

Relationships and Mental Health: A Qualitative Perspective of Individuals within the  
Transgender Community

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**Abstract**

Trans individuals as a population are more likely to endure the effects of depression, anxiety, suicidal ideations as well as discrimination, violence, and traumatic experiences compared to the general population. To begin to understand these experiences, five trans women participated in this study in order to explore their mental health symptoms with the quality of their relationships with their family, friends, partners, and within the community, specifically counselors. As a result, participants grounded their identity in their religious or spiritual beliefs in order to counter their families' dismissal of their identity. Participants disclosed the nature of their experiences regarding the pressure to meet societal expectations, dealing with their mental health, trauma, and social isolation as their identity development progressed. Implications for counseling are discussed as it relates to building resiliency and using the counseling relationship as a beginning to establish support.

*Keywords:* transgender, relationships, mental health, resiliency

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Individuals that identify as transgender have been described to “transcend culturally defined categories of gender” because their sex assigned at birth does not correspond with their gender identity (Bockting, Miner, Swinburn Romine, Hamilton, & Coleman, 2013, p.1). By challenging the hetero-normative definitions of gender, in which sex assigned at birth determines an individuals’ gender identity, these individuals endure societal stigma, discrimination, and an elevation of mental health concerns (McCann, 2015).

There is a gap in the competency of mental health professionals and their understanding of the transgender population in comparison to other group-specific populations. Thus, mental health professionals often diagnose and treat trans individuals for gender identity disorder or gender dysphoria rather than addressing their present mental health symptoms, support systems, and overall quality of life (Benson, 2013). Social support, in general, has been demonstrated to be influential within the transgender community because it creates a space to collectively “learn about medical resources, advocate political concerns, and utilize social networks” (Budge, Adelson, & Howard, 2013, p. 546). There are significant deficits in other facets of social support, such as the importance of fostering human connection within the family system, friendship circles, and within the community for care and wellness. Also, research has been posed from a theoretical lens of the social construct and development of gender within society rather than from the experiences of individuals and their perspectives (McCann, 2015). Furthermore, there is a need to increase mental health professionals’ awareness and cultural competency of working with individuals that do not fit within the ascribed gender binary as biologically male and biologically female.

This research explored the role of relationships, during identity development, and offers recommendations for addressing transgender individuals' mental health concerns (inclusively of the various co-morbid diagnoses that these individuals experience). The types of relationships with family, friends, and partners will be explored as well as the impact of the minority stress model, counselor competency, and gender identity affirmation in order to build up trans individuals' resiliency to the challenges the transition process and identity development present. By increasing mental health professionals' awareness and understanding of possible micro-aggressions, minority stressors, and factoring the role of relationships for this underserved population, then viable solutions to improve their quality of life can be identified.

### **Literature Review**

Transgender people experienced higher rates of suicidality, depression, and anxiety in comparison to the general population. Exploring the quality and description of their relationships, as they relate to these aforementioned mental health issues is an area yet to be substantially studied. Quality of relationships can be defined as the amount of support available, and whether it is considered a protective factor for their mental health, or an aversive element of their health. Also, the absence of relationships, such as social isolation and perceived burdensome, can be linked with the co-morbidity of mental health symptoms experienced by the transgender community.

### **Mental Health and Co-Morbidities**

The transgender population was found to experience disproportionate rates of suicidality, depression, anxiety, and distress in comparison to individuals whose sex assigned at birth and gender match (Budge et al., 2013; Hendricks & Testa, 2012). As a result of these higher rates of mental health concerns, mental health professionals need to increase their awareness of this

community's needs to better serve this population (Austin, Craig, & Alessi, 2017; Budge et al., 2013). For transgender individuals, rates of depression ranged “from 48% to 62%,” whereas “16.6% of the general population” reported experiencing depression (Budge et al., 2013, p. 545). Similarly, anxiety and overall distress rates ranged from “26% to 38%” of the transgender population, whereas “28.8% of general population” was affected by anxiety disorders (Budge et al., 2013, p. 545). Also, the transgender population experienced higher rates of non-suicidal self-injurious behaviors (Austin et al., 2017). According to Budge et al. (2012), greater distress levels, such as engaging in non-suicidal self-injurious behaviors, may be attributed to the individual’s transition process, coping mechanisms, as well as a degree of social support.

The transitioning process can be defined as the phases of accepting one’s gender identity, and usually begins during adolescence and adulthood (Bilodeau & Renn, 2005). These phases of gender identity are considered fluid as individuals encounter phases, such as denial, experimentation, and acceptance (Bilodeau & Renn, 2005). According to Budge et al. (2012), participants reported more emotional hardships during their transitional process, in particularly pre-transition and while in transition. Some of these emotions included “depression, suicidal ideation, misery, sadness...” as well as an “overwhelming sense of hopelessness” (Budge et al., 2012, p. 18-19). These emotional states experienced during the pre-transition and transition phases characterized the severity of mental health symptoms that transgender individuals experienced when social support was absent.

