

## Transgender Youth and Life-Threatening Behaviors

ARNOLD H. GROSSMAN, PhD., MSW, AND ANTHONY R. D'AUGELLI, PhD

Sexual minority status is a key risk factor for suicide among lesbian, gay, and bisexual youth; however, it has not been studied among transgender youth. Fifty-five transgender youth reported on their life-threatening behaviors. Nearly half of the sample reported having seriously thought about taking their lives and one quarter reported suicide attempts. Factors significantly related to having made a suicide attempt included suicidal ideation related to transgender identity; experiences of past parental verbal and physical abuse; and lower body esteem, especially weight satisfaction and thoughts of how others evaluate the youths' bodies. Sexual minority status is a key risk factor for life-threatening behaviors among transgender youth.

Suicide is the third leading cause of death for youth between the ages of 15 and 24 in the United States. In 2002, 4,010 youth between these ages took their lives (Centers for Disease Control and Prevention [CDC], 2002). Estimates of completed suicide rates among subgroups of the population, including sexual minority youth (i.e., youth who engage in same-sex behaviors; have enduring same-sex emotional or sexual attractions; or claim a

same-sex identity such as lesbian, gay, bisexual, and transgender) are uncertain (McDaniel, Purcell, & D'Augelli, 2001). While estimates for life-threatening behaviors (i.e., nonfatal acts where there is evidence that the individual had some intent to die) are available for lesbian, gay, and bisexual (LGB) youth (Russell, 2003), comparable estimates for transgender youth do not exist.

In one study, 19% of gay college students had made suicide attempts; many attempts were related to conflict about their sexual orientation (Savin-Williams & Cohen, 1996). In a recent study, D'Augelli et al. (2005) found that about one third of a community-based sample of 528 self-identified LGB youth, ages 15–19, attempted suicide, which is generally comparable to findings in other studies of sexual minority youth (Remafedi, 1994). That percentage is considerably higher than the 8.5% identified in a recent survey of high school students (CDC, 2004). D'Augelli et al. also found that 15% of the suicides could be classified as lethal and that 17% of the attempts were attributed to the youths' sexual orientation. In another study, involving 77 college students recruited from an undergraduate psychology pool and

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ARNOLD H. GROSSMAN is with the Department of Applied Psychology at New York University; and ANTHONY R. D'AUGELLI is with the Department of Human Development and Family Studies at The Pennsylvania State University.

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Address correspondence to Arnold H. Grossman, PhD, MSW, Dept. of Applied Psychology, New York University, 239 Greene St., Suite 400, New York, NY 10003; E-mail: arnold.grossman@nyu.edu

gay, lesbian, and transgender student organizations, the majority between the ages of 18 and 24 ( $n = 69$ ); Fitzpatrick, Euton, Jones, and Schmidt (2005) found that cross-gender role (i.e., personality traits associate with the opposite sex) was a predictor of suicide symptoms as determined on the Beck Suicide Scale. Based on these and similar findings, sexual minority status has been determined to be a key risk indicator for suicidal behaviors among adolescents (Russell, 2003).

Youth are predisposed to life-threatening behaviors under a variety of conditions, including self-hatred, victimization by bullying from peers, a history of family violence, substance abuse, and sexual identity conflicts. "Research suggests that gay and lesbian youth are highly vulnerable on every count. . . . Conflicts about the disclosure of sexual orientation may influence young people to attempt suicide if they are otherwise predisposed" (van Wormer, Wells, & Boes, 2000, p. 122). Recent research indicates that transgender youth experience victimization from their peers, negative parental reactions to their gender nonconforming expression and identity, substance abuse, and family violence that is similar to their LGB counterparts, who have higher rates of life-threatening behaviors than their heterosexual peers (D'Augelli et al., 2005; Grossman, D'Augelli, Howell, & Hubbard, 2005; Grossman, D'Augelli, & Salter, 2006).

In addition to the exogenous factors of rejection, maltreatment, and victimization, youth who self-identify as transgender also experience personal distress and isolation. A primary area of distress is a gender dysphoria; that is, a strong and persistent (long-term) discomfort and distress with one's birth sex, gender, and anatomical body. Because of this distress, body esteem—especially how one feels about one's appearance and weight, and the perception of how others think of one's body—assumes importance. Gender dysphoria also includes feelings arising from confusion about gender identity, for example, some youth mistakenly believe that engaging in cross-gendered behavior means that they are lesbian or gay (Ryan & Futterman, 1998).

