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Walden University

College of Social and Behavioral Sciences

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Jill Hingston

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Walden University
2019

Abstract

The Impact of Parental Support on the Health Behaviors of Transgender Young Adults

by

Jill Hingston

MA, Chapman University, 2008

BS, Oregon State University, 1987

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

August 2019

Abstract

Paralleling recent increased public awareness of transgender issues, gender nonconforming youth are coming out at increasingly earlier ages. It is important to understand the impact that family acceptance or family rejection has on the health outcomes of transgender young people, who are at increased risk of discrimination, prejudice, harassment, victimization, violence, and possible mental health issues and who are understudied. This understanding can be framed within the minority stress model and Carl Rogers' theory of self, which provide insight into how minority groups experience negative reactions from both society and an internalized sense of congruence. The purpose of this descriptive, cross-sectional, quantitative study was to measure the levels of negative health behaviors between transgender young adults who felt they had the support of their parents for their gender identity and those who did not. Data from 96 young transgender adults, between 18 and 25 years of age recruited through LGBT and transgender community organizations, were analyzed using correlation and logistic regression. Results showed significant relationships between the perception of parental support and suicidal ideation, number of suicide attempts, and illicit drug use. Findings from this study could contribute to positive social change by informing families, schools, health care providers, mental health practitioners, and policy makers about the significance of affirmative support for transgender youth. Quantifiable data regarding the impact of parental responses to a young person's gender identity could lead to the development of programs and policies leading to improved health outcomes for transgender youth.

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Dedication

This research is dedicated to anyone who has struggled with their gender identity in the face of personal and social pressure to be someone other than who they are. I have sat with individuals during therapy sessions and in support groups and been humbled repeatedly by the depths of determination and courage. I have been witness to the emotional brutality that the lack of support produces in both transgender youth and adults. This research is dedicated to all the young people who are changing the world just by being who they are.

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And finally, thank you to J. H., who was my first transgender client (at age 4) when I was still an MFT intern. Her growth and journey taught me the invaluable lesson of the need to live openly and authentically. In the process of this journey, her grandparents showed me the necessity of supporting and advocating for a trans child. I am honored to have walked this path with your family.

And endless gratitude to my parents, who taught me compassion, nonjudgment, the importance of equity, and to stand up for what is right.

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Chapter 1: Introduction to the Study

The topic of gender, and more specifically, the topic of transgender, has increased substantially in mainstream media coverage and public awareness in recent years. Movies, television, magazine articles, blogs, books, and news feeds have highlighted the lives, along with the social and medical transitions, of transgender people. The January 2017 special issue of *National Geographic* magazine focused on the shifting landscape of gender “to a degree unimaginable a decade ago” (“The Gender Issue,” 2017, p. 12), and celebrities such as Caitlyn Jenner, Janet Mock, Chaz Bono, and Laverne Cox have openly discussed gender identity and transition. In the wake of this growing public awareness, more young people are identifying as a gender other than the traditional definitions of male or female (Steinmetz, 2017).

However, despite this recent upsurge in information regarding the lives of transgender people, most young transgender people are forced to navigate confusing gender questions without the help of family, friends, or a supportive culture (Brill & Pepper, 2008; Ehrensaft, 2011). According to Brill and Pepper (2008) and Ehrensaft (2011), transgender youth are coming out at younger ages more than ever before. I examined transgender young adults’ health behaviors in relation to perceived parental support to illuminate associations between family support and deleterious outcomes of a stigmatized and often hidden population.

In this chapter I will present an overview of this dissertation. Sections include (a) the problem statement, (b) the purpose of this study, (c) research questions and hypotheses, (d) the theoretical framework, (e) the nature of the study, (f) definitions of

terms, (g) assumptions, (h) scope and delimitiations, (i) limitations, (j) the significance of the study, and (k) a summary.

Background

As young people are becoming aware of their gender nonconforming status at younger and younger ages (Ehrensaft, 2011; Russell, Toomey, Ryan, & Diaz, 2014), it is important to understand the implications of positive versus negative parental responses to a child's transgender identity. Most studies on transgender populations have been conducted under the LGBT acronym (Breslow et al., 2015; Dargie, Blair, Pukall, & Coyle, 2014) and before the public discourse regarding the importance of parental acceptance was occurring (Olson, Durwood, DeMeules, & McLaughlin, 2016). Experts have argued that the conflation of sexual orientation and gender identity has continued to foster invisibility and marginalization of transgender individuals (Blumer, Green, Knowles, & Williams, 2012). In this study I examined the unique experiences of the transgender young adult population, giving voice to an often omitted or underrepresented group in the literature (see Pflum, Testa, Balsam, Goldblum, & Bongar, 2015; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010).

Several researchers have examined the increased rates of discrimination, prejudice, and stigma experienced by transgender people (Nuttbrock et al., 2013; Sevelius, 2013). Researchers have also explored the elevated levels of suicidal gestures, substance use, and sexually risky behaviors of this population (Grant et al., 2011; Travers et al., 2012). However, much of the data on transgender individuals originates from studies on the lesbian, gay, bisexual, and transgender (LGBT) population as a single

entity. Historically, those who have challenged the sexual or gender boundaries of the binary model have been grouped together (Dargie et al., 2014; Riggle, Rostosky, McCants, & Pascale-Hague, 2011; Worthen, 2013), and the experiences of transgender people, along with the construct of gender identity, have often been conceptualized within those of the larger LGBT community (Galupo, Henise, & Davis, 2014). Due to the common misperception that both lesbian, gay, and bisexual (LGB) and transgender people share the same type of experiences as minority groups, these two distinct groups are often classified together, often muting the experiences of the trans population, contributing to the gap in the literature regarding experiences specific to transgender individuals.

Problem Statement

Findings on health behaviors and transgender youth indicate increased levels of negative health behaviors, including suicidal ideation, suicide attempts, substance use, and risky sexual practices (Grossman & D'Augelli, 2007; Hendricks & Testa, 2012; Nuttbrock et al., 2013). The 2011 National Transgender Discrimination survey revealed that 41% of over 6,400 transgender adults surveyed in the United States reported attempting suicide—a rate 25 times higher than the general population (Grant et al., 2011). Studies have repeatedly established that transgender individuals are subject to negative life events directly linked to their gender nonconforming identity, which may increase the likelihood of experiencing dangerous or negative health behaviors (Beemyn & Rankin, 2011; Hendricks & Testa, 2012; Moody & Smith, 2013). Suicide attempts seem to occur even more frequently among transgender adolescents and young adults

than among the population of older transgender people (Xavier, Honnold, & Bradford, 2007), and trans youth also face increased risk of discrimination, harassment, victimization, violence, and potential mental health issues (Beemyn & Rankin, 2011; Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Mustanski & Liu, 2013). Although there is very limited research about family supportive behaviors regarding transgender youth (Ryan et al., 2010), the few studies that do exist revealed that suicidal behaviors are associated with higher levels of parental abuse (Alanko et al., 2008; Bockting et al., 2013).

I sought to address the gaps in research regarding the relationships between parental support of transgender children and adolescents and the subsequent health behaviors of transgender young adults. Family rejection research has shown associations between negative family reactions to gender nonconformity or sexual orientation and elevated levels of mental health problems, risky sexual practices, and substance abuse (Bockting et al., 2013; Ryan et al., 2010), while parental support for transgender youth has been shown to offer a protective factor against psychological distress and negative health behaviors (Grant et al., 2011; Ryan et al., 2010). For the purpose of this study, parental support and parental rejection were assumed to be bipolar ends of a continuum.

Family acceptance was one construct examined in the 2011 National Transgender Survey, where 6,456 transgender adults in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam were sampled (Grant et al., 2011). Family acceptance was shown to be strongly associated with more positive outcomes, while family rejection was associated with negative outcomes (Grant et al., 2011). Researchers

conducting this study examined family acceptance among a wide range of family members, including the respondent's spouse or partner and children. Young adults, ages 18 to 24 years, were 19% of the sampled population in this study (Grant et al., 2011), and while the overall topic of family acceptance was explored, the role of parental support was not specifically discussed. Whereas some researchers include transgender youth (see Bernal & Coolhart, 2012; Nuttbrock et al., 2010; Simons, Schrager, Clark, Belzer, & Olson, 2013), most researchers studying parental acceptance or rejection focus on the general population or LGB youth (see Cox, Dewaele, Van Houte, & Vincke, 2011; D'Augelli, Grossman, & Starks, 2005; Eisenberg & Resnick, 2006; Needham & Austin, 2010; Russell & Toomey, 2013). Little research exists addressing the impact of parental attitudes on the health behaviors of transgender young adults.

Purpose of the Study

The purpose of this quantitative study was to measure levels of negative health behaviors of transgender young adults in relation to their perceptions of the degree of parental support they received as children or adolescents. For this study, the independent variable was perceived level of parental support, and the dependent variables were the harmful health behaviors of suicidal thinking, suicidal behaviors, alchohol use, marijuana use, illicit drug use, and risky sexual practices. This study is significant because it describes relationships between perceived parental support and the negative health behaviors of a population that is marginalized and underrepresented in the literature.

Research Questions and Hypotheses

I used a quantitative approach, analyzing data from an online survey. I collected data online through local and national transgender LISTSERVs, postings on social media sites related to transgender issues, and contact with leaders in the transgender community. Participants were 18-25 years of age, identified as transgender or along the transgender self-identification spectrum, and acknowledged their gender status during childhood or adolescence, with one or more parents knowing of their gender identity status during childhood or adolescence.

The research questions and hypotheses were as follows:

RQ1. Is perceived parental support for gender identity status during childhood or adolescence related to suicidal ideation in transgender young adults?

Hypothesis 1_0: Suicidal ideation, as measured by the Youth Risk and Behavior Survey, in transgender young adults will not be related to perceived parental support as measured by the Perceived Parental Rejection Scale.

Hypothesis 1_1: Suicidal ideation, as measured by the Youth Risk and Behavior Survey, in transgender young adults will be related to perceived lack of parental support as measured by the Perceived Parental Rejection Scale.

RQ2. Is perceived parental support for their gender identity status during childhood or adolescence related to suicidal ideation in transgender young adults?

Hypothesis 2_0: Suicide attempts, as measured by the Youth Risk and Behavior Survey, will not be related to perceived parental support as measured by the Perceived Parental Rejection Scale.

Hypothesis 2_1: Suicide attempts, as measured by the Youth Risk and Behavior Survey, will be related to perceived lack of parental support as measured by the Perceived Parental Rejection Scale.

RQ3. Is perceived parental support for gender identity status during childhood or adolescence related to alcohol use in transgender young adults?

Hypothesis 3_0: Alcohol use, as measured by the AUDIT Test for Alcohol Addiction, will not be related to perceived parental support as measured by the Perceived Parental Rejection Scale.

Hypothesis 3_1: Alcohol use, as measured by the AUDIT Test for Alcohol Addiction, will be related to perceptions of lack of parental support as measured by the Perceived Parental Rejection Scale.

RQ4. Is perceived parental support for gender identity status during childhood or adolescence related to lifetime marijuana use in transgender young adults?

Hypothesis 4_0: Lifetime marijuana use, as measured by the Youth Risk and Behavior Survey, will not be related to perceived parental support as measured by the Perceived Parental Rejection Scale.

Hypothesis 4_1: Lifetime marijuana use, as measured by the Youth Risk and Behavior Survey, will be related to perceived lack of parental support as measured by the Perceived Parental Rejection Scale.

RQ5. Is perceived parental support for gender identity status during childhood or adolescence related to the use of illicit drugs in transgender young adults?

Hypothesis 5_0: The use of illicit drugs, as measured by the Youth Risk and Behavior Survey, will not be related to perceived parental support as measured by the Perceived Parental Rejection Scale.

Hypothesis 5_1: The use of illicit drugs, as measured by the Youth Risk and Behavior Survey, will be related to perceived lack of parental support as measured by the Perceived Parental Rejection Scale.

RQ6. Is perceived parental support for gender identity status during childhood or adolescence related to risky sexual practices for transgender young adults?

Hypothesis 6_0: Risky sexual practices, as measured by the Safe Sex Behavior Questionnaire, will not be related to perceived parental support as measured by the Perceived Parental Rejection Scale.

Hypothesis 6_1: Risky sexual practices, as measured by the Safe Sex Behavior Questionnaire, will be related to perceived lack of parental support as measured by the Perceived Parental Rejection Scale.

Theoretical Foundation

Theories such as the minority stress model (Meyer, 2003) and Carl Rogers's theory of self (Rogers, 1961) both emphasize the need for understanding, empathy, and support from family, community, and social institutions. These two theories reinforce the importance of equality and a sense of belonging, and contribute to the understanding about responses to internal and external stressors. The minority stress theory offers extensive insight into the impact of stigma, prejudice, discrimination, and elevated levels of stress in minority populations (Figueroa & Zoccola, 2015; Goldblum et al., 2012;

Livingston et al., 2015), while Rogers's theory of self underscores the importance of congruency in matching one's identity awareness and one's experience throughout developmental stages. Both theories will be expanded upon in Chapter 2.

Although the minority stress model was primarily developed to explain mental health disparities in the lesbian, gay, and bisexual populations, it has been applied to other minority populations such as racial and ethnic minorities, women, the poor, and immigrants (see Arbona & Jimenez, 2014; Mulia & Zemore, 2012; Wei, Ku, & Liao, 2011). The minority stress theory outlines different stress processes, such as experiences of prejudice, expectations of rejection, hiding one's identity, threats of violence, and internalized self-hatred, which can help instigate individuals to adapt, but which also have the potential to cause significant psychological stress and subsequently lead to harmful physical and mental health problems (Meyer, 2003). This theoretical model provides insight into how minority populations experience stress associated with stigma, discrimination, and prejudice differently than the general population. The minority stress model posits that these stressors are chronic and socially based, existing outside of the individual, but within the norms and social institutions in society (Bockting et al., 2013).

Although the minority stress model was developed primarily to assess the stress experiences of gay individuals, Hendricks and Testa (2012) proposed an adapted version for the transgender population, and findings have suggested that the minority stress model is an appropriate theoretical foundation in which to frame the impact of prejudice, discrimination, and stigma experienced by transgender people (Herman, 2013). The mechanisms of minority stress for the transgender population can be explained as a

relationship between dominant social norms, expectations, and values and both the internal and external stressors of embodying a gender nonconforming identity and expression (Hendricks & Testa, 2012).

Psychologist Carl Rogers's theory of self acknowledges the impact of conflicts and inconsistencies of the self, and posits that a state of psychological congruence is necessary in order to live as a fully functioning person, and that childhood experience is primarily responsible for this state of congruence (Rogers, 1959, 1961). This model assumes that the state of total congruency is not possible, but that the closer the *perceived self* and the *ideal self* are aligned, the more congruent an individual will feel (Rogers, 1959, 1961). In other words, congruence of the self is influenced by the perceptions of others (i.e., family, society) regarding how a person ought or should be, and an individual's beliefs about their own self-image and ideal self. For many transgender people, the development of self-esteem, self-image, and a sense of congruence can be hindered by struggles with disconnection, isolation, and rejection because of the gender standards and rules of society (Brill & Pepper, 2008; Ehrensaft, 2011).

Rogers's theory of self may provide an explanation of why transgender people face increased levels of negative health behaviors stemming from pressures within family, social, and cultural environments. Transgender identity formation often conflicts with expectations of social rules of normative gender assumptions (Brill & Pepper, 2008; Ehrensaft, 2011), and research shows that family and other social relationships that support an individual's transgender identity permit people who are transgender to

develop a greater sense of congruence with their internal sense of gender and self-acceptance (Budge, Adelson, & Howard, 2013).

Nature of the Study

I used a cross-sectional, quantitative approach for the study. Participants were ages 18 to 25 years; identified somewhere along the transgender spectrum; had one or both parents who had knowledge of participants' trans status during their childhood or adolescence; and lived with one parent, both parents, or a main guardian at least part-time. Cross-sectional designs are often associated with survey research as they permit the collection of data from large numbers of subjects not bound by geography. The objective of quantitative methodology is to determine the relationship between an independent variable and a dependent, or outcome, variable in a particular population, quantifying the relationship between those variables. For this study, the independent variable was perceived level of parental support, and the dependent variables were the harmful health behaviors of suicidal thinking, suicidal behaviors, alcohol use, marijuana use, drug use, and risky sexual practices.

Definitions

Perceived parental support: The level of support participants felt they were afforded by their parental figure(s) regarding their transgender identity. I used the Perceived Parental Rejection Scale (Willoughby, Malik, & Lindahl, 2006) to measure perceived parental support.

Risky sexual practices: Sexual behaviors in which participation may lead to harmful consequences such as HIV. Risky sexual practices was measured by using the Safe Sex Behavior Questionnaire (DiIorio, Parsons, Lehr, Adame, & Carlone, 1992).

Suicide attempts: Actions that are intended to hurt or kill oneself.

Suicidal ideation: Thoughts of wishing one were dead, considering suicide, and suicide planning. Suicidal ideation and suicide attempts were measured by using the Youth Risk Behavior Survey (Centers for Disease Control and Prevention [CDC], 2014) and one question from the Trans PULSE Project (Travers et al., 2012) asking whether suicidal ideation or attempt was related to being transgender.

Substance use: Levels of alcohol, marijuana, or other drug use. Harmful or dangerous alcohol use was measured by using the AUDIT questionnaire (Saunders, Aasland, Babor, de la Fuente, & Grant,1993). Marijuana and other drug use was measured by using the Youth Risk Behavior Survey (CDC, 2014).

Transgender: An umbrella label that includes a variety of identities, including gender roles, the transition process, and gender identity or expression which does not follow conventional binary ideals of male or female (Riggle et al., 2011). For the purposes of this study, transgender was defined as those individuals who identify differently from the generally accepted cisgender, binary model. (Cisgender people are those for whom their internal sense of gender aligns with their physical characteristics (Steinmetz, 2017). Just as with other populations, there is no typical way of being transgender. Transgender persons represent a diverse range of gender identities and expressions (Reisner, Gamarel, Nemoto, & Operario, 2014). For example, someone who

identifies as a transgender woman may or may not be perceived as female by the general population, depending on her access to hormones, her job status, and whether or not she is "out" to family or friends. Today, varieties of identities exist along a gender spectrum under the transgender umbrella, including *transman*, *transwoman*, *bigender*, *agender*, *genderqueer*, and *two-spirit* (Henig, 2017). The word *trans* is synonymous with the term *transgender* and was used in the body of this study.

Assumptions and Limitations

This study should be considered an exploratory study, comparing the levels of negative health behaviors of transgender young adults in relation to perceptions of parental support for their gender identity. Assumptions for this study include participant honesty, valid rating scales to measure the constructs, and that parental support and parental rejection are opposite sides of a continuum. Participants' identities remained anonymous and confidential, and they were allowed to withdraw from completing the survey at any time without adverse implications.

Scope and Delimitations

The population chosen for this research was limited to transgender young adults, aged 18 to 25-years-old. This sample was not generalizable to all transgender individuals, due to the age restrictions and unique characteristics of the developmental stage of young adulthood. For example, older transgender individuals have had more life experiences and exposure to coping strategies, whereas the young adult population is generally not as sophisticated in approaches to life stressors.

It is important to note that the sample was only be representative of those who have access to the Internet. Another possible limitation were an adequate representation of racial, ethnic, and socioeconomic diversity. According to GLSEN, CiPHR, and CCRC (2013), African-American and Asian-American youth spend more time on the internet than White or Latino young people, even after considering differences in household income. While youth in rural and urban areas use school or library computers at higher rates than youth living in suburban areas, young people everywhere tend to have ever-increasing access to the Internet (GLSEN, CiPHR, & CCRC (2013). The survey for this study consisted of questionnaires written and tested in English, which limited participation to those who are proficient in reading and understanding the English language.

Limitations

Limitations of this study include the lack of a sampling frame because the actual number of the transgender population remains unknown. Although it is estimated that 0.3% of the population identifies as transgender (Gates, 2011), this statistic comes from a 2007-2009 study in Massachusetts on the health of transgender adults and a 2003 study in California examining trends in tobacco use within the LGBT community (Paquette, 2015). The use of an Internet survey will help address this limitation. According to the Gay, Lesbian, and Straight Education Network [GLSEN], Center for Innovative Public Health Research [CiPHR], and Crimes Against Children Research Center [CCRC] (2013), access to the Internet is “almost universally available” (p. 5) and LGBT youth commonly use the Internet to compensate for a lack of offline social support, LGBT-

affirming resources, and connection with other like themselves (DeHann, Kuper, Magee, Bigelow, and Mustanski, 2013). Although the number of transgender people in the United States remains unknown, the Internet allows for individuals in hidden and stigmatized populations, such as the transgender community, to be reached (GLSEN, CiPHR, & CCRC, 2013). The lack of a sampling frame and the nature of this hidden and often stigmatized population will not allow for the assumption of generalizability to all transgender young adults. Another limitation is the self-report and retrospective assessment of key variables. Retrospective self-report intrinsically contains potential sources of bias or error due to discomfort in reporting sensitive material or inability to remember specific events or time frames (Testa et al., 2012).

Significance

The transgender population is considerably underrepresented in the literature (Grossman, D'Augelli, & Frank, 2011; Haas et al., 2011; Katz-Wise, Rosario, & Tsappis, 2016). This study is significant in that it examined the relationships between parental support of transgender youth and subsequent negative health behaviors of a marginalized, stigmatized, and little known population of transgender young adults. The influence of either destructive or effective parenting practices for transgender youth has only recently begun to be identified and studied and initial results demonstrate that support from parents is protective against depression, and significantly associated with a higher quality of life and decreased perceived burden about being transgender (Katz-Wise et al., 2016; Ryan et al., 2010; Simons et al., 2013). This study can help explain relationships between

responses of transgender young adults to perceptions of parental rejection, parental support, and subsequent coping mechanisms.

This study can contribute to the literature on the transgender population by offering quantifiable data comparing the health behaviors of transgender young adults who perceived they had parental support for their gender identity and those who did not. Findings from this study may contribute to positive social change by expanding the body of knowledge regarding the importance of parental support for transgender youth. This research could also help inform families, educators, clinicians, healthcare workers, and policy makers about the importance of support for transgender young persons. Results from this study could also have the potential to effect social change by improving the quality of life for transgender people and their families.

Summary

It is well documented that transgender individuals face increased rates of discrimination, violence, and stigma (Beemyn & Rankin, 2011) and that transgender youth have higher rates of negative health behaviors (Grossman & D'Augelli, 2007; Hendricks & Testa, 2012), along with an increased risk of mental health problems (Katz-Wise et al., 2016). Although there is little research on the role of family acceptance and behaviors of transgender youth (Katz-Wise et al., 2016; Ryan et al., 2010), the few studies that do exist have shown associations between suicidal behaviors and parental abuse (Bockting et al., 2013).

