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Transgender Resiliency: A Comparison of Transgender and Cisgender Therapy Clients' Family Functioning and Psychological Symptomology

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Transgender Resiliency: A Comparison of Transgender and Cisgender Therapy Clients' Family Functioning and Psychological Symptomology

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Existing literature often suggests transgender people face increased vulnerabilities in comparison to cisgender people and poorer mental and physical health outcomes. However, studies are increasingly exploring resilience of transgender people and factors contributing to positive coping. The current study compared transgender to cisgender clients at a University-based couple and family therapy center on self-reported psychological symptomology and family functioning. Transgender individuals did not differ significantly from cisgender individuals on family functioning, however transgender individuals reported significantly fewer symptoms on all twelve subscales of psychological symptomology, despite lower income and lower levels of education. Results suggest transgender individuals may develop unique traits or processes allowing them to more effectively cope with stressors, supporting the presence of resiliency in this population.

KEYWORDS transgender, resilience, psychological symptoms, family functioning, mental health

Studies consistently indicate that transgender individuals face increased vulnerabilities such as unemployment, family challenges, discrimination, and violence. The National Transgender Discrimination Survey (Grant et al., 2011; n=6,456), found 63% of participants experienced a serious act of discrimination, impacting their quality of life and ability to maintain financial or emotional stability. Furthermore, 23% of participants experienced three or more of these major events, including loss of a job, eviction, sexual or physical violence, incarceration, homelessness, denial of medical service, bullying, or loss of a relationship with a partner or children due to bias. Participants were also nearly four times more likely to live in extreme poverty (household income less than $10,000) than the general population. Results from the U.S. Transgender Survey (James et al., 2016; n=27,715) confirm these findings, where 30% of participants reported being fired, denied a promotion, or experienced other mistreatment at work in the past year coupled with high reported rates of verbal (46%), physical (9%), and sexual assault (10%). Further, 29% of the sample were living in poverty. Given the large sample sizes of these studies, findings suggest widespread experiences of discrimination that can likely be generalized to the larger population of transgender people.

While smaller in scale, multiple other studies have suggested increased rates of vulnerability and mistreatment of transgender people. Kenagy's (2005) research on the experiences of transgender people indicated 33% felt unsafe in public and over one-half reported experiencing multiple types of violence. In Bradford, Reisner, and Xavier's (2013) study, 41% of participants reported experiencing transgender-related discrimination in healthcare, housing, and

employment. Nuttbrock et al.'s (2010) study found male-to-female transgender participants experienced high rates of psychological abuse (78%) and physical abuse (50.1%). Not only do transgender people face discrimination and mistreatment in society at large, they often experience hurtful or traumatic experiences in their families, often starting in childhood (Ignatavicius, 2013; Grossman & D'augelli, 2006; Riley, Clemson, Sitharthan, & Diamond, 2013).

These unique stressors are often thought to put transgender people at an increased risk for negative physical and mental health outcomes. Studies have found transgender participants to report lower quality of life scores (Newfield, Hart, Dibble, & Kohler, 2006) and higher rates of depressive symptoms and anxiety (Budge, Adelson, & Howard, 2013) when compared to the general population. Transgender people report using drugs or alcohol, specifically to cope with discrimination (Grant et al., 2011) and a 40% rate of attempted suicide (James et al., 2016). Higher rates of suicide attempts have been associated with bullying and harassment at school and surviving physical or sexual assault (Grant et al., 2011). These results are echoed by Goldblum et al.'s (2012) study, which found that transgender participants who experienced gender-based victimization in high school were approximately four times more likely to have attempted suicide. Similarly, in Nuttbrock et al.'s (2010) sample of male-to-female transgender individuals, depression and suicidality were directly linked to experiencing verbal abuse or harassment and being physically abused or beaten.

While it is important to understand the increased stressors faced by transgender populations, it is also necessary to consider the resiliency they may develop in order survive and thrive under such stress. Meyer's (1995; 2003) Minority Stress Model is one way in which to understand both the stress and resilience in minority populations. Meyer first applied this model to gay men (1995), then also to lesbians and bisexuals (2003). Meyer's Minority Stress Model has been applied and tested broadly by many authors, finding relationships between minority stress and variables such as relationship quality, domestic violence, health, and substance abuse among sexual minority women (Balsam & Szymanski, 2005; Lehavot & Simoni, 2011) and HIV and health risk behaviors, substance use, depressive symptoms, and body image concerns among gay men (Hamilton & Mahalik, 2009; Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008; Kimmel & Mahalik, 2009). Additionally, authors have explored how multiple minority stress impacts LGBT people of color (Balsam, Molina, Beadnell, Simoni, & Walters, 2011; Bowleg, Huane, Brooks, Black, & Burkholder, 2003). Recently, Hendricks and Testa (2012) have expanded the adaptation of this model beyond understanding sexual minorities to also understand transgender clients.

