Transgender Youth: Invisible and Vulnerable

Arnold H. Grossman, PhD

New York University

Anthony R. D'Augelli, PhD

The Pennsylvania State University

SUMMARY. This study used three focus groups to explore factors that affect the experiences of youth (ages 15 to 21) who identify as transgender. The focus groups were designed to probe transgender youths' experiences of vulnerability in the areas of health and mental health. This involved their exposure to risks, discrimination, marginalization, and their access to supportive resources. Three themes emerged from an analysis of the groups' conversations. The themes centered on gender identity and gender presentation, sexuality and sexual orientation, and vulnerability and health issues. Most youth reported feeling they were transgender at puberty, and they experienced negative reactions to their gender atypical behaviors, as well as confusion between their gender

Arnold H. Grossman is Professor of Applied Psychology, The Steinhardt School of Education at New York University. Anthony R. D'Augelli is Professor of Human Development, Department of Human Development and Family Studies, The Pennsylvania State University. Correspondence may be addressed: Arnold H. Grossman, Department of Applied Psychology, New York University, 35 West 4th Street–Suite 1200, New York, NY 10012 (E-mail: arnold.grossman@nyu.edu). The New York University Research Challenge Fund funded this research.

[Haworth co-indexing entry note]: "Transgender Youth: Invisible and Vulnerable." Grossman, Arnold H., and Anthony R. D'Augelli. Co-published simultaneously in *Journal of Homosexuality* (Harrington Park Press, an imprint of The Haworth Press, Inc.) Vol. 51, No. 1, 2006, pp. 111-128; and: *Current Issues in Lesbian, Gay, Bisexual, and Transgender Health* (ed: Jay Harcourt) Harrington Park Press, an imprint of The Haworth Press, Inc., 2006, pp. 111-128. Single or multiple copies of this article are available for a fee from The Haworth Document Delivery Service [1-800-HAWORTH, 9:00 a.m. - 5:00 p.m. (EST). E-mail address: docdelivery@haworthpress.com].

Available online at http://www.haworthpress.com/web/JH

doi:10.1300/J082v51n01_06

identity and sexual orientation. Youth noted four problems related to their vulnerability in health-related areas: the lack of safe environments, poor access to physical health services, inadequate resources to address their mental health concerns, and a lack of continuity of caregiving by their families and communities.

KEYWORDS. Transgender, youth, gender, lesbian, gay, bisexual, sexual orientation, vulnerability, health

INTRODUCTION

Transgender youth are invisible in most Western cultures because social structures assume a binary classification of gender. Individuals are expected to assume the gender of their biological sex as well as the gender expectations and roles associated with it. As nearly all people are classified as male or female, those who express characteristics ordinarily attributed to the other gender are stigmatized and seen often as social deviants. Inconsistency in the presentation between biological sex and gender expression is usually not tolerated by others (Gagne & Tewksbury, 1996). Because these individuals violate conventional gender expectations, they become targeted for discrimination and victimization. Thus they become members of a marginalized and vulnerable population that experiences more psychosocial and health problems than other social groups (Lombardi, 2001).

Transgender is a term used to describe individuals who exhibit gender-nonconforming identities and behaviors, or in other words, those who transcend typical gender paradigms (Ryan & Futterman, 1997). This broad category of people includes transsexuals (i.e., those who have made the transition to living in the gender other than the one originally assigned to them), cross-dressers (e.g., transvestites, drag queens, drag kings), and gender benders/blenders (i.e., those who purposefully present an ambiguous gender expression). Although most transgender people are heterosexual, they may also be lesbian, gay, bisexual or asexual (Davenport, 1986; Ryan & Futterman, 1997). However, as sexual orientation is based on the gender of one's erotic object of choice, sexual orientation and gender are often confused (Bornstein, 1994). But gender is a combination of one's birth sex, gender role and gender iden-

tity, whereas sexual orientation encompasses sexual attraction, sexual identity and sexual behavior.

Many transgender individuals, however, seek services from gay-sensitive service providers. As Ryan and Futterman (1997) indicate, and as these providers have come to learn, transgender people are generally more stigmatized than lesbians and gay males in contemporary society and require more support and services. This situation is even more difficult if the person is an adolescent or young adult.

Exhibiting gender-atypical behavior makes transgender youth an especially vulnerable population. Flaskerud (1999) describes vulnerable populations as "social groups who experience relatively more illness, premature death, and diminished quality of life than comparable groups" (p. xv). She relates vulnerability to a lack of resources and increased risk associated with discrimination, marginalization and disenfranchisement. Facing significant prejudice and discrimination in school, employment opportunities, housing, and access to health care, many transgender youth live outside mainstream society (Burgess, 1999; Mallon, 1999b). As gender-atypical behavior is much less accepted in boys than girls, biological males who are transgender are most often the targets of verbal and physical abuse. Without resources and support, these youth often drop out of school, run away, and end up on the streets, where they may engage in survival sex and become at risk for HIV and other sexually transmitted infections (Klein, 1999).