Chapter 2 presents a review of the literature with respect to the topic of transgender status in the United States, the importance of parental support, and negative

health behaviors during young adulthood. Chapter 3 describes the methodology used to collect data and how the results will be analyzed. Additionally, the research model and approach, sampling method, sample size, instrumentation and materials, procedures, and the protection of human subjects will be discussed.

Chapter 2: Literature Review

Introduction

Although 2014 was optimistically welcomed as the "transgender tipping point" by *Time* magazine (Steinmetz, 2014), there remains a deep-rooted social ignorance about transgender people and the issues they face, according to researchers (Beemyn & Rankin, 2011; Herman, 2013; Levitt & Ippolito, 2014; Tebbe & Moradi, 2016). Over the past several years, public awareness of the transgender population has increased dramatically in the United States. Politically and socially, transgender issues are more frequently acknowledged and discussed in the public forum, including President Obama saying the word *transgender* for the first time in a State of the Union address in 2015 (Steinmetz, 2015). Mainstream television, movies, books, and magazines have featured transgender characters or celebrities. A considerable amount of the recent emerging public consciousness regarding transgender people has been activated by celebrities and television shows such as Laverne Cox from the Netflix series *Orange is the New Black*; Janet Mock, author, activist, and MSNBC host; Jeffrey Tambor, Emmy-award winning actor on Amazon Studio's hit series *Transparent*; Jazz Jennings, teenage author, activist, and reality TV star; and Caitlyn Jenner, television personality and former Olympian. Despite all of the social gains and awareness of transgender people during the Obama presidency, the Trump administration began dismantling policies almost immediately. One month after Trump took office, the Departments of Justice and Education withdrew landmark 2016 guidance explaining how public schools must protect transgender students under the federal Title IX law (Thompson, 2018). Currently, the Trump administration

continues to reverse policies protecting transgender people in schools, prisons, health care, the military, and employment.

Even with several years of increased exposure of transgender lives and the issues they face, transgender people continue to be misunderstood, stigmatized, and pathologized when compared to other minority groups (Ehrensaft, 2011; Lev, 2004; Sevelius, 2013; Su et al., 2016). Furthermore, despite recent growing public awareness, transgender people continue to experience elevated rates of victimization, discrimination, prejudice, and stigmatization. Trans people, especially transgender women of color, experience exceptionally high rates of violence and discrimination (Brennan et al., 2012; Nuttbrock et al., 2013; Sevelius, 2013). In 2015 there were 21 murders of transgender women of color, a number greater than any other year on record (Michaels, 2015), and reported transgender teen suicides reached a total of 15 (Dennison, 2015). In 2017 at least 29 deaths of transgender women by fatal violence were recorded (Human Rights Campaign [HRC], 2019). It is important to remember that these types of statistics are for those murders and suicides reported as being connected to a transgender person. The FBI only began keeping data on hate crimes targeting gender identity in 2013; therefore, the tracking and recording of transgender deaths has historically resulted in a lack of accurate or reliable data (HRC, 2015).

For transgender young people, the challenge of growing up in a culture where gender is accepted mainly in binary terms can be described as confusing, conflicting, painful, invalidating, and dangerous (Nuttbrock et al., 2009; Russell et al., 2014). Despite the discrimination, hostility, and stigma faced by transgender young people, the number

of children and adolescents openly identifying as transgender is growing (Bernal & Coolhart, 2012; Russell et al., 2014). Transgender children and adolescents rarely have accessible models of transgender experience, and they have little or no vocabulary to accurately describe their internal sense of gender (Levitt & Ippolito, 2014). Much of this early negotiation is done without the support or guidance from parents, family, teachers, or other adults (Goldblum et al., 2012; Russell et al., 2014), and much public information received by young trans people is often negative and invalidating. Given the levels of stigma, discrimination, and prejudice toward transgender people, it would seem all the more vital for transgender youth to have the support and understanding from their parents and families in order to help protect against the psychological distress experienced in so many transgender individuals.

In conducting this study I sought to address the gaps in research regarding the relationships between parental support of transgender children and adolescents and the subsequent health behaviors of transgender young adults. There have been few studies explicitly on transgender youth. The specific purpose of this quantitative study was to measure levels of negative health behaviors of transgender young adults in relation to their perception of degree of parental support as children or adolescents

With this in mind, the current chapter reviews the literature on transgender research, the conflation of sexual minority status (LGB) with gender minority status (transgender), what has been learned from LGB studies, the impact of parental acceptance and rejection, the unique significance of the developmental stage of young adulthood, and transgender health disparities. Given the association between high levels

of prejudice, hostility, discrimination, and subsequent harmful health behaviors for transgender people (Haas et al., 2011), it seems appropriate to examine the relationship between parental acceptance and rejection and health outcomes in young adulthood. Findings from such research could help elucidate the influence of parental acceptance and rejecting behaviors on health behaviors of transgender young adults and offer suggestions for future research. In this chapter I present an overview of research findings related to the following topics: (a) LGB studies; (b) transgender health disparities; (c) the importance of the young adulthood stage of development; (d) the minority stress model and Rogerian self-theory constructs; and (e) the negative health behaviors of suicide, substance use, and risky sexual conduct. The chapter begins with an overview of my literature search strategy.

Literature Search Strategy

In order to conduct this literature review, I reviewed many primary and secondary sources from the literature. The academic databases I searched included EBSCOhost, PsycARTICLES, PsycINFO, LGBT Life with Full Text, SocINDEX with Full Text, Sage Premier, ProQuest Central, and CINAHL & MEDLINE Simultaneous Search. Research was also obtained on the Internet through search engines such as Google and Google Scholar. I used peer-reviewed journal articles and relevant books for this review. Although the review focused on articles published 2010 and beyond, older frequently cited seminal works were reviewed, along with older research articles on transgender youth. Some of the literature reviewed dates from the 1960s to the 1980s, especially regarding theoretical concepts regarding identity development, LGBT issues, suicide, and

family systems. The main body of the reviewed literature consisted of peer-reviewed articles published during 2010-2015, with many more published during the past several years (2016-2019), along with contemporary national reports on transgender issues.

Searches included, but were not limited to, the following topics: transgender, transsexual, transgender youth, LGBT youth, gender identity, social construction gender, transgender stress, transgender stigma, transgender coping, transgender substance use, transgender negative health behaviors, transgender suicide, and transgender sexual risk. Additional key words included *transgender violence*, *transgender resilience*, *transgender health*, *transgender families*, *minority stress, Carl Rogers's theory of self*, *identity development*, *transgender identity development*, *transitional aged youth*, *emerging adulthood*, *transgender in schools*, *transgender college*, *transgender employment*, *gender expression*, *gender minorities*, *transgender online*, and *transgender mental health*. Searches also included the key words: *quantitative research*, *sampling LGBT*, *snowball sampling*, and *online surveys*.

Theoretical Foundation

Two theories reinforcing the importance of transgender equality, understanding, and support from family and social institutions are the minority stress theory (Meyer, 2003) and the Rogerian theory of self (Rogers, 1961). Both of these theories underscore the need for understanding, empathy, and support from families, communities, and social institutions. Inequities in treatment by families and social institutions have been shown to contribute to increased problems with mental health and stressors such as depression, suicidality, and homelessness (Grossman, D'Augelli, & Salter, 2006; Haas et al., 2011).

The minority stress theory adds considerable insight into the influence of discrimination, prejudice, stigma, victimization, rejection, and elevated stress levels of minority populations (Figueroa & Zoccola, 2015; Goldblum et al., 2012; Livingston et al., 2015), while Carl Rogers' theory of self stresses the importance of congruence and matching one's awareness and experience during developmental stages.

The Minority Stress Model

The minority stress theory adds substantial insight into the impact of discrimination, prejudice, stigma, victimization, rejection, and elevated stress levels of minority populations, and has been applied to minority groups such as racial and ethnic populations, women, immigrants, and the poor. Ilan Meyer (2003) developed this theory primarily to describe mental health disparities in sexual minority populations, and outlined processes of minority stress as they relate to lesbian, gay, and bisexual people. The minority stress model proposed by Meyer (2003) suggests that health disparities in sexual minorities can be explained by living in hostile and discriminatory environments. The model describes various stress processes, including concealment, hiding, experiences of prejudice, expectation of rejection, threats of violence, and internalized homophobia (Meyer, 2003). These types of stressors can compel individuals to adapt, but can also cause significant stress and lead to deleterious physical and mental health outcomes (Meyer, 2003).

Meyer (2003) identified three processes that occur with minority stress. The first process involves stress due to minority status that creates overt stress, including threats to safety and security. The second process concerns the anticipation or expectation of

threats of safety and security and becoming hyper-vigilant in order to avoid dangerous situations. This response often leads to avoidance and rejection from others in the attempt to hide one's identity from certain people or in certain situations. The results of hiding one's identity does not reduce stress levels, but instead, decreases feelings of self-worth and increases feelings of distress (Hendricks & Testa, 2012). The third process involves internalizing outside prejudices and negative feelings and impressions that the person experience over time. Meyer (2003) suggests this would lead to internalized homophobia and result in lower levels of resiliency and a decreased ability to manage negative or oppressive life events. These mechanisms and processes of the minority stress model lead to harmful coping strategies, increased rates of substance abuse, mental health problems, suicidal thoughts, and attempted suicide (Meyer, 2003).

The minority stress model proposes that the stress associated with discrimination, stigma, and prejudice will increase rates of psychological problems in minority populations. According to this model, minority stress implies additional stressors than those experienced by the general population, is socially based, chronic, in which the stressors exist within relatively stable social structures and norms beyond the individual (Bockting et al., 2013). Minority stress can be both external and internal. Externally, minority stress is manifested by actual experiences of rejection, maltreatment, and enacted stigma or discrimination, whereas internally, it can manifest due to expectations of prejudice and discrimination, perceived rejection, or fearing abuse or harm (Bockting et al., 2013). For minority populations, victimization may have added effects beyond

general victimization because it further maligns an individual's identity and underscores a marginalized status (Poteat et al., 2011).

The minority stress model explained the increased levels of stress for the gay population, but did not include experiences of gender minorities. Hendricks and Testa (2012) proposed an adapted version of the minority stress model for the transgender population. Drawing from Meyer's (2003) framework, Hendricks and Testa (2012) offer an outline for understanding how the dynamics of minority stress, rather than gender identity itself, can result in increased rates of psychological problems. Findings on minority stress in relation to being transgender suggest that the minority stress model is appropriate to measure the impact of prejudice and stigma experienced by this population (Herman, 2013). For transgender individuals, the mechanisms of minority stress can be explained as a relationship between the minority status of a nonconforming gender identity and the dominant social norms, values, and expectations. This model suggests the disproportionate rates of negative health behaviors for transgender individuals, can be explained by stressors resulting from rejection, maltreatment, harassment, discrimination, and a transphobic society (Hendricks & Testa, 2012). The internalization of negative attitudes can manifest as negative self-image, self-injurious behaviors, and damaged self-esteem (Hendricks & Testa, 2012; Meyer, 2003), thereby compromising the establishment of identity and self-esteem, especially in trans youth (Goldblum et al., 2012). The most documented elements of the impact of minority stress on transgender communities are external events (Hendricks & Testa, 2012). Several studies have demonstrated that high levels of physical and sexual violence within transgender

populations (Clements-Nolle et al., 2006; Herman, 2013; Nuttbrock et al., 2013). Although there is not yet a determined definitive causal relationship between outer negative stressful events and increased rates of negative health behaviors, the strengths of the relationships between the two indicate a clear correlation, and offer support for the minority stress model in a transgender context (Hendricks & Testa, 2012).

Rogers's Theory of Self

While the minority stress model helps explain both internal and external stress processes, it is important to acknowledge the impact of rejection and maltreatment in the family home, and the internal stressors and implications for transgender children and adolescents forced to live in a way that is distressful. Carl Rogers (1961) agreed with the main core assumptions of Abraham Maslow's hierarchy of needs, but supplemented the idea that for a person to grow and self-actualize, an individual needs an environment providing acceptance, understanding, and authenticity. Rogers is one of several classic theorists positing that conflicts and inconsistencies in the self produce emotional distress (e.g., Alfred Adler, Gordon W. Allport, Sigmund Freud, Karen Horney, and William James). Rogers believed that in order for a person to self-actualize, or live as a fully functioning person, he or she must be in a state of congruence. For Rogers, this meant that an individual's ideal self (i.e., who they would like to be) is congruent with their consistent actions (i.e., self-image), and the main determinant of self-actualization is childhood experience (Rogers, 1959; Rogers, 1961). An individual's perception of how others regard him or her has a direct impact on self-worth. If children perceive they are valued, it is more likely they will develop a positive self-image (Rogers, 1959). Rogers

believed that feelings of self-worth develop in early childhood and are primarily influenced by responses and reactions from the parents.

Congruence is a basic action of Rogers' theory. Rogers (1961) discussed the differences between what others believe a person ought or should be (i.e., the mainstream norms) and a person's own beliefs about their ideal optimal self. Although the state of absolute congruency is an impossible ideal, Rogers' theory of self is contingent upon the concept of congruence, and based on the struggle between the *perceived self* and the *ideal self*, positing that the closer self-image and ideal self are, the more congruent an individual will feel (Rogers, 1959; Rogers, 1961). Congruency is the matching of awareness and experience, and *incongruency*, as defined by Rogers, is the experience of one's feelings and actions in misalignment. The state of incongruency is uncomfortable and leads to stress and anxiety. Transgender people who are forced to live as someone other than their authentic selves, whether the pressure to conform comes from family, society, or an internal source, live in a perpetual state of incongruence, contributing to elevated levels of stress, anxiety, depression, substance use, and suicide (Beemyn & Rankin, 2011). An individual lives in a condition of incongruence when experiences are unacceptable, denying or distorting the self-image (Rogers, 1961). Using Rogers' model, transgender people who feel shame about their gender identity status or are forced to suppress gender nonconforming expression, inevitably live incongruent lives.

Rogers believed that people are inherently creative and good, and only become destructive when the self-image is damaged or external factors impede self-valuing (Rogers, 1959). Although Rogers has been criticized for his excessively optimistic and

simplified interpretation of human nature, his theory of self, in regards to the importance of parental acceptance and interaction on the concept of self-esteem and self-image of the developing person, is shared by most of the major contributors to psychological theories (e.g., Mary Ainsworth and John Bowlby [Attachment Theory]; Albert Bandura [Social Learning Theory]; Erik Erikson [Theory of Psychosocial Development]; Abraham Maslow [Hierarchy of Needs]; and Jean Piaget [Cognitive Development]). Rogers' theory of self provides a framework for understanding the struggle inherent within the development of transgender gender identity. For most people, the formation of gender identity is influenced and supported by the social and cultural environment. In contrast, transgender identity development transpires in conflict with normative gender assumptions and expectations (Brill & Pepper, 2008; Ehrensaft, 2011). As a result, for transgender individuals, identity formation and conflicts with feelings of congruency are often complicated by familial, cultural, and social rules and expectations.

For many transgender individuals, the development of self-esteem, self-image, and sense of congruence is fraught with struggles against social rules and standards. Assumptions about gender as a binary construction, and a language emphasizing polarity, add to the imposing pressure to conform to gender standards and make it difficult for people to understand the dynamic framework of the transgender population (Beemyn & Rankin, 2011). However, for those who are able to attain a sense of congruency, there can be positive implications. For transgender adults, feelings of congruency have been identified with enhanced interpersonal relationships, resiliency, increased empathy, and personal growth (Riggle et al., 2011). Qualitative studies have shown the positive aspects

of transgender individuals experiencing congruency in relation to gender identity and expression (Moody et al., 2015; Riggle et al., 2011). According to Moody et al. (2015), it is important for individuals to be able to live in alignment with their internal sense of gender, not only to match the physical body with identified gender, but because this allows others to view and relate to them in ways that are congruent with how they see themselves in the world. Family and other social relationships that affirm an individual's transgender identity, allow trans persons to develop a greater sense of congruence with their internal sense of gender and self-acceptance (Budge et al., 2013).

Literature Review Related to Key Variables and/or Constructs

Defining Transgender

Gender is a socially created construct, closely monitored by society and rooted in the cultural psyche, and can be defined as a complex dynamic between one's outward presentations and behaviors in relation to one's internal sense of self. Those who fit neatly into the expected gender roles rarely, if ever, have to question or think about what gender means. Gender occurs along a wide spectrum and its complexity is not well represented in the generally accepted binary construct (Garofalo, Deleon, Osmer, Doll, & Harper, 2006). For transgender people, an internal sense of gender differs from biological sex. Transgender people struggle to fit into a society that prefers gender to fit into one box or the other, and this restrictive and limited construct has made it difficult to understand those who do not neatly fit the binary model.

Transgender or *trans* refers to those whose gender identity is inconsistent with assigned sex at birth, often expressing gender atypically, including, but not limited to,

identifying as trans, transgender, transsexual, genderqueer, pangender, bigender, agender, intersex, two-spirit, gender variant, and gender nonconforming. The term *transgender* is an umbrella label that includes a variety of identities, including gender, gender roles, the transition process, and gender identity or expression not conforming to the conventional binary ideals of male or female (Riggle et al., 2011). Some trans people identify with one or more groupings under the term *transgender*, some reject any of the labels completely, and some move between identity labels as they evolve and change over time (Donatone & Rachlin, 2013). Transgender people often affirm an internal gender identity that does not match their assigned gender at birth, and can include aspects of both binary gender identities and more fluid forms of gender expression and nonconformity. *Transgender* can also be defined as incongruence between what an individual knows and feels about sense of gender rather than physical body parts and can include a variety of nonconforming gender identity or expressions (Stieglitz, 2010). Clearly, *nonconformity* can only exist in relation to a definition of *conformity* within the realm of social constructs, with an individual's sense of gender being an interrelation between physical traits and internal sense of being female, male, a combination of both, or neither.

Although society largely operates on rigid gender binaries, there is a full spectrum of gender in which trans people identify. In a survey of more than 10,000 LGBT youth, 925 of the respondents identified within the transgender spectrum (Human Rights Campaign [HRC], 2012). In fact, 33% indicated they identified transgender, while 66% indicated another gender identity, most often citing identities such as *gender fluid, androgynous, gender expansive, bigender*, and *gender queer* (HRC, 2012). Many young

people today are expressing an understanding of gender that goes beyond the classic binary model of two distinct biological labels, with these labels ever-evolving due to the diversity within the definition of *transgender*.

Contemporary media portrayals of transgender people, such as Caitlyn Jenner, Janet Mock, and Laverne Cox, represent the extreme binary version of identifying transgender. This is often the public perception of what it means to be transgender. However, there are diverse ways to be trans (Bernal & Coolhart, 2012; Reisner et al., 2014). Various terminology within the transgender spectrum (i.e., trans woman, trans man, genderqueer, bigender, boi, and gender nonconforming) refer to ways in which individuals self identify with regard to assigned birth gender, and does not necessarily indicate any hormonal, medical, or surgical interventions. Unfortunately, the lack of a more definitive collective label or description of the transgender community may affect influence on social and political issues (Riggle et al., 2011). Religion, culture, and the social *male* or *female* standard of determining an individual's gender by the sex of their genitals at birth plays an enormous role in the disapproval and misunderstandings of gender variance.

For the purposes of this study, *transgender* or *trans* was defined as those people who express themselves differently from the generally accepted cisgender (a person whose physical body matches their internal sense of gender) binary model and self-identify within the trans spectrum. This could be a person who wishes to transition socially and physically in order align their physical body and appearance with their internal sense of gender, someone who does not conform to the typical binary model and

lacks the desire to modify themselves physically, or those who fall somewhere in between. The terminology used within this paper attempts to be the most general and least offensive, striving to respect the identities of transgender persons, while understanding that the use of terminology will not represent all transgender identities all the time.

Conflation of LGB and T. The frequent classification of lesbian, gay, bisexual, and transgender (LGBT) into a single acronym for research purposes suggests that the issues faced by these groups might be similar. However, sexual orientation and gender identity are two different, and often confused, constructs (APA Task Force on Gender Identity and Gender Variance, 2008). Identifying as transgender does not indicate a sexual orientation, and transgender persons can identify heterosexual, bisexual, gay or lesbian. *Transgender* refers to a person whose gender identity is inconsistent with their assigned sex at birth, whereas, sexual orientation signals sexual attraction to a person. Although sexual orientation and gender identity are separate concepts, both populations face elevated levels of discrimination and stigma based on their minority status within a heteronormative and binary-based culture; therefore, LGB research can be informative for transgender populations (Moody, Fuks, Pelaez, & Smith, 2015). However, homophobia and transphobia may function in different ways, and the unique vulnerabilities of transgender youth may not be captured in studies of LGBT youth (Travers et al., 2012). Therefore, it is important that research is able to extract the experiences of transgender people, rather than conflating them with sexual orientation issues.

Studies have established the association with being lesbian, gay, or bisexual with health disparities. Sexual minority status has been shown to be a significant risk factor for dangerous health behaviors with LGB youth (Hatzenbuehler, 2011; Mustanski & Liu, 2013; Russell et al., 2011; Ryan, Huebner, Diaz, & Sanchez, 2009). However, transgender youth as a separate research entity have been extremely underrepresented in the literature (Pflum et al., 2015; Ryan et al., 2010). Within the body of research that exists on sexual minorities, trans people have often been omitted, or it has been assumed the findings will translate to the transgender population (Testa et al., 2012). In addition, when trans people are clustered with sexual minority populations in research, it tends to further erase the experience of being trans because results often do not generalize to the transgender population (Dargie et al., 2014). Consequently, harm is done to gender minority populations when researchers lump gender and sexual identity together, negating the differences of experience (Blumer et al., 2012).

The conflation of sexual orientation and gender identity can be misleading in that it assumes those who identify within the LGBT population are a single sub-population in research (Dargie et al., 2014). The combination of gender identity and sexual orientation within the LGBT acronym has led to confusion in terminology and application of that terminology, and has fostered persistent invisibility and marginalization for transgender individuals (Blumer et al., 2012). Because of this common merging of LGBT in the literature, the unique experiences of transgender individuals have been underreported or lost, and as a separate entity, the transgender population has historically been underrepresented in the research (Breslow et al., 2015; Grossman & D'Augelli, 2007). In

fact, it has be argued that although well-intentioned scholars believe they are being inclusive of the transgender community when they address issues of sexual minorities, this is not necessarily so. The experiences of trans persons are somewhat related, but are qualitatively different from those of LGB people (Blumer et al., 2012).

