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### African-American Transgender Youth

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## **African-American Transgender Youth**

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*The author, a child and adolescent psychiatrist, discusses his experience working with minority transgender youth in Los Angeles. He describes two cases of adolescents he has treated in Los Angeles at a clinic which serves sexual minority youth who are often wards of the foster care and criminal justice systems and who often have chaotic and traumatic family histories. Unlike the classic descriptions of transsexuals, these youth are often varied and fluid in terms of their gender identities, expression, and sexual identities and orientation.*

**KEYWORDS** *transsexual, transgender, youth, African-American, adolescents, mental health treatment*

### INTRODUCTION

In this article, I will discuss the very specific populations with whom I work. I treat approximately 50 transgender (TG) male-to-female youth through one clinic. Before turning to specific cases, let me discuss the historical development of the diagnosis of transsexualism and the ethnic and socioeconomic bias in this literature.

In the 1950s, Christine Jorgensen was the first international transsexual figure. She became a strong role model for an emerging transsexual community, as well as a model for the doctors who shaped the nosology of transsexualism. Historian Joanne Meyerowitz (2002) has highlighted how Jorgensen energetically tried to present an image of transsexual women as feminine and classy. This model not only reinforced gender conventions but also heterosexuality and white ethnicity. The medical model of “true”

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transsexualism largely followed her lead until the 1990s when it underwent intensive debate and criticism within medical circles and the transgender community (Rosario, 2004).

There is not much medical literature on minority transsexuals, including transsexuals from other countries. Most of the literature deals with Anglo, white, and European-American transsexuals (Winter, 2002). The scant literature that does exist regarding transsexual minorities generally comes from the social sciences (e.g., Green, 1999; Prieur, 1998). There is emerging new literature dealing specifically with male-to-female adolescents, mainly from San Francisco. This is a similar population with which I work: urban, very poor, with high rates of substance abuse and psychiatric disorders, frequent histories of physical and sexual abuse, and at high risk for HIV infection. In popular culture, and in the sex trade industry, they would be identified as “she-males,” although this is not a term the youths use among themselves.

In San Francisco, Garofalo et al. (2006) reported on a population of 51 male-to-female transgender teenagers and transitional-age youth (ages 16–25), a high percentage of them African-American (AA). They found high rates of incarceration, homelessness, unemployment, and poor access to health care. African-American transgender youth had the highest HIV infection rates of all the ethnic groups. Many of these TG youth engage in sex work, as is suggested by all of the she-male pornography and “escort” service sites found on the Internet. These TG youth often encounter situations of forced sex, unsafe sex, and substance abuse. There is also a lot of self-injection of hormones that they purchase on the street, as well as self-injection of silicone for breast, hip, and buttock enlargement. In a meta-analysis of HIV prevalence and risk behaviors of transgender people, Herbst et al. (2008) confirmed the particularly high rates of HIV infection among African-American TG. This study also looked at contextual factors for the high risk sex behaviors, unprotected sex, and sex work and found high rates of depression, anxiety, histories of physical and sexual abuse, and poverty in this population. Many of these individuals need to engage in unsafe sex work to make money. In a qualitative study of minority transgender girls in San Francisco, Nemoto et al. (2004) found that these subjects reported engaging in unprotected sex in order to feel closer to their partners, to not distance them, to feel more female, or simply because they needed the money. Nemoto et al. also found high rates of drug use in these TG girls, which helped them cope with their difficult lives on the streets engaging in sex work.

I work half-time at a clinic run by Gay & Lesbian Adolescent Social Services (GLASS), a nonprofit group in Los Angeles. GLASS operates six group homes for adolescents. Approximately half of these youth are in the foster system and about half are on probation. We offer high levels of care and supervision to those who have failed many other less restrictive residential and treatment settings. GLASS also runs an outpatient mental health clinic

that offers care to individuals up to the age of 24, a local health outreach van for sex workers and homeless youth, and transitional living apartments for transitional-age youth.

These clients are of low socioeconomic status; approximately half are Latino and half are African-American. I am going to focus on African-American youth whom I currently treat. These are youth who have almost uniformly had troubled lives scarred by extreme poverty, trauma, and violence with very limited experience of trustworthy adults. Many have been involved in gangs, either directly or via family and relatives, and many have engaged in crime, prostitution, drug abuse, and alcohol abuse from an early age, some since elementary school.