The Minority Stress Model identifies four sources of minority stress, which can be understood on a distal to proximal continuum. Distal stressors include experiences outside of the person, whereas proximal stressors include internalized experiences within the individual. The first source of minority stress, which is the most distal stressor, is external/environmental events. These include experiences related to minority status that create overt stress, such as experiences of discrimination, microaggressions, assaults, and other general threats to safety or security. The second source is the anticipation of mistreatment. The third and fourth sources are the most proximal and are internalized prejudice and concealment of sexual and gender identity. Because transgender people (and other minority populations) are exposed to these additional sources of stress, they sometimes also develop coping skills and social support that help buffer the negative effects of the stressors. This resilience takes two forms, the first being individual resilience, which includes qualities that a person possesses which aid in coping with stress. The second form is community resilience, which refers to identifying with and connecting to other people in one's

community and opportunities for social support, aiding people in building coping strategies (Meyer, 2015).

Researchers are beginning to explore resiliency in transgender populations in order to understand the factors contributing to their success in the face of so many challenges. While some researchers explicitly explore reasons for resiliency, others simply demonstrate resiliency dynamics in the data of transgender samples. For example, Grant et al. (2011) illustrated how despite experiencing barriers to healthcare, harassment and violence in schools, and being fired or evicted due to bias, high rates of transgender participants were receiving hormone therapy, pursuing education, and were employed and housed. Similarly, Conron, Scott, Stowell, and Landers (2012) found that despite higher rates of unemployment and poverty among transgender participants, there were few differences in health outcomes between transgender and cisgender participants. In these studies, factors found within the transgender individuals that may contribute to these results were not empirically explored.

Several qualitative studies have explored specific protective factors that may be contributing to transgender resiliency. Reicherzer and Spillman's (2012) qualitative study of transwomen identified themes of resilience including recognizing accountability, self-acceptance, family cohesiveness, spirituality, improvisational talent, and integrating womanhood into a transsexual identity. These themes seem to support primarily facets of individual resilience as suggested by Meyer (2015), though family cohesiveness, in particular, connects to community resilience. Another qualitative study described the following themes of resilience for transgender people of color: pride in one's gender and ethnic/racial identity, recognizing and negotiating gender and racial/ethnic oppression, navigating relationships with family, accessing health care and financial resources, connecting with an activist transgender community of color, and cultivating spirituality and hope for the future (Singh & McKleroy, 2010). The idea of community resilience is salient among these themes, stressing the importance of not only connecting to transgender communities, but also to communities of color. Also supporting the idea of community resilience and its importance, qualitative interviews with African American and Latina trans women in another study revealed that these women's trans-specific social networks facilitated their development of coping mechanisms (Pinto, Melendez, & Spector, 2008).

The specific mechanisms directly impacting resiliency in trans populations has only begun to be explored quantitatively. Bockting, Miner, Romine, Hamilton, and Coleman (2013) found high levels of depression, anxiety, and somatization in a large transgender Internet sample. Their study indicated that while social stigma was associated with psychological distress, this association was moderated by peer support, again demonstrating the importance of community resilience. Together, such studies lend support to the Minority Stress Model as it relates to transgender people, where coping with stress related to being transgender may buffer negative health outcomes, leading to resiliency (Meyer, 1995; Meyer, 2003; Hendricks & Testa, 2012).

For transgender people who identify within the gender binary and pursue gender transition, another way of thinking about the resiliency of transgender individuals is the idea that beginning the process of gender transition may serve as a protective factor for psychological distress, even when stressors stay the same or worsen. This concept has been commonly explored in the empirical literature. In Grant et al.'s (2011) study, 78% of participants reported feeling more comfortable at work and an improvement in their work performance after transitioning, despite reporting nearly the same rates of harassment at work as the overall sample. Budge et al. (2013) found that as participants were further in the gender transition process, some stressors worsened (decreased income, increased loss), though coping mechanisms became more constructive,

depressive symptoms and anxiety improved, and participants experienced increased social support. In Budge et al.'s (2013) sample, through gender transition, coping processes became more sophisticated and participants experienced less psychological hardship.

Other studies have looked more specifically at the impacts of beginning hormone therapy for gender transition. Gorin-Lazard et al. (2011) found that transgender people who had received hormonal therapy reported a significantly higher quality of life than those who had not received hormonal therapy. In a similar study, Gorin-Lazard (2013) found that transgender people who received hormonal therapy reported greater self-esteem, less severe depression symptoms, and greater scores on dimensions of quality of life in comparison to transgender people who had not received hormonal therapy. Meier, Fitzgerald, Pardo, and Babcock (2011) found that female-to-male transgender participants who received testosterone had lower levels of depression, anxiety, and stress, and higher levels of social support and health-related quality of life than those who did not receive hormone treatment. Similarly, Newfield et al. (2006) found that female-to-male transgender people receiving testosterone reported higher quality of life than those not on hormone therapy. It is important to note that these cross-sectional comparisons do not establish causation, and individuals going through treatment may have already wrestled with and resolved issues related to self-worth and distress enough to go through hormonal treatment.