Transgender in American society. Although there are cultures that have historically accepted, valued, and even revered the existence of transgender persons (e.g. the Hijra of India, the two-spirit of the Americas, and the Mahu of Hawaii), the construct of gender has largely been a binary concept in modern-day Western society. In contemporary Western cultures, transgender people have often been viewed as unnatural or even mentally ill (Bernal & Coolhart, 2012). Unconventional gender expression and identity, the strict social adherence to a binary understanding of gender, and the high levels of psychological distress experienced by transgender persons aided the inclusion of *Gender Dyphoria* (formerly *Gender Identity Disorder*) as a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (fifth edition), rather than in the ICD-10, the manual for physical medical conditions, contributing to the stigma of being transgender by implying that this is a psychological issue (Bernal & Coolhart, 2012). It could be argued that being transgender is a problem of the body not forming in alliance with the brain's sense of gender identity; therefore, although the misalignment of body and brain may cause distress, the initiating issue is the physical body and not the psychological structure of the person.

Although varying gender identities are becoming more visible in the United States, transgender individuals remain highly stigmatized and must process and explore

development within an environment that expects binary gender conformity. Due to the entrenched expectations of gender, transgender people face many psychological issues, both from internal and external sources. Transgender individuals often struggle with identity conflicts and self-doubt, and face a world that stigmatizes and medicalizes gender nonconformity, intimately linking psychological and social challenges (Lenning & Buist, 2013). Even the issue of language can have great implications for transgender people (Bernal & Coolhart, 2012), and can contribute to the more subtle forms of discrimination commonly referred to as *microaggressions*. Microaggressions are brief and everyday verbal, environmental, or behavioral indignities, whether intentional or not, which communicate invalidating, negative, or hostile messages towards members of an oppressed group (Sue, 2010). For example, incorrect use of pronouns by friends, families, partners, or health professionals can have invalidating effects for trans persons (Nadal, Davidoff, Davis, & Wong, 2014). The lack of safe and appropriate public restroom facilities can activate anxiety and fear for transgender individuals (Herman, 2013), potentially contributing to a detrimental or invalidating sense of self and psychological distress (Galupo et al., 2014). The binary concept of gender is an entrenched assumption and built into our environment, with public spaces reinforcing this gender segregation, commonly found in public restrooms, locker rooms, jails, homeless shelters, and prisons (Herman, 2013). Something as seemingly innocuous and natural as the biological urge to urinate, but not having a safe place to go, has the potential to trigger feelings of distress, distress, and a sense of not belonging (Herman, 2013).

Socially rigid and reinforced gender rules lead to a variety of internal struggles for transgender persons, particularly trans youth who may have little autonomy and are dependent on the adults in their lives. Transgender young people are especially vulnerable, experiencing harassment and victimization at school, home, and community settings (Grossman & D'Augelli, 2007; Haas et al., 2011). Most young transgender people experience conflicting emotions and confusion about their gender identity, deciding when and with whom disclosure will take place, and most of this process takes place without support or guidance from a parent or other adults in a child's life (Goldblum et al., 2012). Ineffective or inadequate management of a young person's intense gender identity challenges leave individuals at risk for a variety of negative health behaviors (Stieglitz, 2010). And for young people, behaviors and appearances that conflict with culturally assigned gender norms often instigate maltreatment from parents, teachers, and peers (Nadal et al., 2014; Russell et al., 2011).

Given the high rates of substance abuse, suicidal ideation, suicide attempts, and risky sexual practices that have been documented for sexual minorities (Duncan & Hatzenbuehler, 2014; Hatzenbuehler, 2011; Lehavot & Simoni, 2011; Rosario, Schrimshaw, & Hunter, 2009; Ryan et al., 2009), it is surprising that gender minorities have been the subject of so little focus. There is little research on transgender youth and young adults regarding negative health behaviors, with most studies incorporating small numbers of transgender people into studies of the LGBT population. Although the number of studies focusing on the parent-LGB teen relationship has greatly increased in the past decade (Ryan et al., 2010), the literature on transgender youth and their

relationships with their families remains extremely limited. Additionally, much of the research on the transgender population has examined trans adults and has not specifically identified the ramifications for younger transgender people who experience social and familial rejection.

Historically, most studies have focused on specific transgender populations, such as adults in phases of physical transition or those who have had contact with clinical settings, often presenting a restricted and extreme interpretation of individuals within the trans community (Dargie et al., 2014; Mustanski & Liu, 2013). Because of this approach, much of the research has provided a narrow view, largely focused on diagnosis, etiology, psychopathology, and medical procedures. Additionally, even large samples of LGBT individuals have yielded few transgender persons, if any, who are included in the final sample (Blumer et al, 2012). For example, a content analysis was conducted on marriage/couple and family therapy journals in order to assess the extent of trans-related issues in these journals during a period of 13 years (1997-2009) and whether common themes existed for the trans literature (Blumer et al., 2012). Results showed that out of 10,739 articles examined in 17 journals, only nine (0.0008%) focused on transgender issues or used gender nonconformity as a variable (Blumer et al., 2012).

Research Findings on LGBT Youth

Compared to their heterosexual counterparts, health disparities have been documented among LGB young people since studies on sexual minority youth were first published in the 1970s and 1980s (Haas et al., 2011; Ryan et al., 2009). Researchers have found perceived rejecting behaviors toward an individual's sexual minority status

predicted substance use (Rosario et al., 2009), depression, attempted suicide, and risky sexual behaviors by LGB young adults (Russell & Toomey, 2013; Ryan et al., 2009). A quantitative study, using measures originating from prior qualitative work on family accepting behaviors in response to adolescent sexual orientation and gender identity status, found that family acceptance predicts increased levels of self-esteem, social support, and general health (Ryan et al., 2010). Ryan et al. (2009) found family acceptance important for LGB youth, and in fact, in comparison to those experiencing little or no rejection, those who experienced severe family rejection were more than eight times more likely to report attempting suicide.

A major developmental stage for both sexual and gender minorities involves the acceptance and disclosure of sexual orientation or gender identity to others. This is commonly referred to as the process of *coming out*. Vivienne Cass (1979) developed a six-stage coming out model that is still widely used for understanding gay and lesbian identity development. Not only is the coming out process indicative of acknowledgment and self-acceptance of one's identity, but disclosure can serve to reduce the stress of concealing one's identity from others, and also be a catalyst for acquiring support from others (Cass, 1979). Coming out during adolescence has been shown to be related to increased peer victimization, but is also thought to be fundamental for a congruent sense of self and positive well being over time (Russell et al., 2014).

The coming out process can be very risky, especially for youth who lack resources or support from family or friends. Accepting reactions have been widely hypothesized to facilitate sources of support, relieve fears, increase self-esteem, and help

with psychological adjustment (D'Augelli et al., 2005; Elizur & Ziv, 2001; Ryan et al., 2010). A longitudinal study examining the relationship between types of disclosure reactions (accepting, neutral, rejecting) associated with substance use among 156 LGB youth (ages 14-21) revealed that the increased number of rejecting behaviors was associated with increased substance use and abuse (Rosario et al., 2009). Furthermore, studies have shown rejecting reactions to be associated with increased distress, negative health issues, and poorer psychological adjustment in young LGB persons (D'Augelli, 2002; Rosario et al., 2009; Ryan et al., 2009).

Additionally LGBT youth are at increased risk of victimization, which is linked to negative psychosocial adjustment, and it is the victimization associated with being LGBT (rather than other reasons for victimization) that is particularly undermining for youth (Russell et al., 2011). Parental rejection has been shown to be especially harmful for LGB youth. In a study using quantitative scales retrospectively assessing the frequency of parental rejecting behaviors for LGB individuals during adolescence, researchers found that LGB young adults who reported higher levels of rejection from their parents were 8.4 times more likely to have attempted suicide, 5.9 times more likely to have higher levels of depression, 3.4 times more likely to use drugs, and 3.4 times more likely to report having engaged in risky sexual practices compared to those with parental support (Ryan et al., 2009).

Transgender Health Disparities

Changing attitudes and cultural shifts regarding same-sex marriage have helped expose the "normalcy" and sameness of gay persons' lives. This, however, has not yet

translated to the transgender population. Findings on transgender youth and health behaviors indicate a higher risk for negative health behaviors, including substance use, risky sexual practices, and suicide (Grossman & D'Augelli, 2007; Hendricks & Testa, 2012; Nuttbrock et al., 2013). The National Transgender Discrimination Survey, conducted in 2011, revealed that 41% of the over 6,400 transgender adults surveyed in the United States reported attempting suicide at least once—a rate 25 times higher than the general population (Grant et al., 2011). Suicide attempts appear to occur more frequently among transgender adolescents and young adults than among older transgender people (Xavier et al., 2007), perhaps due in part to underdeveloped coping skills. Transgender youth are also at greater risk for discrimination, victimization, harassment, violence, and possibly mental health issues (Beemyn & Rankin, 2011; Bockting et al., 2013; Mustanski & Liu, 2013). Studies have repeatedly demonstrated that transgender individuals are subject to negative life events directly related to their gender nonconforming identity, which could potentially lead to negative or dangerous health behaviors (Beemyn & Rankin, 2011; Hendricks & Testa, 2012; Moody & Smith, 2013).

Despite the social and political gains made in the gay community, transgender people remain on the fringe of society, misunderstood and stigmatized. Using an online survey examining gender, sexual identity, social support, relationship quality, mental health, and physical health of transgender persons, Dargie et al. (2014) explored group differences and examined factors that predict better mental and physical health outcomes. In an effort to delineate the differences between LGB and trans experiences, differences were explored among transgender people, in addition to comparing trans persons to a

broader group of cisgender LGB individuals (Dargie et al., 2014). The results showed cisgender lesbian, gay, and bisexual individuals reported significantly more social support, significantly fewer symptoms of depression, stress, and anxiety, and fewer physical health problems than transgender individuals (Dargie et al., 2014). Results also indicated while many of the challenges faced by gender and sexual minorities are similar, the transgender population reported distinctive mental and physical health consequences (Dargie et al., 2014).

Transgender youth would seem to be especially vulnerable to increased risk of abuse, violence, and psychological distress, due to their legal status as minors, and rigid social and family gender expectations. Grossman et al. (2011), examined data taken from a 2007 larger exploratory study of the personal and contextual factors influencing the development of transgender youth, 15 to 21 years of age, in order to define what factors help determine psychological resilience and predict mental health problems. More than two-thirds of respondents reported being verbally abused by their parents or peers in relation to their gender nonconformity, while one-fifth to one-third reported physical abuse, with higher levels of abuse being related to higher levels of nonconformity (Grossman et al., 2011). In a 2007 report of transgender people living in Virginia, data showed trans people at an increased risk for violence and mental health problems being consistent with the negative coping responses in the general population (Xavier et al., 2007). However, although negative coping responses were similar, 26.3% of trans women and 30.4% of trans men reported past suicide attempts, as compared to 1-6% of the general population (Xavier et al., 2007).

Parental Support

Extensive research has concentrated on the protective and nurturing role of parents and families for the general population. Although family relationships are understood to be a critical component of childhood and adolescent development, only a handful of studies have focused on the role of LGB youth and parental relationships in relation to subsequent health behaviors, and the literature for transgender youth and parental response is scarce (Ryan et al., 2010). While most studies of sexual minority youth have focused on negative aspects of parental response, there has been very little research on the developmental benefits of family acceptance and support of LGBT youth (Ryan et al., 2010). Given that affirmative parental relationships are considered to be a foundation for optimal healthy psychological development in young people (Ryan et al., 2010), it is no surprise that rejecting behaviors by parents would have detrimental effects on transgender youth. In fact, unlike other minorities such as race, ethnic or religious groups, LGBT youth cannot depend on their parents to accept their sexual or gender minority status (Ehrensaft, 2011). Whereas most children share a minority status with their parents, this is rarely the case for LGBT youth, who are seen in disproportionate numbers throughout the foster care and homeless populations (Ehrensaft, 2011).

Every young person deserves a loving and supportive home, but for many LGBT youth that home is not available. Children, adolescents, and even young adults still living in the family home are subject to the rules and expectations of their parents, and may feel forced to remain in required and expected gender roles for fear of losing housing and financial support. However, this can take a great psychological toll on young people, and

many choose to express their sexual orientation or gender identity, often to unaccepting and rejecting responses from parental figures. In fact, recent estimates project 40% of homeless youth are LGBT, representing a disproportionate number of sexual and gender minorities on the streets, when it is estimated that LGBT youth make up only 5-10% of the general population (Durso & Gates, 2012; Quintana, Rosenthal, & Krehely, 2010). Data from a web-based survey conducted from October 2011 through March 2012 showed that nearly seven in ten (68%) LGBT respondents indicated that family rejection was a main factor for homelessness, and more than half (54%) reported that abuse within the family was another major factor for homelessness for LGBT youth (Durso & Gates, 2012). Homelessness and rejection from families disrupts normal development and can lead to devastating consequences for a young person's educational status, mental and physical health, economic future, and life expectancy (Quintana et al., 2010).

There is a paucity of research regarding the benefits of family acceptance and supportive behaviors for transgender youth (Ryan et al., 2010; Travers et al., 2012). According to Ryan et al. (2010), parental support of gender identity for transgender youth is a protective factor against negative health behaviors and psychological distress. It is not surprising that the family has been shown to be a significant factor in the well being of transgender youth. Most parents react adversely to their child's transgender status, with some being verbally, emotionally, and physically abusive (Grossman & D'Augelli, 2007). At best, parents will be faced with a great deal of cognitive dissonance (Ehrensaft, 2011) as they struggle to come to terms with the concept of their child being a different gender from the gender assigned at birth. According to Nuttbrock et al. (2009), coming

out as transgender may be more problematic in early adolescence than it is later in life, due to the lack of different types of relationships available to young people. Children whose parents react to their child's gender nonconforming expressions in a hostile manner live in a constant state of fear and anxiety, and because of this unrelenting distress, these young people often face increased levels of depression, negative health behaviors (i.e., substance use, suicidal gestures, and risky sexual practices), and lower school performance (Ehrensaft, 2011). The negotiation of a transgender identity, especially as an adolescent within the family relationship, is clearly difficult and challenging (Nuttbrock et al., 2009).

It has also been theorized that parental acceptance and rejection are bipolar ends of a continuum (Rohner, 2004; Rohner & Khaleque, 2002). Parental acceptance is marked by the expression of care, warmth, comfort, concern, affection, support, nurturance, and love for a child, whereas parental rejection refers to the absence or withdrawal of warmth and by the presence of physical or psychological damaging behaviors and affects (Rohner, 2004). According to Rohner and Khaleque (2002), parental rejection can also be subjectively experienced as undifferentiated rejection, which refers to an individual feeling or believing that the parent does not love or care about them, in the absence of objective identifiers indicating the parent is rejecting.

Sentse, Lindenberg, Omvlee, Ormel, and Veenstra (2010) argued that acceptance and rejection are two separate constructs, rather than two opposite ends of a continuum. In their study on parental and peer acceptance or rejection as buffers and risks for early adolescent psychopathology, the authors were interested in testing acceptance and

rejection separately and simultaneously in order to measure the impact on internalizing and externalizing problems in early adolescents (Sentse, Lindenberg, Omvlee, Ormel, & Veenstra, 2010).

Because perceptions of complete rejection or complete acceptance are not everyone's experience, for the purpose of this study, the variable of parental support was assumed to be on a continuum, in order to measure the degrees of negative health behaviors in relation to perceptions of parental support.

With minimum research on transgender youth and young adults regarding parental response, coping mechanisms, or negative health behaviors, little is known about the conditions in which parental acceptance or rejection is predictive of health outcomes among transgender young people (Travers et al., 2012). Transgender youth consistently confront socially expected gender rules, and the demonstration of incompatible behaviors of gender expression put transgender youth in vulnerable, precarious circumstances with parents and peers (Stieglitz, 2010). Although little research exists regarding family acceptance and supportive behaviors for transgender youth, the few studies that do exist have found suicidal behaviors are associated with higher levels of parental abuse (Alanko et al., 2008; Bockting et al., 2013). Family rejection studies have shown a relationship between negative family reactions to sexual orientation or gender nonconformity and elevated levels of mental health issues, risky sexual practices, and substance use (Bockting et al., 2013; Ryan et al., 2010; Toomey, Ryan, Diaz, Card, & Russell, 2010), and unconventional gender expression in childhood was been linked to stressful parental

relationships and rejection, especially on the part of fathers (Thomas & Owen Blakemore, 2013).

For LGB youth, exposure to homophobia is generally considered to have lasting implications (Travers et al., 2012). A 2009 study on the health of LGB adults found clear relationships between parental rejecting behaviors during childhood or adolescence and elevated rates of depression, anxiety, substance use, attempted suicide, and risky sexual practices as adults (Ryan et al., 2010). Some gender experts believe it can be assumed transgender people would suffer the same, and probably worse, outcomes when rejected, abused, or excluded by parents and family (Grant et al., 2011; Ryan et al., 2009). While there is a scarcity of research on transgender youth and family relationships, the small amount of existing literature shows that parental support of transgender youth offers a protective factor against psychological distress and negative health behaviors (Grant et al., 2011; Ryan et al., 2010). Perceived family support and acceptance is associated with positive LGBT mental health, self-esteem, and general health status, and protective against depression, substance abuse, and suicidal thinking and suicide attempts (Poteat, Mereish, DiGiovanni, & Koenig, 2011; Ryan et al., 2010).

The 2012 Trans PULSE Project, a community-based, mixed-methods research study providing preliminary data on the impact of parental support on health outcomes for transgender youth aged 16 to 24 in Ontario, Canada was conducted in order to assess the degree to which parental support impacted a young trans person's overall satisfaction with life. Results showed that for trans youth who were out to their parents, 34% had parents who they described as "very supportive"; 25% reported parental figures as being

"somewhat supportive" and 42% were perceived as being "not very" or "not at all" supportive of their child's gender identity or expression, indicating that a total of 67% of participants perceived their parents to be in the "not strongly supportive" category (Travers et al., 2012). For those participants indicating they had parents who were strongly supportive, 64% reported having high self-esteem compared to only 13% whose parents were perceived as not strongly supportive (Travers et al., 2012). Seemingly indicative of the influence of parental support were the suicidal behaviors in the past year of the participants. Having thoughts of suicide was common, with 35% of those with strong parental support and 60% of those without strong parental support considering suicide (Travers et al., 2012). Almost all of the 60% of participants without strong support from parents had actually attempted suicide in the past year (57%), whereas only 4% of those with perceived strong parental support attempted suicide (Travers et al., 2012). These findings show clear associations between numerous health outcomes and parental support perceptions and signify that parental support reduces many of the health-related risk factors for psychological distress and harmful health behaviors (Travers et al., 2012).

Key findings from the National Transgender Discrimination Survey (Grant et al., 2011) indicated that family support greatly impacts positive outcomes while rejection was connected with negative health behavior consequences. The sample of 6,450 participants ranged from 18 to 89 years of age, with 19% being 18 to 24 years old. This report showed that while 57% of respondents experienced family rejection, those respondents whose families accepted their gender identity had higher levels of social and

economic security than the full sample (Grant et al., 2011). Results also revealed family rejection to be related to a variety of negative health outcomes, including homelessness, risky sex and HIV, and suicide attempts (Grant et al., 2011). Conclusions of the National Transgender Discrimination Survey seem to confirm research from the Family Acceptance Project, examining the impact of family acceptance on LGBT youth showing strong links between family acceptance and health, interpersonal relationships, and economic security (Ryan et al., 2010). However, the data for young adults identifying as transgender (and not as lesbian, gay, or bisexual) indicated that independent of levels of family acceptance, transgender youth suffer from lower social support and general health (Ryan et al., 2010). Exploring protective factors against suicide of transgender adults, Moody, Fuks, Pelaez, and Smith (2015) found receiving support from family and other meaningful people in their lives was perceived by participants to be life saving. Previous research indicates that family support is an important suicide protective factor for transgender adults (Moody & Smith, 2013) and youth (Ryan et al., 2010; Travers et al., 2012). Feelings of acceptance and the sense of being valued were a strong suicide protective characteristic of family and other social support (Moody et al., 2015).

Studies on the mental health of transgender adults consistently report elevated rates of anxiety, depression, and suicidality (Bockting et al., 2013; Clements-Nolle, Marx, & Katz, 2006; Grant et al., 2011), and most studies of children diagnosed with gender-related issues were conducted at a time when public discussion regarding parental support and acceptance of a child's transgender status was rare (Olson et al., 2016). Olson, Durwood, DeMeules, and McLaughlin (2016) examined rates for the internalizing

symptoms of depression and anxiety in socially transitioned transgender children (N = 73). A social transition typically involves a change of pronouns used to describe the child alignment of gender presentation (hair, clothing) with the internal sense of gender. Social transitioning can be a very affirming process for a transgender child in regards to feeling supported by their parents and family (Sherer, 2016). Results showed typical rates of depression and only slightly raised rates of anxiety for children supported in their gender identities compared with population averages (Olson et al., 2016). These findings suggest that children who have parents supporting their gender status and allowing them to socially transition may have better mental health outcomes than those children who are forced to repress their gender (Olson et al., 2016).

Young people today are questioning and expressing nonconforming gender identities at younger and younger ages (Brill & Pepper, 2008; Ehrensaft, 2011; Quintana et al., 2010) and increasingly coming out as transgender during teen years (Russell et al., 2014). However, the influence of either effectual or detrimental parenting strategies of transgender youth is only beginning to be identified (Ryan et al., 2010; Travers et al., 2012). Research on young persons' psychological welfare has shown parental support to be a strong predictor of positive self-esteem (Mustanski & Liu, 2013; Needham & Austin, 2010; Travers et al., 2012). The purpose of this quantitative retrospective study is to identify correlations between how transgender young adults perceive their level of parental support for their gender identity during their childhood or adolescence, and subsequent engagement in negative health behaviors (i.e., suicidal thoughts, suicide attempts, substance use, and risky sexual practices). The identification of correlations

between perceptions of parental support and subsequent negative health behaviors may encourage social institutions to find improved and more extensive ways to support parents and transgender young people.

Importance of the Young Adulthood Stage of Development

Lifespan developmental theories examine the growth, change, and stability of regular transformations throughout a lifetime. Arnett (2000) argues that due to major demographic shifts that have transpired since the 1950s, the late teen and early twenties are no longer a brief period of transition into adulthood, but a distinct time period of adjustment and exploring and considering different life directions. For the purposes of this study, the term *parental* or *parent* refers to the main parental figure (i.e., biological parents, foster parents, adoptive parents, group home leaders) having the bulk of legal responsibility for the care of a minor. The term *support* refers to messages, information, or actions perceived by youth to be affirming of their gender identity.

