

Development, Risk, and Resilience of Transgender Youth

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Transgender youth face unique and complex issues as they confront cultural expectations of gender expression and how these fit with what is natural for them. Striving for balance, learning to cope, questioning, and eventually becoming comfortable with one's gender identity and sexual orientation are of paramount importance for healthy growth and development. Ineffective management of intense challenges over time without adequate social support places youth at risk for a number of unhealthy behaviors, including risk behaviors associated with acquiring HIV. This article explores early foundations of gender identity development, challenges in the development of transgender youth, and the limited data that exist on transgender youth and HIV risks. The concept of resilience is introduced as a counterbalancing area for assessment and intervention in practice and future research with transgender youth.

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Transgender youth are a group of people who are interesting, curious, passionate, and self-motivated. Like their peers, transgender youth strive for independence and take risks. However, they experience some unique challenges in figuring out who they are and who they are attracted to in a society that does not understand them. The stigma they face because of

different gender identity expression places them at high risk for becoming victims of discrimination, verbal harassment, and physical violence.

The purpose of this article is to explore and describe the literature on the childhood development of gender identity and social reactions to nonconforming gender behavior, which in part explain behaviors that place transgender youth at high risk for HIV infection. Related topics include a discussion of common terms used in this article, typical gender identity and sexual development, challenges to development experienced by transgender youth, and HIV risks in transgender youth. The concept of resilience is introduced as a counterbalance for assessment and intervention in practice and future research with transgender youth.

Background

The term *sexual minority youth* encompasses a diverse range of sexual expressions and may be too broad to be useful. However, it removes the lesbian, gay, bisexual, and transgender (LGBT) labels and is more inclusive of the range of feelings and behavioral expressions experienced by youth who are not in the sexual majority (Goldfried & Bell, 2003). There is a distinct literature, particularly in sociology and psychology, about adolescent lesbians

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and gays, yet very little information about bisexual or transgender youth. Whereas there is a paucity of health care literature about lesbian, gay, bisexual (LGB) youth, transgender youth are almost nonexistent in this literature. Published studies have primarily focused on victimization, education in school systems, serious mental health issues such as suicide, and child welfare within legal systems. There is an emerging literature base regarding sexual development.

Common Meanings

At least three major concepts are involved in gaining an understanding of transgender people. These are self-identity, gender identity, and, to a lesser extent, sexual orientation. Self-identity is a process that develops over a lifetime, with rapid formation in childhood, adolescence, and young adulthood. Simply defined, it can be considered as how one views oneself, shaped by social interactions and cognitive processing of experiences and feelings.

Gender identity is the sense of oneself as girl/woman or boy/man and refers to the ways that people act, interact, or feel about themselves (American Psychological Association, 2009). This can be compared and contrasted with biologic sex (i.e., male or female) assigned at birth based on genitalia. Gender identity can be quite complex for people who are not part of the heterosexual majority, including young people who eventually identify as being lesbian or gay. Other issues such as gender fluidity, being intersex (see later in the text), or having intersecting identities testify to the complexity of gender identity; however, these concepts have received much less empirical attention and are poorly understood. *Intersecting identities* refers to gender in the context of race, class, religion, or geographical location (Hannsmann, Morrison, & Russian, 2008).

Sexual orientation is defined by who someone is sexually or romantically attracted to, including erotic feelings, thoughts, and fantasies (Savin-Williams & Cohen, 2004). Attractions can be same-sex (i.e., lesbian, gay, or homosexual), other sex (i.e., straight or heterosexual), both (i.e., bisexual), or none. Sexual orientation is also fluid, particularly in adolescence as a period of questioning and experimentation. Sexual

orientation influences sexual identity and sexual behavior but is independent of these two concepts. For example, some youth may have a same-sex orientation but never identify as gay or may never engage in same-sex behavior (Savin-Williams & Cohen, 2004). Sexual identity is the act of labeling oneself with a socially known label such as gay, straight, or queer, which changes over time in meaning and by culture and historic time (Savin-Williams & Cohen, 2004). The word *queer* has long been considered a negative term both inside and outside of the LGBT community, but some LGBT people have reclaimed it to signify that they question or refuse traditional notions of dichotomous identity categories such as male and female or heterosexual and homosexual (Morgan & Stevens, 2008).

Transgender is a broad term that includes a variety of nonconforming gender expressions or behavior. For many, transgender is an incongruence between what one feels or “knows” she or he is rather than what the physical attributes of her/his body are. Transgender can be broadly defined as living life in the identified gender role rather than a biologic sex role; a transsexual as a person changing one’s body to the other gender through the use of injected sex hormones, electrolysis, plastic surgery, or sex reassignment surgery; and cross-dressers (e.g., drag kings, drag queens, and other gender benders/blenders), persons who cross-dress for entertainment or sexual pleasure (TransProud, 2009). Transsexuals can be preoperative, postoperative, or nonoperative. In brief, the term *transgender* covers many kinds of gender identities while remaining flexible. People further identify with other subcultures such as race, ethnicity, female-to-male (FTM), male-to-female (MTF), queer, or genderqueer (Davidson, 2007). However, the term *transgender* does not include sexual orientation. For many transgender people, who they were attracted to initially remains who they are attracted to after transitioning to the desired gender. For example, an FTM who has always been attracted to girls/women will still be attracted to girls/women and may identify as a straight man after transitioning. He may also choose to identify as a transman. However, he would not be considered a lesbian.

