Risk and Protective Factors in the Lives of Transgender/Gender Nonconforming Adolescents

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ABSTRACT

Purpose: Research suggests that transgender and gender nonconforming (TGNC) youth may be at greatly increased risk of high-risk health behaviors compared with cisgender youth, but existing studies are limited by convenience samples and small numbers. This study uses a large school-based sample of adolescents to describe the prevalence of TGNC identity, associations with health risk behaviors and protective factors, and differences across birth-assigned sex.

Methods: This study analyzes existing surveillance data provided by 9th and 11th grade students in Minnesota in 2016 (N = 81,885). Students who were transgender, genderqueer, genderfluid, or unsure about their gender identity (TGNC) were compared with those who were not, using \( \chi^2 \) and t-tests. Outcome measures included four domains of high-risk behaviors and experiences and four protective factors.

Results: The prevalence of TGNC identity was 2.7% (n = 2,168) and varied significantly across gender, race/ethnicity, and economic indicators. Involvement in all types of risk behaviors and experiences was significantly higher, and reports of four protective factors were significantly lower among TGNC than cisgender youth. For example, almost two-thirds (61.3%) of TGNC youth reported suicidal ideation, which is over three times higher than cisgender youth (20.0%, \( \chi^2 = 1959.9, p < .001 \)). Among TGNC youth, emotional distress and bullying experience were significantly more common among birth-assigned females than males.

Conclusions: This research presents the first large-scale, population-based evidence of substantial health disparities for TGNC adolescents in the United States, highlighting numerous multilevel points of intervention through established protective factors. Health care providers are advised to act as allies by creating a safe space for young people, bolstering protective factors, and supporting their healthy development.

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bathrooms, locker rooms, and sports teams [3,4]. However, from an epidemiologic perspective, this group is poorly understood, particularly its youth. We note that many different terms and phrases are used in reference to this population and by individuals themselves, including gender diverse, gender variant, gender expansive, gender creative, trans/gender nonbinary, and others. We have chosen transgender/gender nonconforming to succinctly refer to this group, in keeping with recent scientific studies and studies from a group of young adult members of this population. The first national prevalence estimates of transgender adults in the United States were recently published (4%–6% of the adult population [5–7]). Using estimates from adults, the Williams Institute has estimated a prevalence of 7% of transgender youth among 13- to 17-year-olds but concludes that refined estimates will depend on new survey data with appropriate assessment of gender identity [7]. Smaller U.S. studies have found slightly higher prevalences of TGNC youth: a study of San Francisco middle school students estimated that 1.3% identified as transgender [8]; 1.6% of participants in a study of high school students in Boston identified as transgender [9]. One national study of New Zealand high school students estimated this group as 1.2%, with an additional 2.5% being “not sure” about their gender [10].

Studies, reports, position papers, and clinical guidelines regarding TGNC populations predominantly focus on gender-affirming medical interventions (e.g., hormone therapy and gender-related surgery) [11–16] or mental health disparities [17,18]; other psychosocial issues have only rarely been considered [19]. However, TGNC youth also engage in the usual developmental tasks of adolescence, often including risk behaviors and experiences. Health and wellness for all adolescents go far beyond treatment for specific conditions, and reductions in substance use, unsafe sexual practices, suicide involvement, and interpersonal violence among youth are national health priorities enumerated in Healthy People 2020. Understanding the needs of vulnerable populations with regard to their health risks and aspects of the social context that can provide support is critical to the development of appropriate prevention activities. A small body of research suggests that TGNC adolescents face substantial health disparities in comparison to their cisgender peers (i.e., those matching in their birth-assigned sex and gender identity). TGNC adolescents are more likely than cisgender adolescents to face violence and bullying, engage in substance use and high-risk sexual behaviors, and struggle with poor mental health [10,18,20–23]. For example, in a recent Canadian study, 65% of transgender 14- to 18-year-olds seriously considered suicide in the past year, compared with 13% in a general sample of Canadian adolescents [18]. However, a critical shortcoming of TGNC research is the predominant reliance on adult samples recruited through nonrepresentative methods (e.g., convenience samples recruited at Pride events or support organizations) that may yield biased findings. Previous population-based studies of adolescents have included small numbers of TGNC participants [8–10], making statistically valid comparisons impossible. To ascertain valid and reliable estimates of personal characteristics, involvement in health risk behaviors, internal strengths, and external supports, research with large population-based samples of adolescents is imperative.

The present study uses a very large, school-based sample of adolescents to describe this hard-to-reach group. Specifically, we address the following research questions: (1) What is the prevalence of TGNC identity among youth and how does it differ across demographic characteristics? (2) How do health risk behaviors and protective factors in TGNC youth compare to cisgender youth? (3) Among TGNC youth, how do health risk behaviors and protective factors vary by birth-assigned sex?

**Methods**

**Study design and sample**

The present study is a secondary analysis of existing data from the Minnesota Student Survey (MSS), an anonymous surveillance program conducted every 3 years in grades 5, 8, 9, and 11, coordinated by the state Departments of Education, Health, Human Services, and Public Safety. All public school districts are invited to participate, and 85% of districts had at least one eligible grade participate in 2016. Key questions about gender identity were only included on the high school survey (grades 9 and 11), so the current analysis is restricted to these grades. Of all students enrolled in regular public schools in Minnesota in 2016, 71% of 9th graders, and 61% of 11th graders provided data, resulting in a total sample of 81,885 students. Passive parental consent was used, in accordance with relevant laws. To improve the validity of self-reported data, approximately 2% of surveys were discarded due to highly inconsistent responses or a response pattern suggesting exaggeration. The University of Minnesota’s Institutional Review Board exempted this analysis from review due to use of existing anonymous data.

**Instrument and measures**

The MSS was originally developed in the 1980s and is revised every cycle with input from experts in public health, education, psychology, youth development, and survey methodology to include new items of interest in recent years. In 2016, the initial gender question was revised to measure birth-assigned sex as biological sex (male/female), followed by a new question regarding gender identity: “Do you consider yourself transgender, genderqueer, genderfluid, or unsure about your gender identity?” (yes/no). This two-item approach is based on recommendations, validated measures [24,25], with modifications to be appropriate for a population-based adolescent health survey and to include newer terms used by adolescents to reflect a nonbinary gender identity (Eisenberg ME, Gower AL, Brown C, et al., unpublished data).

Numerous demographic and personal characteristics were assessed on the MSS. Grade level was self-reported as 9th or 11th. Students indicated all that applied of five race groups. Responses were combined with a separate item regarding Hispanic ethnicity (yes/no) to create a seven-category race/ethnicity variable (Hispanic; non-Hispanic American Indian, Asian, Black, Pacific Islander, white, and multiple race). One item assessed receipt of free/reduced-price lunch at school, and more severe economic hardship was indicated by an affirmative response to either of these two items: stayed in “a shelter, somewhere not intended as a place to live, or someone else’s home because you had no other place to stay” in the past year or having to “skip meals because your family did not have enough money to buy food” in the past 30 days. School location was coded as in the seven-county Minneapolis/St. Paul metropolitan area versus other areas of the state.
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