When left unchecked, both the internal and external factors can lead to an array of adjustment problems, including substance abuse and self-injurious behaviors (Burgess, 1999). Many helping professionals do not have accurate knowledge about the risks for suicidal behavior among transgender youth (Lev, 2004). Our goal in this paper is to enhance the knowledge of helping professionals about transgender youths' and their risk for life-threatening behaviors so they will be prepared to provide effective intervention. In addition, as most parents have control over their children's medical care, helping professionals can play a vital role in helping parents understand the impact of their attitudes, behavior, and decisions on their transgender children as well as assist them in transitioning from their assigned birth sex and gender.

#### DEFINING TRANSGENDER AND RELATED TERMS

*Transgender* is an umbrella term used to describe people whose self-identification or expression transgresses established gender categories or boundaries (Green, 2004; Sears, 2005). People who identify as transgender or "trans" live all or a substantial portion of their lives expressing or presenting a gender identity (i.e., an internal sense of gender) that is other than their birth sex. The term transgender is inclusive of individuals who identify as *transsexuals* (i.e., identify with a gender different from their birth sex), *cross-dressers* (i.e., wear clothes usually associated with a gender other than their birth sex), and *gender blenders* (i.e., present ambiguous gender expressions). Transgender communities include a variety of individuals who regularly transgress conventional gender norms and role expectations.

Most children learn about their birth sex, gender, and gender role expectations early in their development. Developmental research indicates that most two-year-olds know whether they are girls or boys; by the time they reach the age of three, children use the gender labels of "she" and "he" when re-

ferring to females and males. They also play with toys associated with their own gender and generally avoid toys associated with the other gender (Marcus & Overton, 1978). By ages four and five, they know that girls are more likely to play with dolls and boys are more likely to play aggressive sports (Connor & Serbin, 1977; Paley, 1984). While playing, girls tend to assume the roles associated with traditionally female professions (e.g., nurses, teachers, and secretaries), while boys take roles normally associated with traditionally male professions (e.g., doctors, firefighters, and truck drivers). Although some cultural traditions have changed, Perrin (2002) argued that fundamental gender stereotypes have remained in place and that most children express stereotypic ideas about what each sex should wear, feel, and do. Furthermore, children react in approving or disapproving ways toward each other according to their sex-appropriate behavior. Therefore, youth who are gender nonconforming and express identities that differ from their assigned birth sex receive varying responses from others, many of which are disapproving (Ryan & Futterman, 1998). Some gender nonconforming youth will identify as transgender and a subgroup of these youth experience distress leading to life-threatening behaviors. The experiences of life-threatening behaviors among transgender youth have not yet been explored in social science research. Therefore, the investigators had no specific hypotheses in designing and conducting this research; instead, they aimed to generate information that would aid future research (Way, 1998).

## METHOD

Data for this report were taken from a larger exploratory study of the personal and contextual factors influencing the development of transgender youth, aged 15 to 21. In the current report, the investigators focused on the history of life-threatening behaviors and their correlates. There were guided by four research questions: (1) What is the his-

tory of life-threatening behaviors among transgender youth (i.e., frequency of suicide ideation and attempts, methods used, and lethality of attempts)? (2) Do parental reactions to the youths' gender nonconformity and transgender identity relate to youths' life-threatening behaviors (i.e., suicide attempts)? (3) Do youths' feelings about the appearance of their bodies, or body esteem, relate to life-threatening behaviors (i.e., suicide attempts)? and, (4) What are the differences between the transgender youth who had engaged in life-threatening behaviors (i.e., report attempted suicide) and those who had not? Only the components of the assessment done for the larger project used in the analyses to address these questions are discussed in this paper.

The assessment procedure was an interview which focused on the experiences of transgender youth as well as a battery of standard measures that assessed various aspects of adjustment and mental health. The protocol was based on a previous one used in a study of LGB youth (D'Augelli & Grossman, 2006). The earlier protocol was modified based on findings from focus groups with transgender youth and on the advice of a planning and evaluation group of transgender youth, adults, and professionals who had worked with transgender youth (Grossman & D'Augelli, 2006). Because seeking parental consent could put the youth at risk for exposing their gender identity or lead to harm, parental consent was waived. However, a youth advocate was available to discuss questions about the study or the youths' participation in the study. The research procedures and protocols were approved by the institutional review boards on research with human subjects of New York University and Pennsylvania State University.