The term *transitional age youth* (TAY) was developed in order to identity those young people between 16 and 25 years of age who were vulnerable and at-risk, often times ageing out of the foster care system or state custody. Currently, many behavioral health programs include an outpatient TAY programs, acknowledging this as a potential tenuous and vulnerable stage for young people. Some cities, such as San Francisco, have expanded the original definition of TAY to include not only those aging out of the state systems, but youth and young adults who are homeless, parenting, disabled, using illegal drugs, immigrant and undocumented, sexual or gender minorities, and those who have not completed a high school education (TAYSF, 2014).

For most young people in the United States, the stage of development between the late teens and early twenties are years of profound change, exploration, and transformation. The transition from adolescence to young adulthood is important because this developmental stage is characterized by increased distance from parents and a newly found sense of independence. During this time of life, exploration of possibilities can be higher than at any other point in an individual's life, and most people have made choices that have lasting ramifications (Arnett, 2000). Using latent growth curve analysis on data from three waves of the National Longitudinal Study of Adolescent Health, Needham (2008) found that parental support was inversely related to preliminary symptoms of depression during the developmental stage between adolescence (mean age at Wave 1 = 15.28 years) and young adulthood (mean age at Wave 3 = 21.65). Furthermore, adolescents who began the study with higher rates of depression reported less parental support during young adulthood, and those who experienced increasing levels of depression during the course of the study, regardless of their initial levels of depressive symptomology, reported lower levels of parental support at the end of the study (Needham, 2008). For most young people, stress has more negative psychological implications if little or no parental support exists (Needham, 2008). Arnett (2000) argues that although young adults are less reliant on their parents for emotional and financial support, parents remain a vital source of support during the transition to adulthood. Furthermore, research has shown evidence for the importance of parental support for both adolescents and young adults (Needham & Austin, 2010).

It has been well established that being a sexual minority in the developmental stage between adolescence and young adulthood puts an individual at greater risk for a variety of negative health behaviors (Becker, Cortina, Tsai, & Eccles, 2014; D'Augelli, 2002; Needham & Austin, 2010; Poteat et al., 2011; Ryan et al., 2009). Studies on LGB populations during this transitional developmental stage offer some insight into the impact of sexual minority status in relation to health risks (Becker et al., 2014; Jager & Davis-Kean, 2011). During this stage of development, LGB youth can potentially experience more severe identity conflicts than their heterosexual peers. Using the framework of the minority stress theory (Meyer, 2003), life span theory, and identity formation theory (Erikson, 1968), Becker, Cortina, Tsai, and Eccles (2014) compared the developmental paths between LGB and heterosexual populations in psychological functioning from adolescence to young adulthood (16 to 28 years of age). Results showed that compared to their heterosexual peers, LGB youth had elevated levels of depressive symptoms, alcohol consumption, social alienation, and suicidal ideation (Becker et al., 2014). In general, LGB youth showed higher levels of alcohol consumption, but these main differences occurred between the ages of 23 and 28 (Becker et al., 2014). There are no known comparable studies for transgender youth.

For most young people, healthy psychological and identity development is usually accompanied by a sense of hopefulness and plans for the future (Travers et al., 2012). However, very often transgender youth feel there is no way out of the confined roles in which they are forced to live. If, as argued by Jager and Davis-Kean (2011), the phase between adolescence and young adulthood is the most challenging for sexual minorities

in terms of psychological functioning and well-being, the struggle of transgender young people would seem even more difficult and challenging. Younger male-to-female transgender individuals have been shown to be extremely psychologically vulnerable to gender abuse (Nuttbrock et al., 2013). According to Nuttbrock et al. (2013), this may be due to limited coping skills and the ability to mitigate the impact on emotional welfare. Research on the impact of parental rejection is severely lacking, and studies on transgender young adults in relation to parental support is scarce. However, Haas et al. (2011) showed family rejection and hostility has been shown to be factors in negative health behaviors of transgender youth. During the developmental stage between adolescence and young adulthood, many female-identified young people struggle with issues of congruency, guilt, shame, and pressure from family and peers to conform to social norms, often experiencing rejection and marginalization (Brennan et al., 2012). Cultural sexism may also play a role in the increased rates of maltreatment for transgender females.

Attachment theory (Bowlby, 1979) posits that a strong emotional and physical attachment to at least one caregiver (usually a parent) is crucial for healthy personal development. What then are the implications when that bond is broken because the parent rejects a child for an inherent quality such as sense of gender? Studies on LGB youth and parental rejection have shown significant implications for negative health behaviors such as substance use, suicidal thoughts and behaviors, and risky sexual practices (Rosario et al., 2009; Ryan et al., 2009). For example, in a year-long longitudinal study, Rosario et al. (2009) conducted three sets of analysis to examine relationships between the

disclosure of LGB sexual orientation and subsequent substance use and abuse. Participants (*N* = 156), ages 14 to 21 years, were interviewed three times over the course of a year. Pearson correlation coefficients provided an initial test of associations between number of disclosures and the different types of reactions with various substance use and abuse from the information provided from the first interview. Linear regression analysis was conducted in order to assess associations of disclosure with different substance use outcomes. Linear regression analysis was also used to control for emotional distress and to examine accepting reactions and rejecting reactions in relation to substance use, after controlling for covariates. Results showed that rejecting reactions were associated with greater substance use (Rosario et al., 2009).

Social support has been shown to protect LGB youth, LGB adults, and transgender adults from thoughts of suicide and suicide attempts (Ryan et al., 2009; Moody & Smith, 2013). A sample of 133 self-identified transgender adults living in Canada (ages 18 to 75), was recruited online through LGBT and transgender LISTSERVs. A three block hierarchical multiple regression model was used in order to assess suicide protective factors among transgender adults (Moody & Smith, 2013). Results showed that while the sample perceived they had more social support from friends, it was the perceived social support from family that was significantly correlated with lower rates of suicidal behaviors (Moody & Smith, 2013).

Negative Health Behaviors

Research has consistently shown that transgender persons are at higher risk for negative health behaviors (i.e., suicidal ideation, suicide attempts, substance use, and

risky sexual practices) and overall negative health outcomes than the general and LGB populations (Grant et al., 2011). Studies indicate that transgender people who experience discrimination report higher levels of psychological distress, suicidal thinking, suicide attempts, substance use, rates of HIV infection, and interpersonal difficulties (Bockting et al., 2013; Clements-Nolle et al., 2006; Testa et al., 2012). Studying the relationship between family rejection of LGB teenagers with mental and physical health problems in young adulthood, Ryan et al. (2009) utilized a participatory research approach and a self-report questionnaire to survey a sample of 224 White and Latino LGB young adults, aged 21 to 25. The study was designed to associate particular family responses to their children's sexual orientation with health problems in young adulthood (Ryan et al., 2009). Using odds ratios, increased levels of family rejection were shown to be associated with poorer health outcomes, including suicidal thoughts and attempts, substance use, and risky sexual practices in LGB White and Latino young adults (Ryan et al., 2009).

Given the connections between parental rejection and increased levels of negative health outcomes for LGB young adults (Ryan et al., 2009), it might be expected that transgender youth would follow the same pattern. In fact, Ryan et al. (2010) showed clear associations for LGBT young adults between family acceptance in adolescence and health status in young adulthood. This study also indicated that transgender respondents had lower levels of social support and general health than their LGB counterparts; however, the measures for self-esteem, depression, and general substance abuse did not differ considerably from their LGB peers (Ryan et al., 2010).

The high rates of stigma and discrimination can result in detrimental attempts to mitigate the daily stressors of being transgender. Young people struggling with gender identity issues, such as coming out, discrimination, and stigma, and the lack of support or coping mechanisms often lead to problems with depression, anxiety, low self-esteem, and other detrimental mental states (Stieglitz, 2010). Challenges with mental health can, in turn, lead to a variety of destructive health behaviors, including heavy substance use, risky sexual situations, suicidal thinking, and suicide attempts for LGB and transgender youth (Stieglitz, 2010). In fact, transgender people who reported a history of physical and sexual violence were at higher risk for substance use, suicidal ideation, and suicide attempts (Testa et al., 2012).

Suicidal ideation and behaviors. While it is difficult to determine the exact numbers of young sexual or gender minorities who attempt or complete suicide, many studies have found that both LGB and transgender young people attempt suicide at higher rates than the general population. In 2011, suicide was the second leading cause of death for 15-25 year olds in the United States (American Association of Suicidology, 2015), with most studies on suicide or family support regarding transgender youth being conducted under the umbrella of the LGBT acronym. The research clearly delineating the transgender population from sexual minorities shows higher rates of suicide attempts for trans youth (Grant et al., 2011; Ryan et al., 2009), along with a links between family rejection and negative outcomes (Haas et al., 2011; Moody & Smith, 2013). Additionally, the literature has consistently shown that perceived discrimination and internalized

transphobia are related to mental health problems (Herbst et al., 2008; Operario, Nemoto, Iwamoto, & Moore, 2011; Zimmerman et al., 2015).

Although suicidal ideation and attempted suicide rates have been measured in different LGBT communities, it is important to note that the rate of completed suicides in these populations cannot be known due to the lack of collection of sexual orientation and gender identity data after a death (Haas et al., 2011; Haas & Lane, 2015). Lack of data on sexual orientation and gender identity status obscures causes of death and impedes attempts to identity and address disparities in mortality within these populations (Haas & Lane, 2015).

Sexual minority status has been shown to be a significant risk factor for suicide among lesbian, gay, and bisexual youth, but as a separate research entity, transgender youth have been vastly underrepresented in suicide research (Grossman & D'Augelli, 2007; Su et al., 2016). A 2010 qualitative study sampling young adults found that LGBT youth who had low family acceptance as adolescents were more than three times more likely to report both suicidal ideation and suicide attempts as compared with those who reported higher levels of family acceptance (Ryan et al., 2010). Some studies have found suicidal thinking and attempts are associated with more parental abuse (Bockting et al., 2013; Grossman & D'Augelli, 2007; Grant et al., 2011; Haas, Rodgers, & Herman, 2014).

Tebbe and Moradi (2016) examined relationship between minority stressors (i.e., prejudice, discrimination, stigma, and antitransgender attitudes), social support (i.e., friends, family, and other supports), and substance use (i.e., drugs and alcohol use) with

depression and suicide risk in a sample of 335 transgender individuals. The results showed high rates of depresson and suicide risk, with 71.9% of the sample reporting thinking about suicide in the past year, while 28.1% reported having attempted suicide at least once in their lifetime, and of those who attempted suicide, most had attempted at least twice (Tebbe & Moradi, 2016).

The high rate of lifetime suicide attempts for transgender participants (41%) reported in the National Transgender Discrimination Survey (Grant et al., 2011) vastly exceeds the 4.6 % for the general population, and 10-20% for LGB adults reporting suicide attempts in their lifetime (Haas et al., 2014). Using the findings from the National Transgender Discrimination Survey, researchers from the American Foundation for Suicide Prevention and the Williams Institute, UCLA School of Law, conducted an in-depth analysis of the data on suicide in order to identify specific characteristics and experiences of transgender and gender nonconforming people. According to the findings, suicide attempt rates are elevated for those who are out to everyone regarding their trans status (50%), those who reported they are always (42%) or most of the time (45%) perceived as transgender or gender nonconforming even if they themselves do not disclose this. Respondents with a disabling mental health issue (65%), those who are HIV-positive (51%), and those with disabilities (55-65%) reported increased rates of suicide attempts. Furthermore, the prevalence for suicide attempts was higher for those who are 18 to 24 years of age (45%), multiracial (54%), American Indian or Alaska Native (56%), and high school education or less (48-49%). Those who experienced discrimination, victimization, or violence at school, work, or when accessing health care

had even higher rates of lifetime suicide attempts. In addition, respondents who were harassed or bullied at school (50-54%), harassed or discriminated against at work (50-59%), experienced maltreatment or refusal to be treated by medical professionals (60%), and those who suffered physical or sexual violence at work (64-65%) and at any stage of school (63-78%).

Earlier research also linked family rejection with increased lifetime attempted suicide (Ryan et al., 2009; Ryan et al., 2010). Grossman and D'Augelli (2007) provided one of the first studies on related risks for transgender youth. Many of the fifty-five transgender young people (ages 15 to 24) considered themselves at high risk for self-harm and suicidal gestures because of family and social pressures to conform to normative gender and religious standards (Grossman & D'Augelli, 2007). In fact, 45% had seriously considered killing themselves and 26% had actually made an attempt at suicide (Grossman & D'Augelli, 2007).

Positive family relationships and support from parents can offer a safe haven from the stress and pressures of daily life for young transgender individuals. However, if these relationships are strained or abusive, young people are often stuck in unhealthy situations they feel powerless to change. Using data from the National Transgender Discrimination Survey conducted in 2011, researchers from The Williams Institute and the American Foundation for Suicide Prevention found that rates of attempted suicide were lower than the average (33%) for respondents who said family relationships remained strong after coming out as transgender (Haas et al., 2014). In contrast, those who experienced rejection, abuse, or disruption by family members or close friends due to transgender

stigma had elevated levels of attempted suicide (57%), and those who reported being the victim of violence from a family member had the highest rates of suicide attempts (65%) (Haas et al., 2014).

Whether the support comes from peers, the social environment, the Internet, or parents and families, transgender youth often remain without the same kind of support system of their cisgender peers. Several studies on the social environment in relation to suicide attempts for LGB youth show the social environment considerably impacts risk for suicide attempts (Cox et al., 2011; Gattis, 2013; Hatzenbuehler, 2011; Mustanski & Liu, 2013). Controlling for sociodemographic variables and multiple risk factors, Hatzenbuehler (2011), found that LGB youth were significantly more likely to attempt suicide (21.5%) in the previous 12 months than their heterosexual peers (4.2%), and the risk of those LGB youth of attempting suicide was 20% higher in unsupportive environments compared to environments perceived supportive. The issue of support, in general, for transgender people remains an understudied construct.

Transgender youth in the school systems often experience elevated levels of harassment and abuse from peers, teachers, and administration (Johnson, Singh, & Gonzalez, 2014). The Virginia Transgender Health Initiative Survey (THIS) asked an adult sample of 290 adult participants to retrospectively report on their experiences of harassment and insensitivity regarding their gender identity during high school, and in addition report on lifetime suicide attempts (Bradford, Xavier, Hendricks, Rives, & Honnold, 2007). Results showed those who experienced victimization were almost four times as likely to attempt suicide than those who had not experienced victimization, and

over 75% of those who reported attempting suicide had attempted several times (Bradford, et al., 2007).

Transgender youth are subject to various forms of maltreatment, including physical, sexual, and psychological abuse. Clements-Nolle et al. (2006) found that depression, history of substance abuse treatment, forced sex or rape, being discriminated against because of gender identity or presentation, or being beaten or physically abused due to gender identity or presentation, were each independent predictors of attempted suicide for transgender individuals. Nuttbrock et al. (2010) studied five life stages of transgender individuals and the relationship between physical gender abuse, psychological gender abuse, and suicidal ideation and behavior. With the exception of psychological gender abuse in the early-young adult life stage, significant associations were found between both types of abuse and suicidal thinking and behaviors during early and late adolescence (Nuttbrock et al., 2010). Transgender youth often face a myriad of stressors on a daily basis from all levels of society due to their gender identity and expression, leaving them vulnerable to thoughts or acts of suicide.

Self-acknowledgement of a transgender identity has been shown to have both positive and negative ramifications. Su et al. (2016) analyzed the results of a 2010 online survey from 770 LGBT participants in Nebraska in order to compare health disparities and assess whether transgender identity was associated with increased levels of discrimination, depression, and suicide attempts compared to nontransgender LGB persons, and to determine if acceptance of sexual minority and gender identity status is associated with lower levels of depression symptoms. Compared to nontransgender

respondents, transgender individuals reported alarming rates of discrimination that were associated with increased levels of depression and suicide attempts (Su et al., 2016). Acceptance of one's identity was shown to be more important for transgender individuals than the nontransgender respondents. After controlling for selected variables, those who reported higher levels of self-acceptance were considerably less likely to report symptoms of depression (Su et al., 2016). A nonconforming gender expression may lead to increased discrimination, prejudice, and abuse, while the acceptance of transgender identity seems to help mitigate negative responses to such treatment.

Substance use. In 2012, the Human Rights Campaign Foundation surveyed more than 10,000 LGBT youth in the United States, 925 of which represented a cohort of gender-expansive youth. The experiences of youth whose gender identities or expressions expand beyond the mainstream binary conceptualization were examined. Results from this survey indicated showed 48% of gender nonconforming youth reported they have experimented with drugs and alcohol, which is double the rate for their heterosexual cisgender peers (HRC, 2012). Population-based studies have consistently shown that adolescents who identify or are perceived to be LGB are at much higher risk for mental health issues, substance use, and suicide when compared to their heterosexual peers. Although the literature on substance use in transgender populations is relatively small, one study found that approximately 17% of trans females and 33% of trans males reported a history of alcohol problems and 74% of trans females and 77% of trans males reported past illicit drug use (Testa et al., 2012). According to Anestis, Tull, Lavender, and Gratz (2014), substance use is conceptualized both as a coping mechanism for the

psychological pain of suicidality and as a risk factor that can increase impulsivity and disinhibition in relation to suicide attempts. Additionally, a 2013 study found that life stress is associated with sexual risk among young transgender women, and that this relationship may be partly explained by substance use (Hotton, Garofalo, Kuhns, & Johnson, 2013).

Coping with daily discrimination, stigma, and isolation can lead to unhealthy coping mechanisms. The minority stress framework has been applied to explain the elevated levels of substance use among LGB minorities in comparison to heterosexuals. Additionally, increased levels of family rejection during adolescence were shown to be associated with poorer health outcomes, including suicidal thoughts and attempts, substance use, and risky sexual practices in LGB White and Latino young adults (Ryan et al., 2009). However, the application of this model to transgender people remains in its early stages (Hendricks & Testa, 2012).

The National Institute of Health (NIH) estimates that 6.8% of the adult general population in the U. S. had an alcohol use disorder in 2014. Applying the minority stress model, the pervasive social stressors transgender face may result in higher levels of substance abuse (Reisner, Gamarel, et al., 2014). Findings from the National Transgender Discrimination Survey (Grant et al., 2011) showed over 25% of respondents misused drugs or alcohol in order to manage the mistreatment they faced due to a nonconforming gender identity or gender expression. Studying effects of gender minority stressors in substance use behaviors for transgender women and their non-transgender male partners, Reisner, White, Mayer, and Mimiaga (2014) hypothesized that for transgender women

substance use behaviors can be conceptualized as a consequence of persistent social stressors, both internal (i.e., hypervigilance and gender-related self-monitoring) and external (i.e., relationship rejection, employment discrimination, housing, health care, and social and economic marginalization).

Gender minority stressors have been found to be independently associated with elevated levels of alcohol use among transgender women and marijuana use among transmen (Gonzales, Gallego, & Bockting, 2017). In a study comparing mental health, substance use, and sexual risk behviors between rural and non-rural transgender people, Horvath, Iantaffi, Swinburne-Romine, and Bockting (2014) found no overall differences in substance use and that marijuana use was high for both transmen (29-32%) and transwomen (15-21%).

Studies indicate transgender women who participate in sex work have elevated rates of substance use. This is especially true for those who participate in survival sex, sex work, drug sales, and other behaviors associated with an underground economy (Grant et al., 2011). Many transwomen report high rates of unprotected sex and sex under the influence of drugs and alcohol, engaging in survival sex, sharing needles for drugs, hormones, and silicone (Operario et al., 2011). Substance use around sexual behavior has been reported to help with a need to lower inhibitions regarding gender dyphoria and the fear of not finding a partner who will validate and respect an unconventional gender identity (Reisner, Perkovich, & Mimiaga, 2010). Zimmerman et al. (2015) tested mediational models investigating some of the processes of how perceived discrimination and internalized transphobia are related to sexual risk behaviors. Results showed both are

related to mental health problems and that the perception of discrimination and internalized transphobia were related to increased alcohol use in transgender women (Zimmerman et al., 2015). In fact, mental health problems were the weakest predictor of risky sexual behaviors, whereas alcohol use was a strong predictor of dangerous sexual practices, such as multiple partners and unprotected sex, concluding that key components of HIV prevention interventions should target a reduction in alcohol use (Zimmerman et al., 2015).

Risky sexual practices. Experiences of stigma, discrimination, violence, extreme health disparities, and elevated levels of high risk sexual behavior and substance use have been well documented for transgender women, and especially for transgender women of color (Operario et al., 2011). Gender abuse, or victimization due to gender identity, is associated with depressive symptoms and high-risk sexual behaviors for male-to-female (MTF) persons, leading to higher rates of HIV and other STIs (Nuttbrock et al., 2013).

The role of gender affirmation has been used as a framework for conceptualizing risk behavior among transgender women. According to Sevelius (2013), gender affirmation is not unique to transgender people, but may have different, distinct, or more prominent meaning for those with a gender minority status. For transgender individuals, gender affirmation can be much more complicated and vital to sense of self and congruency than it is for others, often due to both the internal and external barriers of identifying transgender. For young people, gender affirmation has been shown more likely come from friends than family (Nuttbrock et al., 2009), but when family is

rejecting of a young family member, there is greater risk for negative health outcomes as young adults (Ryan et al., 2009; Sevelius, 2013).

Examining the social contexts of racism, sexism, and transphobia, Sevelius (2013) explored how the unique cultural experiences and interpretations of these experiences lead to high levels of dangerous health behaviors for transgender women of color. Gender affirmation, and the congruency of an interactive and interpersonal process whereby a person receives recognition and support for their gender identity, has been recognized in the literature (Beemyn & Rankin, 2011; Levitt & Ippolito, 2014; Riggle et al., 2011). According to Garofalo et al. (2006), transgender women report being sexually harassed early in life. Because objectification of trans women simulates the sexual harassment of cisgender women, these experiences may serve as an affirmation of gender, and sex work ultimately provides a path for readily available affirmation (Nuttbrock et al., 2009). For transgender people, especially trans women, this need for gender affirmation can lead to dangerous behaviors.

