identified as TGD (Lytle, Blosnich, & Kamen, 2016). In a comparison between non-white and white TGD people, the former group was significantly more likely to engage in NSSI (38.0% vs 27.8%), develop suicidal ideation (35.2% vs 31.1%), and attempt suicides (29.6% vs 10.0%). A Canadian community-based study, TransPULSE Ontario, recruited 398 TGD people, of whom 32 identified as indigenous (Scheim et al., 2013), and this study found indigenous TGD participants reported high rates of lifetime suicidal thoughts (76.0%) and lifetime suicide attempts (48.0%).

An additive approach is commonly used in relation to the Minority Stress Theory to explain mental health outcomes of those with multiple marginalised identities (Meyer, 2010). This approach treats marginalised identities as independent of each other, and sees social inequality increasing linearly with each additional marginalised identity (Parent et al., 2013). Intersectionality, however, extends on the additive approach, recognising not only the independent effects of minority identity statuses (e.g., being indigenous and TGD) but also the combinative and interactive effects of minority statuses in shaping the experience of a person (Parent et al., 2013). Intersectionality is used to provide explanations for the impacts of multiple and overlapping structural marginalisation (e.g., racism and cisgenderism) in constructing the experiences of those with multiple

marginalised identities (Crenshaw, 1991; Parent et al., 2013).

Two studies have explored intersectionality quantitatively among TGD people. Jefferson, Neilands, and Sevelius (2013) adapted scales measuring experiences of racism and cisgenderism to explore the combined effects of these experiences on trans women of colour and found that combined discrimination related to the likelihood of depression. Scheim et al. (2013) reported only one-fifth of indigenous TGD people in TransPULSE Ontario had parents who embraced their TGD identity. Many indigenous TGD participants, however, were found to develop a strong sense of their indigenous identity, with 56.0% reporting high levels of spirituality and 19.0% having sought cultural or tribal leaders for mental health support (Scheim et al., 2013). A positive integration of indigenous identity and culture has been linked to buffering effects on the impacts of minority stressors, as well as those related to ramifications of colonialism (Chae & Walters, 2009).

Other Trans and Gender Diverse Research in Aotearoa/New Zealand

Three further studies in Aotearoa/New Zealand have examined the experiences of distal stressors among TGD people. The Human Rights Commission's Transgender Inquiry was conducted in 2006 and 2007 to investigate the discrimination experienced by TGD people in Aotearoa/New Zealand (Human Rights Commission, 2008). Based on the accounts of over 200 TGD people, the inquiry reported multiple forms of discrimination that affected TGD people, ranging from individual (e.g., low self-acceptance of their own TGD identity), interpersonal (e.g., facing rejection from peers at school), to structural levels (e.g., difficulty in changing name and gender details on legal documents). The inquiry also identified notable gaps and inconsistencies for TGD people in the provision of health services and accessing gender-affirming services.

In 2015, the Hohou Te Orongo Kahukura: Outing Violence community-based survey was launched to explore the prevalence of intimate partner and sexual violence among rainbow communities (Dickson, 2017). Out of 149 TGD participants, 53% reported being subjected to physical violence by partners, 40% received threats of sexual assault, and 17% experienced gender-affirming resources (e.g., hormones and clothes) being thrown away. Despite facing physical violence threats, TGD participants reported reluctance to seek assistance as 35.0% did not believe that they would be treated fairly and 16.0% were worried about prejudiced nature of specialist violence services. When asked to elaborate on the barriers of seeking assistance in comment boxes, non-binary people raised the issue of cisgenderism, suggesting that most professional organisations were operating within a binary gender framework.

The Auckland District Health Board initiated a project in 2011 to examine the experiences of rainbow communities in accessing mental health and addiction services in the Auckland DHB region (Birkenhead & Rands, 2012). In qualitative interviews with four TGD people, participants reported TGD-specific barriers in accessing appropriate mental healthcare, including stigma

about TGD identities, lack of professional understanding about TGD issues, and an insufficient number of clinicians who were experienced in working with TGD people.

Future Directions for TGD Research in Aotearoa/ New Zealand

Our review has identified a need to account for plural and intersecting identities in future research with TGD people in Aotearoa/New Zealand. Standard western definitions of mental health and understandings of mental health problems are inadequate to the Aotearoa/New Zealand context. During Te Ara Ahu Whakamua, a hui (conference) held in Rotorua in March 1994, more than one thousand Māori health, community, and tribal leaders gathered alongside tauiwi (non-Māori) health leaders, to assess the state of Māori health and propose a strategic direction for Māori health (Rochford, 2004; Te Puni Kōkiri, 1994). The hui was marked as an important indicator of implementing the principles of Treaty of Waitangi into practice in Māori health, and Māori people were consulted to advise on health needs and the direction of health services. They came to an agreement that Māori health should constitute:

a strong sense of identity; self-esteem, confidence and pride, control of his/her own destiny, leadership, intellectual, physical, spiritual, and whānau (extended family) awareness, personal responsibility, respect for others, knowledge of te reo (the Māori language) and tikanga (custom), economic security, and solid whānau support (Rochford, 2004, p. 46)

This definition of Māori health reflects the need to recognise health in a holistic manner and as a state of balance including the self, others, and the environment. Māori models of health should be viewed as complementary to the western biomedical paradigm, as the latter has often neglected the ways in which health is interconnected and interdependent with other components of well-being (e.g., spirituality, whānau support, and cultural connections) (Durie, 2011; Rochford, 2004). Kaupapa Māori health frameworks, in which people are embedded in their social worlds and natural environments, are more consistent with the Minority Stress Theory, which focuses on social stressors, than the pathologisation understanding that only focuses on the individual as a discrete entity.