**Social isolation.** “Humans have a fundamental need to belong” (Budge et al., 2013, p. 546) and social connection is essential in human nature to resolve distress. According to Hendricks and Testa (2012), social isolation has been proven to be a significant predictor of suicide risk, whether it is suicidal ideation, suicide attempt, or lethal suicidal behavior. Thus,

“social support affects mental health” (Budge et al., 2012, p. 37) and there is a need to identify the types of social supports that are and are not accessible in transgender individuals’ lives. For trans individuals, loneliness or social isolation was found to stem from rejection among family members, friends, or coworkers who refused to acknowledge their trans status (Hendricks & Testa, 2012). McCann (2015) found that when trans individuals began processing their gender identity, the quality of relationships with their families appeared to be significantly affected, often for the worse. When there was a severe lack of support, there was a correlation with trans individuals experiencing heightened mental health symptoms, such as depression, anxiety, and suicidal ideations (Budge et al., 2013; Hendricks & Testa, 2012). Budge et al. (2013) found that when trans individuals had a lack of social support, how they managed their psychological distress and well-being worsened.

*Perceived burdensome*, a concept created by from Joiners’ Interpersonal Theory of Suicide, was developed out of liability or the belief that one would be “more valuable dead than alive” and engaging in self-loathing (Hendricks & Testa, 2012, p. 464). Liability develops from life events such as homelessness, unemployment, abuse, or rejection (Hendricks & Testa, 2012). Therefore, liability increases suicide ideations and risk (Hendricks & Testa, 2012). Self-loathing stems from self-blame and low self-esteem that may develop from victimization based on one’s gender identity or outward presentation (Hendricks & Testa, 2012). For trans individuals, there is the possibility of internalizing society’s transphobia. Hendricks and Testa (2012) stated that this led to disconnection within their community and further diminished their sense of belongingness. Perceived burdensome emphasizes the loss of one’s self-worth, the lost connections with others, and the withdrawal and disconnection from their community. Victimization within themselves and from society may further perpetuate the “belief that being transgender presents as a burden

to society” (Hendricks & Testa, 2012, p. 464). For trans individuals, stimulating social

connectedness may decrease the risk of suicide and reduce the effects of depression and anxiety symptoms.

### **Relationships**

The role of relationships with family, friends, partnerships, and community support was found to have a significant impact on the transgender community. These social connections can heighten or reduce psychological symptoms, as it would with those that identify with the cis-gender population (Pflum, Testa, Balsam, Goldblum, & Bongar, 2015). The process of relying on social supports was found to vary among cis-gender adults, in which, cis-women were more likely to seek support from others, and it was often perceived as a more feminine characteristic than for cis-men (Pflum et al., 2015). Researchers have yet to explore this social support seeking behavior within the trans community in research; Pflum et al. (2015), however, found that trans women were more likely than trans men to have supports within the trans community during the initial transitioning process. Furthermore, social support is essential for trans health and as a protective factor for their mental health (Bariola et al., 2015). There is a need for more information to understand the proximal importance of the different types of supports, such as family, friends, and partners for the transgender population.

**Family.** According to Nuttbrock et al. (2009), “the family is a critical theatre,” (p.109) in which the family system is one source in all individuals’ lives that inform how individuals communicate, form relationships, and foster a sense of self. Nuttbrock et al. (2009) described how parents, as well as siblings, may pose as a barrier to the trans person’s development of self-acceptance. Trans individuals hoped for a sense of nurturance and “retroactive credibility” from family members (Nuttbrock et al., 2009, p. 109). Some transgender individuals believed that they

received less support from their parents when compared to their cisgender siblings (Biblarz & Savici, 2010). There was limited information about the adult trans person's coming out process to their families.

Biblarz and Savici (2010) hypothesized that the trans adult coming out process was different from coming out as an adolescent. For trans youth, parents tended to react with alarm when there were "extreme gender nonconforming behaviors" (Biblarz & Savci, 2010, p. 489). As a result, children suppressed their identities at the "cost of depression, anxiety, and low self-esteem" (Biblarz & Savci, 2010, p. 489). This process led to crises within their family systems (Biblarz & Savci, 2010). According to Budge, et al. (2013), transgender youth coping styles stemmed from the family unit. As a result of coming out to their families, resiliency was important in order to counteract crises and negative outcomes that trans youth experienced.

In addition to the adult coming out process, there was limited research on the transgender individuals choosing to have their own families. Biblarz and Savci (2010) described scholarly theory regarding the heteronormative nature of family within the western culture and how it influenced social, cultural, and political dimensions within society. Bariola et al. (2015) discussed how "family of origin may have the most influence in protecting against psychological distress" (p.2112). Despite family of origin having the most influence within the transgender community, individuals have been known to identify members of their chosen family over their family of origin. These chosen families often stem from friendships, building "positive in-group identity development" (Bariola et al., 2015, p. 2112).