The literature suggests the marginalization often experienced by young transgender women contributes to a wide range of negative health outcomes, including psychological distress, substance abuse, and sexually risky practices (Brennan et al., 2012). Anxiety triggered by discrimination and stigma may result in a threat to identity, leading to elevated levels of risky sexual behaviors and has been associated with the need for gender affirmation (Sevelius, 2013). Much of the research on sexual risk behaviors for transgender women has focused on risks associated with commercial or survival sex partners because of the high prevalence of sex work and HIV within this community

(Baral et al., 2013; Brennan et al., 2012; Herbst et al., 2008; Zimmerman et al., 2015). Survival sex or transactional sex has been described as the exchange of sex for food, money, shelter, drugs, and other needs (Walls & Bell, 2011).

Some samples of transgender women have shown experiences of discrimination and stigma increase the need for gender affirmation from male sexual partners, thereby increasing the likelihood of unprotected sex and ability to negotiate condom use and substance use during sexual encounters (Nuttbrock et al., 2013). According to Brennan et al. (2012), substance use, psychological distress, and experiences of violence may contribute to heightened rates of HIV and risky sexual practices. For young transgender women, the combination of substance use, low self-esteem, and violence may present mental and physical burdens that are difficult to overcome (Brennan et al., 2012; Nuttbrock et al., 2013). Comparable to other at-risk populations, sex under the influence of alcohol or drugs is one of the methods used to cope with stigma, loneliness, and the demands of sex work (Garofalo et al., 2006; Zimmerman et al., 2015).

The prevalence of risky sexual practices is less clear for transgender men, due to the scarcity of studies focusing on this population (Bauer, Redman, Bradley, & Scheim, 2013; Herbst et al., 2008; Reisner, White, et al., 2014; Reisner et al., 2010). Although much of the data on risky sexual behaviors come from studies of transgender women, transgender men are also at risk. According to Reisner et al. (2010), the assumption that transgender men only engage in sexual behavior with nontransgender women may have influenced that lack of focus on this population. However, transmen have been shown to have diverse sexual attractions, identities, and needs (Bauer et al., 2013; Grant et al.,

2011; Reisner et al., 2010). Reisner, White, et al. (2014) analyzed data from de-identified medical records of 23 transgender men who screened for STDs between July and December 2007 at a Boston, Massachusetts health center. Risky sex in the prior three months was linked with alcohol use, past suicide attempts, and having sex with only men, rather than both women and men (Reisner, White, et al., 2014). Participants were found to have a complex range of health problems documented in their records, primarily depression, anxiety, abuse histories, and current alcohol use, consistent with research documenting the role of psychosocial stressors with sexually risky behaviors (Reisner, White, et al., 2014).

For homeless transgender youth, survival sex is a common experience and can contribute to increased likelihood of negative psychological outcomes (Walls & Bell, 2011). Economic realities, discrimination, and fewer legal protections for housing and jobs can make life difficult for transgender individuals (Ray, 2006).

Relationships with parental figures may act as a protective factor against harmful health behaviors (Walls & Bell, 2011). In an examination of family influences on problem behaviors of homeless youth, structural equation modeling was used in order to analyze relationships between the latent variables of *time away from home*, *parent relationships*, and r*easons for leaving home because of abuse* and *violence* and the externalizing and internalizing outcome variables of *substance use*, *criminal behaviors*, *survival sex*, and *psychological distress* (Stein, Milburn, Zane, & Rotheram-Borus, 2009). Results showed having a positive maternal relationship was associated with decreased probability of engaging in survival sex, although the same association did not exist

between having a good paternal relationship, while positive relationships with fathers was associated with decreased levels of externalizing behaviors such as substance use and criminal activity (Stein et al., 2009).

Summary

The purpose of this literature review was to provide a synthesis of research studies relevant to the experiences, and health disparities of transgender young adults. Furthermore, based on the minority stress model and Carl Rogers' theory of self, it specifically discussed the role of external forces such as prejudice, discrimination, and violence, along with internal forces, including sense of congruence and gender affirmation. The influence of parental support has been an understudied variable for transgender young persons. However, studies on sexual minority youth and parental rejecting behaviors have found increased risk of negative health behaviors for young LGB adults, and some gender experts believe trans youth have even a more difficult process than sexual minority youth, due to stigma and misunderstanding of gender identity issues.

Gender is a socially created construct, monitored and reinforced closely by society. Parents, religious institutions, teachers, schools, communities, and American culture operate on the generally accepted rigid binary expectations of gender. This pressure to conform and fit into neatly defined boxes can create enormous distress and confusion for transgender young people. Understanding early in life that what they are feeling is unacceptable, they often try to hide it or deny their feelings. The importance of parental support is widely accepted to be a foundational part of healthy development in

children. What happens to the young person who is rejected by their parents, those who are supposed to support and nurture them, for identifying as a gender different from the gender assigned at birth?

The minority stress theory is valuable for explaining how the elevated levels of discrimination, prejudice, and stigma could influence participation in dangerous health behaviors for transgender people. Carl Roger's theory of self, with an emphasis on the importance of congruence, along with the innate need for gender affirmation for trans persons informs an understanding of risky behaviors for this population. Research has shown especially for transwomen, risky sexual practices, such as unprotected receptive anal sex, is often correlated with the need for gender affirmation and substance use. This population is more likely to participate in dangerous behaviors in order to attain affirmation and a sense of congruence for their internal sense of gender.

The literature review shows high rates of suicidal thoughts and behaviors, substance use, and risky sexual behavior among the transgender population. Studies on LGB youth and young adults have established serious health disparities compared to heterosexual peers. Although transgender people are coming out at younger and younger ages, there remains a lack of literature on the impact of parental acceptance and rejecting behaviors. The high rates of homeless LGBT youth represent one result of rejection. Thus, there is a need to examine the relationships of accepting and rejecting behaviors for transgender young adults. This information may provide valuable information to families, educational systems, policy makers, and professionals who work with that population.

Given the importance of the family's role in adolescent development, this study is significant because it addresses relationships between parental support and negative health behaviors of a marginalized and little known population, providing information regarding the implications of parental response to gender identity for transgender youth. This research can help contribute to positive social change by adding to the body of knowledge about the risk factors for transgender people in order to inform families, educators, healthcare professionals, and policy makers.

Chapter 3 will provide methodological information relevant to this study. It will identify and discuss sampling, collection of data, variables, and data analysis.

Chapter 3: Research Method

Introduction

Many of the studies reviewed in Chapter 2 showed that the transgender population in the United States experiences elevated levels of discrimination, stigma, prejudice, and violence. As noted in the literature review, there is a paucity of research regarding the health behaviors of transgender young people in relation to their perception of parental support. The purpose of this quantitative, cross-sectional, online survey study was to examine the differences in rates (frequency and severity) of harmful health behaviors between self-identified transgender young adults, ages 18 to 25, who perceived they had parental support during childhood or adolescence for their nonbinary gender status and those who perceived they did not have parental support. The independent variable was the level of perception of parental support. The dependent variables were negative health behaviors, defined as suicidal thoughts, suicide attempts, substance abuse, and dangerous sexual practices in transgender young adults. In this chapter, I will discuss the methodological approach used to answer the research questions presented in Chapter 1. Also examined in this chapter will be the research design and rationale, target population, sampling method, sample size, recruitment procedures, instrumentation and materials, data collection and analysis procedures, and protection of human subjects.

Research Design and Rationale

This was an exploratory, descriptive, cross-sectional, nonexperimental quantitative study. For this study, several variables were operationalized regarding parental support and health behaviors. The assignment of numbers to quantitative

measure allows for the use of statistical and mathematical analysis in order to describe, clarify, and predict the phenomenon being studied. In addition, descriptive, quantitative research is used to examine the relationship between a characteristic of a person and a corresponding attitude, disposition, or inclination to a particular situation.

Cross-sectional designs are often associated with survey research because they permit the use of data from large numbers of participants not bound by geographical limits, allowing the situations to be studied where the independent variable cannot be manipulated for later comparison. Therefore, a quantitative approach was appropriate to examine whether perception of parental support is related to levels of harmful health behaviors in transgender young adults. Because social science research is more about indicating trends at specific places and times, the relationship between the quantifiable numerical structure of my variables and the concepts being measured was not direct or precise.

For this research, the independent variable was perceived level of parental support. The dependent variables were the levels of harmful health behaviors (suicidal ideation, suicide attempts, alcohol use, lifetime marijuana use, lifetime illicit drug use, and risky sexual practices). I sought to address the relationships between the levels of perceived support received from parents and harmful health behaviors of transgender young adults, a marginalized, stigmatized, and little-known population. The influence of damaging parenting practices for transgender youth has only begun to be identified in the past decade (Ryan et al., 2010), and research indicates family support to be a key

protective factor for both transgender adults (Moody & Smith, 2013) and transgender youth (Travers et al., 2012).

Methodology

Population

Inclusion criteria included being ages 18 to 25 years; self-identification as a person of transgender experience; knowledge of their transgender status during childhood, adolescence, or young adulthood by at least one parent or guardian; and having lived with at least one parent or guardian at least part time before the age of 18. I studied transgender young adults to assess the impact of family responses to their transgender identity at an age when many young people have moved from the family home, have greater independence and autonomy, and have less parental influence or enforced limits on their behavior (Arnett, 2000).

It is difficult to determine the number of transgender people in the United States. It is estimated that 0.3% of the population is transgender (Gates, 2011). However, this frequently cited statistic comes from two separate studies conducted several years ago: The first was a 2007-2009 study in Massachusetts on the health of transgender adults; the second was a 2003 study in California looking at trends in tobacco use for the LGBT population (Paquette, 2015). Another issue making it difficult to determine an accurate count for transgender people is that the U.S. census only allows for two responses when asking about gender (male or female), and gives no category for transgender or gender nonconforming people to identify themselves (Paquette, 2015). Additionally, the definition of transgender can vary within different subsets of the population, and the ever-

shifting classifications of gender (i.e., *gender queer*, *gender fluid*, *bigender*, *agender*, *androgynous*, etc.) contribute to the inability to concisely define *transgender* (Henig, 2017). Consequently, population totals for transgender people cannot be clearly established at this time.

Sampling and Sampling Procedures

For the sampling strategy for this study I used a combination of purposive and snowball sampling techniques. Purposive sampling for this study involved targeting individual participants or community organizations that were likely to forward the study's information to other potential participants. The method of snowball sampling has been accepted as an appropriate way to collect data from hard-to-reach populations, such as underground or stigmatized subcultures that may wish to remain hidden (Bockting et al., 2013). Typically, snowball sampling is utilized in studies of populations that may be active in behaviors that are not socially acceptable and who fear exposure will lead to stigmatization, harm, or discrimination (Penrod, Preston, Cain, & Starks, 2003).

Hard-to-reach populations have been described as (a) being low in numbers, (b) being difficult to identify, (c) having common interests that are rarely recorded, (d) lacking a sampling frame, (e) often refusing disclosure, and (f) lacking appropriate places for researchers to approach them (Marpsat & Razafindratsima, 2010). Matching this description, the transgender population is a small group, often hard to identify, are as diverse and varied as any other minority group, and may not want to reveal their gender status to others.

Researchers who use snowball sampling take advantage of the social networks of identified key participants and organizations, which are then used to provide the researcher with a cumulative set of potential contributors (Johnson & Sabin, 2010). However, because the structure of the sample is dependent upon the choice of initial recruits, snowball sampling lacks validity in representation (Kendell et al., 2008). The intrinsic threat in snowball sampling is that the initial members may have a restricted social network, thus limiting the validity of the findings (Penrod et al., 2003). Nevertheless, despite inherent limitations, snowball sampling is sometimes the only method available to study certain populations because potential participants may be fearful or hesitant to disclose information about their personal status (Crawford, Wu, & Heimer, 2015).

Along with the advantages, there are several challenges that exist when performing Internet-based data collection. First, only those with access to the Internet can participate. It is estimated that more than 89% of households in the U.S. have a computer (Ryan, 2018). However, only geographies with populations of 65,000 people or more were used to collect the data for this estimate (Ryan, 2018). In addition, because enumeration of the transgender population in the U.S. is not possible, researchers are unable to evaluate whether a sample of participants is representative of the population, which is a disadvantage for verifying generalizability and evaluating a study's results (Meyer & Wilson, 2009). Additionally, simple snowball sampling has the potential to recruit participants who have similar characteristics or connections to the key participants, thereby reducing the effective sample size (Johnson & Sabin, 2010; Penrod

et al., 2003). In order to obtain the most accurate results possible, the initial contacts made in the purposeful sampling strategy were varied and diverse. For example, urban and rural LGBT community centers, female-to-male, male-to female, combined gender identity Internet support groups, and transgender advocacy groups were targeted in order to provide a wide range of respondents.

The data for this study was based on retrospective self-report, which also has fundamental limitations, such as biased recall. Biased recall is the difference or accuracy of retrieved memories of events or situations in the past. According to Groves et al. (2009), emotional events are generally easier to recall and using multiple cues can help minimize recall bias.

Nonprobability sampling is effective in exploratory research when a sample or list of potential participants cannot be accurately defined, but because no sampling frame exists for the transgender young adult population in the United States, probability sampling or quota sampling would not be appropriate. However, nonprobability sampling has the disadvantage of volunteer bias (Meyer & Wilson, 2009). In fact, nonprobability sampling may or may not generate results similar to probability samples, and it is not clear when a nonprobability tactic will work or when it will not (Groves et al., 2009). While studies based on convenience sampling may be internally valid, this type of sampling often lacks external validity, specifically if estimates are sought to represent whole population characteristics (Hughes, Emel, Hanscom, & Zangeneh, 2016). According to Meyer and Wilson (2009), before conducting a nonprobability sample, very careful planning must be done because of the many potential sampling biases inherent in

this method. Despite the potential pitfalls, nonprobability sampling is a good alternative if the researcher if estimating a particular population is not a main focus of the study, but when the purpose is to find out whether and how variables interact with each other (Meyer & Wilson, 2009). Participants for this study were ages 18 to 25 years, identified somewhere along the transgender spectrum, had one or both parents who had knowledge of participants' trans status during their childhood or adolescence, and lived with one parent, both parents, or a main guardian at least part time.

A power analysis was conducted using G*Power computations, in order to verify a statistically appropriate sample size for this study. A linear multiple regression model, a test family setting of *F*-tests, and an a priori type of analysis were used in order to conduct the power analysis. Cohen's f^2 was set to the medium effect size value of 0.15, the alpha (significance) value was set at 0.05, and the conventional level of power was set at 0.80. This multiple regression model will include three predictor variables; therefore, the number of predictors was inputted at three. The total significance of the model will be tested with an *F*-ratio for R^2, and thus the test family setting was *F*-tests. Using these parameters and analysis settings, the estimated total sample size for this study was calculated to be 77 participants.

Procedures for Recruitment, Participation, and Data Collection

Recruitment emails were sent to potential participants through LGBT and transgender community organizations, transgender resource providers, websites, transgender rights affiliates, and transgender LISTSERVs. An introduction, explanation, and rationale was included, along with a link to the survey. The URL link included

information about the purpose of the study, the eligibility criteria, risks and benefits of participation, and a confidentiality agreement. Internet sampling has the benefit of potentially addressing gaps in other sampling methodologies, and gives the researcher access to the targeted population in both urban and rural areas, as well as different ethnic and racial communities (Meyer & Wilson, 2009). Data collection was conducted anonymously using a secure survey platform. Participants were asked to register their informed consent and complete a sequence of questionnaires. Participants were given the option to withdraw their consent at any time during the survey, ensuring their answers would not be included in the study. The Trevor Project's contact information was listed at the top of each page in the event that a participant became psychologically distressed during the survey and needed some kind of emotional support or connection. Including these resources on each page insured the contact numbers are readily available in case a participant opts out in the middle of the survey.

Demographic characteristics included assigned sex at birth, current gender identity, age, race/ethnicity, income, education, employment status, current living situation, and age at which they left the nuclear family home (See Appendix B). The term *transgender* is defined to include individuals who have socially, legally, or physically transitioned from one gender to another, as well as individuals who identify as androgynous, genderqueer, or those whom relate their identity to their gender nonconformity.

An online, anonymous data collection methodology was utilized for two reasons. Online participation in research has been described in the literature as an appropriate

method of reaching stigmatized and hard-to-reach populations, including transgender populations (Miner, Bockting, Swinburne Romine, & Raman, 2012). Anonymous research designs provide greater chances of minimizing participant risk (dickey, Hendricks, & Bockting, 2016). Additionally, because data collection was nationally targeted, it was not possible to collect data in-person. Along with accessing a stigmatized population, using the Internet to conduct studies also provides many advantages, including the cost of recruiting large, diverse samples, giving researchers access to a wide scope of social behaviors (Miner et al., 2012). According to Miner et al. (2012), because transgender people are stigmatized and frequently remain hidden, past research has often relied on the more visible population. Common visible populations used in transgender research have included clinical samples and sex workers. While this approach can be efficient in some ways, it lacks validity representation (Kendell et al., 2008). In contrast, the Internet provides a platform that is anonymous and available to permit the more hidden and geographically isolated members of the transgender community to interact with each other (Shapiro, 2004), increasing the availability for recruitment.

In summary, the use of online surveys allows researchers to acquire adequate amounts of data on small, stigmatized, hard-to-reach populations in order to make reliable appraisals of behavior and relationships (Miner et al., 2012). According to the American Psychological Association [APA] (2010a), when conducting research with stigmatized and marginalized populations, it is paramount to protect the dignity of those being studied. Providing an online, anonymous Internet survey helped ensure the minimization of participants encountering risks.

Instrumentation and Operationalization of Constructs

In addition to the standard demographic information previously outlined, this study utilized rating scales measuring perception of parental support system, suicidal behaviors, substance use, and risky sexual behaviors. Rates of harmful health behaviors were measured in relation to rates of perception of parental support during adolescence of transgender young adults.

Independent variable: Perceived Parental Rejection Scale (PPRS). The Perceived Parental Rejection Scale (PPRS; Willoughby et al., 2006) was used to measure gender-identity specific perceived parental support. This scale was developed from the foundations of Weinberg's (1972) love versus conventionality theory and Savin-Williams' (2001) initial reactions model, and used to assess perceptions of parental reactions to disclosure of sexual orientation. The PPRS initially examined nine theoretical dimensions, including: (a) parents' level of perceived general homophobia; (b) parent (or self) focus; (c) child focus; (d) shock; (e) denial; (f) anger; (g) bargaining; (h) depression; and (i) acceptance (Willoughby et al., 2006). However, the items assessing the child-focused dimension were later eliminated based on an initial scale development study, showing these items not correlating with the PPRS total as expected, along with lowered overall reliability estimates in both mother and father versions of the tool. Each dimension uses four items for assessment, and therefore, the current scale is a 32-item scale assessing for eight theoretical dimensions, rather than the original 36-item scale.

For this survey, the "MOTHER/PARENT 1" and "FATHER/PARENT 2" versions were combined into a "parental figure" version. The rationale for combining the

scales was that they are the same (except for the use of the words mother and father), and because it is not assuming that participants grew up with both a mother and father figure present. This allowed the participants to use a single parent, grandparents, foster parents, adoptive parents, or any other parental representative they consider having been their parental figure.

Participants were asked to think back to childhood and adolescence when their parents were aware of their gender identity, and using a 5-point Likert scale, indicate whether they agreed or disagreed with the statements (Willoughby et al., 2006). Because Willoughby's original scale was measuring sexual orientation disclosure, the term "gender identity" will be substituted for sexual orientation references (i.e., "gay," "lesbian," "bisexual," "queer"). The survey instrument uses the primary question, "The week when I told my MOTHER/PARENT 1 (or FATHER/PARENT 2) that I was lesbian/gay/bisexual/queer (or when she/he/they found out I was lesbian/gay/bisexual/queer) she/he/they:" followed by a listing of the 32 questions. Examples of the wording change include, "Wanted me not to be lesbian/gay/bisexual/queer" will be changed to "Wanted me not to be transgender" and "Was ashamed of my sexual orientation" will be changed to "Was ashamed of my gender identity." The PPRS scores range from 32 to 160, with higher scores signifying more negative views of parental reactions. The PPRS also shows item-total correlations of .40 and above and establishes good internal consistencies for both mother (*alpha* = .97) and father (*alpha* = .95) versions. A subset of participants also shows good test-retest

reliability after a 2-week interval for mother (r = .97) and father (r = .95) versions. Permission from the developer to use the instrument was granted (See Appendix A).

Dependent variables. Several established scales were used for measuring the independent variables included in this study. The 2015 State and Local Youth Risk Behavior Survey (YRBS) conducted by the Centers for Disease Control contains measurement scales for suicidal thinking, suicide attempts, lifetime marijuana use, and illicit drug use. The AUDIT Test for Alcohol Addiction (Saunders et al., 1993) was used to test harmful or dangerous alcohol intake. Significant health behavior risks are often established in childhood and adolescence, and extend into adulthood (CDC, 2014). The CDC has been using the YRBS and monitoring six main categories of health behavior risks in youth and young adults since 1991(CDC, 2014). These categories include behaviors that lead to violence or unintentional injury, sexual behaviors that could lead to the transmission of HIV or STI's or pregnancy, tobacco use, alcohol and drug use, dietary practices, and physical inactivity. Data for the YRBS is gathered in a national survey by the CDC as well as school-based state, tribal, and large urban school districts, conducted by educational and health agencies.

The CDC conducted reliability testing in both the 1991 and 1999 national questionnaires. In addition, test-retest reliability studies were conducted in 1992 and 2000 (CDC, 2014). In the 1991 version of the questionnaire, approximately 75% of the questions were found to have a considerable or higher reliability (kappa = 61%-100%) and no statistically significant differences were found between the first and second administration of the test (CDC, 2014). The responses were less consistent for students in

grade 7 than for grades 9-12, indicating the questionnaire was more appropriate for the higher age ranges. Ten questions in the 1999 questionnaire were found to have questionable reliability, and therefore these questions were either revised or deleted in subsequent versions of the questionnaire (CDC, 2014). No study has been conducted to assess the validity of all the self-reported behaviors included in the YRBS. However, in 2003, the CDC reviewed existing empirical literature to evaluate situational and cognitive elements that could affect the validity of adolescent self-reporting of health behaviors identified in the YRBS (CDC, 2014). This review revealed that the validity of self-report is not affected equally by these factors (CDC, 2014).

Suicidal ideation and attempts. Sadness, suicidal ideation, suicide attempts, and the severity of those attempts were measured by the YRBS 5-item subscale for suicide. According to the CDC, persons aged 15 to 24 had a 11.6 suicide rate per 100,000 people in 2014, and cites suicide as the second leading cause of death for those 15 to 34 years of age (CDC, 2014). This is a 5-item questionnaire, which asks yes or no questions about depression, suicide consideration, suicide planning, and suicide attempts. The fifth question asks the number of times suicide was attempted with numerical categories.