Colizzi, Costa, and Todarello's (2014) longitudinal study found that psychiatric distress and functional impairment were significantly reduced after twelve months of hormonal treatment for transgender participants. Together, these studies suggest improved mental health outcomes for transgender people receiving hormone therapy in comparison to those who are not on hormone treatment. In addition, Heylens, Verroken, De Cock, T'Sjoen, and De Cuypere (2014) examined mental health variables in transgender people at three different points: at presentation, after starting hormone therapy, and after receiving gender affirmation surgery. Significant changes were found after the initiation of hormone therapy, such as decreases in anxiety, depression, interpersonal sensitivity, and hostility. Individuals in this study did not report similar decreases in symptoms between pre- and postoperative assessments, suggesting that hormone therapy, and not gender affirmation surgery, was responsible for the decrease in mental health symptoms.

The current study contributes to this literature in three major ways. First, a relatively large sample from a couple and family therapy training center was utilized to compare the psychological symptoms of transgender with cisgender clients. This is important in order to add further information to complex findings in the literature, where studies find both that the transgender population is an "at risk" population with a higher propensity to develop symptoms and also that transgender people are a resilient population with lower symptomology as they undergo gender transition. Further, the existing studies do not compare transgender individuals to cisgender individuals. Second, the current study examined whether self-reported family functioning was related to psychological symptoms and whether it moderated the association between transgender and psychological symptomology. It is possible that early family experiences influence transgender individuals' coping effectiveness. Third, the current study tested how stressful events, income, education, and other resources individuals might have changed the association between transgender and psychological symptomology. Thus, the current study examined family functioning and psychological symptomology in a clinical sample, comparing transgender and cisgender clients. It aims to understand the differences in a clinical sample of cisgender clients and transgender clients who have largely not yet begun hormone therapy.

METHODS

Sample

The sample was drawn from clients who participated in treatment at a University-based couple and family therapy center in the Northeastern region of the United States of America. These individuals had initiated and attended at least one therapy session with a marriage and family therapy trainee between 2003 and 2013. Sessions at the therapy center were provided on a sliding scale ($1-$40) from 2003-2010, at which time services began being offered free of charge. As part of clients' treatment protocol, individuals completed a computerized clinical assessment. In order to have been included within the sample individuals needed to have reported their gender, completed the Self-Report Family Inventory (SFI) and/or Brief Symptom Inventory (BSI).

The final sample consisted of 1712 individuals. The gender category of the individuals was determined by self-report. The participants were asked to respond to one question. The question, which was the second item they encountered in their computerized assessment, was: What is your gender? This item had the following options for an answer: Male, Female, Transgendered, and Other. If the participants answered Transgendered they were directed to a second item: If Transgendered. This item offered the following options for an answer: Transman/FTM, Transwoman/MTF, Genderqueer/Gender Fluid, questioning/Exploring and Other.

Gender was recoded within three categories: transgender (which included participants identifying as transman/FTM, transwoman/MTF, and genderqueer/gender fluid), cisgender female, and cisgender male. One individual within the sample indicated they were 'exploring,' which resulted in the exclusion of the individual from the analyses including gender. Of those that reported their gender (1712) and completed the BSI and/or SFI, there were 96 (5.6%) who identified as transgender, 657 (38.4%) individuals who identified as female, and 959 (56%) individuals who identified as male. Of those that responded to the SFI, 34 were transgender, 414 were cisgender female, and 590 were cisgender male. Of those that responded to the BSI, 95 were transgender, 650 were cisgender female, and 952 were cisgender male.

With regard to sexual orientation, 1441 (84.2%) individuals identified as heterosexual, 26 (1.5%) identified as gay, 39 (2.3%) identified as lesbian, 75 (4.4%) identified as bisexual, 75 (4.4%) identified as "other", and 56 (3.3%) did not respond to the question about sexual orientation. The variable of race/ethnicity was collected by allowing clients to fill in a blank describing their race/ethnicity. This made it difficult to determine exact statistics on race/ethnicity for the sample due to the variability of answers, as well as the large number of participants who did not respond to the question (96; 5.6%). However, it is important to consider the racial and ethnic makeup of samples to understand the generalizability of results, therefore estimates have been made collapsing similar qualitative answers into the largest represented racial/ethnic groups. We coded answers that were similar, such as Black and African-American or Puerto Rican and Hispanic into the same racial/ethnic categories. After this coding, 73.3% of individuals identified as White/Caucasian, 9.8% identified as African-American or Black, 4.2% identified as Hispanic/Latino(a), 1.8% identified as Asian/Pacific Islander, 0.9% identified as Native American/Indian, 0.5% identified as Arab, and 3% identified as multiracial. The remaining individuals identified as various other diverse racial and ethnic categories.

A possible confound in the present study is that some of the transgender clients sought services in order to obtain letters of support to begin hormonal gender transition. For these clients, the reason for seeking services may not have included feeling psychologically distressed.

Additionally, it is possible that these clients under-reported psychological distress because they may have believed if they reported psychological distress, they may be denied a letter of support. While data to explore this possibility empirically is not available, it is important to consider the role of the therapist as a gatekeeper as possibly confounding how transgender clients reported levels of distress.

Measures

Psychological symptomology (i.e. psychopathology) was assessed using the 53-item Brief Symptom Inventory (BSI), which has 12 subscales that assess the following: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism, global severity, positive symptom distress, and positive symptom total. The BSI is a brief psychological self-report symptom scale. This scale was adapted from the Symptom Checklist – 90 – Revised.