Data are based on a convenience sample of male-to-female (MTF; i.e., individuals whose birth sex is male, whose gender identity is female, or who behave in ways traditionally associated with females) and female-to-male (FTM; i.e., individuals whose birth sex is female, whose gender identity is male, or who behave in ways traditionally associ-

ated with males) youth. Because transgender youth are a hidden population, it was not possible to recruit a representative sample. The participants were recruited from programs of two social and recreation services agencies providing services to LGBT youth in New York City. Using a snowball sampling technique, participants referred other youth to the study. Youth were offered a \$30 incentive to participate. The authors recognize that these recruitment techniques limit the generalizability of the results and that the findings may not be characteristic of transgender youth between the ages of 15 to 21. Additionally, generalizability is not possible due to other research limitations, including the fact that a convenience sample was used, that the youth self-identified as MTF and FTM transgender youth, that the youth had access to a community-based organization serving lesbian, gay, bisexual, and transgender youth, or knew someone who did. Also, all data were based on youths' self-reports, which have intrinsic limitations.

#### *Participants*

The investigators studied a sample of 31 MTF and 24 FTM youth between the ages of 15 to 21. The respective mean ages of the two groups were 17.5 ( $SD = 1.6$ ) and 19.5 ( $SD = 1.6$ ), a significant difference,  $t [53] = 4.55, p < .001$ . As to ethnicity, 22 were of Hispanic heritage and 33 were not. Regarding race, 41 identified as White, 7 as Black/African American, 3 more than one race, 2 American Indian, 1 Asian, and 1 did not provide information on race. Twenty MTF and 21 FTM youth identified as White. Twenty-nine youth were attending school, with 22 in college and 7 in high school. Three had graduated from high school, 21 had completed various high school grades, and 2 did not report their levels of education as they could not identify the levels because of repeated interruptions of their education due to periods of prolonged absences from school.

Four fifths of the youth (79%) came from two-person households. Approximately three fourths (42) were raised by their bio-

logical mothers, by their grandmothers (6), or by an adoptive mother (1). There were no differences between MTF and FTM youth regarding those raised by mothers and grandmothers. Of those remaining, six youth were raised by their biological fathers, one by a stepfather, and two by other family members.

#### *Assessment*

Youth were assigned an interviewer who was a master's level clinician with experience working with transgender youth. Interviews took place in private rooms at the agencies or in nearby university offices. After giving their informed consent, the youth completed a questionnaire, and then participated in a structured interview. The interviews were conducted between 2001 and 2003.

*Suicide Ideation.* Suicidal ideation or thoughts about life-threatening actions was assessed with the following three questions: (1) "How often have you seriously thought about taking your own life?" (response options: *never, rarely, sometimes, often*); (2) "Within the last year, how often have you seriously thought of taking your own life?" (same response options); and (3) "How much were these thoughts related to your being transgender?" (response options: *not related, somewhat related, very related*).

*Suicide Attempts.* Past life-threatening behaviors defined as suicide attempts were assessed with questions used in earlier studies of LGB youth suicide (D'Augelli et al., 2005; D'Augelli & Hershberger, 1993; D'Augelli, Hershberger, & Pilkington, 2001). Additional questions were asked determine the seriousness of reported suicide attempts as recommended by O'Carroll et al. (1996). Youth were asked: "Have you ever actually tried to kill yourself?" and "Was this attempt related to your being transgender?" Because four youth reported multiple suicide attempts (ranging from 2 to 20) and detailed questioning about each would have been prohibitive, focused inquiry for those youth was conducted about the suicide attempt during which youth said they were most intent on taking

their own lives. With regard to this attempt, they were asked, "What exactly did you do?" Their responses were classified into 10 methods: firearms, hanging, jumping, drowning, stabbing, carbon monoxide, overdose, slashing/cutting, poisoning, and other. The youth were also asked, "Where did you do it?" "When you did this had you been drinking alcohol?" "What about any drugs?" and "When you made the attempt how likely did you think it was that you would die?" The youth were also asked if they wrote a suicide note or if they did anything else because they believed that they might die, such as give away possessions or say good bye to family or friends. This question would assist in judging the seriousness of youth's intent to die.