**Friendships.** Positive relationships were a protective factor for trans individuals' mental health and "allow[ed] for group-level coping" (Bariola et al., 2015, p. 2112). The sense of belonging enhanced an individual's resiliency to overcome adversity (Bariola et al., 2015). With

the transitioning and coming out process, current friendships sometimes shifted or became re-established (Nuttbrock et al., 2009). Also, peers within Lesbian, Gay, Bisexual, and Trans (LGBT) community were sought for support (Nuttbrock et al., 2009). Friendships were found to be a source of affirmation and a “celebration of identity,” which led to legitimization and provided emotional support to the person (Nuttbrock et al., 2009, p. 109). With ended friendships, trans-people experienced a degree of grief and loss.

**Romantic relationships.** With relationships, cultural and lifestyle factors, such as sexual orientation, ethnicity, and involvement in the sex trade were considered (Nuttbrock et al., 2009). According to Nuttbrock et al., the performance of the “female sexual script or role in conjunction with commercial sexual relationships” was found as “an accessible and powerful mode of gender identity affirmation” (p. 110-111). This lifestyle was based on the presentation and perceived acceptance of the female identity for a male to female (MTF) transgender individuals. There were physical health concerns regarding the actual psychological benefits of this approach with identity affirmation in regards to the potential health risks, such as contracting human immunodeficiency virus (HIV; Nuttbrock et al. 2009).

In long-term sexual relationships, Nuttbrock et al. (2009) found that “gender identity disclosure and desired gender role casting were virtually normative” (p. 122). In contrast, relationships regarding family, school, and work, disclosure and role casting were more delicately suggestive. Based on Nuttbrock et al.’s findings, the more nuclear the relationship, such as long-term sexual relationships, then the more normative or sense of acceptance there was for the individual’s gender identity. Furthermore, when trans individuals pursued long-term sexual relationships, there was a degree of control in regards to controlling the perception, definition, and presentation of their gender identity.

With relationships that stem from family, work or school, during pre-transition and before gender identity affirmation, there were greater feelings of abnormality and a lesser degree of control. In settings involving family, peers, and coworkers, there were more perceived expectations of the trans individuals involved, such as the heteronormative gender roles based on their sex at birth. Bariola et al. (2015) described the detrimental effects of “gender-related stigma” and the need to address transphobia on a more globalized level to overcome societal oppression.

### **Minority Stress Model**

With societal oppression, Meyer’s Minority Stress Model outlined the influence of oppressive and stressful social environments that LGBT individuals experience because of their “sexual minority status” (Hendricks & Testa, 2012, p. 462). Meyer’s Minority Stress model suggested that “stress associated with stigma, prejudice, and discrimination will increase rates of psychological distress” among individuals that identify with the lesbian, gay, and bisexual community (Bockting et al., 2013, p. 1). The stress was “socially based and chronic, stemming from relatively stable social structures and norms beyond the individual” (Bockting et al., 2013, p. 1). This model identified both external and internal processes as a result, of stigma, rejection, and discrimination (Bockting et al., 2013).

**Direct experience.** The external process is a direct experience, such as an “actual experience of rejection and discrimination” that individuals have endured in their environment because of their minority status (Bockting et al., 2013, p. 1). From these external events, individuals experienced internalized stress from discrimination, societal stereotypes, and rejection; therefore, they often felt the need to hide or conceal their identity to avoid possible harm (Bockting et al., 2013). When surveyed, transgender populations consistently reported high

levels of both physical and sexual violence (Hendricks & Testa, 2012). For example, rates of physical violence ranged from 43-60%, and rates of sexual violence ranged from 43-46% (Hendricks & Testa, 2012). According to Hendricks and Testa, there was a positive correlation between transgender individuals that experienced physical or sexual violence and attempting suicide. For example, transgender individuals, who “experienced physical or sexual violence, were approximately four times more likely” to attempt suicide than those who did not experience any violence (Hendricks & Testa, 2012, p. 463).

**Internal experience.** In addition to the direct experience, individuals in the LGBT community experienced the “anticipation and expectation” that a stressful event would occur because of their sexual minority status (Hendricks & Testa, 2012, p. 462). The anticipation and expectation increased probable anxiety and vigilance to evade physical or psychological harm. For trans individuals, fear led to intentional identity concealment and caused more internalized distress (Hendricks & Testa, 2012).

