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Familial Rejection and Psychological Distress Among Young Transgender Women in Chicago and Boston

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Bachelor of Arts, English Literature and Communications
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2006

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Purpose: The central aim of this analysis is to investigate the association between transphobia, sex work, familial rejection and psychological distress and social support, among young transgender women (YTW) aged 16-29.

Methods: These data were collected via in-person surveys. A total of 300 YTW ages 16-29 were recruited through multiple convenience and referral-based sampling techniques and were enrolled over a period of 36 months. Three surveys were incomplete, thus this analysis examines data from a sample of n=297 YTW. Two outcomes were modeled using multivariate regression: self-reported psychological distress and social support. Key covariates included internalized, perceived, and experienced stigma; history of sex work, and relationship equity. Models controlled for age, race/ethnicity, and education.

Results: Nearly half of the sample reported a history of sex work (n=147), and more than 30% reported having attempted suicide in their lifetime (n=90). In this sample, 39.4% (n=117) reported at least one instance of familial rejection from an immediate family member. Women who reported instances of familial rejection experienced a 6.23 unit increase in psychological distress (95% CI: 2.38, 10.08; p: 0.002).

Conclusion: There are significant gaps in the literature addressing transgender health, and too few studies explore familial rejection and psychological distress among transgender women with a history of sex work. The strong association between familial rejection and experiences of psychological distress and suicidality highlights a need for more research. This finding also suggests a critical gap in education for the families of YTW, which could be addressed through evidence-based public health interventions.

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It would not be possible for me to thank everyone who contributed to this project, here, but there are a few people who have been absolutely critical to its success. I am thoroughly indebted to Professor Rob Stephenson, my thesis advisor, whose guidance, advisement, and mentorship helped significantly to make my desire to work in transgender health a reality. I am also grateful to Professor Roger Rochat, whose constant encouragement and support has been a treasured part of my time at Rollins. Stephanie Miedema's contributions in the planning stages of this project, as well as during my analysis, were invaluable.

I would like to thank the faculty and staff of Emory University Rollins School of Public Health, especially those in the Hubert Department of Global Health, for supporting a rigorous academic atmosphere that encourages creativity, requires integrity of character and spirit, and provides safe spaces for students to challenge the status quo and to demand critical inquiry. Without my incredible friends, both at Emory University and elsewhere, who have listened to me when I was struggling and who have supported me in my achievements, this project would have lacked inspiration.

Sincere thanks, as well, to the young women who participated in this research study, whose experiences I have done my best to understand and to illustrate in my analysis.

Lastly, I would like to thank my family – my brothers, Conor Scully and James Nicholas Scully, my parents, Sean and Melissa Scully, my best friends, and colleagues throughout this incredibly challenging and rewarding graduate study experience, Candace Girod and Michael Vaughn, and lastly, my partner, Lisa Ortega, who is my rock and whose generosity and selflessness I can only hope to emulate in my life.

***

in memoriam Jenrose Weldon and Shirley Scully, my grandmothers, who loved their children and grandchildren fiercely, and who both worked, in their own ways, to make the world a better a place for women.

TABLE OF CONTENTS

Author's Note: The term LGBT (lesbian, gay, bisexual, transgendered) has emerged as an umbrella term for persons expressing non-heterosexual sexualities and/or gender identities. Within this group, young transgender women (YTW) are often described as part of a larger community of LGBT people, which encompasses both self-identified homosexual/gay and bisexual individuals and individuals who identify as queer, questioning, heterosexual, transgendered, pansexual, down low, different gender loving, or any other non-straight sexual orientation, including asexuality. This group also encompasses individuals who self-identify as gender queer, non-binary, and anyone who identifies as somewhere along the gender continuum. While YTW are identified as a major risk group for HIV/AIDS incidence and violence, this paper seeks to examine the unique situation of transphobia, relationship equity, history of sex work, social support, and psychological distress as they relate, specifically, to communities of self-identified young transgender women. Terms will be used where appropriate.

CHAPTER I: INTRODUCTION

Negative health outcomes experienced by young transgender women (YTW) as a result of transphobia, stigma, and familial rejection cause lasting damage and are directly connected to the high prevalence of suicide observed within this population.[1] Among young transgender women, 41% are likely to attempt suicide and 57% report having experienced at least one instance of familial rejection, according to a 2002 report from the American Association of Suicidology.[1] An article by Kenagy (2008), reported that two thirds of its sample of YTW in Chicago disclosed having attempted suicide at some point in the past.[2] Research addressing the health outcomes of young transgender people who have experienced familial rejection was reported to be "miniscule" in the literature as of 2010, according to Ryan (2010).[3] A better understanding of the various components that contribute to healthy and unhealthy outcomes for these young women will give service providers and policy experts the tools they need to address YTW's most immediate and pressing needs. It will also provide evidence for public health practitioners to design quality and effective interventions that incorporate a nuanced understanding of the communities in which YTW live and work, and of the ways in which the intersectionality of their various identities can work to compound or alleviate the negative impacts of transphobia.

In recent years, issues relating to transgender populations in the United States have been gaining traction. While transgender health has often been included in larger discussions of Lesbian, Gay, Bisexual, Transgender (LGBT) health, transgender health is now examined as its own field of study. The reasons for this separation are varied, but research has shown that transgender people are at significantly greater risk of experiencing a number of specific health outcomes; namely

violence, sexual assault, HIV, suicidality and poor mental health.[1] Additionally, gender and sex are different phenomena requiring their own respective bodies of research and scientific study. The word "transgender" is a term for individuals whose gender identity, gender expression, or behavior does not conform to that typically associated with the sex to which they were assigned at birth.[4, 5] Gender identity and sexual identity are separate, though related, characteristics that are each associated with specific behavioral risk factors pertaining to health outcomes; thus, in this analysis we consider transgender health as separate from that of LGBT people overall.

In communities throughout the United States, transgender women experience a particularly high prevalence of various kinds of violence, including violent crime, physical assault, emotional abuse, neglect, sexual assault and rape.[6] Young transgender women (YTW) are particularly vulnerable due to factors associated with their age, their exposure to discrimination and marginalization, and their capacity, or lack thereof, to access networks of support within larger LGBT communities.[7, 8] These factors have yet to be adequately explored in the literature.[3] According to Brennan et al. (2012), "during the developmental period from early adolescence through young adulthood, many transgender women struggle to develop a coherent sense of self while addressing feelings of guilt and shame about their identities and pressures to conform to familial, peer, and gender norms."[7] These feelings of perceived, internalized and experienced stigma are sometimes referred to as transphobia - the discrimination of and negative attitudes toward individuals due to perceived gender identity and gender expression.[9] Transphobia, when considered in terms of YTW's intersectional identities – transgender, sexual minority, woman, and youth – can compound the health risks associated with this population in particular.[7]

Transgender populations have only started to attract interest from the public health research community relatively recently, and as such, the literature relating to the health of YTW is still limited. But the specific health outcomes affecting this population have been well researched over time. Numerous studies have documented an association between social support and mental health outcomes such as psychological distress, and this association has been securely established.[8, 10] According to Kawachi et al. (2001), "smaller social networks, fewer close relationships, and lower perceived adequacy of social support have all been linked to depressive symptoms."[8] Data on transgender people living in the U.S also reflect this association between social support and psychological distress.[11] In order to gain a deeper understanding about the specific lived experiences of YTW and how these experiences impact their exposure to risk, this analysis examines social support and psychological distress as two separate outcomes. The role of transphobia, history of sex work, and power within romantic relationships are all explored as potential mediators for the outcomes of social support and psychological distress, respectively.

Several studies have reported a high prevalence of engagement in sex work among YTW in the United States and have linked this prevalence to experiences of violence and psychological distress.[12-15] Among transgender women, an association between stigma and minority stress, defined by Meyer (1995), as psychosocial stress derived from minority status, has also been discussed in the literature, though not as extensively.[16-18] There are a few sociological studies examining relationship norms among transgender people, but those that look at relationship status' effect on health outcomes often explore relationships among members of the broader LGBT community, rather than considering the relationships of YTW specifically.[19, 20] To date, no published study has examined how the combination of these contextual factors – sex work,

relationship control, and experiences of transphobia – influence psychological distress and social support among YTW.