BACKGROUND

Developing and integrating a positive identity is a developmental task for all adolescents. For transgender youth, however, there is the additional challenge of integrating a complex gender identity with their cultural and ethnic backgrounds, personal characteristics, and family circumstances. They are faced not only with the task of developing a sexual identity, but also with reconciling their gender identity with the traditional gender expectations associated with their biological sex. As Woodhouse (1989) observed in her study of transvestites, the appearance of femininity denoting female sex and masculinity denoting male sex is so ingrained in society that we take it for granted; and "all we have to go on is appearance" (p. 3).

Not much systematic, empirically based information is available about transgender individuals. Likewise, there is very limited knowledge about transgender youth. Indeed, Mallon (1999b, p. 9) noted, "If

the research on gay and lesbians persons is slim, the research on transgendered persons is almost non-existent." In a comprehensive review of the needs of lesbian and gay youth in *Adolescent Medicine*, Ryan and Futterman (1997) devoted only two pages (out of more than 340) to transgender youth. They noted that most information has been obtained from transsexuals who have sought counseling or services from gender identity clinics (see Lewins, 1995). Other information has been provided in retrospective anecdotal reports by transgender individuals or their family members (e.g., Boenke, 1999; Bornstein, 1994; Evelyn, 1998). Lewins (1995) deduced that four themes emerge from these accounts: (1) a long history of tension between the person's biological sex and his or her preferred gender, (2) an awareness and experience of being different as a child, accompanied by bullying and teasing at school, (3) a current internal struggle to reconcile the conflict between psychosexual identity and biological sex, and (4) the need for continued coping with the negative social responses to the disclosure of these feelings. Many of the transgender individuals described in the literature have health problems, including high rates of substance abuse, attempted suicide, childhood abuse, past sexual abuse/assault, and psychiatric disorders (Cole, O'Boyle, Emory, & Meyer, 1997; Cosentino, Meyer-Bahlburg, Alpert, & Gaines, 1993; Devor, 1994, 1997; Rottnek, 1999; Ryan & Futterman, 1997). Some (e.g., Burgess, 1999) have suggested that the descriptions based on the self-selected transgender people who seek treatment have led to a pathologizing stereotype of these people. Additionally, many who have used hormones to develop desired female or male secondary sex characteristics, have obtained these hormones on the street, fearing negative reactions from health care providers. The improper use and abuse of sex hormones has led to serious health problems and may have impacted their pubertal growth. Furthermore, obtaining hormones on the streets has put transgender youth at risk for HIV infection due to contaminated needles. Therefore, hormonal therapy and informed, non-judgmental counseling may be lifesaving for transgender teens (Ryan & Futterman, 1997).

Other information about transgender individuals can be found in fiction (e.g., Feinberg, 1993) and in calls to action written by activists (e.g., Feinberg, 1998; MacKenzie, 1994; Wilchins, 1997). In a recent edited volume (Rottnek, 1999), some gay, lesbian and transgender individuals explored their lives as "sissies" and "tomboys," and others examined how their cross-gender behavior and identification led to their being classified as mentally ill, i.e., having Gender Identity Disorder (GID). The major criteria for a diagnosis of GID include a strong and

persistent cross-gender identification, as well as discomfort with one's anatomical gender (American Psychiatric Association, 1994). Rather than "curing" or changing transgender youth, advocates call on providers to offer counseling, support, and access to appropriate resources that would enable adolescents to clarify identity confusion, resolve conflicts, and determine whether treatment (e.g., hormonal therapy following the growth spurt and/or future consideration of sex reassignment surgery) may be appropriate (Mallon, 1999c).

A number of empirical studies have been conducted to examine the relationship of sexual orientation to various gender-related characteristics. In a longitudinal study of 66 feminine boys and a control group of 56 nonfeminine boys (average age of 7 years), Green (1987) found upon reinterview (at an average age of 19 years) that three-quarters of the feminine boys who provided follow-up data had bisexual or homosexual fantasy scores (on a Kinsey rating scale), while none of the control boys did. Of the boys who had had interpersonal sexual experiences, 80% of the feminine boys had engaged in sexual activities with their same sex or both sexes, compared to 4% of the control group. Green concluded that highly feminine boys are more likely to become gay or bisexual adults than other boys. This study was initiated over two decades ago, and a replication is necessary to determine if similar findings would emerge today in a society that allows a wider range of gender behaviors.