Since the early 1980's the instrument has been reported to be well-validated and commonly used to identify psychopathology (Derogatis & Melisaratos, 1983). Since then the instrument has continued to be widely utilized in a variety of fields and consistently found to be both reliable and valid (Zabora, Brintzenhofeszoc, Jacobsen, Curbow, Piantadosi, Hooker, Owens, Derogatis, 2001). For example, Gumley et al. (2003) utilized the BSI to determine psychological distress in their study, a randomized controlled trial, of relapse prevention in schizophrenia. Additionally, this instrument has been successfully normed with multiple and diverse populations (Hale, Cochran, & Hedgepeth, 1984; Cochran & Hale, 1985). Cronbach's alphas for each of the BSI subscales were tested in the current sample and are reported in Table 1, indicating good reliability.

Family functioning was assessed using the Self-Report Family Inventory (SFI), which is a self-report adaptation of the Beavers Model of Family Functioning (Beavers, Hampson, & Hulgus, 1985; Hampson Beavers, & Hulgus, 1989). Clients responded to 36 items, rating their families on a five-point Likert scale, where 1 = "Yes, fits our family very well" and 5 = "No, does not fit our family". Examples of items include, "Family members pay attention to each other's feelings," "We usually blame one person in our family when things aren't going right," and "We argue a lot." The SFI consists of five subscales (i.e. family health/competence, conflict, cohesion, expressiveness, and direct leadership) that yield family health and style scores. This measure has been normed and found to be both reliable and valid (Hampson, Hulgus, & Beavers, 1991). Additionally, Tutty's (1995) review of multiple measures of family functioning found that the psychometric properties of the SFI "are supported with good concurrent validity with other family functioning measures and excellent internal consistency" (p.103). Cronbach's alphas for each of the SFI subscales were determined in the current study and are reported in Table 1, indicating good reliability.

Data for this study were collected prior to the initiation of this study as part of clients' intake for therapy, thus it was a previously existing data set. Data was de-identified by clinic staff before being shared with the researchers. The managers of the data and researchers took special care to protect the identity of all participants. All identifying information had been replaced with unique and non-identifiable participant identification numbers. Because of the aforementioned circumstances the Institutional Review Board (IRB) exempted this study from IRB review.

RESULTS

Initial Mean-level Comparisons

The initial purpose of the study was to compare transgender to cisgender clients with regard to psychological symptomology and family functioning. Therefore, self-reported psychological symptomology individuals were examined and comparisons were performed between transgender and cisgender individuals on each of the BSI scales. A series of one-way analysis of variance were performed comparing cisgender females, cisgender males, and transgender individuals on each of the SFI and BSI scales. As can be seen from Table 1, the gender differences on the SFI Health Symptoms and SFI Disengaged Style were not statistically significant. In addition, the effect size measure (eta-squared) for both were small, as gender explained only .26% of the variance in Health Symptoms and .31% of the variance in Disengaged Style. The gender differences on the BSI were statistically significant for all twelve subscales, with transgender individuals reporting significantly fewer symptoms than both female and male cisgender individuals (as shown in Table 1). In addition, the amount of variance the variable of gender explained in BSI symptoms was between 1.46% and 1.85%. The differences on BSI symptoms between the gender classifications of cisgender males and females were not statistically significant. Thus, the evidence points to transgender clients reporting lower psychological symptoms relative to cisgender clients. Figure 1 shows the difference between cisgender females, cisgender males, and transgender individuals on depression symptoms and is representative of typical gender differences on all BSI subscales. Multiple regression analyses were performed predicting each BSI and SFI subscale from race/ethnicity, gender, and the interaction. The interaction term was not statistically significant in any of the regressions. Thus, there is not enough evidence to support the notion that the gender effects differ by race or ethnicity.

Post Hoc Mean-Level Comparisons

Because previous studies indicated that transgender individuals were at higher risk for psychological symptoms (i.e., Grant et al., 2011; Newfield et al., 2006), further analyses were performed to explore why the current results differed from previous studies. The idea was to test whether transgender clients who reported fewer psychological symptoms (BSI) had experienced significantly less abuse, stress, etc., or had more education and higher income levels. The overall goal was to examine how these variables, as measured by the couple and family therapy center's clinical assessment, may have influenced the association between gender and psychological symptomology. Therefore, the purpose behind the subsequent analyses was to test the hypothesis that transgender individuals might report lower psychological symptoms because they a) have more resources to cope with their problems; or b) report less stress and/or higher levels of support than cisgender individuals.

The gender groups were compared on satisfaction with health, personal life, and family life using one-way analyses of variance. Post hoc Tukey tests were performed and found that the differences in all but one case were between cisgender males and females. With family life satisfaction, transgender individuals (M = 4.72, SD = 1.67) were higher than cisgender males (M = 4.20, SD = 1.62; p = .009), but the difference between transgender individuals and cisgender females (M = 4.49, SD = 1.67; p = .41) was not statistically significant. For the rest of the satisfaction analyses, the differences in satisfaction between transgender individuals versus cisgender males and females were not statistically significant.