Beyond anticipation and expectation, there was the *Proximal Level of the Stress Model*. Within this proximal level, trans individuals internalized the judgment and discrimination from society (Hendricks & Testa, 2012). Also, this level was more subjective, in which the individual disclosed this internalization, as it could not be directly observed by another individual. Internalizing discrimination was found to minimize the individual’s resiliency and ability to handle stressful external events; therefore, researchers believed that it was the most harmful for the trans individual (Hendricks & Testa, 2012). Internalized transphobia was found to develop out of absorbing negative messages projected by societal expectations of what was considered normal (Budge et al., 2013). Bockting et al. applied this model to the transgender community.

According to this model, “social support, self-acceptance, and integration of minority identity can ameliorate minority stress” (Bockting et al., 2013, p.1).

According to Austin et al. (2017), the *Minority Stress Model* was based upon the domino effect of sexual and gender minorities who experienced high-stress levels out of “homophobic and transphobic social conditions,” which caused a greater prevalence of psychological distress among sexual and gender minority populations (p. 142). High-stress levels were attributed to verbal, physical, sexual abuse, trauma, and internalized stigma (Austin et al., 2017).

**Gender dysphoria diagnosis.** Another variable that contributed to trans individuals’ internalized experience of distress was the diagnosis of transgender identity as a disorder within the psychiatric and medical literature (Bilodeau & Renn, 2005). *Gender identity disorder* first appeared in the Diagnostic and Statistical Manual of Mental Disorders (DMS-III, 1980; Bilodeau & Renn, 2005). In the most recent edition, DSM-5 (citation), gender identity disorder was changed to the *Gender Dysphoria* diagnosis. According to Bilodeau and Renn, there was outrage within the transgender community regarding gender dysphoria because the diagnosis reinforced the gender binary construction and classified all trans and gender non-binary individuals with a psychiatric and medical diagnosis. There were criticisms of the state and medical community’s involvement “in constructing and policing transgender identity” (Biblarz & Savci, 2010, p. 489). Examples of the state and medical community’s definition of the trans identity included making surgery or hormone treatment requirements, as well as, official documentation records of the changed gender identity (Biblarz & Savci, 2010). Also, there were several short and long-term side effects of the various medical treatments. The side effects of these treatments were problematic because this population historically was under-insured, as well as, experienced

barriers to accessing health services. Budge et al. (2013) stated that “societal changes must occur in order to ease distress experienced by transgender populations” (p. 556).

### **Solutions to Promote Social Connection**

Rather than focusing on a globalized solution to reduce distress, McCann (2015) believed that improving the quality of relationships that trans individuals have with their supports begins with providing psychological support for families and trans individuals’ inner social circle (McCann, 2015). Direct support systems are hypothesized to benefit from education because it would promote awareness of the transitioning process and gender identity (McCann, 2015). Furthermore, when trans individuals’ immediate social circles accepted their identities, trans individuals were likely to develop “greater self-acceptance and congruence with their internal sense of gender” (Pflum et al., 2015, p. 281). There is a need to develop self-acceptance and resiliency to overcome losses of relationships as well as the need to explore the sense of permanence of the lost connection from a therapeutic perspective.

While recovering a relationship may not be possible, within-group solidarity is a protective factor (McCann, 2015). Examples that promote within-group solidarity include support groups, psychoeducation and therapeutic groups, advocacy groups, and clubs. Also, within-group membership is an opportunity for individuals to evaluate themselves amongst each other than among the dominant culture. As a result, this provides within-group members to develop a “positive view of themselves that effectively counteracts stigma” (Hendricks & Testa, 2012, p. 462). Often these groups, such as LGBT groups, are a source of empowerment and support in order to reduce the effects of minority stress and adverse mental health symptoms (McCann, 2015).

**Gender expression in society.** When encountering individuals outside of the direct support and within-group systems, gender expression and the “ability to pass” as the identified gender appeared significant in regards to mental health symptoms and developing self-acceptance. According to Biblarz and Savci (2010), gender expression has evolved into a hierarchy of distinguishing whether an individual is “fully trans” or “not trans enough” (Biblarz & Savci, 2010). Budge et al. (2013) found that participants not being able to pass based on their gender identity have been linked to specific losses, such as job loss, lowered self-esteem, and inability to fulfill their ascribed gender roles. Furthermore, the researchers suggested how transitioning to male may be perceived as more acceptable based upon the power of gender roles status within society (Budge et al., 2013).

### **Counselor Cultural Competency**

McCann (2015) stated that mental health practitioners “must be familiar with transgender experiences and issues, and be culturally competent and sensitive in the provision of appropriate care and treatment options” (p. 80). According to Shipherd et al. (2010), there was the need to challenge clinicians’ fear regarding their lack of expertise with this population, as their presenting complaints were not always specific to the client’s gender identity. This level of understanding related to mental health vulnerabilities as well as resiliency (Hendricks & Testa, 2012). The small efforts made to increase cultural awareness and sensitivity can have significant effects in the transgender community (Hendricks & Testa, 2012; Shipherd et al., 2010). According to Shipherd et al., counselors provided a valuable service to this underserved population by addressing the gamut of mental health problems outside of gender identity counseling.