There is no known cause for being gender-nonconforming, although theories exist and researchers are

exploring antecedents and consequences. Research has not identified differences in anatomy or physiology in transgender people from the majority, although some differences have been identified in lesbians and gays (Spigarelli, 2007). Historically, transgender people were considered Two-Spirit people in some Native American tribes; an embodiment of both feminine and masculine spirits within one person (Balsam, Huang, Fieland, Simoni, & Walters, 2004).

Intersexed persons are usually included under the transgender umbrella but are a complex and unique gender-variant group. Intersexed persons may have physical or hormonal attributes of both females and males. There are numerous causes of intersex conditions, but they frequently result from defects in the biosynthesis or action of testosterone (Sobel & Imperato-McGinley, 2004). The most common condition is androgen insensitivity, which is inherited as an X-linked recessive gene. This condition occurs in about 2 or 3 of 1,000 births (Diamond & Watson, 2004). In newborns with XY chromosomes, a range of physical attributes may be present from typical male to typical female, depending on the level of androgen insensitivity. For complete androgen insensitivity, boys appear to be girls at birth and are raised as girls. Estrogen effects are present, so youth develop breasts at puberty but have little or no pubic or axillary hair because of a lack of or low levels of “functioning” testosterone, nor do they have menses because they do not have female internal organs (Diamond & Watson, 2004). There are numerous issues to be considered, including determining whether the sex assignment soon after birth fits with self-identity, deciding whether to have corrective surgery, and dealing with secrecy and depression (Diamond & Watson, 2004). However, androgen insensitivity may not be diagnosed until puberty when expected physical changes do not occur (Sobel & Imperato-McGinley, 2004).

Review of Developmental Literature

Gender-Nonconforming Behavior in Children

Sexual behaviors are common and should be expected in infants and children, although this is often

not the case in Western societies (Bullough, 2004). Kinsey, Pomeroy, and Martin (1948) were the first scientists to challenge the traditional clinical view of childhood sexual latency and showed that humans are naturally sexual and orgasmic throughout childhood. Sex play was the principal source of erotic arousal for both sexes including showing and examining genitalia with friends and mutual touching. Same-sex encounters are common because of the availability of willing peers but decline with age because it is usually socially unacceptable to engage in same-sex behavior. Self-exploration of the genitals is common, beginning around 8 to 10 months (Kinsey, et al., 1948). Erotic feelings are stronger in 2- to 4-year-old children, which may be the result of the high levels of hormones that persist during that period. Hormone levels decrease after 5 years of age and remain low until prepuberty, which could be a basis for the less erotic interest observed during those years (Yates, 2004).

Most children learn about their birth sex, gender, and gender role expectations during early development (Grossman & D'Augelli, 2007). Most 2-year-olds know whether they are girls or boys. Children use the pronouns “her” or “him” when referring to females or males by the age of 3 (Grossman & D'Augelli, 2007). Children do not understand that their sex is constant and not subject to change with characteristics such as hair length until age 6 or 7 (Egan & Perry, 2001).

Many children show gender-nonconforming behavior by 2 to 3 years of age, causing parents and society to start shaping behavior to fit what they consider normal early in the child's life. Gender-nonconforming children begin to “foreclose” on their identities, or turn off what they themselves consider normal and desirable at this early age (Piper & Mannino, 2008). Many children experience a great deal of sex and gender confusion before sorting out self-identity. Experimentation with cross-dressing and playing with toys of the other sex are examples of gender-nonconforming behaviors that are natural to all children (Mallon & DeCrescenzo, 2006; Piper & Mannino, 2008). Activities usually attributed to the other sex such as sports or dance may partially define a child. Society rewards parents for raising conforming children (Mallon & DeCrescenzo, 2006), so the pressure to conform begins early in life for both

children and parents. There does seem to be a consistent difference in the literature between societal expectations of boys' and girls' behavior; boys are expected to be more conforming, and girls have more latitude.

Most studies that have explored gender-nonconforming children have relied on adult recollections of childhood experiences and feelings, which may be distorted (Carver, Egan, & Perry, 2004; Grossman & D'Augelli, 2006; Savin-Williams & Cohen, 2004). These studies also tended to include clients who attended gender identity or mental health clinics. One study addressed the problem of retrospective bias by coding childhood videos of adults who later had strong sexual identities. The purpose was to explore the link between childhood gender nonconformity and sexual orientation. "Prehomosexual" children were reported to have more gender-nonconforming behaviors than "preheterosexual" children, with similar patterns for girls and boys that persisted into adulthood (Rieger, Linsenmeier, Gygax, & Bailey, 2008).

A few prospective studies have now focused on gender-nonconforming or "atypical" behaviors in adolescents and children and have eliminated recall bias. These studies should assist in learning more about the developmental nature of identity development. Studies that explore the development of gender identity and/or sexual orientation of future sexual minority youth are relevant to transgender children because of the intrinsic feelings and psychosocial adjustment related to expression of gender-nonconforming behaviors.