Objectives and Aims

Objective:

The central aim of this analysis is to investigate the association between transphobia, sex work, familial rejection and psychological distress and social support among young transgender women aged 16-29 using survey data collected in Chicago and Boston from an HIV/AIDS study out of Chicago's Lurie Children's Hospital (2015).

Aims:

•The analysis will investigate associations between variables related to stigma and outcomes of psychological distress and social support.

•Associations between outcomes and the following key covariates will be explored: Internalized stigma, perceived stigma, familial rejection, history of sex work, and relationship equity.

•The findings of this study will contribute to a growing body of research related to the health of young transgender people in America. It will also contribute to a broader understanding of the effects of stigma on youth. Previous studies have focused on LGBT youth, overall, and have considered young transgender women as an aggregated part of this larger whole. This study will build upon that research by studying young transgender women (YTW) separately and exploring

the relationship between familial rejection, psychological distress and social support. To the author's knowledge, no study examining this particular combination of factors has been previously conducted. This study offers the opportunity to explore wider influences of stigma and rejection on young transgender people in the U.S. and can be utilized to better support women who face discrimination associated with their gender and sexual identities. This research, in light of the epidemic of LGBT youth homelessness, suicidality and depression, is critically important to improving the health and well being of young people in America.

Transphobia – Internalized Stigma; Perceived Stigma, and Experienced Stigma

The concept of *transphobia* captures a collection of experiences and is defined by a combination of sociological, anthropological, and psychological theories regarding various types of stigma and stress experienced by persons who identify as transgender.[13, 21-23]

Discrimination and harassment are normalized experiences among sexual and gender minorities, and legislation that protects these populations from discrimination has yet to be introduced at the federal level.[1] Some States, citing a need to protect religious freedom, are moving in quite the opposite direction by legalizing discrimination against sexual and gender minorities.[24] A number of scholars have defined transphobia, but Tooru Nomoto is cited most often in the literature. Nomoto defines transphobia as "institutional, societal, and individual-level discrimination against transgender persons [that] often takes the form of laws, regulations, violence (physical, sexual, and verbal), harassment, prejudices, and negative attitudes…"[13, 25] Despite a recent and significant increase in visibility for transgender people in the United States and elsewhere,

transphobia persists around the world. Visibility, in and of itself, does very little to support marginalized communities, and can actually cause a backlash of violence and stigma.[26] More work is needed to engage transgender visibility as a weapon in the battle against transphobia and to consider strategies for intervention that go far beyond visibility alone.

Sex Work

Among transgender women, including YTW, epidemiologic evidence indicates a high prevalence of sexual risk behaviors, especially those associated with increased risk for HIV.[7, 14, 19, 22, 27-31] Rates of sexual risk behavior among YTW may be moderated by age, race/ethnicity, and psychosocial factors.[31] A history of sex work has been shown to be prevalent among young transgender women, with one Los Angeles based study reporting that sex work was found to be a central mode of employment for more than 50% of its sample of 244 transgender women.[32] A history of commercial sex work increases the likelihood that transgender women will engage in risky sexual behaviors.[12, 14] Sex workers experience higher rates of violence and sexually transmitted infections, and are often isolated from traditional networks of social support.[33-35] Among sex workers in America, transgender youth are some of the most vulnerable as many of them enter the sex industry because they have been rejected by family, are homeless, and are coerced, either by pimps or by clients, into transactional sex in exchange for food, clothing, shelter and other basic needs.[7, 14] This experience of sex work among young transgender people is often referred to as "survival sex," and is associated with increased risk of HIV, intimate partner violence, and substance abuse.[36-38] While there are a number of factors contributing to YTW's experience of risk, one important characteristic that sets these women apart is the fact

that they are youth, and that, for many of them, if they had a place of acceptance and safety among their family, there would be no reason for them to be on the streets to begin with.[3, 39] Commonly, within this population, young women are rejected by the social networks upon which they depend as young people, they become homeless as a result of this rejection, and are then at risk of relying on survival sex simply to stay alive.[36-38]

Relationship Power

Power differentials in relationships can impact the nature and quality of those relationships and can put those on the least empowered end of the spectrum at increased risk of experiencing intimate partner violence (IPV) and other negative health outcomes.[15] Using the Sexual Relationship Power Scale (SRPS), a validated measure of relationship power developed by Pulerwitz (2001), researchers have found that the ability to negotiate condom use and elevated rates of IPV are strongly correlated with a relationship's power dynamics and this connection has been explored at length in the literature.[30, 40] This scale has yet to be widely applied to transgender populations, nor has it been used to consider relationship equity in terms of access to social support or experiences of psychological distress. Generally, mental health outcomes, such as depression, are common among women who are at an increased risk of HIV infection, and relationship power has been shown to contribute to risk of HIV infection, but the direct connection between relationship power and mental health outcomes has yet to be comprehensively drawn for YTW.[11, 13, 41, 42] Because the nature and quality of relationships are part of an individual's capacity to experience social support, they, too, can directly impact mental health outcomes among young transgender women.[13]

Chapter II: MANUSCRIPT

Familial Rejection and Psychological Distress Among Young Transgender Women in Chicago and Boston

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Contribution of the Student

The work herein is the product of a secondary data analysis performed by the student. The student did not have a role in producing the survey or the collection of data through survey implementation. However, the student did perform all work after data collection independently, including analysis of the data, the construction of regression models, summation of results in tables, and all writing. The student's thesis advisor and committee members provided advisement throughout this process.

Abstract

Title: Familial Rejection and Psychological Distress Among Young Transgender Women in Chicago and Boston

Authors: Catharine R. Scully, MPH; Rob Stephenson, PhD.

Purpose: The central aim of this analysis is to investigate the association between transphobia, sex work, familial rejection and psychological distress and social support, among young transgender women (YTW) aged 16-29.

Methods: These data were collected via in-person surveys. A total of 300 YTW ages 16-29 were recruited through multiple convenience and referral-based sampling techniques and were enrolled over a period of 36 months. Three surveys were incomplete, thus this analysis examines data from a sample of n=297 YTW. Two outcomes were modeled using multivariate regression: self-reported psychological distress and social support. Key covariates included internalized, perceived, and experienced stigma; history of sex work, and relationship equity. Models controlled for age, race/ethnicity, and education.

Results: Nearly half of the sample reported a history of sex work (n=147), and more than 30% reported having attempted suicide in their lifetime (n=90). In this sample, 39.4% (n=117) reported at least one instance of familial rejection from an immediate family member. Women who reported instances of familial rejection experienced a 6.23 unit increase in psychological distress (95% CI: 2.38, 10.08; p: 0.002).

Conclusion: There are significant gaps in the literature addressing transgender health, and too few studies explore familial rejection and psychological distress among transgender women with a history of sex work. The strong association between familial rejection and experiences of psychological distress and suicidality highlights a need for more research. This finding also suggests a critical gap in education for the families of YTW, which could be addressed through evidence-based public health interventions.