**Barriers to service.** Among this population, unemployment rates and access to health insurance presented as barriers to pursuing services and treatment. For example, Shipherd et al. (2012) found that 95% of the sample in the current study endorsed cost as a barrier to accessing mental health services.

In addition to the cost of services, there was a lack of sensitivity with the healthcare system that labeled these individuals with a disorder in order to access medical treatments. According to Shipherd et al. (2012), the lack of sensitivity in healthcare prevented trans individuals from seeking services, as well as, the preconceived notions they had towards mental health treatment. These preconceived notions are hypothesized to be attributed to the cost of treatment, fear of certain aspects of treatment, such as medications and the stigma or social consequences from seeking services (Shipherd et al., 2012). In addition to preconceived notions of treatment, individuals who had a negative experience in counseling, much like the general population, were less likely to return to services out of fear of the experience repeating itself when they were dealing with distress (Shipherd et al., 2012).

Despite preconceived notions about seeking mental health services, the transgender population sometimes sought psychological evaluations in order to move forward with physical modifications, such as hormone treatments or surgical procedures (Hendricks & Testa, 2012). In these instances, trans individuals sought services in order to discuss the physical transitioning process. For individuals, who identified as transgender, there was a drive to “‘correct’ gender deviance through reassignment to the “‘appropriate’ gender” (Bilodeau & Renn, 2005, p. 30). While some had this drive, it is important to note that transgender identity was not solely dependent upon surgery or considered a top priority for some individuals in this population. Furthermore, in these instances, the psychologist needed to be an expert in gender identity,

gender expression, presentation as gender variant, and the transition options available (Hendricks & Testa, 2012).

### **Gender Identity Affirmation**

Mental health professionals need to understand gender-affirming approaches in order to trans clients as a rapport-building manner. Affirmative approaches were developed out of “unethical clinical practices intended to change, pathologize, and invalidate transgender identities and experiences” (Austin et al., 2017, p. 144). As a result, gender affirmative approaches aimed to support and validate transgender identities, their experiences, and their strengths (Austin et al., 2017). Within this practice, there was a need to address the oppressive contexts that these individuals endured, as well as, establish gender inclusive practices. Gender inclusive practices included gender-based services, gender-neutral bathrooms, inclusive language and promotional materials. These steps included transgender-inclusive language on clinical forms without reinforcing hetero-normative assumptions (Benson, 2015). In addition to inclusive practices, counselors were encouraged to convey unconditional positive regard and engage in self-exploration regarding their views, attitudes, and biases regarding gender expression (Austin et al., 2017).

Biblarz and Savci (2010) stated that trans youth may experience rejection by mental health providers by trying to “correct their ‘gender identity disorder’ with aversion techniques in order “to achieve gender conformity” (p. 489). Thus, counselors need to take measures in validating and affirming clients’ gender regardless of their age (Benson, 2015). Affirmation was considered paramount because it presented an opportunity for the client to feel safe and trust their counselors. Benson suggested that counselors explore their clients’ experiences as they

relate to presenting issues for counseling, without the expectation that the primary focus will be on identity development or psychiatric diagnosis.

**Capacity for resiliency.** In addition to affirmative approaches and overcoming barriers to service, Austin et al. (2017) stated that social connectedness, social support, and self-advocacy promote an “individual’s capacity for resiliency” (p. 143). The impact of positive social supports encouraged healthy coping strategies and reduced symptoms of depression and anxiety (Austin et al., 2017).

**Coping strategies.** Coping strategies, adaptive or maladaptive, are developed out of the need to be able to tolerate a distressing event. For transgender individuals, these mechanisms were theorized to “buffer the effects of psychological distress due to stigma, internalized homo (or transphobia), and experiences of discrimination and violence” (Budge et al., 2013, p. 545). According to Nuttbrock et al. (2010), social stressors and exclusion from peers may attribute to the higher rates of depression. While there were some explanation for these contributing factors, there was not enough “generalizable information regarding the actual process which individuals cope with and experience depression and anxiety” (Budge et al., 2013, p. 545).

It was theorized that coping skills build up the resiliency to distress (Budge et al., 2013). According to Budge et al. (2013), there are two types of coping styles. They are facilitative and avoidant coping. Avoidant coping prevents an emotional response to the stressor by minimizing the problem, detachment to the problem, and ignoring the problem (Budge et al., 2013, p. 546). Facilitative coping can be described as seeking social supports, learning new skills, modifying behavior to positively adapt (Budge et al., 2013, p. 546). Therefore, if trans individuals seek out support, whether from mental health practitioners or within-group supports, then there is the possibility to develop facilitative coping strategies that will build up resiliency when dealing

with external and internal distress. Thus, these coping mechanisms could be defined as protective factors for building self-acceptance and healthful managing depression, anxiety, or suicidal ideations, and decreasing the need to isolate from others.