Suicide ideation was assessed by three questions: “Since you realized you were transgender, have you ever felt so sad and hopeless almost every day for two weeks or more in row that you stopped doing some usual activities?”, “Since you realized you were transgender, have you ever seriously considered attempting suicide?”, and “Since you realized you were transgender, have you made a plan about how you would attempt suicide?” These three items were yes or no questions and will be scored 0 for no and 1 for

yes. The three items will be added together as a composite measure, with 0 being the lowest score and 3 being the highest score. Additionally, suicide attempts will be measured by two questions: “Since you realized you were transgender, how many times have you actually attempted suicide?” and “If you ever attempted suicide, did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse?” These two questions will be scored 0-4 and 0-2 respectively. These two items will also be summed as a composite measure.

The sequencing of the questions assess increasing risk, and skip out patterns were inserted in order to eliminate conflicting or unnecessary answers. Results from a 2011 review of the validity of the suicidality items form the YRBS showed support for convergent and discriminant validity (May & Klonsky, 2011). The phrase “Since you realized you were transgender” was used to replace the phrase “During the past 12 months” in order to measure lifetime suicidal behaviors. The YRBS questionnaire is in the public domain. No permission was required.

Alcohol Use Disorders Identification Test (AUDIT). Harmful or dangerous alcohol use was measured by the AUDIT questionnaire (AUDIT; Saunders et al., 1993). This self-administered questionnaire consists of 10 items rating alcohol consumption, drinking behavior, and problems related to alcohol. The AUDIT was the first instrument of its kind to originate from the basis of a cross-cultural study of six countries (Australia, Bulgaria, Kenya, Mexico, Norway, USA) by the World Health Organization (WHO) to identify people whose alcohol consumption could be harmful to their health. The AUDIT was originally tested on primary care patients in the six countries, and then validated

among external reference groups of alcoholics and non-drinkers (Saunders et al., 1993). In addition, a comparison of the validity of three different alcohol-screening measures (i.e., CAGE questionnaire, Short Michigan Alcohol Screening Test [Short MAST], Alcohol Use Disorders Identification Test) showed that more reliable and valid information can be obtained from the Short MAST and AUDIT (Hays, Merz, & Nicholas, 1995). The AUDIT has been validated for use in several patient populations and settings, and with the HIV population (Surah et al., 2013). Good reliability has been reported, with internal consistency (Cronbach's alpha) .80 to .83, and test-retest reliability .82 -.83 for total scale in an adolescent sample (DiIorio et al., 1992).

Along with adequate reliability and validity levels, differences exist between the AUDIT and other screening tools, including the following: (a) the AUDIT tries to identify problem drinkers at the lower end of the spectrum rather than only those with established alcohol dependence; (b) it focuses on frequency of intoxication and harmful consumption rather than the consequences of drinking behavior; (c) it asks about alcohol experiences in the last year as well as over the person's lifetime, improving the relevance of current behavior, and does not require the participant to identify as a problem drinker. Questions 1-8 on the 10-item scale have 4-choice response based on frequency, and questions 9-10 have 3 responses scored 0, 2, and 4. By summing item responses, total scores of 8 to 15 represent medium levels of harmful alcohol use, whereas scores over16 indicate high levels of alcohol use problems (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001). The AUDIT takes approximately three minutes to complete (Surah et al., 2013). Sample questions include: "How many alcoholic drinks do you have on a

typical day when you are drinking?" "How often during the past year have you felt guilty or remorseful after drinking?" "Has a relative, friend, doctor, or health care worker been concerned about your drinking, or suggested that you cut down?" The AUDIT questionnaire is in the public domain. No permission was required.

Drug Use Questionnaire (YRBS). The scale to measure marijuana and illicit drug use was taken from the 2015 Youth Risk Behavior Survey (CDC, 2017). The question asks about the lifetime use of marijuana: "During your life, how many times have you used marijuana?" Because the focus of this study was to examine overall lifetime health behaviors, the second and third questions, "How old were you when you tried marijuana for the first time?" and "During the past 30 days, how many times did you use marijuana?" will be excluded. The next nine questions ask about other drugs, including cocaine, inhalants, heroin, methamphetamine, ecstasy, synthetic marijuana, steroids or pharmaceuticals without a doctor's prescription, and intravenous drug use. The YRBS survey included a question on illegal drug activity on school property: "During the past 12 months, has anyone offered, sold, or given you an illegal drug on school property?" This question was removed from the current survey due to respondents being age 18 or older, most will no longer be in high school, and many may no longer attend any type of school. Scores used in the analysis will be on a continuous scale and calculated by summing item responses. The range for total scores for the marijuana question is 0-6, and the range for total scores for use of other drugs is 0-54. Although there have been no studies conducted to assess the validity of all the self-reported items in the YRBS, a CDC review of existing empirical literature found that the validity of self-report is not affected

by situational and cognitive elements (CDC, 2014). The YRBS questionnaire is in the public domain. No permission was required.

Safer Sex Behavior Questionnaire (SSBQ). The Safe Sex Behavior Questionnaire (SSBQ) (DiIorio et al., 1992) was designed to measure the frequency of use of safe sex practices in adolescents and young adults. References from a government pamphlet entitled "Understanding AIDS" were categorized into four areas: (a) protection during intercourse, (b) avoidance of risky behaviors, (c) avoidance of bodily fluids, and (d) interpersonal skills used to negotiate safe sex practices and obtain information about the partner's sexual history. The SSBQ contains 27-items on a 4-point Likert scale ranging from 1 (never) to 4 (always). The total possible scores range from 27 to 108 with higher scores indicating greater use of safe sex practices and lower scores indicating less use of safe sex practices. The content validity index calculated for the SSBQ was 98%. Initial reliability computed for sums of items of the total measure was .82 among 89 college freshmen. In a second sample of 531 people, reliability coefficients for sums of leading items ranged from .52 to .85, when the SSBQ was factor analyzed separately for males and females. Using a third sample of 174 subjects, measures of general assertiveness and general risk-taking were correlated with the SSBQ measures. The results showed relationships were considerable and provided support for the construct validity of the instrument. Good reliability of the SSBQ has been reported, with internal consistency (Cronbach's alpha) of .80 to .83, and test-retest reliability .82-.83 in adolescent samples for the total scale (DiIorio et al., 1992).

Several emails were sent to the main researcher, Dr. DiIorio. No response was obtained. According to Walden protocol, (Section VI of the IRB application) three emails were sent to the author's most recently listed institution within a reasonable timeframe (2 weeks). (See Appendix A.)

Variable operationalization. The independent variable of parental acceptance/rejection was examined, along with the dependent constructs of suicidal ideation, suicide attempts, substance use, and risky sexual practices.

Parental support. *Parental support* was defined as the participants' overall feelings of being supported for their gender identity by their parental figure(s) during childhood or adolescence. Parental acceptance has been associated with having better mental and physical health, greater self-esteem, and lower levels of depression, anxiety, substance use, risky sexual practices, and suicidal thinking or gestures (Ryan et al., 2009; Ryan et al., 2010).

Suicidal behavior. *Suicidal behavior* was defined by levels of suicidal ideation, numbers of suicide attempts, and level of lethality. Thinking seriously about suicide, attempting suicide, and the means taken to attempt suicide will measure the suicidal behavior of participants. A study using a sample of 2,255 youth who had at least one same-sex sexual experience, showed both males and females who reported higher levels of parental support and family connectedness, had almost half the odds for suicidal ideation and suicide attempts (Eisenberg & Resnick, 2006). Examples of questions regarding suicidal thinking and attempts include: "Since you realized you were transgender, did you ever seriously consider suicide?" and "If you have ever attempted

suicide, did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse?"

Substance use. *Substance use* was defined as using alcohol or drugs in a way that negatively impacted health. Alcohol use will be measured by the AUDIT questionnaire and the results will be analyzed with the levels of perceived parental support. Examples of AUDIT questions include: "How many alcoholic drinks do you have on a typical day when you are drinking?" and "How often during the past year have you found that you drank more or for a longer time than you intended?"

Risky sexual practices. *Risky sexual practices* was defined as the infrequent practice of safe sex behaviors in the realm of contracting HIV and other STIs. These safe sexual behaviors include using some form of barrier or protection during sexual intercourse, avoiding hazardous behaviors such as anal sex, avoiding contact with bodily fluids, and interpersonal skill to discuss sexual histories and the use of condoms and other protection. Some questions from the Safe Sex Behavior Questionnaire include: "I ask potential sexual partners about their sexual histories" and "I avoid direct contact with my sexual partner's semen or vaginal secretions." Questions from the Ontario, Canada survey (Travers et al., 2012) include: "In the past 12 months, while receiving oral sex, how often did your partner(s) get your sex fluids or menstrual blood in their mouth(s)?" and "In the past 12 months, have you been the receptive partner in anal sex?"

Data Analysis Plan

Data was collected by utilizing an anonymous online survey using SurveyMonkey, a cloud-based software. In the first phase of the data analysis,

demographic characteristics were analyzed, using descriptive statistics to summarize and quantify the sample. The question of whether negative health behaviors in transgender young adults are related to perceived parental support for gender identity during childhood or adolescence required several data analysis plans. Linear regression was used to identify associations between the independent variable of perceived parental support and the dependent variables of suicide ideation, and suicide attempts, substance use, and risky sexual practices.

The goal of a statistical regression is to predict the value of one variable when given the value of another. This study utilized linear regression to assess relationships between two variables. According to Field (2013), the assumptions for linear regression include: (a) the outcome variable should be linearly related to the predictor; (b) for any two observations the residual terms should be independent; (c) at each level of the predictor variable, the variance of residual terms should be constant; and (d) the differences between the model and actual data are most often zero or very close to zero. The linear regression assumption of multicollinearity and will not be an issue in this analysis because there will be only one predictor variable. Two-tailed tests will be utilized to test the significance of regression coefficients, using the criterion probability of .05, in order to assess the rejection of the null hypotheses. Data will be analyzed through IBM SPSS Statistics (Version 21.0).

The following research questions and hypotheses will be addressed:

RQ1. Is perceived parental support for gender identity status during childhood or adolescence related to suicidal ideation in transgender young adults?

Hypothesis 1_0: Suicidal ideation, as measured by the Youth Risk and Behavior Survey, of transgender young adults will not be related to perceptions of parental support as measured by the Perceived Parental Rejection Scale.

Hypothesis 1_1: Suicidal ideation, as measured by the Youth Risk and Behavior Survey, of transgender young adults will be related to perceptions of parental support as measured by the Perceived Parental Rejection Scale.

To answer the first research question and determine if suicidal ideation is related to perceptions of parental support, Hypothesis 1_1 was tested using a linear regression measuring the relationship between the independent variable of perceived parental support and the dependent variable of suicidal ideation.

RQ2. Is perceived parental support for their gender identity status during childhood or adolescence related to suicide attempts in transgender young adults?

Hypothesis 2_0: Suicide attempts, as measured by the Youth Risk and Behavior Survey, will not be related to perceptions of parental support as measured by the Perceived Parental Rejection Scale.

Hypothesis 2_1: Suicide attempts, as measured by the Youth Risk and Behavior Survey, will be related to perceptions of parental support as measured by the Perceived Parental Rejection Scale.

To answer the second research question and determine if suicide attempts are related to perceptions of parental support, Hypothesis 2_1 was tested using a logistic regression measuring the relationship between the independent variable of perceived parental support and the dependent variable of suicidal attempts.

RQ3. Is perceived parental support for gender identity status during childhood or adolescence related to alcohol use in transgender young adults?

Hypothesis 3_0: Alcohol use, as measured by the AUDIT Test for Alcohol Addiction, will not be related to perceptions of parental support as measured by the Perceived Parental Rejection Scale.

Hypothesis 3_1: Alcohol use, as measured by the AUDIT Test for Alcohol Addiction, will be related to perceptions of parental support as measured by the Perceived Parental Rejection Scale.

To answer the third research question and determine if alcohol use is related to perceptions of parental support, Hypothesis 3_1 was tested using a logistic regression measuring the relationship between the independent variable of perceived parental support and the dependent variable of alcohol use.

RQ4. Is perceived parental support for gender identity status during childhood or adolescence related to marijuana use in transgender young adults?

Hypothesis 4_0: Marijuana use, as measured by the Youth Risk and Behavior Survey, will not be related to perceptions of parental support as measured by the Perceived Parental Rejection Scale.

Hypothesis 4_1: Marijuana use, as measured by the Youth Risk and Behavior Survey, will be related to perceptions of parental support as measured by the Perceived Parental Rejection Scale.

To answer the fourth research question and determine if marijuana use is related to perceptions of parental support, Hypothesis 4_1 was tested using a logistic regression

measuring the relationship between the independent variable of perceived parental support and the dependent variable of marijuana use.

RQ5. Is perceived parental support for gender identity status during childhood or adolescence related to the use of illicit drugs in transgender young adults?

Hypothesis 5_0: The use of illicit drugs, as measured by the Youth Risk and Behavior Survey, will not be related to perceptions of parental support as measured by the Perceived Parental Rejection Scale.

Hypothesis 5_1: The use of illicit drugs, as measured by the Youth Risk and Behavior Survey, will be related to perceptions of parental support as measured by the Perceived Parental Rejection Scale.

To answer the fifth research question and determine if the use of illicit drugs are related to perceptions of parental support, Hypothesis 5_1 was tested using a logistic regression measuring the relationship between the independent variable of perceived parental support and the dependent variable of illicit drug use.

RQ6. Is perceived parental support for gender identity status during childhood or adolescence related to risky sexual practices for transgender young adults?

Hypothesis 6_0: Risky sexual practices, as measured by the Safe Sex Behavior Questionnaire, will not be related to perceptions of parental support as measured by the Perceived Parental Rejection Scale.

Hypothesis 6_1: Risky sexual practices, as measured by the Safe Sex Behavior Questionnaire, will be related to perceptions of parental support as measured by the Perceived Parental Rejection Scale.

To answer the sixth research question and determine if risky sexual practices are related to perceptions of parental support, Hypothesis 6_1 was tested using a logistic regression measuring the relationship between the independent variable of perceived parental support and the dependent variable of risky sexual practices.

Threats to Validity

Because of the nonprobability sampling approach and the lack of a clear sampling frame, the external validity in this study was weakened because results cannot be generalized to all transgender young adults. However, reliability and validity of the data was addressed by using validated and reliable measures. Using an anonymous online survey, there is no way to ensure that all participants met the eligibility requirements, or did not produce random or inconsistent reports. Due to the lack of validated instruments specifically designed for transgender people, the tools utilized came from the Youth Risk Behavior Survey (YRBS), the well-established AUDIT tool for measuring levels of alcohol use, one question from the Trans PULSE Project's survey, and the Safe Sex Behavior Questionnaire which has shown to have good construct validity. The main wording was not changed on any of the instruments. However, phrases within the suicide inventory were altered from "During the past 12 months" to "Since you realized you were transgender" in order to measure lifetime suicidal behaviors, as previously noted. Additionally, questions regarding transgender status were added to the survey in order to keep the focus on being trans (e.g., "At what age did you realize you were transgender?" and "If you have seriously thought about, or attempted, suicide, was this related to being

transgender?"). Validity and reliability may be threatened by using measures that were not specifically normed with the transgender community.

Ethical Procedures

IRB approval was granted for this study (#03-02-18-0372381). As participation was anonymous, and IP addresses were not collected, the possibility exists that participants completed the survey twice, generating duplicate submissions. This possibility was minimized or eliminated by hand-checking demographic information. Participants were provided a confidentiality statement and guidelines for completing the survey. There were national hotlines and transgender resources provided in case participation in the survey created emotional upset. These resources included transgender support organizations and websites, with links for drug and alcohol recovery information, HIV information, and mental health information. At the top of each page was the phone number for the Trevor Project's Lifeline, where young people can call, text, or chat with a trained counselor 24 hours a day, seven days a week.

I used SurveyMonkey to distribute the survey. I stored data on a password-protected encrypted drive to which I am the only one who has access. Data will be destroyed 5 years after publication of this research (APA, 2010b).

Summary

Relationships between perceived parental support and negative health behaviors were examined in this study. Associations between the independent variable of perceived parental support and the dependent variables of suicidal behavior, suicide attempts, alcohol use, lifetime marijuana use, and illicit drug use, and risky sexual practices has

been shown to be correlated in studies of LGB youth. Various tests were performed in order to measure associations between negative health behaviors of transgender young adults and corresponding retrospective perceptions of parental support during childhood and adolescence. This quantitative research study was based on relevant constructs of the minority stress model and the Rogerian theory of self. Chapter 4 will present the results of the study.

Chapter 4: Results

Introduction

In this quantitative study, using an anonymous online survey, I examined the relationship between perceived parental support of gender identity during childhood or adolescence and subsequent negative health behaviors of transgender young adults. Perceived parental support was measured with the Perceived Parental Rejection Scale (PPRS; Willoughby et al., 2006). Negative health behaviors measured included suicidal ideation, suicide attempts, alcohol use, marijuana use, illicit drug use, and risky sexual behaviors. I measured suicidal ideation and attempts by using the Youth Risk Behavior Survey (YRBS; CDC, 2014), alcohol use by using the Alcohol Use Disorders Identification Test (AUDIT; Saunders et al., 1993), marijuana and illicit drug use by using the Youth Risk Behavior Survey (YRBS; CDC, 2014), and risky sexual behavior by using the Safe Sex Behavior Questionnaire (SSBQ; DiIorio et al., 1992). The purpose of the study was to measure levels of negative health behaviors of transgender young adults in relation to their perception of degree of parental support as children or adolescents. A summary of research questions and hypotheses addressed in this study is found in Table 1. A complete list of research questions and hypotheses can be found in Chapter 1 and Chapter 3.

Table 1

Summary of Research Questions and Related Hypotheses

Research questions	Hypotheses
RQ1: Is perceived parental support for gender identity status during childhood or adolescence related to suicidal ideation in transgender young adults?	H11: Suicidal ideation of transgender young adults will be related to perceptions of parental support.
	H10: Suicidal ideation of transgender young adults will not be related to perceptions of parental support.
RQ2: Is perceived parental support for gender identity status during childhood or adolescence related to suicidal attempts in transgender young adults?	H21: Suicide attempts of transgender young adults will be related to perceptions of parental support.
	H20: Suicide attempts of transgender young adults will not be related to perceptions of parental support.
RQ3: Is perceived parental support for gender identity status during childhood or adolescence related to alcohol use in transgender young adults?	H31: Alcohol use of transgender young adults will be related to perceptions of parental support.
	H30: Alcohol use of transgender young adults will not be related to perceptions of parental support.
RQ4: Is perceived parental support for gender identity status during childhood or adolescence related to marijuana use in transgender young adults?	H41: Marijuana use of transgender young adults will be related to perceptions of parental support.
	H40: Marijuana use of transgender young adults will not be related to perceptions of parental support.
RQ5: Is perceived parental support for gender identity status during childhood or adolescence related to the use of illicit drugs in transgender young adults?	H51: The use of illicit drugs of transgender young adults will be related to perceptions of parental support.
	H50: The use of illicit drugs of transgender young adults will not be related to perceptions of parental support.

(*table continues*)

Research questions	Hypotheses
RQ6: Is perceived parental support for gender identity status during childhood or adolescence related to risky sexual practices in transgender young adults?	H61: Risky sexual practices of transgender young adults will be related to perceptions of parental support.
	H60: Risky sexual practices of transgender young adults will not be related to perceptions of parental support.

I conducted a preliminary analysis of the sample using descriptive statistics in order to summarize and quantify the sample. Main analyses consisted of logistic regression and bivariate correlation analysis. In this chapter, I will report on data collection, present descriptive and demographic statistics of the sample, and provide the results for all the statistical analyses conducted.

Data Collection

Using SurveyMonkey, I collected data by using an anonymous online survey between March 2018 and September 2018 (see Appendices A for the variables used in the study). As explained in Chapter 3, recruitment e-mails were sent to potential participants through LGBT and transgender community organizations, transgender resource providers, websites, transgender rights affiliates, and transgender LISTSERVs. After deletion of cases with missing values, 96 individual cases were available for analysis.

Sample Descriptive and Demographic Characteristics

For the current study, the dataset consisted of complete information for 96 individual, self-identified transgender persons with ages ranging from 18 to 25 years (M = 20.34). The most common age was 18 years old (27.1%), although there were a number

of participants who were 19 years old (15.6%) or 20 years old (16.7%). See Figure 1for details.