Doorn, Poortinga, and Verschoor (1994) found that the development of a feminine gender identity system was present at an early age for male transsexuals, although the individual may not be aware of this identity until later in life. Zuger (1984) conducted a prospective study of 55 feminine boys. The boys were first seen at an average age of 9 years, and a follow-up study of 48 boys was conducted when they were at an average of 20 years. Similar to Green's findings, Zuger found that 73% were judged to have homosexual or bisexual orientations, 6% were judged to have heterosexual orientations, and 21% could not be determined because of lack of information. Tsoi (1990) conducted a study of the sexual development of male transsexuals. Findings indicated a distinct sexual developmental pattern. This pattern included the prepubescent appearance of effeminate traits, the development of homosexual feelings during puberty, a cross-dressing phase during the mid-to-late teen years, and a transsexual phase characterized by surgery and the adoption of living life as a woman. In a comprehensive analysis, Bailey and Zucker (1995) reviewed 32 studies in which both gay men and heterosexual men were asked retrospectively about behaviors related to

childhood and gender identity. On all measures, gay men's scores reflected more traditionally feminine characteristics.

Unfortunately there are no prospective studies regarding gender-atypical females ("tomboys") becoming lesbians; however, retrospective studies have indicated that such an association exists. These studies suggested that, on average, lesbians were more traditionally masculine as children than heterosexual women. However, findings have indicated that masculine childhood gender identity in females is less predictive of adult same-sex sexual orientation than feminine childhood gender identity is for males (Bailey & Zucker, 1995).

Although there has been a growing number of empirical studies examining various developmental and adjustment issues of gay, lesbian and bisexual adolescents during the last decade (see Anhalt & Morris, 1998, and D'Augelli & Patterson, 2001, for reviews), these studies have not reported on gender atypicality. A recent report by D'Augelli, Pilkington, and Hershberger (2002) is an exception. They examined the victimization experiences of 350 lesbian, gay and bisexual high school and college age youth. Among the significant predictors of anti-lesbian-gay-and-bisexual victimization was childhood gender atypicality as well as parental rejection of this atypicality. In a qualitative study of lesbian and gay youth, Mallon (1998) found that not only was gender atypical behavior not acceptable to relatives and family members, but these distressed family members acted to discourage the expression of gender nonconforming ideas. Cooper (1999) has noted the serious challenges to families that transgender adolescents pose; the redefinition of a youth's gender may well be more difficult than the challenges faced following a youth's coming out as lesbian, gay, or bisexual.

STUDY DESIGN

The purpose of this study was to determine factors that affect the experiences of youth, ages 15 to 21, who either identify as transgender or describe their gender expression as atypical. Focus groups were used to examine the youths' social and emotional experiences. Focus groups, conducted in a nonthreatening environment, have been recommended as a research tool especially when working with people who have limited power and influence (Morgan & Krueger, 1993). The groups that comprised this study provided qualitative data on topics of interest and enabled the participants to present their own viewpoints, stimulated by the presence of group interaction to the researchers' questions (Morgan &

Krueger). In addition to examining the youths' experiences related to gender identity, gender presentation, and sexual orientation, the focus groups explored the transgender youths' vulnerability related to health, including exposure to risks (e.g., emotional, physical, sexual), discrimination, marginalization, and access to health resources. The focus groups were conducted in June and July 2000.

Transgender youth from the New York City metropolitan area were invited to participate in the focus groups. Announcements requesting volunteers were made to youth attending social, educational and recreational programs for lesbian, gay, bisexual, and transgender youths. It is estimated that transgender individuals comprise 3% to 10% of the United States population (Ettner, 1999). At the agencies from which the youth were recruited, they were estimated to be 10% of the population, as these agencies provided some of the safest spaces for gender nonconforming youth in the city. As transgender youth are a hidden population, it was decided that recruitment would take place at venues likely to yield a sufficient number of youths at one time so that a focus group could be conducted. A master's-level certified social worker with considerable professional experience working with lesbian, gay, bisexual, transgender and questioning youth facilitated the focus groups.

Each group contained eight individuals. This size allowed the members to explore issues in depth, gaining the benefits of small group interaction without splitting into subgroups. The groups lasted approximately two hours, in addition to time needed for explaining the purposes of the study, reading and signing consent forms, completing demographic questionnaires, and agreeing on ground rules (e.g., safe space, not "putting anyone down," speaking one's own thoughts and feelings). The sessions were conducted in private rooms of agencies providing services to lesbian, gay, bisexual, and transgender youth, and they were audio taped with youths' permission. In addition to providing consent, the youth could use their own names or pseudonyms during the group sessions. Each youth received $30.00 for participation.