Of the several dozen transgender teens I treat, I will present two cases of African-American adolescents. These young people had dramatically different outcomes, even though there are many notable similarities in their histories.

## CASES

### Case 1: Starr

Starr first came into my care at age 17. She had been in the foster care system since the age of eight. She also had been in the probation system for grand theft auto, shoplifting, truancy, and probation violations. Starr was a very unstable child. She had grown up in the Bay Area. Her father abused cocaine and was in jail for rape and lewd acts with a child. Starr, however, denied that her father had ever molested her. Her mother had a history of drug abuse. Starr had limited contact with her mother, whom she described as very immature. She had a number of half-siblings, all of whom were in protective custody. A maternal grandmother was the only relative who maintained any sustained, albeit irregular, contact with Starr.

Starr had been cross-dressing virtually full-time since 15 but had only self-identified as transgender since age 16. With her biological family so unstable, her real support network and social connection was the drag ball scene.

Jennie Livingston's documentary *Paris is Burning* (1990) is a poignant and accurate depiction of the transgender club scene in New York City in the 1980s. The predominantly African-American and Latino gay and TG subculture represented in this documentary is still very much alive in San Francisco, Los Angeles, and probably in New York. The clubs are supported by competing "houses" dominated by a "mother": an older transgender woman or queer man who has become "legendary" (i.e., a frequent winner in the drag balls). The houses are places where gender atypical preteens as well as teenagers who are homeless can gather under the support and guidance of a more senior, experienced transgender person. They can find social support

as well as compete with other houses at the drag balls. In addition to dance competitions (involving break dancing, vogue, and “krumping”), individuals compete for “realness” in a variety of categories, not only female drag but also male drag—usually mimicking and subtly mocking white, upper-class styles (e.g., tennis club, suburban male, Wall Street banker).

Starr found her home in the “house” scene. By her own report, she had a long history of “bad attitude”—acting defiant, loud, demanding, or taciturn. This behavior was normative in the houses and especially valued in ball competitions.

Starr had had a very tumultuous childhood with extreme mood lability and one psychiatric hospitalization at age ten for a suicide attempt, which she insisted was not really suicidal, “just for attention.” She had received Special Education services since the seventh grade. She had a long history of fights and marijuana use since 15. She gave a fairly classic history of lifelong gender atypicality: as long as she could remember she had been very feminine and liked to cross-dress since preschool. However, she had only been cross-dressing full-time for two years.

Despite a long history of gender-variant behavior and episodic cross-dressing, Starr reported that she had only been self-identifying as a transgendered female for one year. Part of her resistance to taking on a trans-identity was that she did not identify as gay and was not attracted to self-identified gay men. In fact she held very negative stereotypes about gay men, describing them as effeminate, weak “punks”—all the things that she believed she was not. She was one tough girl and she could fight—and frequently did.

Unlike many of the transgender teens I treat, at our very first meeting Starr expressed an interest in going to a gender clinic and beginning cross-gender hormone treatment. I suspected that she had already been using street hormones in Oakland, since she was fairly conversant about them and had realistic expectations of what such treatments could do. She told me she had learned about hormones from friends, houses, and clubs. She wanted to have breasts, and she knew that she might need breast implants in order to have “big enough” breasts. She wanted hormones to reshape her body and explicitly hoped to better compete for “realness” in the balls. She had no interest in genital surgery. Quite unlike the classic descriptions of male-to-female transsexuals, such as Christine Jorgensen, Starr did not report severe gender dysphoria, horror of her genitals, or discomfort in her own male body verging on body dysmorphic disorder. She primarily wanted a more feminine looking exterior to boost her female “realness” in order to attract and retain heterosexual men as sexual clients and partners.

Starr had rigid notions of what straight men and gay men were like and reported she was only interested in straight men. They were tough and aggressive; in other words, they were “real men.” Her goal was to become a model. She was very pretty, tall, and thin.

She lasted five months in residential placement, which was longer than I had expected. These were a difficult five months. She repeatedly ran away from the group home, only to return a few days later with new clothes, handbags, and shoes, thanks to money she probably earned engaging in sex work on the strip of Hollywood Boulevard where the transsexual girls hang out. Starr denied prostituting after these excursions, yet she always asked to get HIV tested whenever she came back. In peer groups Starr was extremely tough and confident. She was especially vicious with the other transgender peers who were just starting to experiment with cross-dressing. She would cut them down ruthlessly, which was something she had picked up from the balls. Yet when speaking to her one-on-one, she eventually revealed poor self-esteem and great insecurity about her own appearance.