Gender Identity Development and Adjustment

Two major research groups have published contributory results in the last decade regarding gender identity development and awareness in children and transgender adolescents. In Egan and Perry's original study (2001), 182 children (101 girls, 81 boys) in grades four through eight self-appraised their gender identity and psychosocial adjustment. The components of gender identity assessed were (a) feelings of psychological compatibility with one's gender (i.e., feeling one is a typical member of one's sex and feeling content with one's biological sex); (b) feelings of pressure from parents, peers, and

self to conform to gender stereotypes; and (c) the sentiment that one's own sex is superior to the other (i.e., intergroup bias). Adjustment was assessed in terms of self-esteem and peer acceptance. Felt gender compatibility was positively related to adjustment, whereas felt pressure and intergroup bias were negatively associated with adjustment (Egan & Perry, 2001).

The second study by this group was important because it described key developmental aspects of gender identity development between the preschool and preadolescent years (Carver, Younger, & Perry, 2003). The researchers offered support for the construct and discriminant validity of the various gender identity dimensions of a multidimensional model. They reported that preschoolers tended to play with same-sex peers, which was important because it reflected that the girls and boys were socialized differently into gender-conforming roles and rules. Carver et al. (2003) noted that, "Strong felt pressure for gender conformity also is normative for young children, who tend to regard gender stereotypes as moral imperatives" (p. 97). This may explain why it is so important to children to know what someone's gender identity is. Gender contentment or dysphoria is also apparent in the preschool years. In the school-age years, children relax gender rules and see gender conformity as more of a choice (Carver et al., 2003). The same-sex peer group continues to be a major source for socialization, but advances in cognitive development lead children to see stable traits in themselves. School-age children want to fit in, so this becomes a challenging time for gender conformity (Carver et al., 2003).

Younger, Carver, and Perry (2004) discussed the influences of gender identity on changes in adjustment in the original cohort over a 2-year period. Data on three measures of gender identity (i.e., felt gender typicality, contentment with gender assignment, and felt pressure for gender conformity) and four measures of adjustment (i.e., self-esteem, internalizing symptoms, externalizing symptoms, and acceptance by peers) were obtained. Low gender typicality, low gender contentedness, and high felt pressure all predicted decreases on one or more indexes of adjustment. The combination of low gender typicality with high felt pressure to

conform was particularly associated with internalizing problems (Yunger et al., 2004). Interestingly, children who viewed themselves as gender-typical showed an unexpected increase in externalizing symptoms.

These collaborators also published a subanalysis of the same dataset (Carver et al., 2004). They tested hypotheses about the correlates, causes, and consequences of childhood questioning of heterosexuality. Questioning was brought on by same-sex attractions and same-sex sexual exploration or if the child was teased or exhibited cross-sex behaviors in play activities, friendships, interests, mannerisms, or styles of speech. Heterosexual-questioning children reported more impaired self-concepts, fewer same-sex-typed attributes (but not more cross-sex-typed attributes), a greater sense of feeling different from other same-sex people, and less satisfaction with their gender assignment.

In 2007, Corby, Hodges, and Perry (2007) reported results from a study of 863 Black, White, and Hispanic fifth graders (mean age = 11.1 years). The authors reported that the relationship between gender identity and adjustment varied across ethnic and/or racial groups, indicating that Egan and Perry's (2001) model required revision. The results suggested that the meanings that a child attached to gender varied across and within racial and/or ethnic groups and that the implications of gender identity for adjustment depended on the specific attributes that the child regarded as desirable for each sex.

The Egan and Perry (2001) multidimensional model is helpful in that it assists in understanding gender identity and implications for adjustment. The collaborative team's program of research has suggested that different facets of gender identity serve different psychological functions, follow different developmental trajectories, or affect adjustment in different ways. The results have also suggested that appraisals of the self as gender-typical and contentment with one's gender assignment are thought to be positive influences on adjustment, whereas feeling strong pressure for gender conformity is believed to be a negative influence. There are unexplored differences in ethnic and racial differences. These results take on added significance through the adolescent years.

Although this information may help to understand how transgender children are likely to manifest their true selves and the negative effects of societal expectations early in life, it is important not to mislabel transgender children as lesbian or gay. The reverse is also true: lesbian and gay children should not be mislabeled as transgender. A helpful distinction between transgender and lesbian or gay children has been offered by Mallon and DeCrescenzo (2006), who wrote that some gender-atypical children may say they *wish* they were the other sex, but transgender children will say they *are* the other sex. Other studies have not supported this supposition because "wishing" has been prevalent among transgender youth in research studies.

Awareness of Gender Identity and Sexual Orientation

Studies have reported various ages of awareness of gender identity and sexual orientation. Grossman and D'Augelli (2006) reported that transgender youth ($N = 31$) in their study were first aware that their gender identity or expression was not the same as their biologic sex at a mean age of 10.4 years (range = 6-15 years). The youth first realized that other people labeled them as transgender at a mean age of 13.5 (range = 7-16 years). About a year later, youth first labeled themselves as transgender (range = 7-18 years) and made their identity known to others by cross-dressing or seeking hormones.

Grossman, D'Augelli, and Salter (2006) reported that all MTFs were called sissies in middle childhood, suggesting that the term had significance and could be helpful in assessing risk. Awareness of personal sexual orientation in transgender youth was reported to occur between ages 4 and 9 or between ages 13 and 15 when they were physically attracted to others of the same sex.