Key Words: Psychological distress; social support; familial rejection; sex work; transgender

Introduction

Young transgender women living in the United States face a multitude of health issues related to their identities; one of these is poor mental health.[4, 9, 17, 27, 43-48] Increased suicidality relative to their hetero-normative peer group is an observed result of this poor mental health, with 41% of transgender women in the United States reporting at least one suicide attempt.[49-51] The highest rates of suicidality among transgender people occur among 18-24 year olds (45%) and 25-44 year olds (45%).[1] Transgender women also experience disproportionate numbers of hate crimes, especially violent crimes, with recent research reporting sexual violence and assault at catastrophically high levels. One study authored by Clements-Noelle (2006), found that 59% of transgender people reported a history of forced sex or rape, and that same year, a study published by Garofalo (2006), found that 52% reported unwanted sexual intercourse.[6, 49, 52] More recently, the National Transgender Discrimination Survey in 2011, found that transgender women are nearly twice as likely to have been physically assaulted in a shelter (29%) compared with transgender men (15%).[1] Transgender participants for this survey were much more likely (23%) to report sexual assault than non-transgender individuals (4%), and transgender women were more likely (26%) to report sexual assault than were transgender men (15%).[1]

Background

One area of this critical research that is receiving significant attention is the poor mental health of young transgender women.[7, 43, 45] In a study published by Clements-Nolle (2001), 62% of transgender women and 55% of transgender men reported symptoms of depression, while 32%

had attempted suicide.[27] A 2007 study, published in Journal of HIV/AIDS Prevention in Children and Youth by Garofalo (2007), reported that "although self-esteem and depression were within the normal range on average, both were independently associated with unprotected anal intercourse."[53] This research suggests that the specific factors contributing to poor mental health among YTW appear to be directly associated with factors which also put them at risk of sexual violence and contracting sexually transmitted diseases.

Research related to broader LGBT populations has shown social support to be deeply connected to health outcomes.[54-58] Research around social support for young transgender women is still limited, but is growing.[11, 13, 59, 60] A study conducted by Factor and Rothblum (2008) found that an absence of social support from immediate family members was a common experience among transgender individuals and in this study, that absence was "associated with discomfort and lack of security and safety in public settings."[61] In another study published in the Journal of Consulting and Clinical Psychology, Budge (2013) reported that within their sample of 226 transgender women, compared to non-transgender individuals, 51.4% of transgender women experienced depressive symptoms and 40.4% experienced anxiety.[11] Additionally, this study found that "social support was directly related to distress variables, as well as indirectly related through avoidant coping."[11] Furthermore, familial rejection and marginalization have been shown to cause lasting damage in youth populations and have serious consequences in terms of developmental outcomes.[7]

A history of commercial sex work has also been shown to have negative health effects, especially on women, and has also been shown to impact intimate relationships for transgender

women, specifically.[12-15, 33, 34, 42] Again, studies found that transgender women who report a history of sex work experience higher rates of violence and depression and have less social capital than their non-transgender peers. In a 2011 study published in the American Journal of Public Health by Nemoto (2011), findings showed that more than half of their sample of 573 transgender women with a history of sex work experienced depression, 64% of White respondents reported that they had attempted suicide, 50% of the overall sample reported having experienced violent assault before the age of 18, and 38% reported having been sexually assaulted or raped before the age of 18.[13] The Nemoto (2011) study is the only study to the author's knowledge, which has looked at psychological distress, sex work and social support among YTW, but it did not consider familial rejection independently as a predictor of distress or support, nor did it consider relationship equity among YTW and their partners. More studies are needed to understand these associations.

This analysis attempts to understand how familial rejection is associated with psychological distress and social support, and how a history of sex work, and low relationship equity, might impact those associations. Better understanding of these associations will support work that provides informed interventions and policy recommendations that support young transgender women. This research also informs harm reduction strategies employed by various stakeholders who work in transgender health.

Data & Methods

Emory University's Institutional Review Board (IRB) approved this research. The data for this

study were collected as part of a larger study to test the efficacy of a uniquely targeted HIV risk reduction intervention for sexually experienced young transgender women, ages 16 to 29. Data were collected, per the research protocol cited here, via in-person Life Skills surveys developed by researchers at Lurie Children's Hospital in Chicago. The three-arm, randomized controlled efficacy study compares a 6-session group-based Life Skills intervention with a standard-of-care (SOC) control condition and a time-matched attention control condition. Life Skills surveys were conducted at Community-Based Organizations (CBOs) serving YTWs in Chicago and Boston, and at Lurie Children's Centers in Chicago.

YTW are a unique and hidden population, with no sampling frame, and as such, participants were recruited through multiple convenience and referral-based sampling techniques including both active and passive approaches. Research assistants, who were also members of the YTW community, actively recruited participants at local gathering spots for YTW, such as nightclubs, pageants/balls and other public places. Participants were also asked to refer eligible friends, co-workers, or acquaintances. A total of 300 YTW ages 16-29 were enrolled in this study over a period of 36 months.

Eligibility for inclusion in the study was based on the following criteria: (1) age 16-29; (2) self-identified as transgender, transsexual, and/or female with a male biological or birth sex; (3) self-reported history of unprotected anal or vaginal intercourse, anal or vaginal intercourse with more than one sexual partner, anal or vaginal sex in exchange of money, food, shelter or diagnosis with HIV or another sexually transmitted infection in the previous 4 months; (4) able to speak and understand English; (5) willing and able to provide informed consent/assent; (6) intention to

reside in the local area throughout the 12 month follow-up period. Exclusion criteria included: (1) if YTW were unable to provide informed consent due to severe mental or physical illness, or substance intoxication at the time of interview; or (2) if researchers discovered active suicidal ideation at the time of baseline interview (these patients were referred immediately for treatment, but had the option to join the study after receiving and completing their treatment).

The study enrolled 300 YTW at risk for HIV acquisition or transmission (with a self-reported history of unprotected anal sex or other sexual risk behavior in the 4 months prior to their baseline enrollment visit), ages 16-29; two-fifths of the sample (N=120) randomized to the intervention participated in the 6-session group-based Life Skills intervention; two-fifths (N=120) were randomized to the standard-of-care (SOC) control; and one-fifth were randomized to the time-matched attention control (N=60) and received standard health promotion information in a group-based multi-session format. All three arms received HIV and STI (Chlamydia and gonorrhea) testing and pre-posttest risk reduction counseling; sexual risk was assessed in these baseline data at, 4, 8, and 12 months. Researchers considered the degree to which the experimental intervention impacted the number of sexual partners engaged with, and whether this increased transgender adaptation and integration, collective self-esteem/empowerment, and HIV related information, motivation, and behavioral risk reduction skills. Of the 300 young transgender women who completed the Life Skills survey, 3 responses contained incomplete information, resulting in a sample size for this analysis of n = 297.

Measurements

Relationship Power

Participants were asked to answer a series of 15 questions related to relationship control. These questions are part of a validated scale for understanding control within relationships and are measured using the Relationship Control Subscale (RCS) of the Sexual Relationship Power Scale (SRPS).[30, 40] The Decision-Making Dominance Subscale (DMDS), the other part of the SRPS, was not included in the Life Skills survey as the RCS is the more internally consistent of the two measures. Relationship control questions include questions regarding condom negotiation, level of commitment to partner, intimate partner violence, fidelity, communication and compromise. The RCS has been shown to be a useful measure for relationship control, especially among women and youth populations.[40] Each of the 15 items in the subscales was scored on a 4-point Likert scale, with 1 = strongly agree, 2 = agree, 3 = disagree, and 4 = strongly disagree. Higher scores represent higher sexual relationship power. The RCS has demonstrated good predictive validity and internal consistency in a number of published analyses.[40] In this analysis researchers created a categorical variable to capture 0 = women not in relationships, 1 = women in good/equitable relationships, and 2 = women in bad/inequitable relationships (anyone who fell below the mean for the continuous relationship power variable).