No significant differences were found by gender for being a victim of physical abuse or for experiencing parental domestic violence. There were significant differences by gender for both sexual abuse and frequency of stressful events. Cisgender females (M = 1.24, SD = .71) reported lower rates of sexual abuse than cisgender males (M = 1.59, SD = 1.07; p = .000) and transgender individuals (M = 1.57, SD = 1.12; p = .006). However, the difference between cisgender males and transgender individuals was not statistically significant (p = .98). For stressful events, cisgender males reported more stressful events than both transgender individuals and cisgender females. However, the difference between cisgender females and transgender individuals was not statistically significant. Thus, the current results do not seem to fit the previously stated model (i.e., transgender clients had fewer psychological symptoms, as measured by the BSI, because they had experienced significantly fewer stressful events, etc.).

Finally, the relationship between income, education and gender was examined. Income and education were both assessed categorically where participants answered "what is your current household income?" and "how much education have you completed?" Income categories were as follows: 1 = Less than $10,000, 2 = $10,000-$19,000, 3 = $20,000-$29,999, 4 = $30,000-$39,999, and so on. Cisgender individuals' average incomes were 3.28 (SD=2.39) and transgender individuals' average incomes were 2.42 (SD=2.37). Independent-samples t-test were performed to compare cisgender and transgender individuals on income. Despite the difference in sample sizes for cisgender (N = 1498) and transgender (78), the variability for the two groups was similar. The t-test assuming equal variance was t = 3.43, p = .001. Thus, the income for transgender individuals was statistically significantly lower than for cisgender individuals.

Education levels were as follows: 1 = less than elementary school, 2 = elementary school, 3 = some high school, 4 = high school diploma, 5 = some college/tech, 6 = Associate's degree, 7 = Bachelor's degree, 8 = graduate school degree. Average education levels for cisgender individuals were 5.49 (SD=1.55) and for transgender individuals, average education levels were 4.70 (SD=1.56). Independent-samples t-test was also performed to compare cisgender and transgender on education. Despite the difference in sample sizes for cisgender (N = 1563) and transgender (86), the variability for the two groups was similar. The t-test assuming equal variance was t = 4.58, p = .000. Thus, the personal education level for transgender individuals was statistically significantly lower than for cisgender individuals. Because transgender individuals had significantly lower incomes and education levels than cisgender individuals, it again does not support the previously stated model that transgender individuals have fewer mental health symptoms because they have access to more resources to manage stress.

Mediation Analyses

In addition to mean-level comparisons, further analyses were performed to examine how various variables may mediate BSI and SFI scores. First, tests were performed to examine how symptomology was related to various conditions and experiences in individuals' lives. Once again, the idea was to investigate whether gender differences in symptomology could be explained by existing or past conditions. If so, symptomology would have to be related to these conditions. Thus correlations were performed between the BSI/SFI subscales and the following variables: satisfaction with health, personal life, and family life, physical abuse, parental domestic violence, sexual abuse, and frequency of stressful events (see Table 2). SFI Health was negatively related to satisfaction with health (r = -.17), personal life (r = -.35), and family life (r = -.57). SFI Style was statistically significantly related to satisfaction with health, personal life and family life at -

.10, -.21, and -.33, respectively. However, the associations with BSI variables were inconsistent. Satisfaction with personal life was significantly and negatively associated ($p<.05$) with SFI Health ($r = -.35$). and Style ($r = -.21$) and all BSI subscales (r's ranged from -.05 to -.14). Physical abuse and reported domestic violence between parents were negatively associated with SFI health ($r = .09$ & .21, respectively) and style ($r = .09$ & .20, respectively) and also with several BSI subscales (r's ranged from -.02 to .09). Sexual abuse was related to SFI health ($r = .17$) and SFI style ($r = .08$) but was unrelated to BSI subscales. Experiencing more stressful events was positively correlated to SFI health ($r = .21$) and style ($r = .18$) as well as all BSI subscales (r's ranged from .13 to .17).

Gender was unrelated to SFI health and style but was related to all BSI subscales, such that transgender individuals (coded 1 instead of 0) reported better mental health (see Table 2). Therefore, a series of regression variables were performed predicting each BSI subscale from gender, satisfaction with health, personal life, and family life, and stressful events. As can be seen in Table 3, results indicated that gender's effect on BSI subscale scores was relatively independent of satisfaction and stressful event variables. Controlling for those variables did not change the magnitude, direction, or statistical significance of gender appreciably. The standardized beta coefficients for gender without the control variables ranged between -.09 and -.11. The coefficients controlling for the other variables were often exactly the same, with the range being from -.08 to -.10. Thus, associations between satisfaction, abuse, and stressful event variables seem to be relatively independent of gender.

Finally, psychological symptomology was regressed on gender, income, and education (see Table 4). Multiple regressions predicted each BSI health variable from gender, income, and education. Controlling for income and education did not affect the magnitude or statistical significance of the associations between gender and psychological symptomology. Therefore, the association between gender and health outcomes cannot be explained by these background variables.