In a survey of LGBT college students, most became aware of their same-sex attraction at ages 10 to 14 years and "came out" at ages 15 to 18 (Lindley, Nicholson, Kerby, & Lu, 2003). Reactions ranged from sadness and withdrawal to happiness when they discovered a same-sex attraction (Grossman & D'Augelli, 2006). This same-sex attraction and the display

of nonconforming social and sexual behaviors in childhood led to much confusion about gender identity and sexual orientation.

Adolescent Sexual Development

All adolescents have sexual lives, whether with others, themselves, or through fantasies (Ponton & Judice, 2004). A vital part of adolescence is spent thinking about and experimenting with areas of sexuality. It is through experimentation and risk-taking that adolescents develop their identities and discover who they are and will be. Risk-taking also involves making mistakes, sometimes serious ones, but it is the tool of discovery and growth for adolescents. Discoveries, and possibly mistakes, are key factors for youth who are participating in many sexual activities for the first time. Risk-taking also involves the development of personal risk-assessment skills for all types of behaviors (Ponton & Judice, 2004).

Considerations of one's sexual self can be either a large or small part of the overall identity of adolescents. Aspects of adolescent sexual awareness include self-esteem, desire, and fantasy life; sexual orientation; biologic factors including a capacity for physical pleasure and orgasm; sexual drive and the level of physical development; fertility and reproduction; sexual style (includes how one makes sexual decisions [e.g., adventurer, exploiter]); sex or gender role; patterns of developed sexual behavior; relationships with sexual partners, parents, and others; life events such as severe trauma; and spirituality (Ponton & Judice, 2004, p. 497).

Sexuality can potentiate positive experiences in the lives of adolescents, although very little support is present in our culture to make sex growth-affirming for them (Moser, Kleinplatz, Zuccarini, & Reiner, 2004). Boys may be made to feel ashamed of having erections, and girls may learn to feel that their sexual desires are dangerous. Masturbation may be the most common sexual behavior among youth, but adolescents are often conflicted about masturbation because they learn that it is morally wrong in most religions but have difficulty in refraining. Youth are expected to control their sexual conduct without being told how to manage their desires (Moser et al., 2004).

Just as sexual orientation may be more fluid than was commonly believed, sexual behaviors can be

extremely fluid. Internalized homophobia might lead some adolescents to explore heterosexual acts even if they prefer same-sex partners, reject sexual activity altogether, or act out aggressively against those who are perceived to be homosexual. Alternatively, peers may exert extreme pressure for adolescents to engage in sexual acts in which they have no erotic interests (Moser et al., 2004).

Transgender youth (but not intersexed youth) experience the same hormonal influences as other adolescents. However, the focus of transgender life is not on sexual behavior, although society often frames transgenderism as such. Everyone's sexual identity is a part of self-identity, but it is certainly not all of it.

Challenges in Development of Transgender Youth

Developing a Transgender Identity

Developing and integrating a positive identity is a developmental task for all adolescents. However, transgender youth have the challenge of integrating a complex gender identity with their personal characteristics, family circumstances, and cultural and ethnic backgrounds (Grossman & D'Augelli, 2006). They also must reconcile their gender identity with gender expectations of their biologic sex. This should include the gradations between the inner experience of gender identity and masculinity and/or femininity (Bailey, 2003). However, gender identity is not a binary characteristic—not just female or just male. Transgender youth must also resolve their gender identities with sexual orientations.

Grossman et al. (2006) conducted a study to explore gender expression milestones in a sample of MTF transgender youth. Thirty-one youth, aged 15 to 21, participated in focus groups. In this sample, all the youth preferred the term *transgender* for themselves. Consistent with other literature that has suggested that wishing one had been born the other sex was typical (Mallon & DeCrescenzo, 2006; Piper & Mannino, 2008), only one youth reported never wishing being born the other sex. Of the 31 participants, 14 (45%) identified as heterosexual, eight (26%) as gay, four (13%) as bisexual, one (3%) as

lesbian, and four (13%) not wanting a label. Being able to “pass” as the preferred gender is an important milestone for transgender people; 10 youth indicated that strangers would “never” identify them as transgender, and only one participant reported “always” being able to be identified. Twenty-five of the participants (81%) said they always liked to wear clothes of the other sex, and 29 (94%) of the MTF youth described themselves as female (Grossman et al., 2006).

Disclosure

Grossman and D’Augelli (2006) conducted another study using three focus groups with eight transgender youth (83% anatomical males, 17% anatomical females of mixed gender identities; 90% youth of color; ages 15-21 [$M = 16.5$, range = 15-20]) in each ($N = 24$). They reported that disclosing transgender status or having others disclose it were important concerns for transgender youth. They reported that the groups to whom the youth were most likely to disclose their transgender identity were friends (83%) and teachers (75%). Two thirds (66%) had disclosed to their parents or siblings, 50% to grandparents, and 63% to aunts or uncles. However, the youth reported that discrimination and victimization were frequent outcomes of disclosure. As one of their participants reported, “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 (Grossman & D’Augelli, 2006, p. 125). However, some of the youth did perceive support from peers, transgender peers, extended family members, teachers, and lovers (Grossman & D’Augelli, 2006).