After five months in the group home, she left for good. I heard from other kids who had a similar pattern of AWOL that Starr had been spotted on the boulevard turning tricks. When she turned 18, she reappeared again. I do not know if she turned herself in or got arrested, but she was transferred from the probation system back to the foster system. She went into one of the GLASS transitional-living apartments. She had ongoing problems with school truancy and was expelled from three different schools, but eventually she settled down significantly.

It has been a great pleasure and a challenge for me to work for GLASS for seven years, treating extremely troubled kids whose lives were severely traumatized. Over a length of time in treatment, these kids often gradually calm down and are able to open up in the therapy.

However, one stable figure cannot trump a world of turbulence outside the office. Starr ended up meeting a tough young man who became her pimp. He quickly became a nuisance at the transitional-living facility by trying to pimp out some of the other transgender girls living there, and trying to have sex with them. One day Starr and this man had a fight and smashed the apartment windows. The program managers decided they could not handle the two of them, and a few months later Starr was emancipated and returned to Oakland.

## Case 2: Robert/Taisha/TJ

Robert is an African-American transgender youth who I have seen for the past seven years, since he was 14 years old. He was very difficult to connect with initially. He had been in the Department of Children and Family Service's (DCFS) custody since the age of six. He had a very unhappy childhood and got into a lot of trouble in school. He also had a significant psychiatric history of depression and anorexia and was extremely thin.

When I first met Robert, he wore skin-tight boys' clothes, such as jeans, but already had a fairly strong interest in becoming a girl. She had begun to identify as transgender self-consciously about nine months before I met her

and chose to go by the name Taisha. During our second session, she was already inquiring about hormones and sex reassignment surgery with the goal of becoming, as she called it, “fishy.” This was unusual, since most of the transgender kids that I see are not interested in bottom (genital) surgery, but instead, like Starr, prefer to be “she-males.”

Taisha was interested in starting hormones right away. Three months after I started treating her, she began cross-dressing full time. She was extremely convincing as a female. She went to school cross-dressed, and everybody knew her as a girl. She visited home for the first time dressed as a girl and reported that it was “kind of weird and tense.” Taisha’s mother was “guilt tripping” her, and as a result she started to avoid the family for months. However, she was dating and was actually very popular and outgoing. Her mood improved significantly during this time. Her behavior in the group room improved significantly and she became a favorite of the staff. She was in relationships and at one time was in a long-term relationship.

Taisha initially had a boyfriend but later started dating a girl and became more ambivalent about sex reassignment surgery. Yet from outward appearances, she was completely comfortable and passable as a girl.

During the time that I was treating Taisha, I ran a transgender therapy group for GLASS which was made up of mostly male-to-female adolescents who identified as straight girls and were erotically attracted to boys. She was the only one in the group who was attracted to girls. Because of this, she was marginalized in the group. The other transgender kids would say, “Girls are disgusting—how can you like girls?”

Taisha continued to be interested in hormone treatment and started going to the gender clinic at Los Angeles Children’s Hospital. Their gender clinic, funded as an offshoot of HIV education and prevention, is one of the rare such facilities in the country. The clinic mostly treats homeless, transgender male-to-female (MTF) youth, but also some female-to-male transgender (FTM) youth. Many of the MTF adolescents are homeless sex workers, who through this clinic are able to get individual and group therapy, assessment for hormones, and hormone treatment in a medically supervised fashion, rather than turning to black-market, self-administered hormones.

After Taisha had been coming to GLASS for some period of time, her grandmother, who was her main source of emotional support, died right before the holidays. This loss led to a descent into depression. Nevertheless, during this period Taisha decided that she finally wanted to gain weight. She had a rough time with family over the holidays that year but also started to connect more with them. Curiously enough, the family felt more comfortable with her as a girl. They were extremely homophobic, and although she was a transgender girl who was interested in girls, that scenario was more acceptable to them than her being a gay man.

Unfortunately, after New Year’s, Taisha started abusing alcohol and began to have more trouble at school, probably because of drug use. She broke

up with her long-term girlfriend, who became pregnant by another partner. Taisha then started to become more and more despondent with life in the group home. When she turned 17, she stopped having girlfriends, stopped going to the gender clinic, and became more ambivalent about taking hormones. Finally, she admitted to serious alcohol binge drinking.