Psychological Distress

The18-item Brief Symptom Inventory (BSI-18) is a screening tool that was developed by Zabora (2001).[62] The BSI-18 was created by performing a principal components factor analysis specifying four factors on the 18 questions included in the inventory. Reliability of the BSI-18 was assessed based on the calculation of the internal consistency; mean item scores, and correlations with the total score of the larger 53-item BSI developed by Derogatis (1983).[63] In addition, sensitivity and specificity was calculated to determine the ability of the BSI-18 to discriminate positive and negative cases.[62] The BSI-18 serves as a brief psychological screening instrument and has been implemented to prospectively, and rapidly, identify individuals with elevated levels of distress who may be in need of mental health intervention. Since publication in 2001, the BSI-18 has been cited by more than 2,400 published articles and is a widely used measure of psychological distress. The BSI is written at a sixth grade reading level and only requires 5 to 7 minutes to complete. Each item is rated on a 5-point Likert scale ranging from 0 (not at all) to 4 (always). Participants in the Life Skills study were asked questions regarding suicidality, feelings of worthlessness, physical experiences of distress, and experiences of sadness, fear, and loneliness. Each question is asked in terms of "how [participants] have been feeling during the past 7 days."[62, 63]

Social Support

This study used a 6-item measure for Social Support pulled from the California Health Interview Survey. The California Health Interview Survey (CHIS), supported by UCLA's Center for Health Policy Research, is a geographically stratified, random-digit-dialed, two-stage telephone

survey conducted every other year among individuals who live in California and are over the age of 18.[64] This survey is used to monitor chronic health conditions such as heart disease, cancer, stroke, diabetes and asthma, as well as to monitor unhealthy behaviors and risk factors like tobacco and alcohol use and obesity. The six social support questions used in the CHIS were extracted from the Medical Outcomes Study Modified Social Support Survey (MOS-SSS), an 18-item multidimensional measure of perceived social support that has established internal-consistency reliability (Cronbach's $\alpha = 0.91$) and that is fairly stable over time.[64-66] Participants were asked to consider their experiences with a variety of types of support over the past 4 months. Questions address financial and romantic types of support, as well as support related to illness, leisure-time, work and personal challenges. Participants were asked how often they had support for specific scenarios over the past 4 months, where 1 = none of the time and 5 = all of the time. Higher numbers along this continuum are therefore associated with greater amounts of social support.

Transphobia

A handful of scales have been developed to measure attitudes towards transgender people, and the Genderism and Transphobia Scale (GTS) has been validated to measure violence, harassment, and discrimination toward cross-dressers, transgenderists, and transsexuals.[21] The GTS was proposed in 2005, by Hill and Willoughby, but has yet to be widely applied in the literature, and is currently only cited by 186 published articles. Recently, Tebbe (2014), revised and shortened the scale, but as this is a very new development, it was not used in this survey.[67] The Minority Stress literature discusses stigma as it relates to matters of identity and

intersectionality, while HIV literature tends to focus on experiences with and effects of disease-specific stigma; HIV-related stigma, namely. Just last year, in 2015, two important studies began the work of exploring stigma as it relates to sexual and gender minorities, but only one of these was related to transgender people specifically.[16, 68] For the purposes of this analysis, transphobia is measured by three sub-variables: Internalized Stigma, Perceived Stigma and Experienced Stigma. This categorization is supported by both bodies of research, but is unique to this analysis.

Internalized Stigma

Participants were asked to consider their membership within a larger community of people who identify as transgender and respond to a series of statements on the basis of how they felt about the group and their membership within it. For this analysis, internalized stigma is measured by a single variable, which asked participants to respond to this statement: "Overall the trans community is considered good by others." Participants were asked to score their responses on a 7-point Likert scale, with 1 = strongly disagree, 2 = disagree, 3 = disagree somewhat, 4 = neutral, 5 = agree somewhat, 6 = agree, and 7 = strongly agree. Historically, in other literature, the Internalized Homophobia Scale (IHPS) has been used as a validated method for measuring internalized stigma.[68] The IHPS was not included in this survey, and thus was substituted with a measure of how participants rank themselves in terms of societal value.

Perceived Stigma

This analysis uses a Perceived Social Status Questionnaire (PSSQ) to measure each participant's levels of perceived stigma related to their transgender status. Participants were first asked to imagine a ladder and to think about the top of the ladder as representing the portion of the population that is best off in terms of wealth, education, and occupational respect. Those at the bottom of the ladder are worst off. Participants were then asked to place themselves on one rung of the ladder where 1 = bottom rung and 10 = top rung.

The second question asked participants to think of a new ladder representing where people stand in their communities. The survey instructs participants to define community however they choose and to think of the top of the ladder as the people who have the highest standing in their community, and the bottom as representing people who have the lowest standing in their communities. Again, participants were then asked to place the transgender community on one rung of the ladder where 1 = bottom rung and 10 = top rung.

These two questions were added together to create an index variable measuring perceived stigma. Measures for perceived discrimination have been created for LGBT populations, but no measure to capture perceived stigma among young transgender women has yet been developed.[41, 43, 56]

Experienced Stigma

This survey asked a number of questions, which could be conceptualized as measuring experiences of stigma related to YTW status, but given what is known about young transgender women in the United States, it is well established that this population experiences stigma and discrimination, from a variety of sources, on a nearly continuous basis.[1, 4] This chronic exposure to stress requires a triage approach, so that the most damaging kinds of stigma and discrimination can be addressed directly and with the most effective interventions achievable.[16, 68] Among sexual and gender minorities, in terms of lived experiences relating to stigma and discrimination, familial rejection is by far the most destructive force in the lives of young transgender people.[3, 39, 60, 69-72]

The Life Skills survey, in a section of the Transgender History Questionnaire, asked the women to answer a series of questions regarding familial response to disclosure of transgender status. The survey asked specifically about the family into which the women were born, and not the woman's chosen family or "found family," which is a common phenomenon among young LGBT people.[70] Participants were asked to respond to each statement with whether or not an instance of familial rejection or acceptance had occurred. For each immediate family member [sister, brother, mother and father], participants were asked to answer first whether or not they had told the respective family member, and were then asked about the initial response and the current response to transgender status. Responses included: Accepting, Tolerant, Intolerant, Rejecting, Don't know. These variables were consolidated into a series of index variables, which produced a final count variable measuring how many instances of rejection occurred per

participant. This measure does not distinguish between initial and current instances of rejection. It merely counts whether or not rejection occurred at all. If they responded to the question regarding current level of rejection or acceptance with "don't know," those responses were not counted as rejection.

A second variable was made to illustrate the ratio of those who experienced familial rejection over every woman who had disclosed her status with at least one family member. This variable attempts to adjust for the fact that the count variable includes women with varying risk of experiencing familial rejection. Those who told 4 family members, for example, are at a greater risk of experiencing familial rejection than those who told only 1 family member. Other important information is not captured by either variable. Was familial rejection tacit or explicit? If a woman experiences tacit rejection, i.e. clear disapproval without vocalized disapproval could be more damaging if it increases the length of exposure to rejection over time.

These data were analyzed using StataSE-14 (StataCorp. 2015. *Stata Statistical Software: Release 14*. College Station, TX: StataCorp LP). Differences in outcomes across group strata were assessed using ANOVA testing at the $\alpha=0.05$ level. The two final models include two separate outcomes of interest – psychological distress and social support. Both models are adjusted for three key covariates – transphobia variables, history of sex work, and relationship power/quality. The demographic variables of age, race/ethnicity, and education level were controlled for in both models.

Results

[Insert Table 1]

The mean age of the women in this data set was 23.3 years old. Among these women, 26% of the sample was White and nearly half (n=145) of the sample self-identified as African American. Of the 297 women, only 131 reported being in a relationship at the time of the survey. Of these, 47.3% (n=62) reported being in a relationship in which they felt disempowered. The mean score for experience of psychological distress in the last 7 days among the sample was 16.8 on a scale ranging from 0 to 72, where higher numbers mean more psychological distress. The mean score for experience of internalized stigma was 4.2 on a scale of 1 to 7. Lower scores for this variable indicate less internalized stigma. The mean score for experience of perceived stigma was 11.9 on a scale from 2 to 20. Lower scores for this variable indicate less perceived stigma.

Of the 297 women, roughly half report a history of sex work (n=147), and of these, 104 report having engaged in sex work in the last 4 months. More than 30% of the sample reported having attempted suicide in their lifetime (n=90), with 52 women reporting that they had experienced thoughts of suicide at the moderate level or higher or above in the past 7 days. Among these women, 39.4% of this sample (n=117) reported at least one instance of familial rejection from an immediate family member. Of those who disclosed their status to at least one family member, 22% experienced at least one instance of rejection. The mean score for the social support measure was 18.9 on a scale ranging from 6 to 30 where low numbers indicate that support was never available and high numbers indicate that support was always available. Of the six support

questions, the greatest number of women responded “never” to: “How often have you had someone available to take care of you if you are sick?” (n=76). Homelessness in this sample was also relatively high compared with non-transgender youth in the literature. Within this sample, 49.2% (n=146) women reported that they had been homeless at some point in their lives, while 49% of that group (n=71) reported that they had been homeless at some point within the last 4 months.