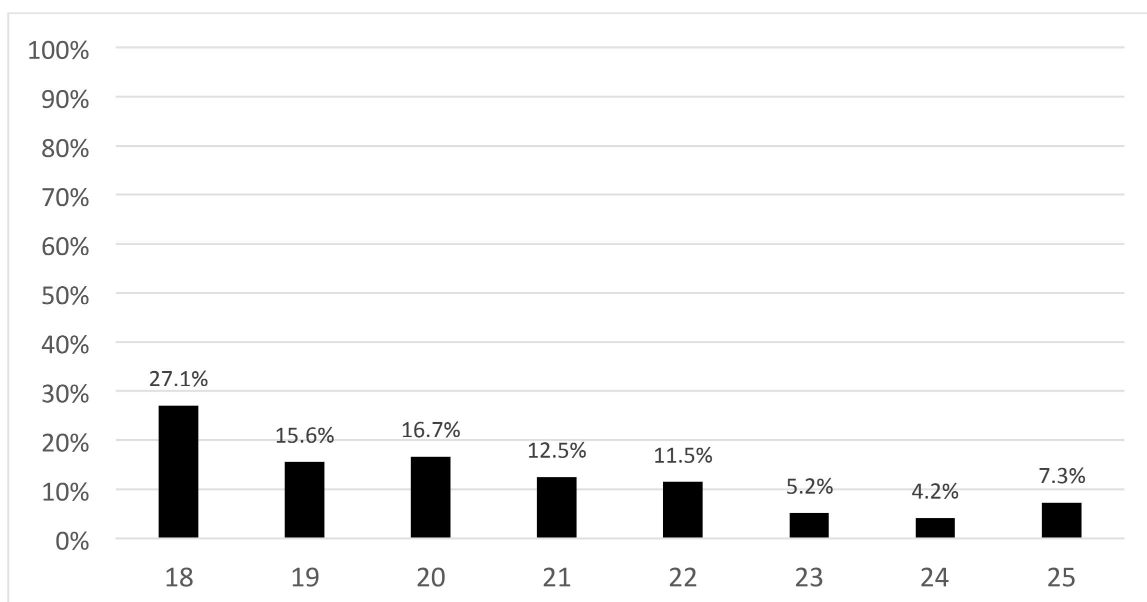


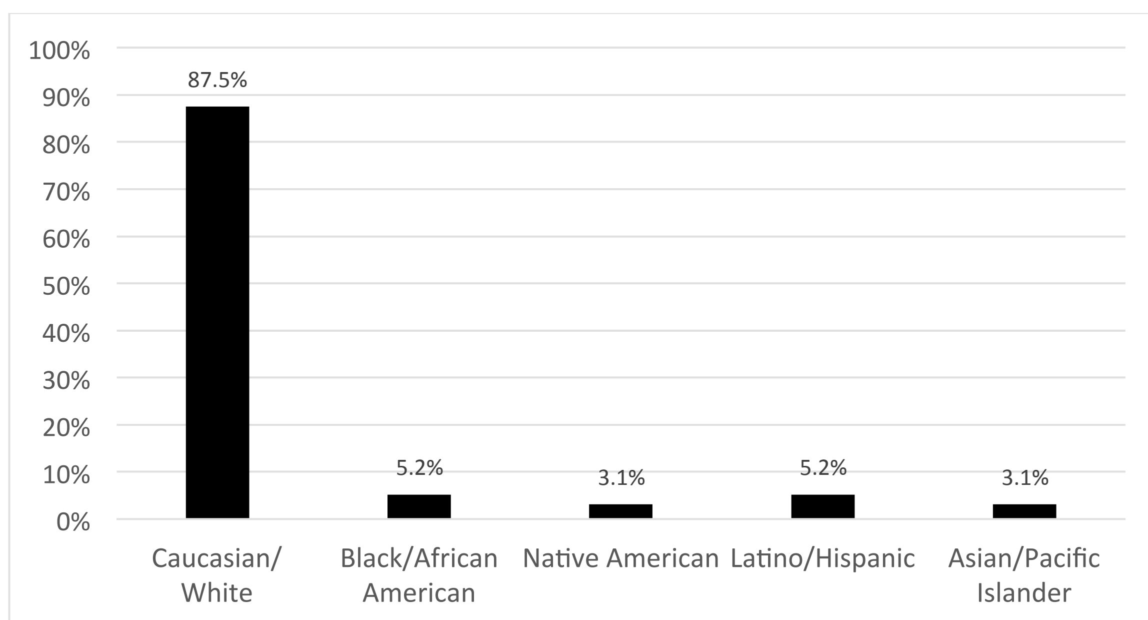
Figure 1. Age of participants.

Participants largely consisted of individuals who self-identified as transman or male (70.8%). In other words, 86.6% of the participants were identified female at birth and now identify as male or masculine. There were only a few transwomen (6.3%) who participated in this study. Other genders reported include agender (6.3%), genderqueer (4.2%), gender fluid (3.1%), and gender nonconforming (1.0%). Roughly 8.3% reported their gender as "other," which consisted of transmasculine (*n* = 2), nonbinary male (*n* = 2), nonbinary (*n* = 1), demi boy (*n* = 1), and nonbinary transmasculine (*n* = 1).

Participants also reported their sexual orientation. The most common sexual orientations included pansexual (32.3%), gay (21.9%), bisexual (20.8%), and asexual

(17.7%). There were also some who reported that they are heterosexual (5.2%) or lesbian (2.1%).

The most common ethnicity of participants was Caucasian/White (87.5%). There were fewer people who indicated they were Latino/Hispanic (5.2%), African American/Black (5.2%), Native American (3.1%), or Asian/Pacific Islander (3.1%). There were also a few participants who indicated they were biracial (3.2%) or multiracial (5.2%). See Figure 2 for details.



Note. *n* = 96.

Figure 2. Race/Ethnicity of participants.

The majority of participants have at least completed their high school degree. Roughly 31.6% have a high school degree, 17.9% have less than one year of college, and 26.3% have one or more years of college.

Results

Six research questions and associated hypotheses were addressed within the dataset.

Research Question 1

A bivariate correlation analysis was conducted to examine the relationship between parental support and suicide ideation in transgender young adults. After deletion of cases, a total of 93 transgender individual cases were available for analysis. Suicidal ideation scores ranged from zero (representing low suicide ideation) to three (representing high suicide ideation).

Results of the bivariate correlation are statistically significant. There is a significant negative relationship between parental support and suicide ideation—meaning the more parental support the less suicidal ideation (r = -.209; p = .04). See Figure 3 for details.

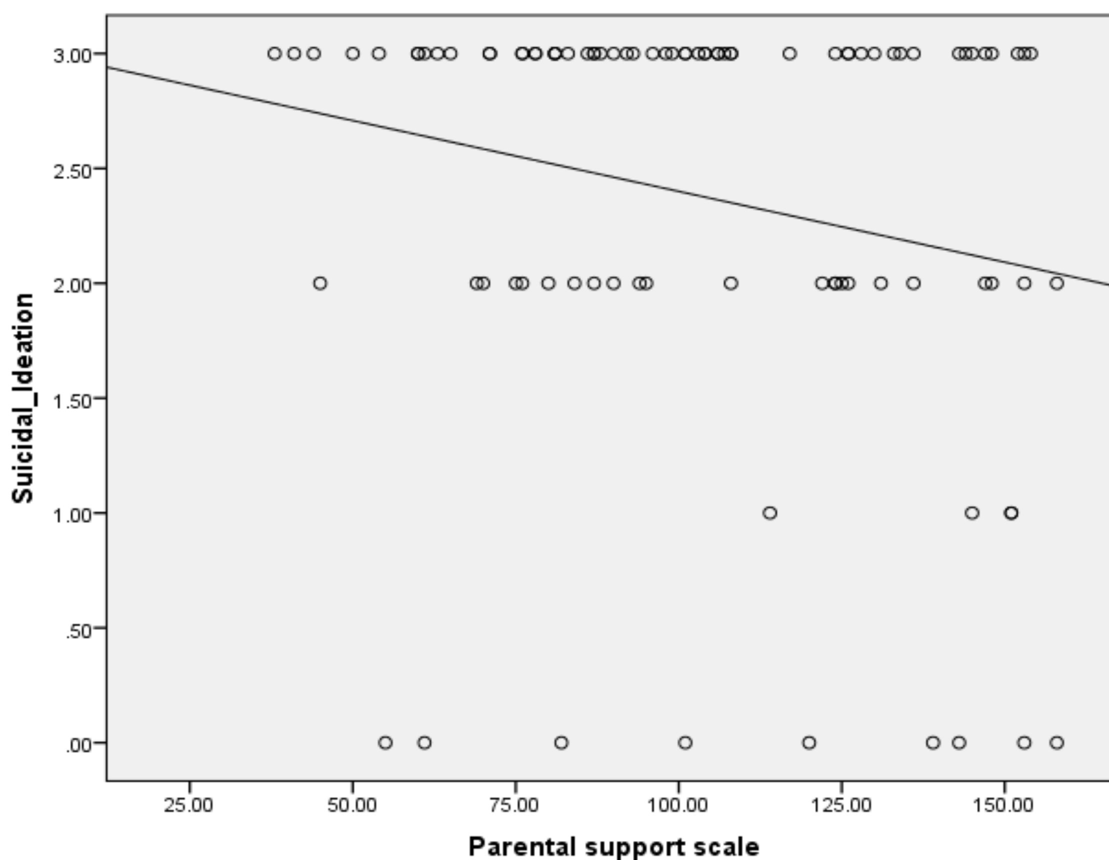


Figure 3. Bivariate correlation between parental support and suicide ideation.

Research Question 2

A bivariate correlation analysis was conducted to examine the relationship between parental support and number of suicide attempts in transgender young adults. After deletion of cases, a total of 96 transgender individual cases were available for analysis. Number of suicide attempts ranged from zero (*n* = 56) to six or more times (*n* = 5).

Results of the bivariate correlation are statistically significant. There is a significant negative relationship between parental support and number of suicide

attempts—meaning the more parental support the fewer suicide attempts (r = -.303; p = .003). See Figure 4 for details.

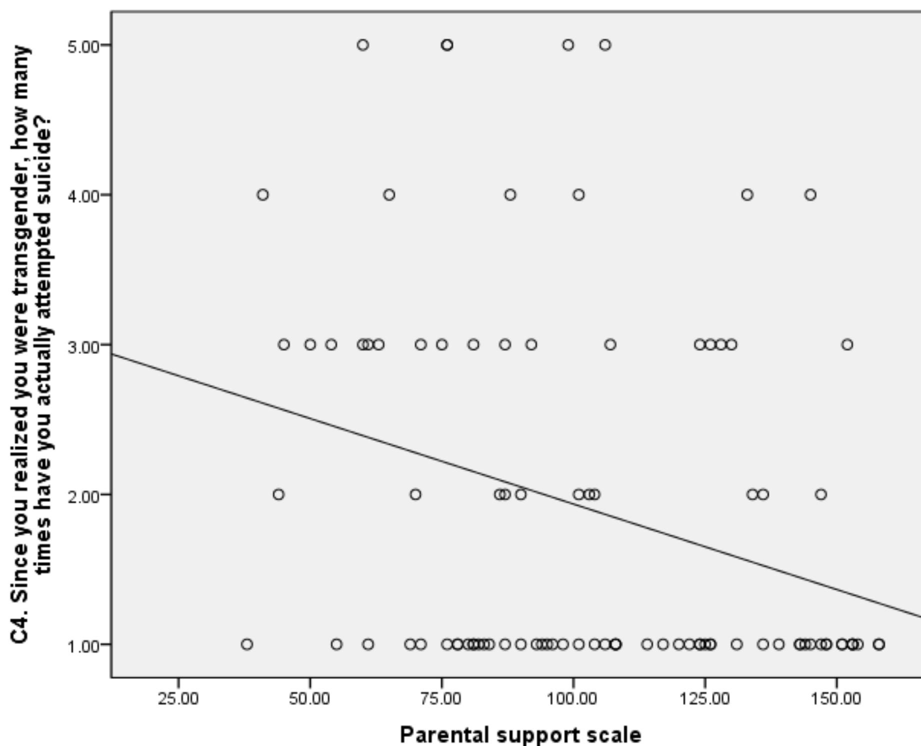


Figure 4. Bivariate correlation between parental support and number of suicide attempts.

Research Question 3

Logistic regression was used to relate the likelihood of alcohol use (medium use versus high use) using parental support as a predictor variable. After deletion of cases, a total of 86 transgender individual cases were available for analysis: 63 who report medium alcohol use and 23 who report high alcohol use.

Results of the logistic regression are not statistically significant. Statistical results of the full model indicate that parental support does not reliably correlate with those who have high alcohol use and those who do not ($\chi[1] = 0.55$, p = .46). Table 2 displays

descriptive and inferential statistics for each predictor variable including the beta (*B*), standard error, Wald, degrees of freedom (*df*), significance (*p*), and Odds Ratio. See Table 2 for details.

Table 2

Descriptive and Inferential Statistics from Logistic Regression Analysis

Variables	B	S.E.	Wald	df	Sig.	Odds Ratio
Parental Support	-0.006	0.008	.545	1	0.460	0.994
Constant	-.0389	0.801	.236	1	0.627	0.678

Research Question 4

Logistical regression was used to relate the likelihood of marijuana use (used versus never used) using parental support as a predictor variable. After deletion of cases, a total of 95 transgender indivual cases were available for analysis: 38 who report no marijuana use and 57 who reported they have used marijuana.

Results of the logistic regression are not statistically significant. Statistical results of the full model indicate that parental support does not reliably correlate with those who have used marijuana versus those who have not ($\chi[1] = 2.79$, $p = .09$). Table 3 displays descriptive and inferential statistics for each predictor variable including the beta (*B*), standard error, Wald, degrees of freedom (*df*), significance (*p*), and Odds Ratio. See Table 3 for details.

Table 3

Descriptive and Inferential Statistics from Logistic Regression Analysis

Variables	B	S.E.	Wald	df	Sig.	Odds Ratio
Parental Support	-0.11	0.007	2.707	1	0.100	0.989
Constant	1.558	0.746	4.367	1	0.037	4.751

Research Question 5

A bivariate correlation was conducted to examine the relationship between parental support and illicit drug use in transgender young adults. After deletion of cases, a total of 93 transgender indivual cases were available for analysis. Illicit drug use scores ranged from 9 to 38; and the average score was 10.96.

Results of the linear regression are statistically significant. There is a significant negative relationship between parental support and illicit drug use. In other words, the more parental support, the lower the illicit drug use (r = -.354; p = .001). See Figure 5 for details.

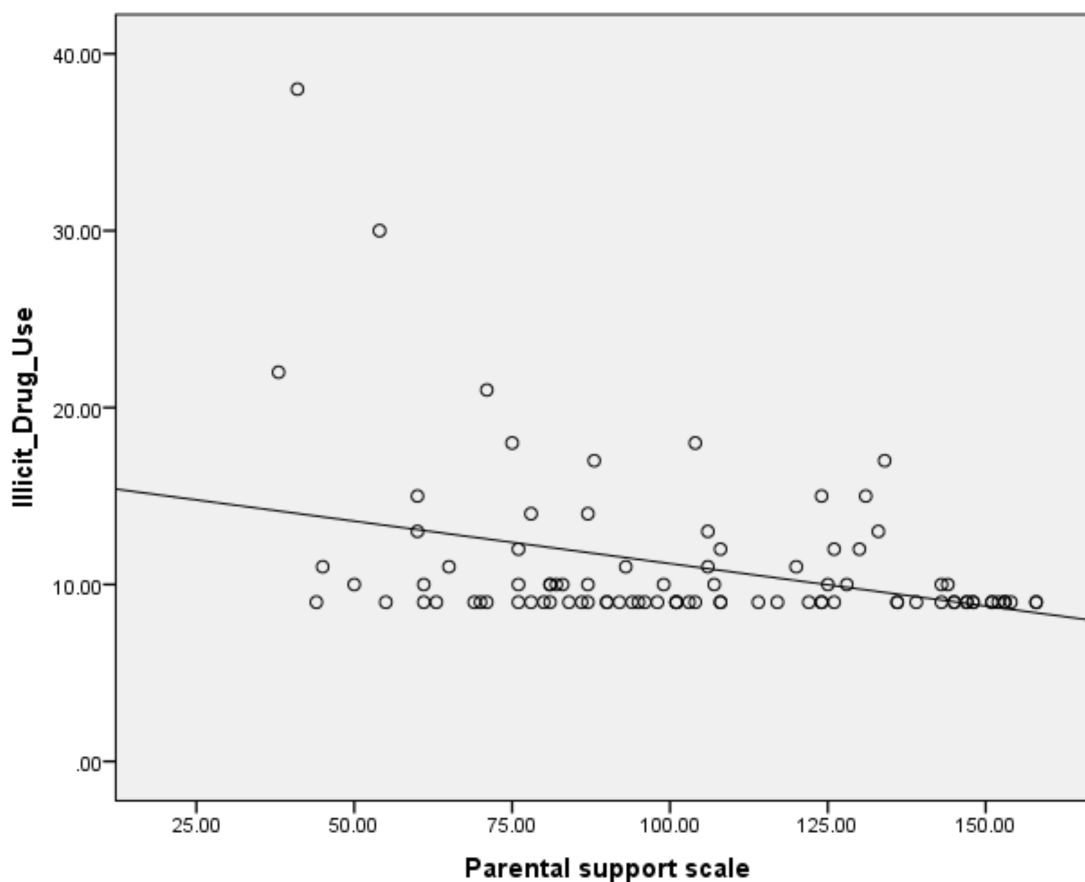


Figure 5. Correlation between parental support and illicit drug use.

Research Question 6

A bivariate correlation was conducted to examine the relationship between parental support and risky sexual behaivor in transgender young adults. After deletion of cases, a total of 80 transgender individual cases were available for analysis. Scores for risky sexual behavior ranged from 47 to 100. The average score was 77.96.

Results of the linear regression are not statistically significant. There is not a significant relationship between parental support and risky sexual behavior (r = .200; p = .076). See Figure 6 for details.

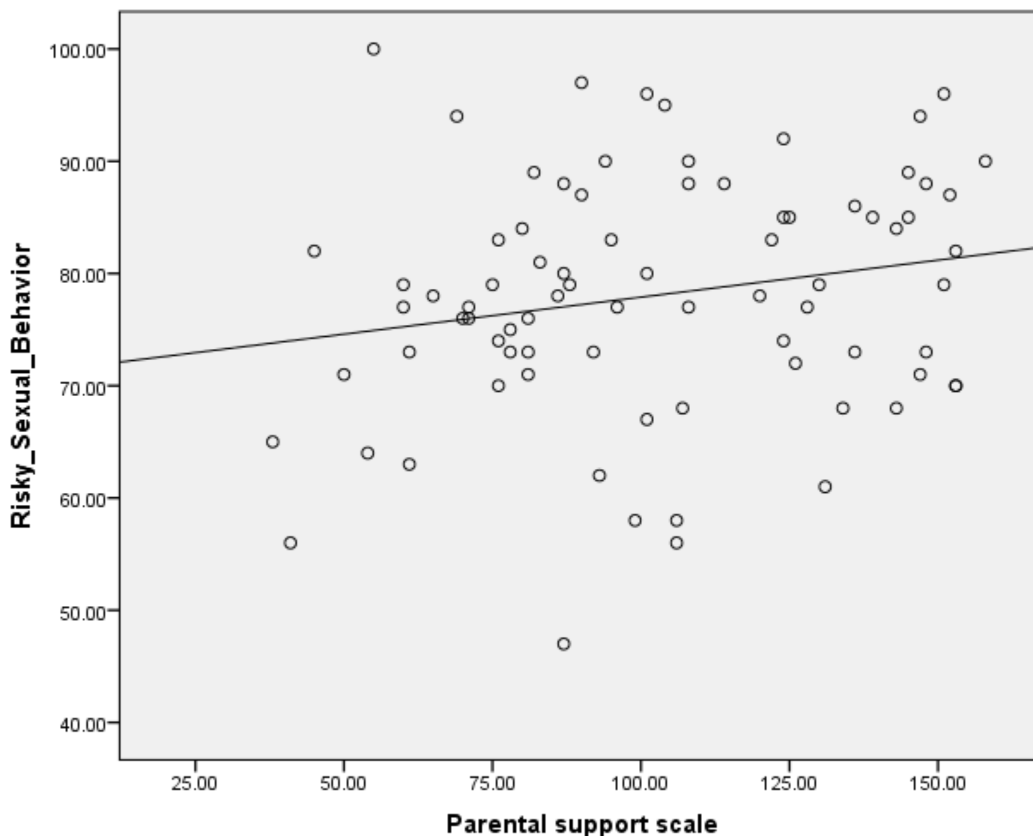


Figure 6. Bivariate correlation between parental support and risky sexual behavior.

Summary

In this study, I examined the relationship between levels of parental support and levels of negative health behaviors in transgender young adults. Statistical analysis of the dataset indicated support for Hypothesis 1_1. The null hypothesis was rejected. Perceptions of parental support was a significant predictor of suicidal ideation in transgender young adults. The analysis also indicated support for Hypothesis 2_1, rejecting the null

hypothesis. Perceptions of parental support showed a significant negative relationship to the number of suicide attempts in transgender young adults.

Nonsignificant results were found for the relationship between perceived parental support and alcohol use. Hypothesis 3_1 was not supported. I failed to reject the null hypothesis. Levels of alcohol use in transgender young adults were not associated with perceptions of parental support. The statistical analysis also indicated that marijuana use was not significantly related to perceived parental support. Hypothesis 4_1 was not supported, and I failed to reject the null hypothesis.

The results for the relationship between perceived parental support and illicit drug use were statistically significant. The analysis indicated support for Hypothesis 5_1. The null hypothesis was rejected. The relationship between perceived parental support and risky sexual behavior in transgender young adults was not shown to be statiscally significant. The results of the dataset analysis did not indicate support for Hypothesis 6_1. I failed to reject the null hypothesis.

In Chapter 5, I present an interpretation of the results, discuss the limitations of the study, offer implications for social change, and make recommendations for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

I conducted this study in order to examine the relationship between perceived parental support of gender identity during childhood or adolescence and subsequent negative health behaviors of transgender young adults. I used an anonymous online survey, targeting self-identified transgender people between the ages of 18 and 25. The frequent classification of LGBT people into a single construct for the purpose of research suggests the experiences are similar for sexual minorities and transgender people. However, because of this merging in the literature, the unique experiences of transgender people has been historically underrepresented and muted (Blumer et al., 2012; Breslow et al., 2015; Grossman & D'Augelli, 2007; Pflum et al., 2015).

Past research has shown that the stage between adolescence and adulthood has been especially challenging for sexual minorities regarding psychological functioning and well-being. Therefore, it would seem transgender youth today would also experience this stage as very difficult and challenging. For most young people, stress has higher levels of psychological implications if little or no parental support exists (Needham, 2008). Studies have shown an increased risk of discrimination, harassment, victimization, violence, and potential mental health issues in LGBT youth (Ryan et al., 2009), while parental support has been shown to offer protective factors against psychological stress and negative health behaviors (Ryan et al., 2010). Given the high rates of suicidal thinking and gestures, substance use, and risky sexual behaviors that have been documented for sexual minorities (Hatzenbuehler, 2011; Mustanski & Liu, 2013; Russell

&Toomey, 2013), it is surprising that so little emphasis has been on transgender youth, their behaviors, and their relationships with parental figures. In fact, much of the research on the transgender population has focused on transgender adults, in medical or clinical settings, without considerations for young trans people (Dargie et al., 2014; Mustanski& Liu, 2013).

Key findings of this study showed that perceptions of parental support significantly predicted levels of suicidal ideation, number of suicide attempts, and illicit drug use for transgender young adults. Perceived parental support was not found to predict alcohol use, marijuana use, or risky sexual behaviors for transgender young adults. As a whole, the findings varied in showing predictions for various negative health behaviors based on perceptions of parental support.

Interpretations of the Findings

I sought to uncover relationships between negative health behaviors of transgender young adults in relation to the perception of parental support for gender identity. Findings for descriptive statistics showed that the majority of participants identified themselves as transgender males (70.8%). Only 6.3% of participants identified as transgender women, with other categories of gender identifiers totaling 22.9%. It is reasonable to infer from these demographics that the weight of the findings is more indicative of the transgender male experience. Previous research results have shown a higher risk for negative health behaviors, such as suicidal ideation, suicide attempts, substance use, and risky sexual practices (Grossman & D’Augelli, 2007; Hendricks & Testa, 2012; Nuttbrock et al., 2013), among transgender youth. With minimal research on

transgender youth and young adults about parental response to gender identity, negative health behaviors, or coping mechanisms, little is understood about how parental support or parental rejection is predictive of health outcomes of transgender young people.