### **Current Study**

Given the current literature on transgender individuals, the quality of relationships plays a significant role, whether directly or indirectly, upon their mental health. Thus, the present study looks to answer: “how do individuals who are transgendered perceive the role of social support in their mental health and their quality of life?” from a grounded theory approach.

## **Method**

### **Participants**

Participants of this study were individuals that identified with the transgender community and were 18 years or older. Transgender was defined as any individual that self-identified as “trans,” “transgender,” “transsexual,” or identified as a “woman,” but the sex assigned at birth was male. Relationships were defined by the participants and the types of connections they had with the community, family, and friends.

All of the participants identified as trans-women. Three of the trans-women were 50 years old or older, while the remaining were in their late twenties and early thirties. Two participants identified as African American, two participants were Caucasian, and one participant identified as Hispanic. Two of the participants were employed, the remaining were unemployed. Among the participants, one was beginning to transition as a woman; therefore, has not started any hormone treatments or changing her name or gender marker. Three of the participants were in the process of obtaining sex-reassignment surgery letters, and the remaining participant completed her sex re-assignment surgery several years ago. Exclusion criteria included any

individuals that were psychiatrically unstable and actively using substances, younger than 18

years old, and did not identify with the transgender community.

### **Sampling Procedures**

The researcher selected participants through convenience sampling and snowballing techniques.

The researcher recruited participants from the affiliate organization of a community-based clinic, the clinic's care management team's support group as well as the patient liaison. The researcher screened nine participants to become involved with the study. One elected not to participate in the interview because of compensation. Three individuals that were assessed and agreed to participate in the study did not attend their scheduled meeting. The researcher interviewed six participants. One participant's interview was ruled out of the study because she was experiencing delusional ideations and struggling to follow the semi-structured interview process. This participant presented for walk-in hours immediately after the interview to address her behavioral health symptoms.

### **Measures**

Participants had the choice to be audio recorded or for the researcher to take extensive notes. All five of the participants were audio-recorded. The researcher transcribed the interviews verbatim. The results of the transcribed interviews were coded into themes based on the number of times participants shared similar viewpoints and experiences in response to the researcher's questions.

### **Research Design**

The research design of this study was qualitative, in which semi-structured interview questions were discussed to answer the following research question: How do individuals who are transgendered perceive the role of social support in their mental health and their quality of life?

The data collected from the interviews are specific to the members of the trans community and receive services from a community-based, integrated medical clinic that specializes in the treatment of individuals with HIV/AIDS and identify within the LGBTQ+ community.

Participants met with the researcher for at least two meetings. Individuals, who were interested, met with the interviewer once for a screening that lasted approximately ten to fifteen minutes.

Screening questions included the following: do you identify on the trans-spectrum, are you receiving services from this health center at this time, are you 18 years or older, and if you have a mental health diagnosis, are you currently participating in mental health services? Observations were made based on the mental status exam. The researcher assessed appearance, behavior, attitude, consciousness, speech and language, mood, affect, thought process/form and content, insight/judgment, attention span, memory, intellectual functioning. Suicidality and homicidality were inquired and assessed.

If the individual was a candidate for the study, the researcher scheduled the interview. The interview lasted between 45 to 90 minutes. The researcher invited participants to return for a third meeting to review their transcript. The study took place over the course of six months, which included the time of recruitment, data collection, and research analysis. The prescreening, interview, and transcript review took place at the non-profit agency in the researcher's office. The prescreening was scheduled around the participants' convenience to meet with the researcher as soon as possible (within one week of contacting the researcher), followed by the arranged interview. For some participants, it was best to schedule the interview after the screening because of travel expense and appointments. When the researcher completed the transcript, participants were contacted to see if they would like to review the content.

### **Interventions**

The researcher based the semi-structured interview questions on Budge et al.'s (2012) interview questions and modified the questions for this study. The interview questions were the following: Please describe your identity. What was your experience like identifying as trans? When did you begin to identify as trans? Did any aspects of your life change? Did you have any negative emotional experiences throughout coming out and/or within your transition? If so / If comfortable, how did you cope with them? During any negative experiences throughout, what types of supports have you had with coming out and/or within your transition? Did you have any positive emotional experiences throughout coming out and/or within your transition? If so / If comfortable, how did you cope with them? During any positive experiences throughout, what types of supports have you had with coming out and/or within your transition? Describe the types of relationships you have had since transitioning (with friends, family, significant others, within the community)? What are your perceptions of counselors/ therapists? If you have met with a counselor, what was the experience like? What do you hope to gain from the therapeutic relationship? What characteristics would/ have you looked for in a counselor/therapist? What has been your experience like seeking support in the community?