Discrimination and Victimization

Transgender youth constantly confront socially expected gender norms. Exhibition of gender-atypical behaviors makes transgender youth vulnerable to victimization, especially by parents and peers. They also face significant discrimination at home as well as in school, employment, and health care, and are frequently targets of abuse (Grossman & D’Augelli, 2006). It is difficult for transgender youth to feel

safe. Places that should provide safety for youth are often places where verbal and physical abuse occurs. These settings can include schools, after-school programs, health care centers, social service agencies, group homes, homeless shelters, and foster care homes and agencies.

Ryan and Rivers (2003) provided an extensive review of the literature that documented the frequency of violence, discrimination, harassment, and serious negative outcomes against LGBT youth. They included the National Longitudinal Study of Adolescent Health (Add Health, n.d.). Add Health is the largest, most comprehensive nationally representative longitudinal survey of adolescents ever undertaken and is the only adolescent study that asks all respondents about romantic attractions. Other studies from the United States and United Kingdom were also included in the analysis, and all pointed to the magnitude of victimization of LGBT youth, particularly in school and community settings. Anecdotal evidence suggested that transgender youth were even more vulnerable than their LGB counterparts. Likewise, Varjas et al. (2008) presented a review article on the causes, risk factors, and consequences of verbal and physical bullying of sexual minority youth in schools and proposed a research agenda for future investigations in this area.

Grossman and D’Augelli (2006) reported that transgender youth feared that the constant verbal harassment and discrimination they faced might escalate into physical violence and sexual abuse because they found themselves being continually sexually objectified and regularly propositioned for sex. Youth also expressed resentment for not being seen for their other personal qualities but rather only for their gender and sexuality. Some youth also experienced rejection within the LGB community based on their racial or ethnic background and/or gender identity. Many youth in the sample had experienced serious academic problems and had dropped out of school because of the lack of support at home and stigmatization at school.

In the previously discussed study of MTF transgender youth (Grossman et al., 2006), victimization had an onset at a mean age of 13 years. Twenty-seven (87%) of the 31 youth had experienced verbal abuse including being called names, teased, or threatened with physical harm. Physical abuse had

a mean age of onset of 14 years. Eleven (35%) reported past physical abuse, including being punched, kicked, beaten, or hurt with a knife, gun, stick, bat, or other weapon. The perpetrator was male in 91% of these events. Five participants (16%) had experienced past sexual abuse or rape, all by male perpetrators. Verbal harassment was inflicted upon 24 (77%) youth by parents and/or stepparents, 15 (48%) by brothers or sisters, and 20 (65%) by police officers. Abuse by the people who are supposed to help or love you is a grave concern and provides a reason for why so many transgender youth leave home. Hence, discrimination and victimization frequently set into motion a chain of events that can result in a host of challenges for transgender youth including homelessness, isolation, limited educational opportunities, unemployment, a need to engage in sex work and other illicit means for survival, and substance abuse.

Lack of Role Models

There are few role models for transgender youth. There are increasingly more transgender people portrayed in movies and on television. Some youth are fortunate to live in urban areas with a transgender community, sexual minority youth group, or a school-based gay-straight alliance group. For example, Grossman and D'Augelli (2006) reported that half (54%) of a sample in New York City indicated that they spent time with other transgender people every day, and 44% indicated that they spent some time with transgender people on a weekly basis. More than two fifths (42%) reported that they belonged to transgender groups.

Some youth prefer role models in their felt gender. It is possible that the Internet will open up more possibilities for online communities because it has provided more readily available information in many other areas. Adolescents who find a community of others who share their interests may do better psychosocially than those who are isolated (Moser et al., 2004).

Mental Health Issues

Grappling with gender identity, issues related to disclosure, discrimination and victimization, and

lack of role models also challenges the mental health of transgender youth. Without adequate coping mechanisms and support, low self-esteem, depression, and substance abuse may result. Grossman and D'Augelli (2006) documented that a lack of mental health resources was identified as a major unmet need by transgender youth.

Suicide risk and suicide are of tremendous concern for all adolescents, and much more so for sexual minority youth. Suicide is the third most common cause of death for adolescents. Many studies have reported related risks and data for LGB youth, but only one was found for transgender youth. Grossman and D'Augelli (2007) studied 55 transgender youth (31 MTF, 24 FTM). Nearly half (45%) had seriously contemplated suicide, and more than one quarter (26%) had actually attempted suicide. Significant factors involved in the suicide attempts included ideation related to transgender identity, experiences of past parental verbal and physical abuse, and low body-esteem related to both how others viewed their bodies and their own weight satisfaction. The youth considered themselves as having a high risk of self-harm because of the pressures their families and communities placed on them to conform and their religious backgrounds. Most coped by seeking supportive others (e.g., counselor, psychologist, social worker, or minister). Recommendations for interventions included the following:

1. Education programs for parents and other guardians about their transgender children and the negative outcomes of psychological verbal or physical abuse.
2. Psychoeducation programs for transgender youth about approaches to changing their bodies incrementally so that they gain higher body esteem by knowing they would be able to facilitate change over time.
3. Intervention programs for transgender youth with personal conflicts and distress related to a transgender identity to enhance the ability to cope with the stress of living as a transgender person.
4. Training programs for mental health professionals (e.g., counselors, social workers, psychologists, psychiatrists) to increase their abilities to work with transgender youth and

their parents and guardians to reduce psychological distress and decrease the likelihood that youth will engage in life-threatening behaviors.