DISCUSSION

Results of the current study suggest that transgender individuals, within a couple and family therapy clinical population, and relative to their cisgender counterparts, report fewer psychological symptoms. While most other studies do not directly compare transgender to cisgender individuals, it is common for studies to report high levels of psychological symptomology for transgender individuals (e.g., Budge et al., 2013; Grant et al., 2011; Newfield et al., 2006; Nuttbrock et al., 2010). The current results do not support the previous findings of increased symptomology in transgender individuals. Further, transgender individuals reporting significantly fewer psychological symptoms was not due to them faring better with regard to family functioning, levels of satisfaction with health, personal life, or family life, sexual or physical abuse experienced, parental domestic violence, frequency of stressful events, income, or level of education. In fact, transgender individuals had lower levels of income and education than cisgender individuals, which would seem to make them the more stressed subsample.

Because of these findings, it must be considered why transgender individuals in this sample were psychologically healthier than cisgender individuals, particularly considering increased stressors. It is possible that transgender individuals have developed unique traits or processes that allow them to more effectively cope with stressors, supporting the presence of resiliency in this population. According to Meyer's Minority Stress Model (1995; 2003), this resilience may

develop, not in spite of the additional stress, but as a response to it. Clients in this sample were accessing a clinic that was known in the community to be a trans-affirmative resource and known to serve a large number of transgender clients. Most of the time, transgender clients are in the waiting room with other transgender clients, possibly providing a sense of community and belonging. Thus, just in the act of accessing the clinic, they may have had access to a tangible resource, which is part of community resilience, as described by Meyer (2015). A limitation to the current study is that specific protective factors contributing to this resiliency cannot be identified. Future research should examine potential mechanisms and processes that might explain these differences more thoroughly.

Another interesting consideration given the current findings is that some of the transgender clients that were a part of this sample sought treatment at the couple and family therapy center in order to obtain letters of support to begin hormonal gender transition. Therefore, it is likely that some of the clients had not yet begun hormones at the time they self-reported psychological symptoms. Previous studies have suggested that hormone therapy improves mental health outcomes for transgender individuals (e.g., Colizzi et al., 2014; Gorin-Lazard et al., 2011; Gorin-Lazard, 2013; Heylens et al., 2014; Meier et al., 2011; Newfield et al., 2006). The results of the current study do not necessarily support this previous claim, as transgender clients reported better psychological functioning than cisgender clients, some of them prior to beginning hormone therapy. It is possible that there is another step in transgender identity development (prior to beginning hormone therapy) that contributes to improved psychological functioning. Perhaps wrestling with one's transgender identity, coming to a place of acceptance of this identity, and making the decision to take steps in gender transition, could lead to improved mental health. These personal qualities may buffer the impact of stress and support Meyer's (2015) notion of individual resiliency.

Budge et al. (2013) measured transition status on a five-point scale based on Devor's (2004) transgender identity formation model, where 1 = "I have been thinking about transitioning, but have not taken any steps to make any changes" and 5 = "I have made most of the changes I wanted to make and consider myself living full time with my transgender identity". Transition status was negatively correlated with depressive symptoms and anxiety, suggesting that the further a person is in the gender transition process, the less depressed and anxious they become. However, Budge et al. (2013) did not discuss changes in depression and anxiety as people moved through specific stages in transgender identity formation. Future research should explore the complexities of transgender identity development, perhaps utilizing Devor's (2004) fourteen-stage transgender identity formation model, and its relationship to multiple aspects of psychological functioning, beyond depression and anxiety. Specifically, shifts from discomfort with to acceptance of one's transgender identity as well as the choice to take action in gender transition should be examined.

In understanding the current study's results of transgender individuals reporting fewer psychological symptoms than cisgender individuals, further consideration is necessary of potential limitations in the transgender portion of the sample. Shipherd, Green, and Abramovitz (2010) examined barriers to mental healthcare utilization for transgender clients. Identified barriers included cost of treatment, previous bad experiences with healthcare, fear of treatment, and stigma concerns. These barriers could have served to filter out those within the transgender population who were experiencing increased psychological symptomology.

A further limitation in the current study's sample is the possibility that, because some of the transgender clients initiated treatment in order to obtain letters of support for medical gender transition, they may have been less stressed by their psychological symptoms than their cisgender

counterparts at the time of intake. In other words, cisgender clients may have been seeking out therapy more often for their psychological distress, whereas transgender clients may have been seeking out therapy more often for assistance with gender transition. However, it is worthy to note that, because the therapy center is a training facility with master's students providing the therapy, clients presenting with serious mental illness and/or extreme distress are referred out to facilities with higher levels of care. Therefore, cisgender clients seen in this clinic are not typically extremely distressed, buffering the limitation that transgender clients may be less distressed because of their reasons for seeking therapy. Future research comparing the psychological functioning of transgender and cisgender individuals should control for this dynamic.

Also limiting, and possibly confounding the study's results is that transgender clients who sought services for a letter of support for medical gender transition may have underreported psychological symptoms in order to assure receipt of the letter. Ideally, transgender clients seeking services specifically for a letter of support could have been compared with those who sought services for other reasons for differences in psychological symptomology. Because this study utilized a preexisting data set that did not assess this difference, it was not possible to compare the two groups. Thus it is unknown what impact this dynamic had on the current study's results.