The focus groups were conducted informally to simulate "rap sessions" that youths commonly have when they discuss topics with friends. They started with wide-ranging areas such as their experiences in childhood and early/middle adolescence (including feelings of being different), discovering their sexual and gender identities, their educational histories, types of support networks, access to resources, and their understanding of the notions of sex and gender. As the groups progressed, the facilitator was guided by a list of additional factors related to the youths' views of their vulnerability and health-related concerns.

The primary and secondary questions and probes used by the facilitator in leading the groups had been decided upon by a Planning and Evaluation Group convened for the project. That group consisted of the two investigators, the facilitator, and four consultants, i.e., three transgender youth and one adult transsexual. After the three focus groups were conducted, a three-member data analysis team individually listened to the audiotapes from each session and recorded themes that emerged from the group sessions. The team then met to compare and contrast the thematic points of the interviews and to ensure that the analyses were systematic and verifiable (Krueger, 1993). Findings from the data analysis team were presented to the Planning and Evaluation Group, which reviewed the themes for accuracy and categorized them in three major areas: gender identity and gender presentation, sexuality and sexual orientation, and vulnerability and health.

Before presenting the results, several important limitations to the study should be acknowledged. A main limitation was the use of convenience samples drawn from particular sites. This was necessary because there was no economically feasible method for selecting a random sample of transgender youth. Additionally, the participants had to self-identify as "trans" or "transgender" youth, make themselves visible to organizations providing social, educational and recreational services, and volunteer to participate in a group discussion. Therefore, the participants may have been more cooperative and sociable than other transgender youths. Furthermore, the focus groups met only once, and the sexual and gender identities of the youth may have been in transition. Thus, the findings may not be generalizable to all transgender youth. However, based on the professional and personal experiences of the members of the Planning and Evaluation Group, the authors believe that many of the participating youths' experiences were common among transgender youth.

RESULTS

Participants

The mean age of the 24 participants was 16.5 (range 15 to 20), and their average grade was the 11th (range 9th to 12th), with some youth returning to school for equivalency high school diplomas after having dropped out. Ninety percent of the youth lived in a major metropolitan area, and 95% were youth of color. Fifty percent of the youth lived with

parents or other relatives, 29% lived in a group home, and the remainder had "other" living arrangements. A large majority of the youth (87%) had two or more siblings of both biological sexes; only 2.5% (3 youth) were only children. Half of the youth estimated their parents' or guardians' yearly family income to be less than $25,000, while the other half indicated that it ranged from $26,000 to over $100,000.

A large majority (83%) of the participants identified their anatomical gender as biologically male, while 17% identified as biologically female. When asked about their preferred gender, 54% indicated that it was male-to-female (M-to-F), 17% said female-to-male (F-to-M), and 29% expressed a preference of male-to-male. Members of this third group saw themselves as having a feminine gender expression, but would have preferred a masculine one. Because gender identity and sexual orientation are often conflated, the youth were asked how they would identify (if they would) their sexual orientation. All of the youth responded to this question, with 50% of the biological males identifying as gay, 35% as heterosexual, and 15% as "uncertain." Of the females, 75% labeled their sexual orientation as bisexual, and 25% as lesbian. The biological males indicated that they were moderately or very sexually attracted to other males, while the biological females were sexually attracted to both females and males.

Approximately two thirds of the youth (69%) indicated that they acted and dressed in the gender opposite their birth sex and, therefore, have started the processes of transitioning. Some of these individuals planned on taking hormones as part of their transitioning process, while a much smaller percentage (14%) were already taking hormones. More than three fourth of the male-to-female youth planned on having sex reassignment (confirming) surgery.

In addition to determining the experiences of the transgender youth through the focus groups, the investigators wanted to learn about the social context of these youths' lives. Therefore, on the demographic questionnaire the investigators also asked such questions as: to whom they have disclosed their gender identity, how many people in their families were transgender, if they attended groups for transgender people, and the percentage of people who were aware of their transgender identities. The responses to these questions form the next section of the findings.

Since we were interested in comparing and contrasting their developmental trajectories to those of lesbian, gay, and bisexual youth, the demographic questionnaire also included questions about the milestones in these youths' sexual orientation development in these youths' lives. Questions ranged from the age they first became aware that their gender

identity did not correspond to their biological sex to the age when they first demonstrated visible signs of their transgender identity. Their responses to these questions comprise the third section of the findings.

The fourth section of the findings describes the three major themes that emerged from the groups: gender identity and gender presentation, sexuality and sexual orientation, and vulnerability and health. The Planning and Evaluation Group thought that these three themes best summarized the conversations that occurred.