5. Training mental health professionals to recognize and treat mental health problems, such as bipolar disorder and major depression, specifically associated with individuals who are at risk for suicide (Grossman & D'Augelli, 2007, p. 536).

Health Care Barriers and Issues

Many transgender people seek services from lesbian- or gay-sensitive service providers. Transgender people are generally more stigmatized than lesbians and gay males in society and often need more support and a variety of services. The choices for care are even more limited for adolescents and young adults with few resources. In a small focus group conducted with two White FTMs and two Black MTFs aimed at identifying barriers to health care in an LGBT community health center, the youth reported that many transgender peers did not seek health care because of earlier incidents of discrimination (Stieglitz, 2004). They also reported that waiting rooms with positive images of sexual minority youth and trans-friendly brochures would be viewed as a positive environment and that they needed supportive providers. Neither the FTMs nor the MTFs had any idea of the other group's issues or concerns, nor had they ever engaged in a conversation with members of the other group. This result suggested that the two subcommunities were strikingly different. It was apparent that transgender life experiences of the participants had also been influenced by race and socioeconomic status (Stieglitz, 2004).

Grossman and D'Augelli (2006) reported on focus group results in which transgender youth identified four problematic areas related to health care: safety issues, including the lack of safe environments; poor access to physical health services, including HIV and sexually transmitted disease (STD) counseling and testing; inadequate resources to address mental health concerns; and a lack of continuity of caregiving by families and communities. Participants

also reported that they feared discrimination by health care providers. The strong negative reactions they had experienced when disclosing gender and sexual identities had negatively affected their self-esteem. The lack of competent mental health services was internalized by participants as reflective of their marginality and lack of value to society (Grossman & D'Augelli, 2006).

Health Care Treatment and Legal Issues

Transgender youth also are challenged by the protocol for managing gender identity disorder. The World Professional Association for Transgender Health (formerly Harry Benjamin International Gender Dysphoria Association) has recommended that treatment of minors should only involve counseling and reversible medical interventions necessary to decrease distress to protect youth against irreversible decisions (Beh & Pietsch, 2004). The World Professional Association for Transgender Health acknowledged that in some instances, adolescents at age 16 years and with parental consent may begin partially reversible interventions such as masculinizing or feminizing hormone treatment. They advised against surgery before an individual experienced at least 2 years in the preferred gender role and was at least 18 years old (Beh & Pietsch, 2004). Some youth preferred starting on hormones before puberty so that they had fewer body changes with which to contend, such as increased musculature, more body hair, deepened voice, and narrower hips (Stieglitz, 2004).

The legal status of children (generally defined as youth under the age of 18) in matters of sex, reproduction, gender, and orientation hold competing interests for stakeholders (Beh & Pietsch, 2004). The major issues seem to be (a) privacy and autonomy of individuals, (b) states' interests in promoting public health and community values in sexual conduct, and (c) a discord between children's legal status and physical and psychological maturity levels. Laws related to sex, reproduction, sexual identity, and gender are often unpredictable and variable. Ambiguity regarding the legal status of children and adolescents is complicated by values and morals. Society holds the view that parents should be involved in decision making and that adolescents

should be discouraged from having sex but also attempts to acknowledge the reality of adolescent behavior and expression. Many states permit adolescents to obtain treatment for STDs, including HIV, and pregnancy without parental consent. Twenty-one states allow pregnancy terminations without parental consent, whereas 22 require parental notification (Beh & Pietsch, 2004). The legal prescription of hormones for transgender minors is controversial if parents or guardians are unwilling or unavailable to provide consent. State guardians are often reluctant to approve hormone use because of the somewhat unpredictable effects and unknown long-term consequences of hormone use. However, seeking hormone therapy is often what brings transgender youth into health care and is the link for them to obtain other health care services, including HIV counseling and testing.

Transgender Youth and HIV Risks

Transgender youth are concerned about acquiring HIV and other STDs (Grossman & D'Augelli, 2006). Sex partners often do not perceive MTF as health risks because they cannot become pregnant and think of them as being sexually less inhibited because they are transgender. Sex partners then expect unprotected sexual activity, and resisting that expectation can lead to sexual abuse and other forms of violence. HIV risk among FTMs is not well understood because much of the research has focused on MTFs (Morgan & Stevens, 2008). There is a common assumption that FTMs are lesbian or engage in only female body to female body sex (Kenagy & Hsieh, 2005). Because many only consider factors such as sex with men and history of an STD as HIV risk factors among lesbians, FTMs are generally not considered to be at risk. However, FTMs have a range of sexual orientations like those in other groups and can be heterosexual, bisexual, lesbian, or gay (Kenagy & Hsieh, 2005).