[Insert Table 2]

Bivariate analysis was performed for psychological distress with each individual key covariate and three demographic variables (age, race and education). The resultant beta coefficients, p-values and 95% Confidence Intervals are summarized in Table 3. Age, history of sex work, low-equity relationships, and all three transphobia components were significantly associated with increased psychological distress. Familial rejection is significantly associated with psychological distress (95% CI: 3.45, 11.06; p: <0.001) in this sample. The ratio for experienced stigma was also significant, and had a greater effect on the outcome of psychological distress (95% CI: 2.57, 16.91; p: 0.008). Perceived and internalized stigma were also significantly associated with psychological distress, so that as stigma increases, psychological distress decreases by somewhere between 0.7 (95% CI: -2.16, -0.02; p: 0.047) and 1.1 (95% CI: -1.08, -0.22; p: 0.003) units. History of sex work is significantly associated with an increase (95% CI: 0.57, 8.12; p: 0.024) in psychological distress. And being in a low-equity relationship is also associated with an increase (95% CI: 2.16, 13.49; p: 0.007) in psychological distress. Interestingly, age is also significant with psychological distress (95% CI: 0.08, 1.16; p: 0.024), suggesting that as

transgender women age, they experience increasing amounts of psychological distress or that that stress is compounded over time.

[Insert Table 3]

Bivariate analysis was performed for social support with each individual key covariate and three demographic variables (age, race and education). The resultant beta coefficients, p-values and 95% Confidence Intervals are summarized in Table 3. Being in a good relationship, and decreases in perceived and internalized stigma were significantly associated with increased social support. As experience of internalized stigma decreases, psychological distress increases (95% CI: 0.38, 1.39; p: 0.001) in this sample. Increases in perceived stigma are significantly associated with increases in psychological distress (95% CI: 0.27, 0.67; p: <0.001) in this sample. Counter-intuitively, being in a good relationship is significantly associated with a decrease in social support (95% CI: -5.63, -1.21; p: 0.003) among the women in this sample.

[Insert Table 4]

Multivariate analysis was performed for psychological distress with every key covariate and three demographic variables (age, race and education). The resultant beta coefficients, p-values and 95% Confidence Intervals are summarized in Table 4 – Model 1. Model 1 indicates that experiencing more perceived stigma and more familial rejection (experienced stigma) are both significantly associated with psychological distress. Being a sex worker and being in a low quality/low equity relationship are also significantly correlated with higher amounts of

psychological distress. Accordingly, women with lower than the mean score for relationship equity had significantly higher levels of psychological distress, as increasing the measure of disempowerment is significantly associated with an increase in the psychological distress measure after adjusting for all other variables in the model (95% CI: 1.79, 12.85%; p: 0.010) and when compared to women who are not in relationships.

Additionally, a significant positive association was found between having a history of commercial sex work and experiencing psychological distress (CI: 0.38, 7.96; p: 0.031). Engagement in sex work was significantly associated with an increase in psychological distress after accounting for the other key covariates and the three control variables.

Both increasing experiences of perceived stigma as well as increasing experiences of experienced stigma, or familial rejection, were found to be significantly associated with increased amounts of psychological distress after adjusting for all other variables. Women who reported greater perceived stigma (95% CI: -1.04, -0.19; p: 0.005) experience increases in psychological distress compared to women who reported lower perceived stigma. Women who reported instances of experienced stigma, or familial rejection, experience a significant increase in psychological distress for every instance of rejection (95% CI: 2.38, 10.08; p: 0.002).

When the experienced stigma ratio variable is added to the model as a continuous variable, instead of the count variable, a history of commercial sex work, perceived and experienced stigma, and being in a low equity relationship all remain significant, but the effects of each

variable, except for perceived stigma, increase slightly. Perceived stigma remains the same. [See Table 4]

[Insert Table 5]

Multivariate analysis was performed for social support with every key covariate and three demographic variables (age, race and education). The resultant beta coefficients, p-values and 95% Confidence Intervals are summarized in Table 5 – Model 2. Model 2 indicates that decreases in internalized stigma and perceived stigma are predictive of an increase in received social support. Experienced stigma is not significant in this model, indicating that increased familial rejection could either lead women away from social support networks or might cause them to seek out additional support. Being in a higher quality/equitable relationship is also significantly associated with a decrease in social support (95% CI: -5.98, -1.70; p: <0.001), while being in a low equity relationship is not associated with a change in the social support outcome. Sex work is not significantly connected to social support for these women.

When the experienced stigma ratio variable is added to the model as a continuous variable, instead of the count variable, perceived and internalized stigma, and being in a high equity relationship all remain significant, but the effects of relationship quality increase slightly. The other significant variables remain the same. [See Table 5]

Discussion

These results clearly illustrate a connection between family support and health for YTW, and that the significance of this connection highlights a need for increased support for transgender youth, in particular. Relationship equity, familial rejection, and perceived stigma, in particular, were all found to have significant associations with psychological distress and social support. Experienced stigma, for example, measured in two different ways, was significantly associated with psychological distress in every model, and perceived stigma was significantly associated with both psychological distress and social support, in each of the models reported in this analysis. Other characteristics of these transgender women, such as age, and having a history of sex work, were also found to have significant associations with psychological distress. Older women and women reporting a history of sex work were significantly more likely to report experiencing psychological distress. Relationship equity among these women changes the outcomes depending on which kind of relationship the women report and which outcome is being modeled. For women in low equity relationships, a significant association with increased psychological distress was found, but for women in high equity relationships, decreases in social support were found. Additionally, experienced stigma, irrespective of the way in which it was measured, was highly correlated with psychological distress, but completely unassociated with social support.

The finding that social support and experienced stigma have no association could provide an opportunity for the application of Cultural Consonance Theory in future research designs. Cultural Consonance, Dressler (2000), is a model that comes out of the Medical Anthropology

literature, and is used to assess the approximation of an individual's behavior compared to the guiding awareness of his or her culture. Dressler (2000) describes Cultural Consonance in this way:

> "Individuals may be limited for a variety of reasons in their abilities to act on cultural models; that is, they may know the model, but they may be unable to act in accordance with it (by economic constraints, for example). This source of variability in individual behavior relative to shared cultural models is captured by the concept of cultural consonance."[73]

When researchers attempt to apply an understanding of LGBT culture to YTW populations, results are flawed, and they become even more opaque as we move down to the individual level, due to the highly contextual nature of being a transgender woman. This study, as an example, chose to include women who self-identified as transgender, transsexual, and/or female with a male biological or birth sex. These identities are distinct within YTW culture, yet in this research they have been aggregated. A lack of discussion of YTW culture at the individual level leads to a decrease in our ability to understand the varied phenomena to which this population has been normalized over time. Additionally, as argued by William Dressler,

> "an exclusive focus on culture as a descriptor of social groups runs the risk of reification, attributing uniform beliefs and practices to individuals and ignoring variation… without a focus on individuals, we cannot trace the steps by which culture shapes human biology. Therefore, a concept of culture that can help us to understand variation within social groups, as well as differences between social groups, is essential."[74]

Transgender women are a minority population, but that does not mean that they are not also a diverse population, and this diversity might be connected to their health outcomes. To the author's knowledge, no application of the Cultural Consonance model has yet been applied to a population of young transgender women.

Another application for this theory might be to account for the decrease in social support associated with being in an equitable relationship. It could be that empowered women, who are in equitable relationships, have more visible commitments to their partners, which could put them at greater risk for discrimination and stigma. Women in equitable relationships might also experience less social support because it is expected that their partners are providing that support. Whatever the reason, there is clearly something different about the women who are in strong, equitable relationships, and the Cultural Consonance model could be applied to better understand how these experiences are occurring at the individual level.