Durie (1985) developed a Māori model of health, Te Whare Tapa Whā, which conceptualises four dimensions of Māori health that interconnect with each other and are interdependent. These four dimensions comprise taha wairua (spiritual health), taha hinengaro (mental and emotional health), taha tinana (physical health) and taha whānau (family and social health). Future TGD mental health research is needed to investigate the interconnection of dimensions of wairua, tinana and whānau in relation to the hinengaro (mental health) of TGD people. The roles of spiritual and family health acting as protective factors for mental health among indigenous TGD people were documented in the TransPulse Ontario study (Scheim et al., 2013).

The recent published guidelines for gender-affirming healthcare in Aotearoa/New Zealand recognise the negative repercussions of the heavy reliance on pathologising diagnoses among health professionals in granting TGD people access to healthcare services (Oliphant et al., 2018). The guidelines use Māori health frameworks, Te Pae Māhutonga and Te Whare Tapa Whā, to inform the provision of culturally competent, as well as TGD-competent healthcare services. For example, health professionals are encouraged to facilitate autonomy to TGD people in making decisions about their own care, as well as to connect mental health with other components of health as part of the holistic healthcare delivery. The guidelines also highlight the need to avoid pathologising TGD people as being mentally disordered, as this approach negates the minority stress results from everyday distal stressors that TGD people experience.

To ensure that indigenous conceptualisations of health are accounted for comprehensively in psychological research, researchers need to consider how they are collecting data. Bethune et al. (2018) discussed the importance of using self-reported health to examine the health outcomes of indigenous populations, as this allows participants to incorporate multiple dimensions of health when considering satisfaction with their lives. In Aotearoa/New Zealand, self-reported health is necessary for researchers who may wish to incorporate the four Te Whare Tapa Whā dimensions into their conceptualisation of health. It is also important to consider which topics are focused on. Contemporary TGD mental health research often takes a deficit approach, which emphasises the relative vulnerability of TGD people in manifesting mental health problems. Brough, Bond, and Hunt (2004) suggested a focus on deficits may obscure investigation into the strength of populations and their resilience in sustaining mental health and wellbeing. Durie (2011) encouraged an examination of indigenous resilience that centres on the potential of indigenous people to overcome the effects of racism and colonialism through the formation of collective bonds with whānau and communities, and engagement with te ao Māori (Māori worldview), for example through fluency in te reo and connection to whenua (land).

Quantitative research that employs categorisation to classify gender and ethnicity run the risks of overlooking the breadth of diversity within the TGD populations and rendering indigenous concepts of gender invisible (Adams et al., 2017). For instance, the term transgender has been criticised for its inadequacy in representing the deeper underlying meanings of the Māori and Pacific gender diverse identities (Brown-Acton, 2014; Kerekere, 2017). Durie (2011) pointed out that adoption of an indigenous identity assists people in conveying a sense of connectedness to their indigenous identity and wider indigenous communities. Kerry (2018) conducted unstructured interviews with indigenous TGD people in Australia and reported that those who affiliated with indigenous identities have an improved sense of self, spirituality, mental health and wellbeing. Cisgenderism was found to generate stigma towards TGD people, which detached TGD people from their indigenous communities, consequently hindering them from adopting indigenous identities (Kerry, 2018). The strength of quantitative approaches in generating data from a larger population can be complemented with qualitative approaches which better encapsulate the nuanced

differences of experiences among TGD people across a range of diverse backgrounds. These can include TGD people with disabilities, non-binary people who situate their gender within a gender spectrum, and Māori and Pacific TGD people who have gender diverse identities that are relevant to their cultural backgrounds.

We recommend community-based participatory research (CBPR) approaches for TGD health research. CBPR emphasises conducting research with a community rather than on a community (dickey, Hendricks, & Bockting, 2016). TGD people in Aotearoa/New Zealand who have knowledge and interest in advancing the health of TGD populations should be invited to participate as research team members to provide input on research design. In doing so, it would be optimal to include TGD people with a diverse range of intersecting identities. Other than allowing the research to benefit from extensive TGD in-group knowledge, partnership with TGD people also enhances the efficacy of the research through the provision of opportunities for marginalised voices to have space in research (Adams et al., 2017).

Conclusion

International literature has documented the relationships of social determinants of health and mental health of TGD people. This article extends the existent literature in some important ways. We found that existent research on TGD people's mental health in Aotearoa/New Zealand has focused on TGD youth, and that the limited research that currently exists shows that TGD people have a high prevalence of experiences of distal stressors and mental health problems. We suggest psychologists and researchers working in TGD health in Aotearoa/New Zealand to ensure they are accounting for Māori and Pacific notions of gender diversity and indigenous understandings of mental health as interconnected with other dimensions of health. Psychological and research instruments should avoid utilising problematic juxtapositions that pathologise TGD people (e.g., attributing TGD identities with mental health problems).

While the Gender Minority Stress Framework has been commonly used to elucidate the effects of cisgenderism on TGD mental health, we proposed a need to complement this framework with the use of intersectionality. Intersectionality plays a crucial role among psychology practitioners and researchers in Aotearoa/New Zealand to meet the diverse needs of TGD people across ethnicities, genders, abilities, and other areas of need. In particular, a TGD-competent psychologist workforce requires a comprehensive understanding the nuanced differences among people with intersecting identities to fully understand and formulate their mental health problems and presenting problems. This will allow psychologists to take into account the impacts of colonialism and racism for indigenous Māori, Pacific and other TGD tauiwi of colour in Aotearoa/New Zealand.

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