To further assess the relation between suicide attempts and the youths' transgender identity status, the youth were asked to respond to three statements from the Revised Homosexuality Attitude Inventory (RHAI; Shidlo, 1994) related to life-threatening thinking and behavior: (1) "There have been times when I've felt so rotten about being LGBT that I wanted to be dead," (2) "I have tried killing myself because it seemed that my life as a LGBT person was too miserable to bear," and (3) "I have tried killing myself because I couldn't accept my being transgender." The RHAI is answered on a 4-point scale from 0 (*Strongly Disagree*) to 3 (*Strongly Agree*). These three items formed an index of transgender-related suicide negativity. Cronbach's alpha for this index was .89.

The lethality of the reported suicide attempt was evaluated by the interviewer during the interview using the lethality rating scale developed by Cairns, Peterson, and Neckerman (1988). The 7-point scale of suicide attempts ranged from verbal threats to near death. Specifically, the points were defined as: 1 (*verbal threat or ideation with no evidence of actual attempt*), 2 (*action leading to some self-injury with suicidal intent*), 3 (*self-injurious action with potentially serious physical consequences but not life-threatening*), 4 (*potentially life threatening action*), 5 (*seriously life-threatening action, often requiring medical treatment*), 6 (*critical life-threatening action that required rapid emer-*

*gency medical treatment*), and 7 (*very close to death upon discovery with intervention or fortuitous circumstances saving child's life*). Following Cairns et al., life-threatening actions occurred when the actions were rated 3.0 or above (i.e., "not serious" or "serious"). In addition, youth were asked about their seriousness in wanting to die. The question was: "Do you think you really wanted to die? Would you say *definitely yes, yes, no, or definitely no?*" A review of the protocol material describing the suicide attempt was later conducted by another project staff member and given a second lethality rating. Discrepancies between interviewer ratings and the second ratings were resolved by the first author, a licensed master social worker with many years of clinical experience with youth; there was 64% agreement between the interviewer rating and the final rating. Youth were categorized as having engaged in life-threatening behavior or not.

The youth who engaged in life-threatening behaviors were asked if they ever discussed any emotional problems with a counselor, psychologist, psychiatrist, social worker, or minister (*yes/no*); if yes, they were asked at what age they first saw this person and the presenting problem(s). A question also assessed if they had ever been hospitalized because of emotional problems, not including substance abuse (*yes/no*); if yes, they were asked their age, the length(s) of stay, and the presenting problem(s).

*Childhood Gender Nonconformity.* The participants completed a modified version of the Gender Conformity Scale (Hockenberry & Billingham, 1987) previously used by D'Augelli, Hershberger, and Pilkington (2002) in their examination of gender atypicality among lesbian, gay, and bisexual youth. The scale contains 16 items reflecting childhood frequency of thinking or acting in a manner typically associated with males and females (sample items: "I like rough-and-tumble play," "I like dolls," "I preferred boys' games"). Participants indicated the extent to which each item described them when they were under 13 years of age, with response options ranging from 0 (*never*) to 6 (*always*).

This scale is a reliable measure of gender nonconformity; Hockenberry and Billingham reported reliabilities of .89 to .91 for different versions of the measure.

*Childhood Parental Abuse.* Parental psychological abuse was measured with seven verbal abuse and six physical abuse items from the Child and Adolescent Psychological Abuse Measure (Briere & Runtz, 1990). The youth were asked how often seven kinds of verbal abuse occurred when they were growing up as a child under 13 years of age. The question was, "Verbal fights and arguments can range from quiet disagreements to yelling, insulting, and more severe behaviors. When you were growing up, how often, if ever, did the following happen?" (Sample items: "yelled at," "made you feel like a bad person"). With regard to the six kinds of physical abuse, the question was, "Sometimes physical blows or violence occur between parents and their children. When you were growing up, at the worst point, how often, if ever, did the following happen?" (Sample items: "slapped you," "beat you," "kicked you"). For both sets of questions, youth answered with four options: 0 (*never*), 1 (*rarely*), 2 (*sometimes*), and 3 (*often*). Cronbach's alphas were .92 for the verbal abuse subscale and .93 for the physical abuse subscale.