Intuitively, we might expect to find an association between experience of familial rejection and social support, because the immediate family is one component of an individual's social support network. It could be that, with a larger sample, were we to put social support in a model with familial rejection, social support might change the relationship between the familial rejection and psychological distress due to a temporal factor that this analysis did not capture. If a young transgender woman already had a robust social support network at the time of the initial rejection, it is possible that the occurrence of familial rejection may detract from her capacity for social support. However, if she did not have support at the time of rejection, i.e. if she was already experiencing tacit disapproval and lack of support from family, and had also not yet formed a community among other YTW, it could be that the rejection forces her to reach out for support and thus increases her capacity for social support over time. A hypothesis could be tested to determine whether social support moderates familial rejection's impact on psychological distress depending on the time at which rejection occurs, and the specific ways in which that rejection occurs. If this hypothesis were found to be valid, then we could not only address mental

health disparities among YTW due to familial rejection, but we might also be able to prevent these disparities from occurring by bolstering community for YTW, especially the youngest of these, outside the home, and by providing education for those family members who do wish to be supportive. This study is among the first to examine the relationships between various aspects of transphobia and experiences of social support.

The observed prevalence of intimate partner violence reported in this sample (15.3%; n=20/131) is significantly lower than previous studies of intimate partner violence among transgender women. This is likely attributable to a) the fact that only women currently in relationships at the time of the survey were asked this question; and b) That these women could only respond to this question for one specific partner and no other. Additionally, the lack of association between race and either of the outcomes is surprising. While, being African American (n=145) was not associated with either outcome in this analysis, disaggregation of racial and ethnic identities shows that being Mexican (n=6) and being Puerto Rican (n=34) were associated with increased psychological distress after adjusting for all other key covariates and demographics (results not shown). Further research could explore the nature of being a YTW and Latina in Chicago and Boston.

These results are consistent with previous studies that have found a high prevalence of sex work among transgender populations; however, direct comparisons are limited due to the lack of consistency in the literature with regards to definitions for sex work. The high prevalence of a reported history of sex work reported here by YTW indicates an immediate and pressing need for economic opportunities geared towards YTW, specifically, as well as some understanding and

disaggregation of "sex work," in order to capture the differences between commercial sex work as an occupation, and more coercive, transactional sex as a means of survival. Screening for a history of sex work, and experiences of familial rejection, as well as a deeper and more nuanced understanding of the way in which YTW create social support networks should be incorporated into all HIV interventions, focusing specifically on strategies for accessing YTW's vast potential for resilience, and providing them with healthy methods for coping with the various forms of familial rejection they face.

The primary limitations in this analysis are related to the small sample size. As this is baseline, data, however, there will be opportunities to conduct logistic regression analyses in the future, with more predictive potential for the research. Additionally, due to the methodology used to collect data, that is, a cross-sectional face-to-face interview recruiting from places where YTW spend time, there may be some selection bias occurring towards women who are publically open about their gender status because we are not accessing women who are less open or "out." Additionally, a small number of the surveys were incomplete, meaning that only women who answered questionnaires completely were selected for analysis. It is possible that women who experience more stigma and who are in lower equity relationships are less likely to be willing to answer questions about transphobia, which points to the marginalization experienced by these most vulnerable populations. All data are self-reported, which may explain the lower proportion of women who report sex work due to social desirability bias, though such bias is likely limited because other young transgender women were conducting the surveys and given the small size of the sample, it is likely that the women know each other. Because the data are cross-sectional, causality cannot be ascertained; that is, we do not have enough information to determine whether

transphobia, specifically perceived and internalized stigma, predicts experience of psychological distress, or if the psychological distress itself induces transphobia. Additional research, using a much larger sample, is needed to clarify how the varied components of transphobia effect risk for psychological distress and improve experiences of social support among YTW.

This study addresses several key gaps in the literature, despite the limitations discussed above, and examines relationships between certain areas of transphobia, psychological distress and social support for the first time. Remembering that the larger purpose of this study is to test the efficacy of an HIV risk reduction intervention for sexually experienced young transgender women, ages 16 to 29, it is important to consider how transphobia and experiences of social support might impact the way in which risk reduction interventions operate for YTW. Despite research documenting high rates of sexual risk behaviors and HIV infection among transgender women, only three intervention studies have been identified that have attempted to reduce HIV-related risk behaviors in transgender women, none of which focused specifically on YTW. Two of these studies documented modest reductions in risky sexual behavior and HIV risk among transgender women, but effects diminished over time.[25, 75] None of these studies were evaluated using an RCT research design, and to date, there are no HIV prevention interventions rigorously evaluated or proven efficacious for YTW, and very few theoretically grounded interventions exist targeting determinants of risk specific to the lives of transgender women of any age. While this analysis does not explore HIV risk specifically, it does explore determinants of risk specific to the lives of young transgender women.

This analysis provides evidence that in addition to being a significant burden in and of itself in the larger LGBT community, familial rejection has dynamic intersections with health-related outcomes for YTW, including psychological distress and social support. That there are nuances in the data relating to the way communities are formed and when and for how long familial rejection occurs, suggests a need to address the social, cultural, and attitudinal contexts in which YTW experience psychological distress and other negative health outcomes. While there are a few studies that suggest that multiple stigmatized identities might be additive and could, thus, compound risks for a variety of negative health outcomes, there is also an argument in the literature suggesting that having multiple stigmatized identities might damper the impact of being transgender alone.[47, 76] Certainly, if we want to study YTW using assets-based approaches, such as resilience thinking, it will be important to determine how these multiple identities – women, women of color, transgender, sex worker, and youth – impact the overall identity of the woman. Resilience is something that we are all born with, so those with increased resilience are those who have had to tap into their reservoirs of strength, endurance, and tenacity in ways that others have not. Transgender women, and the communities in which they thrive, are some of the most resilient communities in the United States, and approaching their health from this perspective might encourage the development of more nuanced, feasible, and culturally sensitive interventions for this population.[77, 78]

Conclusion

This study is the first of its kind to investigate the association between covariates of transphobia, sex work, and relationship equity and outcomes of psychological distress and social support.

These results add to a growing body of literature specific to YTW and the health disparities they face. The strong association between familial rejection and experiences of psychological distress and suicidality found in this sample highlight a need for more research, as well as a need for the development of infrastructure designed specifically to support YTW outside of their familial homes. These findings also suggest a critical gap in education for the families of YTW, which could be addressed through evidence-based public health interventions. A need to provide more specific mental health services for YTW is also clearly illustrated above, and findings should encourage school-based counselors and health providers to increase awareness of the impact of familial rejection on YTW health. The association between various forms of stigma and social support also illustrates a need for increased access to communal safe spaces and adult mentorship for young transgender women who feel marginalized and stigmatized and who may have fewer positive and supportive relationships to access in times of need.

Author Disclosure Statement

No competing financial interests exist.