A study was conducted to describe the life context and HIV-related risk behaviors of MTF youth of color in a convenience sample of 51 participants (median age = 22 years, range = 16-25; Garofalo, Deleon, Osmer, Doll, & Harper, 2006). Data were collected at two community-based sites in Chi-

cago using an anonymous questionnaire that included demographic variables, psychological measures, and items on substance use and sexual risk behaviors. In contrast to other studies of sexual minority youth, scores for depression and self-esteem were reported to be within the range of the general population. Major life stressors included lack of transportation (65%), difficulty finding a job (63%), sex in exchange for resources (59%), being frequently bothered by the police (53%), forced sexual activity (52%), difficulty finding a safe place to sleep (46%), difficulty accessing health care (41%), history of incarceration (37%), and homelessness (18%). Friends, rather than family, were the most frequently cited sources of social support, money, or "other things." More than two thirds of the sample reported that mothers were at least "somewhat" helpful, whereas 69% reported that fathers were unavailable for emotional support. Physicians or case managers were perceived as at least "somewhat" helpful in terms of emotional support by over 60% of the sample. (Note: no data were reported for nurses.)

The youth reported high rates of substance use and HIV risk, which did not vary with age. Marijuana and alcohol were the most commonly reported substances used in the previous year. Forty-four percent of the sample injected hormones, and 29% injected silicone; 8% indicated that they shared needles and syringes to inject hormones or silicone. Of 51 participants, 50 reported having sex with men within the previous year. Risk factors for HIV infection included sex in exchange for money, drugs, or shelter; forced sexual intercourse; and unprotected oral or anal sex. More than one fifth (22%) of the sample self-reported that they had been diagnosed with HIV infection (all but one were African American), and 12% had been diagnosed with an STD in the previous year. In contrast to results from studies of adults, having unsafe sex because of new and improved HIV medications was not a reason for inconsistent condom use (Garofalo et al., 2006). In summary, these results suggested that transgender MTF youth had high rates of daily stressors, substance use, HIV risk through unprotected anal intercourse and needle sharing, risk of migrating silicon, and sexual victimization. However, in spite of these risks, they

had a high degree of support from friends and had depression and/or self-esteem scores comparable to the general population (Garofalo et al., 2006).

Resilience as a Mitigator of Risk

Unfortunately, most of the literature on transgender youth has concentrated on their risks rather than their strengths. This focus provides a limited, negative view of the life contexts of transgender youth. Dyer and McGuinness (1996) noted that difficult issues and risks are inherent in everyone's life, although some people are more vulnerable than others. These investigators defined the concept of resilience as a process whereby people overcome and bounce back from adversity and argued that "...the identification of protective factors associated with competence in high risk individuals has important implications for primary, secondary, and tertiary prevention" (Dyer & McGuinness, 1996, p. 281). In addition to individual characteristics such as a sense of self and determination, they also indicated that it would be important to consider situational demands and the social environment when evaluating risk and resilience.

The concept of resilience grew out of the discipline of developmental psychopathology to help explain why some children and adolescents who face adversity early in life go on to do well whereas others do not. Tusaie and Dyer (2004) noted that the domains of resilience were developmentally appropriate and changed with different life stages. For example, children who function well in school and in peer relationships in spite of risk exhibit resilience. However, in adolescence and young adulthood, resilience may be reflected by achievement in career development, happiness, relationships, and physical well-being in the presence of risk factors. Therefore, resilience is complex and dynamic rather than static. These authors also noted that resilience had been studied most in relation to developmental (e.g., school entry, individuation from parents) and situational (e.g., disaster, family disruption) transitions. Hence, resilience is a particularly relevant concept in assessing and intervening with transgender youth who are at various stages in the process of transitioning from one gender to another.

Ahern, Kiehl, Sole, and Byers (2006) presented a systematic review of six instruments used in clinical and research contexts to measure resilience in adolescents. They concluded that the Resiliency Scale, a 25-item measure with two factors (personal competence and acceptance of self and life), developed by Wagnild and Young (1993) was most suitable for use with adolescent populations. However, this instrument would need to be tested in samples of transgender youth. Subsequently, Ahern, Ark, and Byers (2008) published a review and summary of literature on resilience and coping strategies in adolescence and offered recommendations for promoting resilience in adolescents in nursing practice and research.

The concept of resilience as a counterbalancing force to risk and vulnerability has also been explored in the HIV literature (De Santis, 2008). Using a case study approach, Dyer, Patsdaughter, McGuinness, O'Connor, and De Santis (2004) documented how providers served as role models and supporters in the development of resilience in HIV-infected adults who were members of marginalized populations. However, many of these strategies may need to be adapted for use with transgender youth who are at risk for or infected with HIV, particularly as Dyer and McGuinness (1996) noted that the "presence of at least one caring, emotionally available person at some point (even briefly) in the person's life" (p. 277) was a necessary prerequisite to the development of resilience.

Discussion

Clearly, much research needs to be conducted with and for transgender children and adolescents. Because individuals are not identified as transgender until late childhood through middle adolescence, it is an extremely hard-to-reach population. Large-scale, longitudinal studies with convenience samples are needed from which gender-nonconforming youth can be identified. Despite this challenge, some early work has documented psychological difficulties at very early ages. These difficulties stem from cultural expectations for gender norms that may conflict with what children feel is true of themselves and with how content they are.