*Body Esteem.* Many transgender people have feelings of estrangement from the bodies of their birth sex; commonly expressed as feeling trapped in the wrong body. Body esteem was assessed using the Body-Esteem (BE) Scale for Adolescents and Adults (Mendelson, Mendelson, & White, 2001). The BE Scale has three subscales: BE–Appearance (i.e., general feelings about appearance), BE–Weight (i.e., satisfaction with one's weight), and BE–Attribution (i.e., others' evaluation of one's body and appearance). The BE–Appearance contains 10 items (sample item: "I like what I see when I look in the mirror"), the BE–Weight has 8 items (sample item: "I am satisfied with my weight"), and the BE–Attribution contains 4 items (sample item: "People my own age like my looks"). The scales are scored on a 5-point scale from 1 (*never*) to 4 (*always*). Cronbach's alphas were

.85 for BE–Appearance, .87 for BE–Weight, and .79 for BE–Attribution.

## RESULTS

### *Descriptive Findings*

Twenty-five of the transgender youth (45% of the 55 youth in the study) seriously thought about taking their lives, and 30 (55%) never had such thoughts. While 11 (20%) reported *sometimes* or *often* having serious thoughts of taking their lives, 14 (26%) reported that they had *rarely* such thoughts. Approximately the same number of MTF ( $n = 12$ ) and FTM ( $n = 13$ ) youth reported that they *sometimes* or *often* having seriously thought of taking their lives. One-half of the 25 youth who seriously thought of taking their lives ( $n = 12$ ) said that the thoughts were *somewhat* or *very related* to their being transgender, with more MTF youth ( $n = 7$ ) than FTM youth ( $n = 5$ ) relating the thoughts to their transgender identity. Of the 25 youth who ever thought seriously of taking their own lives, 8 (5 MTF and 3 FTM) seriously thought of taking their lives within the last year.

Fourteen (26%) youth reported a history of life-threatening behaviors (i.e., a suicide attempt), 6 MTF and 8 FTM. Ten youth reported one attempt, three reported two attempts, and one reported 20 attempts. The ages of the youths' suicide attempts ranged from 10 to 17; with half of the youth first attempting suicide at ages 15 or 16. All youth reporting a suicide attempt said that at least one of those attempts related to their being transgender. Ten of the 14 youth reported that the first attempt related to their gender identity. These findings were supported by their responses to the statements of transgender-related suicide negativity index. Six (3 each MTF and FTM) youth reported that they *mainly agree* or *strongly agree* with the statement that they tried to kill themselves because they could not accept their being transgender, while 10 (5 each MTF and FTM) of the youth gave the same responses

saying that there had been times that they felt so badly about being LGBT that they wanted to be dead. Finally, 8 youth (5 MTF and 3 FTM) indicated that they *mainly agree* or *strongly agree* with the statement that they tried killing themselves because they felt that their life as an LGBT person was difficult.

Regarding the methods used for the suicide attempts in which the youth were most set on taking their lives, the most frequent methods were drug overdose ( $n = 6$ ), and slashing/cutting ( $n = 5$ ). Two reported hanging ( $n = 2$ ) and one poisoning ( $n = 1$ ). The MTF youth reported using all four attempt methods, while FTM reported only using overdosing and slashing/cutting. Ten youth reported that these attempts took place at home; three said on the street or in their neighborhoods; and one indicated an "other" setting. Five youth made the attempt when they knew someone was in the vicinity that could stop them, while nine indicated no one was nearby. When asked how long they had been planning the suicide attempt, three youth reported no prior planning, seven reported 1 day, three reported 7 days, and one did not respond. Thirteen youth reported that they had not been drinking or using drugs when they made the attempt, while one reported using drugs and being intoxicated on alcohol or drugs.