The Context of the Experiences

When asked who knew of their gender identity or gender expression, two-thirds (66%) indicated that their parents, brothers and sisters knew, 50% said that their grandparents knew, and 63% had disclosed their gender identity to their aunts or uncles. The two largest groups to which the youth had disclosed their gender identity were friends and teachers, 83% and 75%, respectively; these larger percentages are inflated by those who were living in a group home or attended an equivalency high school educational program. About one-quarter (22%) of the youth reported that they knew of relatives who were also transgender.

To determine the frequency of youths' interactions with others who describe themselves as transgender, the youth were asked how often they spent time with other transgender people and how many groups for transgender people they belonged. Half (54%) indicated that they spent time daily with other transgender people, while 44% spent time weekly, but not daily. Only one youth indicated never spending time with other transgender people. Additionally, 42% said that they belonged to groups for transgender people, with 33% of those attending the groups on a regular basis. Finally, the youth were asked to indicate the percentage of people who were currently aware of their transgender identity. Of the 21 youth who responded to this question, 19% indicated "less than 25%," while 24% said between "25% and 50%," and 9% indicated between "51% and 75%." Almost half (48%) indicated that "more than 75%" of the people that they knew were aware of their transgender identity.

Developmental Milestones

The youth indicated that they were, on the average, 10.4 years old (range 6 to 15) when they first became aware that their gender identity or gender expression did not correspond to their biological sex (even

though they might not have labeled their feelings). At a mean age of 13.5 (range 7 to 16), the youth first realized that other people labeled them transgender. It was approximately a year later, at the mean age of 14.3 (range 7 to 18), that they first labeled themselves transgender, and that they disclosed their gender identity to someone else (mean age of 14.5, with a range of 8 to 18). At the same time (mean age of 14.1, range 10 to 18), they first made their transgender identity known to others, either by cross-dressing or by seeking hormones to change their physical appearance.

Of the 22 youth who responded to a question about their sexual activity, 95% of the males (19), and 75% of the females (3) had sexual experiences with biological males. Eighty-five percent of the males had their first sexual activity with a good friend or boyfriend, while three (15%) reported having anonymous sex. The mean age (13.3, range 9 to 17) of their first sexual partners was similar to their own. Four percent of the males also reported having biologically female sexual partners, whom they described as girlfriends of similar ages (mean age = 13, range 10 to 15). All three of the biological females reported having had sexual experiences with both biological males and females; all of these partners were described as friends or girls similar in age. Because of the small numbers involved, a mean age will not be reported; however, the range was from 9 to 17.

The mean ages of the developmental milestones reported in this study are similar to those given in recent studies for lesbian gay, and bisexual youth (e.g., D'Augelli & Hershberger, 1993; Rosario et al., 1996). While developmental averages for lesbian, gay, bisexual and transgender youth gives us a picture that highlights awareness and experiences that appear to be concurrent with pubescence, the age ranges remind us of the diversity of the life paths within these groups.

Theme #1: Gender Identity and Gender Presentation

Although for most youth, the awareness that their gender identity did not correspond to their birth sex occurred around puberty, but, for a few, it was at an earlier age. As one youth (M to F) said, "I used to play baseball and hangout with the boys, but I always felt like a girl." Another youth stated, "I knew that I was biologically a girl, but ever since I was little, I always wanted to be a man so bad. Other people said I want to be a lawyer, a doctor, and I said I want to be a man." A third youth (M to F) said, "Since I can remember, I always thought I was a girl. I used to do things as a girl, sit on the toilet. I wouldn't stand up. I never liked using

urinals. I never liked boy things. I didn't like boys' stuff, I always liked girls' stuff." This awareness of difference later evolved to gender atypical behavior, i.e., wearing the clothes of the other sex, playing with an individual of the other sex whom they emulated, or presenting themselves as their preferred gender during adolescence. In the words of one youth (F to M), "Since I was young, and I would see people getting married, I always pictured myself in the groom's place instead of the bride's." Another youth (M to F) said, "I thought people would beat me up because I looked like a man in girls' clothes, but then people said I wiggle like a girl."

Reactions of others to their gender atypical behavior were mostly negative. The reactions ranged from physical assault by family members and neighbors to having their gender and sexual identity questioned. Attending school was reported to be the most traumatic aspect of growing up. As one youth (M to F) said, "At school there was a lot of harassment. I could walk around minding my business, and someone would throw something at me, would call me faggot, spit at me, do this do that." Verbal harassment and assault were not the only negative reactions. There were other things, such as regularly being propositioned for sex and being called by one's birth name after indicating that a chosen name was preferable. "Teachers don't realize," as one youth (F to M) said, "that when they call me by my 'government name,' everyone is going to call me that it's going to cause a fight. Because, if they don't stop, I'm going to fight." However, many of the youth found that some peers, transgender friends, lovers, teachers, and extended family members supported their gender identity and presentation. They reported that they had less access to knowledge about transgender individuals than about lesbian, gay, and bisexual people. Most indicated that they gained knowledge about the existence of transgender people either from the media, from transgender adults in their neighborhoods, or when they moved to New York City. Most whose gender identity was static began to identify as transgender or to live in their preferred gender role between ages 11 and 18, and told others (if anyone) between 11 and 18.