Table 1. Internet Resources for Transgender Youth and Health Care Providers

Resource	Content	Web Site
Transgender Awareness Training and Advocacy	Samuel Lurie's Web site contains links to resources on general health care, HIV, family and ally support, youth, education, policy change, and other training and education resources.	http://www.tgtrain.org
TransProud	Web site of OutProud, The National Coalition for Gay, Lesbian, Bisexual Transgender Youth contains news, publications, a link for parents, health information and resources, school information, communication forums, and links to other transgender sites.	http://www.transproud.com/
TransYouth	Web site created and maintained by Lydia Sausa, PhD, MS Ed, contains links, information, and resources on coming out, transpride, health care, body modification, dating and sex, school, work, and more.	http://www.transyouth.com
Youth Resource	A project of Advocates for Youth: A Web site by and for gay, lesbian, bisexual, transgender, and questioning youth; contains links to information and resources on health including transgender health, HIV, STIs, and healthy living; also has links to information on advocacy, queer living, news, and peer support.	http://www.youthresource.com/
WPATH	World Professional Association for Transgender Health; includes the Standards of Care for Gender Identity Disorders (6th edition), which provides information on psychiatric, psychological, medical, and surgical management of gender identity disorders.	http://www.wpath.org/

NOTE: STI = sexually transmitted infection.

By adolescence, many sexual minority youth have clinically diagnosed depression as well as abnormally high rates of suicide ideation, attempts, and completion. The literature on transgender youth has documented high rates of verbal harassment, physical abuse, bullying, and violence. Although no studies were found that identified a direct link between early life sanctions for nonconforming behaviors and later abusive acts of discrimination and victimization, there is a plausible association that needs to be further explored through research studies.

The simplest solution to decrease social sanctioning and acts of discrimination would be to accept people for who they are and value the diversity brought to communities. Given limited power to effect such changes, health care providers can first be role models of acceptance in professional and social settings. Second, health care providers can be authors or advocates of policies that are based on social justice and evidence-based research. Policy extends the rights of transgender people further than individuals can do alone and can provide further protection from discrimination than is currently available. A number of transgender activist groups are willing to assist in policy formulation and are also amenable to working with practice settings to

help decrease barriers and improve health care access.

It is important to understand the developmental stages of gender and self-identity to frame why transgender youth are more vulnerable to risk factors associated with acquiring HIV infection. The stigma and discrimination with which transgender children must cope begin at a very young age, perhaps as early as preschool and kindergarten. By middle childhood, many children have experienced verbal and physical abuse in places in which they should feel safe (e.g., at home and in school). Research has shown that psychological distress, beyond personal confusion about identity, is present at this stage of development. By adolescence, the time of increasing independence and autonomy, youth are more confident in exploring cross-gender behavioral expressions, including cross-dressing and sexual attractions. Physical abuse, bullying, and verbal harassment also increase with more obvious cross-gender expression. Alcohol and illicit drugs are more available, and youth often use substances to cope with increasing stressors.

Transgender youth are often falsely perceived by others as being more promiscuous or sexually daring,

which places them at risk for rape and other forms of sexual abuse. They are at risk for HIV, other STDs, and chemical dependency at an early age. Some youth are ejected from their families because of parental, most often paternal, inability to cope with transgender children and fear of societal repercussions. Homelessness and a lack of resources ensue, so youth may turn to sex work to support themselves, further increasing the risk for HIV infection. Depression has also been shown to be a major risk factor for acquiring HIV. Transgender youth have tremendous challenges to maintaining mental and physical health and are vulnerable to all the known risk factors for HIV infection.

A major factor for youth resilience seems to be social support, primarily from family and friends. Emotional support and acceptance serve as protective factors, along with ongoing support in terms of housing, food, clothing, and education. Many transgender youth would be more likely to seek health care if providers were also supportive, accepting, and shared needed resources (see Table 1). Providers should also attempt to identify and promote competencies, protective factors, and strengths as components of resilience in addition to assessment and intervention in areas of risk.

Nurses and other health care providers can become more knowledgeable about adolescent transgender health and be sensitive to cultural differences between transgender youth. It is important for providers who work with youth to become familiar with legal consent issues in their states. Providers should also become knowledgeable about the use and prescription of hormones. Billing for services should be flexible, because inadequate resources are often an issue. Skill in obtaining sexual histories and use of appropriate language (e.g., the term “protection” for condoms and contraceptives and “partner” rather than girlfriend/boyfriend) are important. Providers should ask which name and pronoun a person prefers and recognize that there are multiple steps in transitioning. Explanations about specific sexual behaviors and needle use practices should be sought to ascertain risk. Finally, transgender youth need risk reduction education along with appropriate referrals for health and social services. The health and well-being of transgender youth will be greatly enhanced by more transgender-competent providers.

Clinical Considerations

- Nurses and other health care providers should become familiar with developmental trajectories of transgender youth.
- Transgender youth may have many risks for HIV infection including unsafe sexual practices; mental health issues such as depression, substance abuse, and victimization; participation in sex work; and needle sharing.
- Transgender youth need access to resources and services that meet specific needs, including sensitive and effective physical health care, mental health services, schooling, employment, and housing.
- Nurses and other health care providers can help improve quality of care for transgender youth by removing barriers, becoming knowledgeable and skillful in adolescent and transgender health, and adhering to standards of professional practice.
- Peer, family, and professional support are important to the mitigation of risk and development of resilience in transgender youth.
- When not contraindicated, hormone prescriptions may help reduce harm from street hormone use and needle sharing, although state statutes on youth consent and treatment must be considered.

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