## **Results**

The results of this study presented with overlapping themes of religion and spirituality, how relationships changed because of imposed with expectations, dealing with isolation as well as mental health and trauma. The results revealed an overtone of hope and acceptance within the participants and a perception that society was slowly becoming more inclusive. The presence or absence of relationships (e.g., family, romantic) influenced participants' transitioning process and their overall wellness.

### **Religion & Spirituality**

Spirituality emerged as participants described their faith in God in order to become stronger within themselves. Participants demonstrated their spirituality when they described their wish to live in their “true light” and gaining a sense of enlightenment when participants began to identify as transgender. With the transition process, some felt that their lives were in the “Lord’s hands,” and they had faith that they were becoming who they were destined to be. All participants indicated that they were meant to be “this way” (trans), as they described a feeling of something missing within themselves. They described the outcome of their process as life or death consequence. If they were unable to fulfill their goals of completely transforming and passing as a woman, one participant stated that she “couldn’t function as a male without becoming suicidal.” This strong and compelling notion was identified by all of the participants, except for the participant that was in the beginning stages of identifying as a woman.

Also, participants relied on their faith and spirituality as protective factors for their mental health; therefore, improving their resiliency. The participants’ faith seemed to challenge family members to gain a sense of self-acceptance and further push themselves within the transition process. This notion appeared contradictory because participants also described their family members’ beliefs as well as members of society that by dressing and behaving as the opposite sex that the participants were in contempt of sin. Participants’ family members often told participants that they were “going to Hell” or that they were “doing something God never intended.” The family members’ beliefs influenced their relationships with the participants.

### **Family Relationships**

When participants began to identify as transgender, there was a significant change within their family systems. Their family members were often the first to notice “the little things.” Participants often described the lack of initial support from their family members. Participants

described how their biological parents, specifically their mothers, were unsupportive of their gender identity development. For example, one participant described how her mother “came over and brought (her) some boxers and large t-shirts” knowing that she no longer dressed in masculine clothing. Others described their frustration with being called their name at birth by parents and extended family.

Aside from their parents, participants reported mixed responses from their siblings, in which some described how they were still referred to as their brother, while others' siblings accepted them as their sister. Participants also described feeling as though their nieces and nephews are being “raised to hate” them based on what their families have said about them. As a result, these participants described how they moved away from their families, whether it was changing cities or having them “stay away” until participants felt stable. Participants emphasized the loss of the relationship with family members, by questioning whether or not their parents would rather “lose a child, than gain a daughter.”

As participants moved along in their transition, they described their optimism for the relationships to mend and “blossom.” Some of the participants were firm regarding any “leeway” with their family members in regards to the participants' expectations and out of respect that their identified name and pronouns would be used. Participants recognized that this transition was “harder for them [their family members].” Participants' conscientiousness of their family members' process and understanding of this transition appeared to occur more so with individuals that have been identifying as trans for several years and presented with self-acceptance of their own identity in comparison to the other participants that were in the earlier stages of transition and identity development.

Within the study, there was a distinction of individuals whom they identified as their chosen families. Participants described how supports “adopted them,” “making family ties with people,” and “building their family.” Also, participants wished that they could have received the same support from their own family rather than relying on others as well as how they were not there “when I needed them the most.”

When building their own family, participants described their desire to “be loved back” without conditions and experience a love that was “wholehearted.” Participants discussed having “motherly instinct,” wishing to be “bless[ed] with one [child],” and dealing with the grief that she “will never have a baby” of her own when asked about parenting and having children. These two participants described being in a long-term partnership or were married.

**Romantic Relationships.** Participants connected their romantic relationships with the preconceived notions of sex work in regards to how their partners viewed the companionship. One participant referred to as the “lady in the night,” in which her partner did not want to admit their relationship openly. Participants appeared to long for a healthy romantic relationship and to feel “loved” by somebody. They described the struggle with finding a partner that doesn’t treat them like “a sexual object,” “being treated like a less than” and being “nothing more than just fun.” One participant described the risk of pursuing a relationship and the traumatic consequences that transwomen experience. She stated:

“He doesn't know and I like him, I like him a lot, but it's like nine out of ten I always tell them what I am, because I'd rather let them be the one to say, "Yay," or "Nay," to it. Because I have lost of a lot of friends that they haven't told men, and one they end up being killed...”

Some participants described how they needed to prioritize their own needs first before engaging in a relationship; however, it was evident that being mindful of their safety, mentally

and physically, was imperative when pursuing new relationships. It also appeared that the expectation of sex work was more prevalent for women that were older, whereas, the younger participants stated that “there are so many girls out there that have legitimate jobs [sic]... we’re not only subjected to sex work anymore, like we can go out and live a normal life... like any other woman.” Throughout the interviews, participants described their hope to live a “normal life” and there appeared to be pressure to meet societal-imposed expectations in order to fit within the paradigm of what it means to be a woman.