Theme #2: Sexual Orientation

For the large majority of the youth, awareness about their sexual orientation occurred between ages 4 and 9 or between 13 and 15. Physical attraction to others of the same sex informed this awareness. When they discovered this same-sex attraction, their reactions ranged from sadness and withdrawal to happiness. This same-sex attraction and their display

of atypical social and sexual behaviors in childhood led to much confusion between their sexual orientation and gender identity. Two youths (M to F) stated it clearly, "I was really confused as to who I am. I looked at boys and I looked at girls, until I would identify as transgender when I was 17." As teenagers, most came to view their "gender" as about gender self-identification and gender expression, and they saw "sex" as their biological or birth sex.

They talked about their experiences of verbal harassment and physical assault by family members, neighbors, strangers and classmates because of their assumed or disclosed sexual orientation. As one youth (M to F) said, "The kids would say, 'That's just the faggot of the school.' I was the town's faggot and they would taunt me." Attending school, particularly high school, was a painful event for many of the youths. An example provided by one youth (M to F) was: "When I was in gym with another feminine boy and I had my pen in my mouth, there was this teacher; and he asked me if I wanted something else in my mouth. He grabbed me and said, 'This time I have you.'" Some youth transferred to high schools for lesbian, gay, bisexual and transgender youth (two of which exist in the New York City area), or to public high schools known to have large sexual minority populations. Some found support for their sexual orientation either from lesbian, gay or bisexual relatives, their friends, parents of those friends, or group home peers. Access to knowledge about their being lesbian, gay, or bisexual came from people in their neighborhoods or schools, family members who were lesbian, gay, bisexual or transgender, or youth who belonged to organizations that provided social and recreational services to sexual minority youth.

Theme #3: Vulnerability and Health Issues

Almost all of the youth talked about four major issues related to their vulnerability in health-related areas: the absence or lack of safe environments, lack of access to health services, few resources for their mental health concerns, and a lack of continuity of caregiving by their families and communities. The clear exception to the dismal picture of how others were not meeting their needs concerned organizations specifically dedicated to services for sexual minority youth.

The most important of the youths' concerns was safety issues related to being potential victims of violence on their disclosure of their transgender status or that information being disclosed by others. One youth (M to F) stated it directly, "I have no comfort or safety zones, and that puts me at risk for suicide." They also expressed fear that the con-

stant verbal harassment and discrimination they faced might escalate into physical violence and sexual abuse, as they found themselves being continually objectified sexually. One youth (F to M) stated, "Men keep saying to me, 'I can turn you straight.'" They also expressed resentment for being seen only for their gender and sexuality and not for their other personal qualities.

Their primary concerns about the lack of access to health services related to two areas. First, they were concerned about sexually transmitted infections, including HIV. Sexual partners often do not perceive the male-to-female transgender youth as health risks because they cannot become pregnant; they are also thought of as sexually less inhibited because they are transgender. Consequently, others expect unprotected sexual activity, and resisting the expectation can lead to sexual abuse. Not only did they express concern about their lack of access to health care services for counseling and testing regarding sexually transmitted diseases, but they also feared discrimination by health care providers. A second concern was the lack of access to ongoing health care services to obtain hormones to change their secondary sexual characteristics to correspond to their preferred gender.

Lack of resources related to their mental health needs was strongly voiced by the youth. They realized that nondisclosure of their gender and sexual identities hide their selfhood and uniqueness; however, the negative reactions they receive on disclosure often has a severe negative effect on their self-esteem. Although they have come to rely on avoidance coping skills and to seek supportive others as their main coping mechanisms, the lack of competent mental health services to assist them reflects, in their views, their marginality and unimportance to society. Some consider themselves as having a high risk of self-harm because of their religious backgrounds and the pressures their families and communities put on them to conform to traditional gender behaviors. In the words of one youth (M to F), "If you come out, you may want to kill yourself if you come from a Catholic background, or Christian, or a very religious background. You love your parents so much you will try to kill yourself to keep them from misery."