Taisha then switched suddenly to a “stud” persona, which was a dramatic and confusing change for staff and peers alike. Gay girls in the clinic typically identify as either “studs,” “fems,” or “stems.” Studs are masculine or “butch” girls. Fems are conventionally feminine in their gender role, while stems are between a stud and a femme. Either they present a hybrid gender role or switch between stud and fem roles.

Since the girls, especially the studs, follow a strict gender complementarity (studs can only date fems), stems are seen as risky. A stud’s social status to some degree is measured by how pretty and feminine her girlfriend is. So for a fem girlfriend to switch to a stud role is an affront to her stud partner, diminishing the partner’s butchness in the eyes of her peers. Taisha switched to being a stud, dressing up in masculine girl’s clothes, wanting to gain weight and to become more muscular. She started taking a high calorie dietary supplement.

At 17-1/2, she decided that she wanted to return to being a boy. She cut her hair short and stopped wearing a bra. Her family became confused and angry. They had become accustomed to her being a girl and did not like the idea of her now declaring that she was a gay man. Her friends in high school were also confused because they had always known Taisha as a girl and now thought that she was a female-to-male transsexual. Now adopting the moniker “TJ,” he had to relearn masculinity.

TJ’s explanation for this radical change was simply that he was tired of being female and a “transy.” He complained that it was a lot of work, that it was boring, and that he “had already done it.” He stated that she had done the “transy” thing just to get attention and now was going to go back to being a boy. He claimed that he was bisexual for a year and tried to adopt a more masculine appearance, enhanced by a new gang tattoo. At 18 he was transferred to transitional housing and then dropped out of treatment for a year.

TJ reappeared in the clinic at age 19, and at this point he had to be moved from one of the transitional living apartments in Los Angeles to the one in the distant suburbs because of the trouble he was getting into in the city. Although he had yet to complete his high school credits, he had been attending school while under the supervision of the group home. Once he was living independently and was 18, his school attendance had become erratic, and he eventually dropped out entirely. Drugs and alcohol abuse had become more of a problem when he started gravitating to the club and house scene. During this time he was practically cut off from his family and had difficulty obtaining employment.



At 19 he was transferred to a homeless youth shelter, also under GLASS's auspices. Therefore, I was able to continue seeing TJ. His therapy changed tone dramatically at this point. He was very open and trusting, and reflected on his life, asking questions such as: "What was I thinking? What was I doing? Why was I...?" He admitted that previously he had been self-administering estrogen that he had gotten on the street. He could not understand how he could have been so committed to becoming a girl. At this point he felt that the desire for a gender change was due to extreme discomfort with the idea of being an effeminate, gay man. Now, however, he was only interested in sex with men—gay men, not straight men. Yet he still wondered if he might be bisexual and sought my reassurance that it was okay to be bisexual.

TJ became increasingly anxious about not having finished school and not being able to obtain and maintain employment. He also reported feeling uncomfortable with being a flamboyant gay man and facing much hostility because of it. He felt that his "fishy" mannerisms and speech led to harassment in public and impeded his getting hired for jobs. He continued to participate in the drag ball scene, and his drug use there was getting out of control. He finally decided to go into a residential drug rehabilitation facility.

At this time, he was assaulted by some gangbangers on the street, and was clearly targeted for being a flamboyant man. After this attack, he became more depressed and isolative. He spent a lot of time online and discovered black gay chat rooms. Always very sassy, he was arrested for talking back to a police officer and spent five days in jail. He initially described this experience as amusing. He was detained in the gay unit at the Los Angeles jail—the "fag box" as the police call it—at the Twin Towers, the mental health jail which is the largest provider of mental health care in Los Angeles. He noted that he encountered many of his old friends there, former GLASS group home residents who had probably been arrested for prostitution. During a subsequent session, he expressed feeling extremely distressed realizing that he was leading the same kind of life as his peers in jail, and that this was not what he wanted. He continued to have severe anxiety with the challenges of transitioning to independent adulthood.