When asked if they ever discussed emotional problems with a counselor, psychologist, social worker, or minister, 12 of the youth who engaged in life-threatening behaviors answered in the affirmative; two youth indicated that they did not. Those who did were a mean age of 13 years ( $SD = 4/6$ ) when they first saw this person. The most frequent presenting problems were "sexual orientation concerns" and "family problems." Other problems identified by the youth were: depression, mood disorder, and bipolar disorder; one half of the youth listed two problems. Additionally, 5 of the 12 youth indicated that they had been hospitalized because of emotional problems (not including substance abuse); 3 of the 5 youth were admitted to a psychiatric facility after a suicide attempt. They were a mean age of 15 ( $SD =$

1.5) and they stayed an average of 21 days. Not surprisingly, the presenting problems were "suicidal thinking" and "self-injury."

With regard to the likelihood of death as a result of the suicide attempt, three said it was likely, seven were unsure, and four reported death to be unlikely. This finding corresponds to their reports about writing suicide notes, giving away possessions, or saying good-bye to family or friends, as only three youth responded affirmatively to this question. There were no differences between MTF and FTM youth with regard to planning the suicide attempt, drinking or using drugs when making the attempt, intending to die, writing a suicide note, or being admitted for psychiatric treatment.

In response to the question, "Do you think you really wanted to die?" three youth said *definitely yes*, three said *yes*, five said *no*, and three said *definitely no*. However, the lethality ratings indicated that attempts of six youth were "not serious" and eight were "serious." Consequently, the lethality of the attempts of two more youth than those who indicated that they really wanted to die was "serious" or "very serious." There were no significant differences between MTF and FTM with regard to the lethality of their suicide attempts.

Although the lethality ratings indicated eight youth were "serious" about their attempts being life-threatening and six were "not serious," comparisons between the two groups on the variables of interest were non-significant. Therefore, they were combined as "attempters" ( $n = 14$ ), and they were compared to the "non-attempters" ( $n = 41$ ) to determine if those variables could distinguish those two groups.

#### *Comparisons of Youth Who Did and Did Not Attempt Suicide*

A multivariate analysis of variance (MANOVA) was performed to test for differences across youth suicide attempter groups (i.e., attempted suicide yes or no) on the following seven psychological variables: childhood gender nonconformity, transgender-

related suicide negativity, parental verbal abuse, parental physical abuse, body esteem—appearance, body—esteem weight, and body esteem—attribution. The significant MANOVA,  $\lambda = .55$ ,  $F = 5.20$  (1, 53)  $p < .001$ , was followed up with seven univariate  $F$  tests. Study results indicated that five of these psychological variables were related to suicide attempt status. The results of these analyses are presented in Table 1.

*Suicide Attempts and Childhood Gender Conformity.* We examined whether or not the childhood gender conformity differed between suicide attempters and nonsuicide attempter. A significant difference was not found.

*Transgender-Related Suicide Negativity.* As can be deduced from the results discussed earlier, the suicide attempters, on average, “mainly agreed” or “strongly agreed” with the three items on the transgender-related suicide negativity index. A significant difference was found on the index of transgender-related suicide negativity between those youth who attempted suicide and those who had not attempted suicide.

*Parents’ Reactions to Atypical Gender Expression.* From 35% to 73% of the youth reported “sometimes” or “often” being verbally abused by their parents related to their gender expression on each of the seven items. The largest percentages reported being yelled at or criticized; however, approximately 50% reported “sometimes” or “often” being in-

sulted, made to feel guilty, and embarrassed in front of others. From 13% to 36% of the youth reported “sometimes” or “often” being physically abused by their parents related to their gender expression on each of the six items. More than 25% reported being slapped, beat, or hit very hard, and from 13% to 20% reported being punched, kicked, and pushed very hard. Significant differences were found between those who attempted suicide and those who did not with regard to verbal abuse and physical abuse; attempters reporting more verbal and physical abuse by their parents than non-attempters.

*Body Esteem.* The means for the three body esteem scales were all mid-range on the 5-point scale: BE–Appearance ( $M = 3.3$ ,  $SD = .82$ ), BE–Weight ( $M = 3.4$ ,  $SD = .91$ ), and BE–Attribution ( $M = 3.4$ ,  $SD = .86$ ). Significant differences were found between suicide attempters and non-attempters with regard to BE–Weight and BE–Attribution, but not in relation to BE–Appearance: those youth who attempted suicide were less satisfied with their weight and others disliked their bodies more than those who had not attempted suicide.