Finally, this sample was largely a white sample and findings may not be able to be generalized to transgender people of color. Studies indicate that transgender people of color are at increased risk for violence, mistreatment, poverty, and discrimination in employment (Grant et al., 2011), making it particularly important to further understand this specific population. Further research should explore the experiences of transgender people of color and potential unique risks for psychological challenges as well as mechanisms utilized in this population leading to resiliency.

In general, pathways to transgender resiliency need to be better understood. What allows this marginalized population to succeed in the face of often cruel and violent treatment? Understanding these resiliency mechanisms will not only help mental health professionals develop better treatment protocols for transgender clients and their families, it will also serve as invaluable information in the development of better protocols for all clients. Torres Bernal and Coolhart (2005) argued that there is no better way to learn about resilience than by studying the populations that face the greatest adversities (e.g. physical and psychological harm). Thus by collaborating with oppressed and marginalized groups, such as transgender clients, researchers and clinicians alike can attain greater knowledge about what makes human beings resilient, and what mechanisms they can organically develop to protect them in the face of great adversity and danger.

Unfortunately, being a member of these marginalized oppressed groups often coincides with being part of the segments of our population that are the most underserved and understudied. The authors are hopeful that this study confirms that there is a great deal to be learned and appreciated from the transgender population (and by extension other marginalized groups). Thus, creating a proliferation of studies that examine the vitality of transgender individuals and their families will not only help clinicians to better serve this population but will also enhance services for all populations.

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Table 1.
Comparisons of SFI and BSI between Genders.

Dependent Variable	Gender	Mean (SD)	F	p-value	Eta-squared	Cronbach's alpha
Health Symptoms (SFI)	Female	2.64 (.86)	1.37	.255	.26	
	Male	2.73 (.96)				.94
	Transgender	2.74 (.93)				
Disengaged Style (SFI)	Female	2.76 (.63)	1.59	.205	.31	
	Male	2.83 (.66)				.97
	Transgender	2.85 (.56)				
Somatization (BSI)	Female	29.13 (23.87)	15.31	.000	1.78	
	Male	30.50 (25.03)				.81
	Transgender	15.96 (21.83)				
OCD (BSI)	Female	28.13 (23.26)	14.51	.000	1.68	
	Male	28.97 (24.06)				.86
	Transgender	15.32 (21.08)				
Interpersonal Sensitivity (BSI)	Female	26.94 (22.58)	15.07	.000	1.75	
	Male	29.63 (24.66)				.84
	Transgender	15.96 (22.10)				
Depression (BSI)	Female	27.21 (22.62)	14.85	.000	1.72	
	Male	28.66 (23.60)				.90
	Transgender	15.14 (20.92)				
Anxiety (BSI)	Female	25.76 (21.65)	15.98	.000	1.85	
	Male	27.64 (23.09)				.86
	Transgender	14.12 (12.68)				
Hostility (BSI)	Female	30.08 (24.55)	14.28	.000	1.66	
	Male	30.82 (25.10)				.78
	Transgender	16.62 (22.89)				

Phobic Anxiety (BSI)	Female	28.21 (23.12)	12.52	.000	1.46	
	Male	29.01 (23.81)				.80
	Transgender	16.40 (22.40)				
Paranoid Ideation (BSI)	Female	30.47 (24.79)	13.87	.000	1.61	
	Male	30.97 (25.28)				.79
	Transgender	16.91 (23.31)				
Psychoticism (BSI)	Female	28.14 (23.52)	14.94	.000	1.73	
	Male	29.17 (24.26)				.76
	Transgender	15.18 (20.86)				
Global Severity (BSI)	Female	26.79 (22.48)	14.84	.000	1.72	
	Male	28.21 (23.87)				.97
	Transgender	14.64 (20.21)				
Positive Symptom Distress (BSI)	Female	34.16 (27.49)	13.41	.000	1.56	
	Male	34.88 (28.55)				N/A*
	Transgender	19.34 (26.40)				
Positive Symptom Total (BSI)	Female	27.59 (23.48)	12.69	.000	1.48	
	Male	27.20 (23.65)				N/A*
	Transgender	14.85 (20.73)				

N = 1038 for SFI scales; N = 1697 for BSI scales. Eta-squared is expressed as a percent. Categories of "Female" and "Male" refer to cisgender individuals.
*These values were not able to be calculated because the exact items included in these scales differ across participants based on their positive answers to other items.

Table 2.
Correlations between Satisfaction and Background Variables and Health.

	SFI Health	SFI Style	BSI SOM	BSI OBS	BSI INS	BSI DEP	BSI ANX	BSI HOS	BSI PHOB	BSI PAR	BSI PSY	BSI GSI	BSI PSDI	BSI PST
Health	**-.17**	**-.10**	-.04	**-.03**	**-.03**	**-.03**	-.03	-.00	-.01	.01	**-.01**	**-.04**	.01	**-.04**
Personal Life	**-.35**	**-.21**	**-.07**	**-.09**	**-.10**	**-.14**	**-.11**	**-.05**	**-.06**	**-.07**	**-.10**	**-.12**	**-.06**	**-.12**
Family Life	**-.57**	**-.33**	-.02	**-.04**	**-.05**	**-.07**	**-.06**	-.02	-.01	**-.02**	**-.05**	**-.07**	-.02	**-.07**
Physical abuse	**.09**	**.09**	**.08**	**.07**	.06	**.06**	**.07**	**.07**	.06	**.07**	**.07**	**.08**	**.06**	**.08**
Par Violence	**.21**	**.20**	**.06**	.04	.05	.04	**.05**	**.06**	.05	**.07**	**.05**	**.06**	.04	**.07**
Sex Abuse	**.17**	**.08**	.01	.00	.02	.01	.01	-.00	.01	.00	.01	.03	.00	.02
Stress events	**.21**	**.18**	**.15**	**.15**	**.15**	**.15**	**.16**	**.13**	**.13**	**.14**	**.15**	**.16**	**.14**	**.17**
Gender[+]	.01	.01	**-.13**	**-.13**	**-.12**	**-.13**	**-.13**	**-.13**	**-.12**	**-.13**	**-.13**	**-.13**	**-.12**	**-.12**