Appendices

Table 1. Descriptive statistics for social support and psychological distress variables

Life Skills Baseline Data, 2015 (n=297)		
Variables	***Mean (SE) or %***	***Number or Range***
Age (mean years)	23.3 (3.5)	(16.0, 29.9)
Race		
White	25.6	76
Non-White	74.4	221
Education		
Below high school	28.9	86
*High school diploma+	32.7	97
College or above	38.4	114
History of Commercial Sex Work		
Never	50.5	150
Yes	49.5	147
Relationship Quality		
Not in a relationship	23.2	69
Equitable relationship	55.9	166
Bad relationship	20.9	62
Internalized Stigma	4.2 (1.8)	(1, 7)
Experienced Stigma (count)		
Never (no familial rejection)	60.6	180
Yes (familial rejection)	39.4	117
Experienced Stigma (ratio)	0.2 (0.3)	(0,1)
Perceived Stigma	11.9 (4.4)	(2, 20)
Social Support	18.9 (7.9)	(6, 30)
Psychological Distress	16.8 (16.6)	(0, 72)

* + = Trade or associate school

Table 2. Bivariate regression analysis of all key variables regressed onto psychological distress

Life Skills Baseline Data, 2015 (n=297)			
Variables	***Coefficient (β)***	***95% Confidence interval***	***p***
Age (mean years)	0.62	(0.08, 1.16)	0.024
Race			
White	*Ref*		
Non-White	-1.27	(-5.63, 3.09)	0.566
Education			
Below high school	*Ref*		
*High school diploma+	-1.41	(-6.27, 3.45)	0.568
College or above	0.59	(-4.10, 5.27)	0.805
History of Commercial Sex Work			
Never	*Ref*		
Yes	4.35	(0.57, 8.12)	0.024
Relationship Quality			
Not in a relationship	*Ref*		
Equitable relationship	1.27	(-3.36, 5.91)	0.589
Bad relationship	7.82	(2.16, 13.49)	0.007
Internalized Stigma	-1.09	(-2.16, -0.02)	0.047
Experienced Stigma			
Never (no familial rejection)	*Ref*		
Yes (familial rejection)	7.26	(3.45, 11.06)	<0.001
Experienced Stigma (ratio)	9.74	(2.57, 16.91)	0.008
Perceived Stigma	-0.65	(-1.08, -0.22)	0.003

* + = Trade or associate school

Table 3. Bivariate regression analysis of all key variables regressed onto social support

Life Skills Baseline Data, 2015 (n=297)			
Variables	***Coefficient (β)***	***95% Confidence interval***	***p***
Age (mean years)	-0.19	(-0.45, 0.07)	0.149
Race			
White	*Ref*		
Non-White	1.93	(-0.14, 3.99)	0.068
Education			
Below high school	*Ref*		
*High school diploma+	0.21	(-2.11, 2.52)	0.861
College or above	-1.05	(-3.28, 1.18)	0.356
History of Commercial Sex Work			
Never	*Ref*		
Yes	1.44	(-0.37, 3.25)	0.118
Relationship Quality			
Not in a relationship	*Ref*		
Equitable relationship	-3.42	(-5.63, -1.21)	0.003
Bad relationship	-2.49	(-5.19, 0.21)	0.070
Internalized Stigma	0.88	(0.38, 1.39)	0.001
Experienced Stigma (count)			
Never (no familial rejection)	*Ref*		
Yes (familial rejection)	0.20	(-1.66, 2.05)	0.836
Experienced Stigma (ratio)	-1.07	(-4.53, 2.39)	0.543
Perceived Stigma	0.47	(0.27, 0.67)	<0.001

* + = Trade or associate school

Table 4. Multivariate regression analysis modeling all variables regressed onto psychological distress and social support with familial rejection count

Life Skills Baseline Data, 2015 (n=297)						
Covariates	**Model 1 - Psychological Distress (n=297)**			**Model 2 - Social Support (n=297)**		
	Coefficient (β)	***95% Confidence Interval***	***p***	***Coefficient (β)***	***95% Confidence Interval***	***p***
Age (mean years)	0.42	(-0.16, 1.01)	0.152	-0.21	(-0.49, 0.06)	0.128
Race						
White	*Ref*			*Ref*		
Non-White	0.50	(-4.07, 5.07)	0.831	0.67	(-1.50, 2.83)	0.544
Education						
Below high school	*Ref*			*Ref*		
High school diploma or trade school	-2.02	(-6.75, 2.71)	0.420	1.08	(-1.16, 3.32)	0.344
College or above	-1.73	(-6.73, 3.27)	0.496	0.76	(-1.60, 3.13)	0.526
History of Commercial Sex Work						
Never	*Ref*			*Ref*		
Yes	4.17	(0.38, 7.96)	0.031	1.43	(-0.37, 3.22)	0.119
Relationship Quality						
Not in a relationship	*Ref*			*Ref*		
Equitable relationship	2.36	(-2.15, 6.87)	0.304	-3.84	(-5.98, -1.70)	<0.001
Bad relationship	7.32	(1.79, 12.85)	0.010	-2.59	(-5.21, 0.03)	0.052
Internalized Stigma	-0.67	(-1.74, 0.41)	0.219	0.63	(0.12, 1.14)	0.015
Experienced Stigma Count						
Never (no familial rejection)	*Ref*			*Ref*		
Yes (familial rejection)	6.23	(2.38, 10.08)	0.002	0.33	(-1.49, 2.83)	0.721
Perceived Stigma	-0.62	(-1.04, -0.19)	0.005	0.40	(0.20, 0.61)	<0.001

Table 5. Multivariate regression analysis modeling all variables regressed onto psychological distress and social support with familial rejection ratio

Life Skills Baseline Data, 2015 (n=297)						
Covariates	**Model 3 - Psychological Distress (n=297)**			**Model 4 - Social Support (n=297)**		
	Coefficient (β)	***95% Confidence Interval***	***p***	***Coefficient (β)***	***95% Confidence Interval***	***p***
Age (mean years)	0.46	(-0.13, 1.05)	0.125	-0.21	(-0.49, 0.07)	0.134
Race						
White	*Ref*			*Ref*		
Non-White	0.37	(-4.25, 4.99)	0.876	0.63	(-1.54, 2.79)	0.570
Education						
Below high school	*Ref*			*Ref*		
High school diploma or trade school	-1.85	(-6.63, 2.92)	0.446	1.10	(-1.15, 3.34)	0.336
College or above	-1.33	(-6.37, 3.71)	0.604	0.84	(-1.53, 3.20)	0.487
History of Commercial Sex Work						
Never	*Ref*			*Ref*		
Yes	4.37	(0.54, 8.20)	0.025	1.44	(-0.36, 3.24)	0.116
Relationship Quality						
Not in a relationship	*Ref*			*Ref*		
Equitable relationship	2.00	(-2.54, 6.55)	0.386	-3.88	(-6.01, -1.75)	<0.001
Bad relationship	7.69	(2.12, 13.27)	0.007	-2.54	(-5.16, 0.07)	0.057
Internalized Stigma	-0.66	(-1.74, 0.43)	0.233	0.63	(0.12, 1.14)	0.015
Experienced Stigma Ratio	7.57	(0.35, 14.79)	0.040	-0.19	(-3.58, 3.20)	0.913
Perceived Stigma	-0.59	(-1.03, -0.16)	0.007	0.40	(0.20, 0.61)	<0.001

Chapter III: Recommendations

Public Health Implications

The most critical finding of this analysis has widespread implications for young LGBT people in America, especially YTW; Young transgender women face high levels of rejection from their immediate families, and among women who have a history of sex work, rejection is even more prevalent. In this analysis, these instances of rejection are directly connected to women's experiences of psychological distress. Among women with a history of sex work, psychological distress is higher than among those with no history of sex work; a mean score of 19.0 vs. a mean score of 14.6. Despite these findings, and despite the growing body of research that examines the high prevalence of mental health problems among YTW, as well as the increased risk of attempted suicide and homelessness, familial rejection for these young people has yet to be addressed as a significant social determinant of health and well-being by the broader public health community.

The National Transgender Discrimination Survey, the largest longitudinal survey conducted among transgender Americans, reported in their 2011 full report, *Injustice at Every Turn*, that 57% of their respondents had experienced rejection from their families, and that these individuals were significantly more likely to face negative health outcomes compared to those who had experienced acceptance.[1] The report describes family acceptance as "of great importance," and goes on to highlight the finding that family acceptance had a protective affect against many threats to overall quality of life "including health risks such as HIV infection and suicide."[1]

Another article, published in the Journal of Family Psychology by Koken (2009), states that "the Parental Acceptance–Rejection (PAR) theory indicates that a child's experience of rejection may have a significant impact on their adult lives."[39] This argument supports a life course understanding of YTW's experience of familial rejection or acceptance. Life course theory asserts, "that one of the most important functions of age and time are not simply their biological and developmental significance, but also their social significance."[79-81] Because of the specific developmental stage at which YTW generally experience rejection, during their middle to late adolescence, it could be hypothesized that these initial assaults on their sense of self and security might have ongoing consequences throughout their lives. This hypothesis calls for greater research and could be explored through a prospective cohort study comparing YTW who experience rejection to those who experience acceptance, over time.