## DISCUSSION

The findings of this study provide evidence that transgender youth, whether MTF

**TABLE 1**  
*Means and Standard Deviations for Psychological Variables for Transgender Suicide Attempters and Nonattempters (N = 55)*

Variable	Attempters (N = 14)		Nonattempters (N = 41)		F
	M	SD	M	SD	
Childhood gender nonconformity	3.58	1.47	3.94		ns
Transgender-related suicide negativity	1.10	.99	.20	.53	18.13***
Parental verbal abuse	1.60	.85	1.09	.71	4.86*
Parental physical abuse	1.42	.99	.73	.63	8.90*
Body esteem—appearance	3.01	.88	3.34	.79	ns
Body esteem—weight	2.92	1.11	3.54	.80	5.05*
Body esteem—attribution	3.11	.95	3.68	.77	4.89*

\* $p < .05$ ; \*\*\* $p < .001$ .



or FTM, are at risk for suicidal ideation and life-threatening behaviors. Almost half of the transgender youth in the study thought seriously of taking their lives, and half of those related these thoughts to their transgender identity. One quarter reported a suicide attempt, with almost three quarters of those youth relating their first or only suicide attempt to their transgender identity, while the remaining youth attributed subsequent attempts to their being transgender. This proportion of sexual minority youth is larger than the proportion of LGB youth found by D'Augelli et al. (2005) who attempted suicide and attributed their attempts to their sexual orientation.

Five youth said that they had been admitted to psychiatric hospitals after a suicide attempt. In relation to the lethality of the suicide attempts in which the youth were most intent on ending their lives, six were rated as not serious, and eight were rated as serious or very serious. These results support findings from a qualitative study using focus groups in which transgender youth described themselves as vulnerable (i.e., having no comfort or safety zones), a situation which put them at risk for suicide (Grossman & D'Augelli, 2006).

Nonheterosexual youth are stigmatized in most cultures. While there are different responses to gay, lesbian, bisexual, and transgender people, all of these groups experience negative judgments and discrimination (Perrin, 2002), and the most vulnerable lack family and peer support systems (Grossman & Kerner, 1998; van Wormer et al., 2000). In comparing the suicide attempters with the non-attempters in this study, the investigators found that the youth who attempted suicide experienced more verbal and physical abuse from their parents than those who did not. These findings are consistent with those of Proctor and Groze (1994) who studied 221 self-identified LGB youth. In comparing those who attempted suicide with those who did not, Proctor and Groze found significant differences in family relations, peer relations, school performance, and self-perception to be the most salient.

Although physiology is the most fun-

damental difference between males and females, there are also systems of social rules and customs concerning what males and females are supposed to be and say (Perrin, 2002). When youth transition from their assigned birth sex, they contradict many of these rules and customs. They may also indicate that the physiology which led to designating them one gender or the other was not accurate. Consequently, it is important to learn about transgender youths' feelings about their bodies and how they think others evaluate their bodies. The findings indicate significant associations between suicide attempts and two aspects of body esteem, weight satisfaction and others' evaluation of one's body and appearance. In his discussion of transgender people and their bodies, Green (2004, p. 90) stated, "Most of us are not seeking perfection when measured against external stereotypes; rather, most of us are seeking an internal sense of comfort when measured against our own sense of ourselves." In other words, transgender people endeavor to change their bodies so that they can be perceived by others as the males and females they consider themselves to be. Most transgender youth do not have the access and resources needed to change their bodies so that they are pleasing to themselves and to others.

The findings indicate that there is a need for a variety of interventions with both transgender youth and their parents. Among these should be: (1) educational programs for parents and other guardians about their transgender children and the negative outcomes of psychological abuse, verbal or physical; (2) psycho-educational programs for transgender youth about approaches to changing their bodies incrementally so that they gain higher body esteem by knowing that they will be able to facilitate changes over time; (3) intervention programs for transgender youth who have personal conflict and distress related to their transgender identity to help them cope with the stress of living as a transgender person; (4) training programs for mental health professionals (e.g., counselors, social workers, psychologists, psychiatrists) so that they can work with transgender

youth, and their parents and guardians to reduce the youths' psychological distress and decrease the likelihood that youth will engage in life-threatening behaviors; and (5) training mental health professions to recog-

nize and treat mental health disorders, such as bipolar disorder and major depression, specifically associated with individuals who attempt or complete suicide (Moscicki, 1997).

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