Experiencing rejection and inconsistent caring from most of their parents, schoolmates, teachers, and communities, transgender youth have to constantly fight feelings of shame and unworthiness. As one youth said, "Throughout my whole life, I was abused physically and mentally by relatives in my family. I have marks on my body. I have things that I remember happened to me." Some of the youth have distanced themselves from their parents, while others have been forced to

leave their homes, which can be an extremely traumatic experience. One youth told the following anecdote: "When my mother, who is a PhD, found out what I was (i.e., transgender), she used to hurt me with things. She hit me on the head with an iron once, and I had five staples. Finally, she disowned me." The lack of housing was frequently accompanied by an absence of financial support that forced a few of the youth into prostitution. (This may have been underreported, as engaging in survival sex is not something that youth readily talk about in public settings.) Some also experienced rejection in the lesbian, gay and bisexual community because of discrimination based on their racial or ethnic background as well as their gender identity. With the lack of support at home and the routine stigmatization at school, many had experienced serious academic difficulties, and dropped out of school. Some thought that they were very fortunate to attend an alternative high school for lesbian, gay, bisexual and transgender youth. But at the same time, they found themselves at risk for social isolation, as a result of being alone in a big city, and for substance abuse, as a way of coping with the others' negative reactions (e.g., peers, teachers, parents). As a number of youth said at the end of the focus groups, "There is nothing for transgender youth. Please help us."

CHALLENGES, IMPLICATIONS, AND RECOMMENDATIONS

It is unlikely that adequate health and other services for transgender youth will be provided until more is learned about this population and their needs. Consequently, research that recruits youth from various groups within the transgender community (e.g., male-to-female, female-to-male, cross-dressers, drag kings, drag queens, tranny fags, tranny dykes) need to be conducted. Additionally, studies of transgender youth must include youth from diverse socioeconomic and racial/ethnic backgrounds. It is especially important that our knowledge base not be built only on information gathered from youth who seek health or mental health services, or who attend support groups. Future investigations must develop inclusion and exclusion criteria regarding static and fluid gender identities and sexual orientation, and common operational definitions for key variables, such as gender, sex, gender identity, and sexual orientation, must be established (see Mallon, 1999a).

To reduce the harm currently experienced by transgender youth, a number of key actions are required. First, health and social service providers must acknowledge that transgender youth exist and that atypical

gender expression is an acceptable way of behaving. Second, providers must intervene to reduce the risks experienced by transgender youth because of discrimination and marginalization, not only on an individual or group basis but also through the use of advocacy and public health education. Third, steps must be undertaken to reduce the vulnerability of these youth by providing them access to resources that meet their specific needs, including sensitive and effective physical health care, mental health services, schooling, employment and housing. Fourth, programs have to be established to assist families and communities to create culturally safe environments for transgender youth and to provide a continuity of caregiving when youth come out as transgender. Fifth, specialized programs should be established to assist transgender youth in developing plans to attain their preferred gender identity, including the steps to reduce the harm that some experience by taking "street hormones," or by being forced into prostitution. Sixth, education about transgender people should be included in the professional preparation and in-service training programs of all health care and social service providers. Finally, youth who identify as transgender must be educated about society's gender constructs and how these contribute to their vulnerability and devalue their health status. Strategies to enhance emotional, social and physical development must be established to assist transgender youth in building the resiliency they need to live in a culture that tenaciously maintains a binary concept of gender.

REFERENCES

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders, 4th ed.* Washington, DC: American Psychiatric Association.

Anhalt, K., & Morris, T.L. (1998). Development and adjustment issues of gay, lesbian, and bisexual adolescents: A review of the empirical literature. *Clinical Child and Family Psychology Review*, *4*(1), 215-230.

Bailey, J.M., & Zucker, K.J. (1995). Childhood sex-typed behavior and sexual orientation: A conceptual analysis and quantitative review. *Developmental Psychology*, *31*, 43-55.

Boenke, M. (Ed.). (1999). *Transforming families: Real stories about transgender loved ones*. Imperial Beach, CA: Walter Trook Publishing.

Bornstein, K. (1994). *Gender outlaw: On men, women, and rest of us*. New York: Vintage.

Burgess, C. (1999). Internal and external stress factors associated with the identity development of transgendered youth. *Journal of Gay & Lesbian Social Services*, *10 (3/4)*, 35-47.

Cole, C., O'Boyle, M., Emory, L., & Meyer, W. (1997). Comorbidity of gender dysphoria and other major psychiatric diagnoses. *Archives of Sexual Behavior*, *26*(1), 13-26.

Cooper, K. (1999). Practice with transgendered youth and their families. *Journal of Gay & Lesbian Social Services*, *10 (3/4)*, 111-129.

Cosentino, C., Meyer-Bahlburg, M., Alpert, J., & Gaines, R. (1993). Cross-gender behavior and gender conflict in sexually abused girls. *Journal of the American Academy of Child and Adolescent Psychiatry*, *32*(5), 940-947.