The public health response to familial rejection among young transgender women has been minimal, at best. In order for the effects of familial rejection within this population to be addressed comprehensively, several actions need to be prioritized. Fortunately, there are a number of evidence-based youth programs already in existence that could be modified for young transgender women at various stages in their development. This response on the part of public health practitioners requires a nuanced understanding of the specific experiences of young transgender women, and will demand significant investments of time and resources from institutions that already support young people in America. A multi-faceted approach that reaches YTW before, during and after rejection occurs, and works to engage families and transgender adults as external resources, has the greatest opportunity to succeed.

1. Increase understanding and awareness of familial rejection and its mental health consequences among existing stakeholders providing support and healthcare for YTW in America.

In the analysis above, transphobia, defined operationally as internalized, perceived and experienced stigma, has been shown to be significantly associated, in various ways, with poor health outcomes among young transgender women in America. As the health and wellbeing of transgender people have long been wrapped-up with that of the larger LGBT community, greater awareness around the prevalence of poor mental health among YTW, and increased action against transphobia, should be incorporated into advocacy campaigns within the LGBT movement – for example, explicit opportunities for LGB people to act as allies to their transgender community members would help to recognize both the connection between communities of sexual and gender minorities as well as the distinct qualities that separate transgender experiences from that of LGB experiences. Already, there has been action taken by the broader LGBT community to acknowledge the increased risk of violence among adult transgender women of color, but greater work needs to be done to provide transgender people with an equitable platform upon which to advocate for the specific needs of their communities, while also supporting the priorities and approaches they identify and implement.

A number of well-established and well-resourced advocacy organizations for transgender people are already in place. The National Center for Transgender Equality, the organization that oversees the National Transgender Discrimination Survey, partners with a number of research institutions in the development, implementation and analysis of their survey. Some of these

analyses have led to greater awareness of familial rejection, but this awareness has yet to translate into interventions and policy changes.

The Transgender Law Center (TLC), founded in 2001, engages institutions and individuals in an effort to change laws, policies, and attitudes to promote increased safety, visibility, and equity for transgender people and to decrease the discrimination, stigma, and transphobia which lead to a number of poor health outcomes for YTW. Gender Proud, another advocacy organization founded by trans model and actress, Geena Rocero, works internationally to create a safer environment for young transgender people struggling around the world to survive. Lastly, the Family Acceptance Project (FAP) produces research, designs evidence-based interventions and offers a variety of educational tools to address the increased risk of mental health problems among LGBT children and youth. FAP uses "a research-based, culturally grounded approach to [assist] ethnically, socially and religiously diverse families" in the development of strategies and methods for supporting their young people.[60] These organizations, and others like them, should be leveraged to increase awareness around health outcomes for young transgender Americans, but also to identify and expand federal funding opportunities for YTW interventions.

2. Promote policies that require institutions, by law, that are working with YTW to support and protect these young people and to foster environments of safety and equity for all of their youth.

Health care providers and educators should be provided with sensitivity training and should be expected to have a basic understanding of the issues specific to the vulnerable populations of

YTW in America. These service providers and administrators should also understand and have access to explicit strategies for supporting YTW as needed. Given the legal climate for transgender people in this country, especially at the State level, greater resources are needed to support youth who identify as transgender within schools and clinics. Outreach and support groups should be incorporated into existing programming for this population.

According to the 2011 National School Climate Survey, transgender students were more likely to have negative experiences at school than were individuals from every other group of students.[57] Fewer than half of all LGBT young people live in states where they are legally protected from bullying and discrimination based on their sexual or gender identity. Only 1% of the total LGBT population in America live in states where schools employ regulations or teacher codes that protect students from bullying on the basis of their gender identity, while a staggering 42% of this population live in states with zero laws in place for the protection of LGBT students.[57, 58, 82, 83]

There has been an increase in research in recent years regarding transgender experiences of stigma during healthcare access and the consequences of that stigma on long-term health for transgender people.[27, 46, 84, 85] In a recent 2013 study conducted by Poteat et al., and published in Social Science and Medicine, researchers conducted qualitative analysis of in-depth interviews with 30 transgender women. The authors reported that these women shared common experiences of blaming, shaming, othering and discrimination during their healthcare encounters and the paper also reported that not enough is known about health care providers' attitudes towards transgender patients, in general.[84] Young transgender women face discrimination across every

area of their lives, and are therefore in greater need of sensitive, ethical, and quality health care provision. Much more work needs to be done to understand how best to support transgender patients in clinical settings across America.

Until the United States government makes an asserted effort to promote the health and well being of LGBT young people unilaterally, independently of who they are or where they live, young people will continue to face disproportionate harassment, violence, homelessness and increased risk of suicide. These outcomes cost a great deal in terms of service-related expenses and loss to productivity. Expanded opportunities for federal funding would bolster response capacity of healthcare and educational institutions to prioritize programming that protects and supports young transgender people in America.

3. Create mentorship programs for YTW, that employ effective mechanisms for referral, both in and out of schools, where rejected youth can engage with adult transgender women who have been through similar circumstances and survived.

There are myriad evidence-based resources already in place for the adult and peer mentorship of young people in the United States, and while some of these are specific to LGBT youth, very few programming curricula have been adapted for young transgender people separately from the larger LGBT community.[86] Fortunately, in 2014, the Williams Institute produced a report titled "Ensuring Access to Mentoring Programs for LGBT Youth" that explores the differing mentorship needs within this diverse population in light of their higher risk of arrest and involvement with the juvenile justice system. The publication reports that LGBT youth

underutilize social services compared to their heterosexual peers, and that many report no access to an adult with whom they could speak about personal problems.[86] Another article by Bird (2012) and published in the Journal of Adolescent Health, explored the impact of role models on health outcomes for LGBT youth. It found that "participants with inaccessible role models showed increased psychological distress versus those with accessible or no role models."[87] This finding, when coupled with the findings in the analysis above, suggest that mentoring programs designed specifically by and for YTW might be an effective intervention among youth who have experienced rejection.

One evidence-based mentorship program exists and has already been adapted for YTW ages 13-24. This program is called Project Adult Identity Mentoring (AIM) and it was created and adapted by researchers working in the Division of Adolescent Medicine at Children's Hospital Los Angeles. An article by Forbes (2016), explores Transgender Adult Identity Mentoring (TG-AIM) as one possible behavioral intervention with the ability to expand YTW's access to "positive personal resources" that might mitigate the impact of the discrimination and stigma they face.[88] Project AIM uses a curriculum that helps young participants to imagine their futures in positive and hopeful ways, and this intervention has been shown, in other populations, to improve a number of health outcomes across different groups of young people. While this research is very new, and no publications have yet evaluated the Project AIM curriculum that was adapted for YTW, these resources could provide the basis for replicable mentoring models specific to YTW to be employed in the future.[88]

A multi-faceted approach to addressing the needs of YTW who have experienced familial rejection must include: increased understanding and awareness of familial rejection and its

mental health consequences as well as education for YTW's supportive family members; the promotion of policies that legally require institutions working with YTW to support and protect these young people and to foster environments of safety and equity for all of their youth; and the creation of mentorship programs for YTW, both in and out of schools, through which rejected youth can engage with adult transgender women who have been through similar circumstances and survived. Furthermore, these programs and services should develop and incorporate mechanisms for referral that can be used to connect YTW with trans-specific services nation-wide. These interventions have the potential to comprehensively address the negative health consequences associated with familial rejection before it has occurred and to diminish the impact on each, individual YTW's long-term health outcomes. While working towards the implementation of each of these interventions, surveillance of suicide, homelessness, depression, and reported experiences of familial rejection among YTW should be financially and politically supported at the federal level. Additionally, resources that support research in transgender health, and that use cohort designs to monitor effects related to stigma over time should be developed. This research will work to create an urgently needed evidence-base for best practices in addressing the complex obstacles to good health faced by young transgender women growing up in America.

Chapter IV: References

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