Ns range from 1025 – 1754. Bold values are statistically significant at $p < .05$. [+]male/female = 0, transgender = 1

Table 3.
Multiple Regression Analyses Predicting Health Variables from Gender, Satisfaction, and Background Variables.

	BSI SOM	BSI OBS	BSI INS	BSI DEP	BSI ANX	BSI HOS	BSI PHOB	BSI PAR	BSI PSY	BSI GS
Gen	**-.10/-.10**	**-.10/-.10**	**-.09/-.09**	**-.09/-.09**	**-.10/-.09**	**-.11/-.10**	**-.09/-.09**	**-.10/-.09**	**-.10/-.10**	**-.10/-.0**
r^2	**.01/.04**	**.01/.04**	**.01/.04**	**.01/.04**	**.01/.04**	**.01/.03**	**.01/.03**	**.01/.04**	**.01/.04**	**.01/.05**

Ns ranged from 1124-1125. Bold values are statistically significant at $p < .05$. First values are for gender (codec male/female, 1 = transgender) alone as the predictor. Second values are controlling for Health Satisfaction, Per Family Life Satisfaction, Physical Abuse, Parent domestic violence, Sexual Abuse, and Stressful events.

Table 4.
Associations between Health and Gender

	Step 1	Step 2	R-squared
Somatization	**-.12**	**-.11**	**.019**
OCD	**-.12**	**-.11**	**.021**
Interpersonal Sensitivity	**-.11**	**-.10**	**.020**
Depression	**-.12**	**-.10**	**.019**
Anxiety	**-.12**	**-.11**	**.020**
Hostility	**-.12**	**-.10**	**.021**
Phobic Anxiety	**-.11**	**-.10**	**.017**
Paranoid Ideation	**-.11**	**-.11**	**.017**
Psychoticism	**-.12**	**-.11**	**.020**
GSI	**-.12**	**-.11**	**.018**
PSDI	**-.11**	**-.10**	**.020**
PST	**-.11**	**-.10**	**.015**

Note: Health was regressed on Gender, Income, and Education. Reported coefficients are standardized regression coefficients for Gender. Step 1 represents independent effect of Gender. Step 2 is the effect of Gender after controlling for Income and Education. Boldface values are significant at $p < .05$.

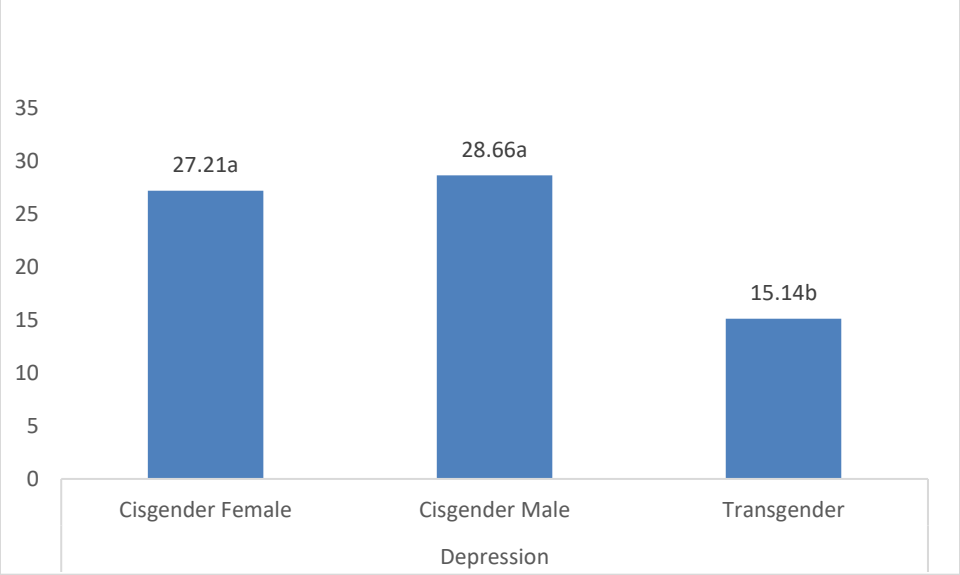

Figure 1.
Gender Differences on Depression Symptoms on the BSI.
Note: These differences are representative of typical gender differences on all BSI subscales. The bars labelled "a" are not statistically significantly different from each other, but the bar labelled "b" is statistically significantly different.