D'Augelli, A. R., Pilkington, N. W., & Hershberger, S. L. (2002). Incidence and mental health impact of sexual orientation victimization of lesbian, gay, and bisexual youths in high school. *School Psychology Quarterly*, *17*, 148-167.

D'Augelli, A. R., & Patterson, C. J. (Eds.) (2001). *Lesbian, gay, and bisexual identities and youth: Psychological perspectives*. New York: Oxford University Press.

Davenport, C. (1986). A follow-up study of ten feminine boys. *Archives of Sexual Behavior*, *15*(6), 511-517.

Devor, H. (1994). Transsexualism, dissociation, and child abuse: An initial discussion based on nonclinical data. *Journal of Psychology and Human Sexuality*, *6*(3), 49-72.

Devor, H. (1997). *FTM: Female-to-male transsexuals in society*. Bloomington: Indiana University Press.

Doorn, C.D., Poortinga, J., & Verschoor, A.M. (1994). Cross-gender identity in transvestites and male transsexuals. *Archives of Sexual Behavior*, *23*(2), 185-201.

Ettner, R. (1999). *Gender loving care: A guide to counseling gender-variant clients*. NY: W.W. Norton.

Evelyn, J. (1998). *Mom, I just need to be a girl*. Imperial Beach, CA: Walter Trook Publishing.

Feinberg, L. (1993). *Stone butch blues*. New York: Firebrand Books.

Feinberg, L. (1998). *Trans liberation: Beyond pink and blue*. Boston: Beacon Press.

Flaskerud, J.H. (Ed.). (1999). Preface. Emerging nursing care of vulnerable populations. *Nursing Clinics of North America*, *34*(2).

Gagne, P., & Tewksbury, R. (1996). Hide in plain sight: Conformist pressures and the transgender community. Paper presented at the annual meetings of the Society for the Study of Social Problems, New York, NY.

Green, R. (1987). *The "sissy boy syndrome" and the development of homosexuality*. New Haven: Yale University Press.

Klein, R. (1999). Group work practice with transgendered male to female sex workers. *Journal of Gay & Lesbian Social Services*, *10 (3/4)*, *95-109*.

Krueger, R.A. (1993). Quality control in focus group research. In Morgan, D.L. (Ed.), *Successful focus groups: Advancing the state of the art* (pp. 65-85). Newbury Park, CA: Sage.

Lewins, F. (1995). *Transsexualism in society: A sociology of male-to-female transsexuals*. South Melbourne, Australia: Macmillan Education Australia.

Lombardi, E. (2001). Enhancing transgender health care. *American Journal of Public Health*, *91*, 869-872.

MacKenzie, G. (1994). *Transgender nation*. Bowling Green, OH: Bowling Green State University Press.

Mallon, G.P. (1998). *We don't exactly get the welcome wagon: The experiences of gay and lesbian adolescents in child welfare systems*. New York: Columbia University Press.

Mallon, G. P. (1999a). Appendix: A glossary of transgendered definitions. *Journal of Gay & Lesbian Social Services*, *10 (3/4)*, 143-145.

Mallon, G. P. (1999b). Knowledge for practice with transgendered persons. *Journal of Gay & Lesbian Social Services*, *10 (3/4)*, 1-18.

Mallon, G. P. (1999c). Practice with transgendered children. *Journal of Gay & Lesbian Social Services*, *10 (3/4)*, *49-64*.

Morgan, D.L., & Krueger, R.A. When to use focus groups and why. In Morgan, D.L. (Ed.), *Successful focus groups: Advancing the state of the art* (pp. 3-19). Newbury Park, CA: Sage.

Rosario, M., Meyer-Bahlburg, H.F.L., Hunter, J., Exner, T.M., Gwadz, M., & Keller, A.M. (1996). The psychosexual development of lesbian, gay, and bisexual youths. *The Journal of Sex Research*, *39*(2), 113-126.

Rottnek, M. (Ed.). (1999). *Sissies and tomboys: Gender nonconformity and homosexual childhood*. New York: New York University Press.

Ryan, C., & Futterman, D. (1997). Lesbian and gay youth: Care and counseling [Special issue]. *Adolescent Medicine*, *8*(2).

Tsoi, W.F. (1990). Developmental profile of 200 male and 100 female transsexuals in Singapore. *Archives of Sexual Behavior*, *19*(6), 595-605.

Wilchins, R.A. (1997). *Read my lips: Sexual subversion and the end of gender*. New York: Firebrand Books.

Woodhouse, A. (1989). *Fantastic women: Sex, gender and transvestism.* London: Macmillan.

Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Diseases*, *172*, 90-97.