As TJ approached his twenty-first birthday, this second threshold of adulthood again seemed to impel him to overcome his anxieties and be more proactive about his future. He knew that when he turned 21 he would age out of transitional youth housing, and he really had nowhere else to turn. He started working on obtaining other housing support and started earning money doing handyman work. He worked hard at being less flamboyant and tried to pass more as a masculine man, yet he still had difficulty landing full-time employment. He had several boyfriends but had a different perspective on dating. Rather than making a boyfriend the focus of his life, he realized that he first had to focus on getting his own future in order. His future success still remains precarious, as an effeminate, gay African-American man

who grew up from inner-city poverty and in the foster system and who, despite his intelligence, did not complete his high school education. TJ will continue to face many challenges in contemporary American society.

## DISCUSSION

With this population of gender variant youth, it is important to appreciate the diverse expressions of gender identity, gender roles, sexual orientation, and sexuality. In addition to being shaped by potential innate, temperamental factors, these psychosexual elements also are molded by the socio-economic, religious, and familial milieu as well as the unique subcultures of urban gay/queer life. Health-care workers treating these youth need to be attentive to their specific needs and goals: do they want hormones or not, do they want top or bottom surgery or not? In my experience with this population, few of them want bottom surgery.

Many of the transgender adolescents at GLASS decide they do not want to be transgender anymore as they turn 18. There may be a variety of reasons for this. Some become disappointed or disaffected with the only role model they have of transsexual womanhood: she-male prostitutes. Many become more comfortable identifying as a gay male as they develop attachments to stable gay and lesbian professionals at GLASS and overcome deeply ingrained community prejudices against homosexuals. If they manage to continue participating in mental health care, some experience major improvements in psychological well-being, sobriety, and most importantly, envisioning a different future for themselves. In the rare cases where families engage in therapy and are able to be more accepting of the child's gender expression and sexuality, the child experiences enormous psychological relief and freedom to settle into the gender and sexuality that allows them to be most content and functional.

Gender identity, at least in this population, is still extremely fluid and is shaped by a variety of complex and often traumatic experiences that these individuals have concerning gender and gender expression which come from society, culture, religion, and especially from the very strong homophobic messages they receive from their families. The role models that they get to see at GLASS have a strong influence in terms of the adolescents' gender identity and sexuality.

The most important aspect to remember when working with these youth is the impact of their socioeconomic and ethnic milieu, particularly on issues of gender roles. More broadly speaking, the notion of what transsexualism is has changed enormously in the last couple of decades since the model provided by Christine Jorgensen. As the sixth version of the *Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders* (2001) repeatedly highlights, treatment does not

consist in a rigid regimen of “triadic care”: “real-life experience” (passing), sex hormones, and gender-reassignment surgery. Treatment should be tailored to desires and needs of the individual patient to help them achieve their own sense of gender identity and sexuality.

## QUESTIONS POSED AT THE SYMPOSIUM

**Question from the audience:** You have described kids who seem so different to the sorts of trans kids that the other speakers discussed. These kids seem to have such socially chaotic lives, with a breakdown of social identity, gender identity, and personal identity. I wonder if you could give us some flavor of what these folks are like as people. Do they have some emotional depth at times? Are they able to talk with you? Are there strengths that some of them are able to hold onto socially and in terms of their internal identities?

**Vernon Rosario, MD:** These kids have horrible lives, which sadly is not that uncommon for kids in the foster and delinquency system. They are very tough to connect with. They have probably never had contact with adults that they could or should trust. Their parents have mistreated them or abused them. So why are they going to trust me, a complete stranger? Many of them, unfortunately, have had very negative experiences with the mental health system in juvenile hall. It has been very important that I have been working at GLASS for years, so that the kids come back again and again, see me, and develop a relationship of trust. I see kids who have left the system and return to see me voluntarily for therapy. And that's been very important for their treatment long term, and the most rewarding aspect of working with these kids for me. They have no judge compelling them to treatment, but simply realize that they are distressed and they are open to talking with me. In summary, their major strength is being able to survive.

**Question from the audience:** Is the attitude of the African-American families that you discussed, that they actually prefer for their gender variant kids to be transgender than to be gay, or do you find that in general it varies from family to family?

**Vernon Rosario, MD:** I think it varies from family to family, but it is a message that I get from many of the kids whom I treat. Being gay, being a “punk,” is a very weak position. It is seen as sinful and bad, and as inviting to be beaten up. The other role model they have is of tough street girls (sex workers) who can kick ass, and this is a better role model for dealing with their innate gender variance and finding another way to be and to survive.

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