Suicidal Ideation

I asked three questions to assess suicidal ideation: “Since you realized you were transgender, have you ever felt so sad and hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?”, “Since you realized you were transgender, have you ever seriously considered attempting suicide?”, and “Since you realized you were transgender, have you made a plan about how you would attempt suicide?” These questions assessed for depressive symptomology, thinking about suicide, and planning suicide. I conducted a bivariate correlational analysis to assess the possible relationship between perceived parental support of gender identity in childhood or adolescence and suicidal ideation. Results indicated that there is a significant relationship. For this research question, there was a -.209 correlation between perceived parental support and suicidal ideation. This correlation represents a moderate, negative relationship between perceived parental support and suicidal ideation. This confirms prior research suggesting that family support is an important suicide protective factor for transgender youth (Ryan et al., 2010; Travers et al., 2012). Feelings of support and acceptance from family and other social situations have also been shown to be strong suicide protective factors for transgender adults (Moody & Smith, 2013), and children whose parents express supportive attitudes and behaviors for gender status may have better mental health outcomes (Olson et al., 2016). This finding also seems to support

earlier research showing that young people struggling with gender identity issues often also struggle with mental health challenges, such as depression and suicidal ideation (Stieglitz, 2010; Testa et al., 2012).

Suicide Attempts

While most researchers studying suicide or family support have conflated sexual orientation and gender identity, the little research delineating the transgender population from sexual minorities shows higher rates of suicide attempts for trans youth. While it is difficult to determine conclusive numbers of young sexual or gender minorities who think about or attempt suicide, many researchers have found that both LGB and transgender young people attempt suicide at rates higher than the general population. LGB youth experiencing severe family rejection, in comparison to those who experienced little or no rejection from their families, were more than eight times more likely to report attempting suicide (Ryan et al., 2009). Estimated lifetime rates of suicide attempts for trans populations range from 26% to 45% (Clements-Nolle et al., 2006; Grant et al., 2011), compared to 2% to 9% for the general population (Nock et al., 2008). Previous research on transgender youth has shown that almost all of the 60% of participants without strong parental support had attempted suicide in the past year (57%), while only 4% of those who perceived they had strong parental support attempted suicide (Travers et al., 2012). Research distinctly delineating transgender from the LGB population shows higher rates of suicide attempts for trans youth (Grant et al., 2011; Ryan et al., 2009).

In this study, I used two questions to determine number of suicide attempts: “Since you realized you were transgender, how many times have you actually attempted

suicide?" and "If you ever attempted suicide, did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse?" A bivariate analysis was used to determine a possible relationship between perceived parental support of gender identity in childhood or adolescence and number of suicide attempts. These results showed a -.303 correlation between perceived parental support and number of suicide attempts. This correlation represents a moderate, negative relationship between perceived parental support and number of suicide attempts. In other words, the more parental support, the lower the number of suicide attempts. This finding seems to support prior research which showed that there are higher rates for suicide attempts for transgender youth when compared to LGB youth and the general population (Grant et al., 2011; Ryan et al., 2009). As shown in Chapter 2, and in alignment with the minority stress theory, perceived social discrimination, prejudice, and lack of family support can lead to elevated mental health issues, including elevated levels of suicidal ideation and suicide attempts. This finding confirms the importance of parental support and signifies that such support decreases health-related risk factors for psychological distress and suicidal behaviors.

Substance Use

Researchers conducting a 2010 study on LGB youth found that family acceptance predicted increased levels of self-esteem, social support, and general health (Ryan et al., 2010), while perceived rejecting toward a sexual minority status by others predicted substance use by other researchers (Rosario et al., 2009). Although the majority of studies on LGB youth have shown associations between rejection parental behaviors and

substance use, the specific types of substances used has not always been clearly defined. Studies have consistently shown that sexual and gender minorities experience increased levels of drug and alcohol use. Researchers have applied the minority stress theory to explain these elevated levels of substance abuse among LGB minorities as compared to heterosexuals. Ryan et al. (2009) showed that LGB young adults who had experienced higher levels of rejection from their parents were 3.4 times more likely to use drugs. The Human Rights Campaign Foundation's findings showed that 48% of gender nonconforming youth had experimented with drugs and alcohol, which is twice the rate for their heterosexual, cisgender peers (HRC, 2012). In addition, findings from the National Transgender Discrimination Survey (Grant et al., 2011) revealed that over 25% of respondents overused drugs or alcohol in order to manage pervasive social stressors.

For this study, no significant correlation was found between alcohol or marijuana use and perceptions of parental support, while illicit drug use was found to be related to perceptions of parental support. Despite the numerous studies showing a connection between parental rejecting behaviors and increased levels of substance use, this study failed to find that same relationship with alcohol and marijuana.

The results of this study regarding alcohol use by transgender young adults may be explained, in part, because of the majority number of female-to-male participants in this study. For the current study, only 6.3% of the participants identified as trans females. The odds ratio of .94 demonstrates little change in the likelihood of alcohol use on the basis of a one unit change in perceived parental support. Several studies have shown increased alcohol use in transgender women, especially those who in engage in survival

sex and risky sexual practices (Operario et al., 2011; Reisner et al., 2010; Zimmerman et al., 2015). Additionally, Zimmerman et al. (2015) found alcohol use to be a strong predictor of dangerous sexual behaviors for transgender women. In contrast, alcohol use was found to be in the low range in relation to minority stressors, social support, and depression in a sample of 335 trans-identified individuals and was found to be negatively related with suicide risk (Tebbe & Moradi, 2016). Although the literature on substance use in transgender populations is scarce, Testa et al. (2012) found that approximately 17% of trans females and 33% of trans males reported histories of alcohol problems. Furthermore, young adults often use alcohol and this may not be related to perceptions of parental support. A 2016 study examining the relationship between minority stressors, social support, and substance use, found that drug use was positively related to suicide risk, whereas alcohol was not (Tebbe & Moradi, 2016).

For this study, one question was asked about marijuana use: “During your life, how many times have you used marijuana?” This question was used to get a general idea of the use of cannabis by transgender young adults. The odds ratio of .99 demonstrates little change in the likelihood of marijuana use on the basis of a one unit change in perceived parental support. As with alcohol, many young people experiment with marijuana, but this may or may not be related to perceptions of parental support.

Although the literature on substance use in the transgender population is scarce, one study showed that 74% of transgender females and 77% of transgender males reported past illicit drug use (Testa et al., 2012). The results of this study seem to confirm prior studies regarding elevated drug use among sexual and gender minorities.

There was a -.354 relationship between perceived parental support and illicit drug use. This correlation represents a significant, negative relationship between perceived parental support and illicit drug use and confirms prior studies on parental rejecting behaviors and substance use of LGB young people.

Risky Sexual Behaviors

As described in Chapter 2, most of the findings for transgender risky sexual practices have been focused on commercial or survival sex and the procurement of gender affirmation through sexual experiences for transgender women. Younger transgender females have been shown to be extremely vulnerable to gender abuse (Nuttbrock et al., 2013), and struggle with elevated levels of shame, issues of congruency, and rejection (Brennan et al., 2012). These social pressures may play a role in the increased rates of risky sex for transgender females, and prior studies suggest a clear and strong relationship between alcohol use and risky sexual behaviors for transgender women. Due to the lack of literature, the prevalence of risky sexual practices for transgender men is less clear. There was a .200 relationship between perceived parental support and risky sexual behaviors. This correlation is positive and extremely weak, suggesting these two variables are not related. This finding does not confirm prior studies showing family rejection to be related to risky sexual practices. However, the demographic characteristic of many more transgender males than transgender females should be taken into consideration, and the results of this study may not be representative of the transgender population as a whole.

Theoretical Considerations

It is not gender identity itself that causes problems or distress, but rather the dynamics of minority stress and living in a constant state of incongruence. Discrimination, prejudice, threats to safety, anticipating rejection, and internalizing negative messages create internal and external sources of stress, and invalidation of the individual's ideal self can create a state of incongruence. Since the mechanisms of minority stress for the transgender population can be explained as a relationship between the dominant social norms, expectations, and values and both the internal and external stressors of embodying a gender nonconforming identity and expression, clearly transgender individuals face elevated levels of minority stress which is socially-based and chronic. The theory of self posits that the main determinant of self-actualization and development of self-esteem and feelings of worth comes from childhood experiences and are primarily influenced by parental responses and reactions. Some of the findings which are inconsistent with prior studies may be the result of the imbalance of male-identifying participants due to the different experiences and reactions they may face. Additionally, the way young people receive messages, whether it's from parents, peers, or society, may differ than even a few years ago. For example, today there are numerous examples of positive portrayals of transgender individuals, whereas only a few years ago, there were very few. Today young people have wide access to the Internet and therefore to abundant sources of support and connection. Perhaps other types of support help mediate the need for parental acceptance.

Limitations of the Study

There are several limitations of this study. For example, this study employed a cross-sectional, Internet-based design. The cross-sectional design of the study does not allow for causal or directional conclusions (Creswell, 2014). The online data collection and the results may not be generalizable to those without access to a computer or Internet. Transgender people, such as homeless youth, who do not have access to computers or Internet may also not have access to other social support networks or resources. Participants self-selected to participate in this study about trans people; therefore, the results may not generalize to trans people who don't have access, or who are not interested in, online transgender networks to self-select into a study. In addition, there is an underrepresentation of transgender youth of color and trans feminine individuals within the sample. The sample included 86.6% of participants who were identified female at birth and now identify as male or masculine on the transgender spectrum, whereas only 6.3% identified as trans feminine or female. Research has shown younger male-to-female transgender individuals are extremely vulnerable to gender abuse (Nuttbrock et al., 2013) and cultural sexism, issues of congruency, guilt, and shame (Brennan et al., 2012). The findings of this study may not represent a balanced profile of male-to-female and female-to-male experience. This may, in part, be due to cultural sexism, making the lives of transgender females more difficult, yet underrepresented in the current study. The sample was approximately 87.5% Caucasian/White, with the remaining sample identifying as Black/African American, Latino, Asian/Pacific Islander, and Native American. Additionally, 59.4% were ages 18 to 20, with 40.7% being 21 to 25 years of age.

Recommendations

Although there is a growing body of literature related to the lives of transgender people, further research is needed in the following areas: experiences of transgender youth of color in relation to parental support, experiences of transgender males versus females in relation to parental support, experiences of resiliency for transgender adolescents and young adults, experiences of family advocacy for their transgender child, and the role of online versus family support systems for young trans people. As pointed out in Chapter 1, the Internet is widely available and LGBT youth frequently use the Internet to compensate for lack of offline support, as well as affirming resources and connections with others like themselves. Although recent research on resilient strategies of transgender youth (Singh, Meng, & Hansen, 2014) did not focus on online support strategies, many of that study's participants indicated the importance of online communities in support systems and identity formation. Additionally, it would be important to better understand how online peer support networks and other trans-affirming communities, in comparison with parental and family support, play a role in health behaviors of young transgender people, in relation to one's identity formation, shared identities, shared experiences, validation, and acceptance.

Because the mechanisms of minority stress for the transgender population can be explained as a relationship between the dominant social norms, expectations, and values and both the internal and external stressors of embodying a gender nonconforming identity and expression, it will be important to explore specific mechanisms of coping and mediating factors for coping within the transgender population. Currently,

adolescents and young adults have much more access to the Internet than several years ago it may be valuable to consider shifting modes of accessing support. Additionally, the landmark research used in this study was published in 2010 (Ryan et al., 2010), 2011 (Grant et al., 2011), and 2012 (Testa et al., 2012). Only a few years later, young people may be receiving a wider variety of affirming messages from a variety of sources. For example, stories and examples of transgender people in successful careers, in the military, or with families are more readily accessed today. Carl Rogers's theory of self and the focus on the importance of congruence of identity for one's sense of self-esteem and self-image could be explored within the construct of the developing transgender young person within the family unit.

Based on this study's findings, there are many opportunities for future research on health behaviors among transgender individuals in relation to family, peer, social support, minority stress, and an internal sense of congruence. For instance, are there gender patterns within the negative health behaviors? Do trans males or trans females have different ways of coping? The participants in this study largely consisted of male-identifying trans people, making this distinction difficult. Based on Sevelius's (2013) theory of gender affirmation theory, transgender individuals may participate in substance use in order to validate their gender identity. Several studies have shown that among transgender women, excessive alcohol and marijuana use was found to be associated with feelings of gender dysphoria and living part-time as their affirmed gender. Therefore future studies examining the differences in substance use between transgender males and transgender females is recommended. Furthermore, future studies focusing on the sexual

behaviors of transgender males, and the differences between how transgender males and females use sex to affirm their gender identity, and how they view sex and sexual practices, could add insight into the differences in coping mechanisms of the young transgender population.

Additionally, future studies could focus on differences in minority stress factors between young transgender males and young transgender females. For example, it seems possible that transitioning socially and then medically could be less traumatic for transgender males due to society's easier acceptance of "tomboys" and lesbians. For those individuals transitioning from male to female, the daily microagresssions and social misogyny and sexism could make this journey much more difficult. As explained in Chapter 2, prior studies have shown that the mechanisms of minority stress can help explain the disproportionate rates of negative health behaviors for transgender individuals, due to elevated rates of maltreatment, harassment, and living in a transphobic culture. Both the minority stress theory and Carl Rogers' theory of congruence could be examined with the framework concerning the importance of living authentically and being accepted by others. Gender differences could be examined in reference to how discrimination, prejudice, victimization, violence, and rejection are processed. As described in Chapter 2, the results of hiding one's identity does not serve to reduce levels of distress, but instead, decreases feelings of self-worth and increases feelings of distress (Hendricks & Testa, 2012). Because transgender identity development emerges in conflict with normative assumptions of gender and expectations, and because adolescents and young adults often lack autonomy, it may be important to explore differences

between transgender males and females, in light of cultural sexism and role expectations. Also, an examination of the mediating factors that may help young transgender people learn to cope in healthy ways would be important information.

Implications

This study was undertaken to develop information that could be used quantitatively to inform families, educators, clinicians, healthcare workers, and policy makers about the importance of supporting transgender youth. The transgender population is considerably underrepresented in the literature (Grossman et al., 2011; Haas et al., 2011; Katz-Wise et al., 2016.) The underlying motive of this study was to help explain particular health behavior responses of young transgender people to perceptions of parental support or rejection. It has been firmly established that a supportive parental relationship for both the general population and LGB children is the foundation for optimal healthy psychological development in young people. Whereas most minority children share the same race, ethnicity, or religion with their parents, this is rarely the case for LGBT youth. Where do young people turn to access some sense of support for their gender identity? Coming out has been shown to add to a sense of congruence for self-image and improved positive well being for sexual minority youth. It would seem that this could be a similar experience for transgender young people. Although there is risk involved in coming out for both sexual and gender minorities, the acceptance and disclosure of one's identity can also garner support from others. While Nuttbrock et al. (2009) showed that coming out as transgender is often more problematic in early adolescence than later in life, due in part to the lack of relationship variety available to

younger people, today's trans youth widely have access to the Internet, online resources and personal connections with other trans youth.

Findings from this research may help contribute to the increasing body of knowledge regarding the relationship between parental support and transgender young adult health behaviors. Additionally, this study illuminates the need for further research on families of transgender children who often have little autonomy or independence. As more research is conducted and distributed, outcome data can potentially highlight current barriers, as well as opportunities to best support young transgender people, contributing to their overall well-being. This research could also help inform families, educators, clinicians, healthcare workers, and policy makers about the importance of support for transgender young persons. Results from this study could have the potential to effect social change by improving the quality of life for transgender people and their families, and encourage social institutions to find improved and more extensive ways to support transgender youth and their families. As long as transgender people continue to face repeated microaggressions, minority stress, and a sense of internal incongruence, they will continue to struggle as individuals and as a community.

Conclusion

This study sought to examine relationships between perceived parental support for a nonconforming gender identity and subsequent health behaviors of transgender young adults. Numerous studies, many of which have conflated sexual minority and gender minority status, have shown health disparities in association with being LGBT, and sexual minority status has been shown to be a significant risk factor for dangerous health

behaviors for youth. This study sought to extract the experiences of transgender young people, in order to try and obtain a clearer picture of their lives regarding perceptions of parental support and health behaviors. Although prior studies on transgender youth and health behaviors have found a higher risk for negative health behaviors, including substance use, suicide, and risky sexual practices (Grossman & D'Augelli, 2007; Hendricks & Testa, 2012; Nuttbrock et al., 2013), the current study did not come to some of those same conclusions. While suicidal ideation, suicide attempts, and illicit drug use were found to be comparable to other findings, alcohol and marijuana use and risky sexual behaviors differed from the results of earlier studies.

These differences in findings indicate several opportunities for further research. Most of the landmark studies on transgender youth were conducted approximately 10 years ago before the word "transgender" was common in mainstream media and before most people had at least minimal access to Wifi and internet resources. Additionally, due to the age range of respondents in this study (18 to 25), there is the possibility that many had yet to develop appropriate coping skills to deal with social attitudes and rejecting behaviors by parents. Young people are typically more vulnerable to increased risk of psychological distress, abuse, violence, and rigid family and collective gender norms. Identifying relationships between perceptions of parental support and subsequent health behaviors can potentially encourage families, schools, and social institutions to improve and develop more ways to support transgender youth.

While it has been established that perceived family support and acceptance is associated with better LGBT mental health, self-esteem, general health status, more

research is needed specifically focusing on transgender youth and family relationships. The small amount of existing literature shows that transgender youth who feel supported by their parental figures develop protective factors against psychological stress and negative health behaviors. As scientific information emerges about the relationship of parental support to health behaviors of transgender youth reach the general public and policy makers, more understanding and less discriminatory behaviors and policies could change, allowing transgender people to live full and productive lives.

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Appendix A: Permission of Use Measurement Tools

Re: questions about your survey

From Trans PULSE Project hide details
To Jill Hingston

Wed, Apr 27, 2016 4:18 p

Hello Jill,

Thank you for your email. We posted the survey specifically so that other people could use it. So please feel free to use any questions you would like. We just ask that you credit the project in any publications or presentations about your research.

Please note that many of the measures were developed specifically for this survey because suitable measures didn't exist. Some worked very well, while we wouldn't recommend adopting others (particularly questions that use complex matrix response options). If you have questions about measures you are considering adopting for your research, please feel free to get in touch and ask us.

All the best,
Ayden Scheim
on behalf of the Trans PULSE Project team

Safe Sex Behavior measurement tool

Jill Hingston to show details

Oct 9 2016

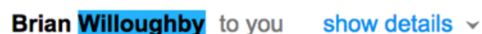
Hello Dr. Dilorio,

I am a PhD candidate at Walden University. My dissertation topic is about transgender young adults and their health behaviors in relation to perceptions of parental support/rejection. I am hoping you will allow me to use the SSBQ for my survey. Please let me know if you have any questions about my study in order to use your index.

Thank you for your time,

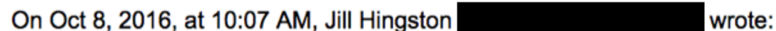
Jill Hingston, LMFT

Re: permission to use your parental rejection scale


Brian Willoughby to you show details

Oct 8 2016

Hi Jill - yes, you have my permission to use this scale. Thanks
Brian

On Oct 8, 2016, at 10:07 AM, Jill Hingston  wrote:

> Hello Dr. Willoughby,
>
> I am hoping I can use the PPRS in order to measure parental rejection in a young adult population. I am a PhD candidate at Walden University working on my study of transgender young adult health behaviors in relation to their perception of parental support/rejection.
>
> Thank you,
>
> Jill Hingston, LMFT

Appendix B: Demographic Questions

DEMOGRAPHICS

1. What is your age?
    a. ________

2. Do you consider yourself to be transgender or gender nonconforming in any way?
    a. Yes
    b. No. If no, do not continue.

3. Were your parents or caregivers aware of your gender identity when you were a child and/or teenager?
    a. Yes
    b. No. If no, do not continue.

4. Did you "come out" to your parents or caregivers about your gender identity in your childhood or adolescence?
    a. Yes
    b. No

5. If you did come out to them, what age did you do so?
    a. _______

6. What sex were you assigned at birth (sex noted on your birth certificate)?
    a. Male
    b. Female
    c. Intersex

7. What is your primary gender identity today? Which label do you most closely identify?
    a. Male (FTM female to male)
    b. Transman
    c. Female (MTF male to female)
    d. Transwoman
    e. Gender fluid
    f. Gender queer
    g. Androgynous
    h. Bigender
    i. Agender
    j. Two-spirit
    k. Gender nonconforming
    l. Gender variant
    m. Intersex

8. What is your race/ethnicity?
    a. White
    b. Black
    c. Native/American Indian
    d. Latino or Hispanic
    e. Asian or Pacific Islander
    f. Arab or Middle Eastern
    g. Biracial
    h. Multiracial

9. What is the highest level of school or degree you have completed? Check ONE box. If you are currently enrolled, please mark the highest degree or level of education completed.
    a. Elementary and/or middle school
    b. Some high school
    c. High school graduate or equivalent (e.g., GED)
    d. Some college credit (less than a year)
    e. Technical school degree
    f. One or more years of college, no degree
    g. Associate's degree (AA, AS)
    h. Bachelor's degree (BA, BS, AB)
    i. Other

10. At what age did you move away from your original family home?
    a. ________

11. Did being transgender or gender nonconforming **contribute** to your decision to move out?
    a. Yes
    b. No

12. Did your parents/family pressure you to move out?
    a. They kicked me out.
    b. They made me feel so unwelcome that I felt I had to leave.
    c. No. They did not pressure me to move out.

Appendix C: Variables

Variables	Level of measurement	Scoring rules	Range of outcomes
Dependent			
Suicide ideation (CDC, 2014)	Interval	Summation of items 1-3 on suicide scale. Scoring range 0 or 2 for each item.	0-6
Suicide attempts (CDC, 2014	Interval	Summation of items 4 and 5 in suicide scale. Scoring range 0-4 and 0-2 for items.	0-7
Alcohol use (Saunders et al., 1993)	Interval	Summation of 10 items. Scoring range 0-4 for each item.	0-40
Lifetime marijuana use (CDC, 2014)	Interval	One item question. Scoring range 0-6 for each item.	0-6
Lifetime illicit drug use (CDC, 2014)	Interval	Summation of items 1-9. Scoring range 0-6 for each item.	0-54
Risky sexual behaviors (DiIorio et al., 1992)	Interval	Summation of items 1-27. Scoring range 1-4 for each item.	27-108
Independent			
Perceived parental support (Willoughby et al., 2006)	Interval	Summation of 32 items. Scoring range 1-5 for each item.	32-160