### **Meeting Societal-Imposed Expectations**

During the interviews, participants described the pressure of not meeting expectations based on their parents and society’s values. They expressed their frustration with their treatment in their communities because they did not follow the “heterosexual normalcy.” When participants began to identify as transgender as children, families put them in counseling to rectify the problem. Participants described the pressure of “doing everything [they’re] supposed to do” and “wanting to please them” (their family), in order to overcompensate for rejecting their sex assigned at birth. This pressure stemmed from the need to pass as a woman and what it means to look like a woman according to societal standards. Participants identified various milestones, such as “starting hormones,” “getting a name changed,” “breast augmentation,” “lip injections,” and “sex reassignment surgery” to “feel normal.” Participants also described the initial risk of wearing feminine clothing and taking steps to walk outside their doors and being seen in public dressed as a woman.

To reach these milestones, participants discussed how they “learned” and “emulated” from women whom they trusted, women that were close to them, and women who accepted their decisions. Participants relied on female role models to be “taught the ways” and “learn from

social interaction.” Participants also described how a “new thing comes out of my life,” such as achieving a milestone, and “another light comes on” in regards to receiving positive reinforcement within themselves to become who they are. In addition to physical attributes, participants described the process of developing emotions and being able to communicate them, dealing with uncertainty, and building upon their self-acceptance.

### **Intersectionality**

As participants developed their self-acceptance, some identified how people they encountered would make additional assumptions about their gender, sexual orientation, age, and race. Participants described always having “that femininity.” Femininity appeared to be fluid definition among the participants based on how they liked to dress, their interests, and how they presented themselves among others. They emphasized how it was not about “liking guys.” Participants’ families “automatically assumed” they were gay. The confusion of gender identity with sexual orientation created more frustration and misunderstanding of the participants’ identity. For example, one participant described:

“I was always taught, you’re a pretty girl, you should be with a guy that’s this way, this way, and this way. It’s not right for you to be trans and like girls or to be trans and like feminine men, or trans and be different... your goal is to be a straight woman, that’s what they have always gotten stuck in my head.”

For individuals who identify as transgender, not only are they expected to look a certain, “feminine” way, but they are expected to adhere to the expectations for cisgender sexual orientation.

When interacting in the community, participants described how there was tension with associating with other members of the trans-community, in which some older trans-women would not offer guidance on how to pass as a woman to individuals who are just beginning to

transition. One participant described how these women were “not so nice,” “catty,” and described how she was called a “disgrace.” Age also seemed to be a factor in regards and identifying as a woman, rather than a transwoman. Some rejected being associated with the gay community based on their sexual preference and identity, stating “while I could go to the gay community and find people who were accepting of each other, there weren’t that many transgender people out yet.” One participant felt discriminated against because of feeling divided based on her race with other organizations that support LGBTQ+ community members. She described an interaction she had with another LGBTQ organization:

“Instantly, I was the colored girl and when I told them that I went to [name of organization] ... like it’s a bad connotation... ‘oh, that’s where the Puerto Ricans and Blacks go, and I looked at them like, did you really just say that? Like, so instantly I felt the divide between the black community and the white community...”

### **Mental Health & Trauma**

In addition to dealing with the labels of gender, race, age, and sexual orientation, participants described their experiences with mental health. Participants recalled being sent to speak with a child psychologist or a counselor to discuss how they “wanted to be a girl” and how they “never been male.” One described participating in anger management, specifically how she was “so bottled up,” “started exploding [on others],” and “acting out.” In addition to anger, participants reported experiencing significant depression and suicidal thoughts, some attempting suicide. Participants described how they would “fall into a negative space,” “experience turmoil within myself,” and felt that they would have “to kill myself or change.” Despite these strong suicidal ideations, there was fear of reporting having these thoughts to mental health providers and being hospitalized. One participant stated, “some girls are afraid of being judged and put into predicaments where they have to go spend the night in the loony bin or a psychiatric facility...”

When participants re-engaged with mental health services, it was a result of needing the required documentation to move forward with their surgeries. One participant described her frustration of having to go to a “psychiatrist because ... hey, they’re already putting a label... I’m gender dysphoric and ... my disorder was adjusting to my new life”. Participants described feeling judged and having to “wearing their flaws on their sleeves” for everyone to see. Two of the participants also disclosed alcohol and substance use, in which one participant described her experience, stating:

“When I was younger, I didn’t know how to talk about certain stuff because I still thought people were out to get me because of my past experiences with me and certain people and were like “oh, yeah I’m your friend” and then the next thing you know... I’m always getting done dirty... I didn’t have any outlets; I didn’t know how to deal with it... I turned to drugs... I did everything and anything whatever you had I was with you.”

The majority of the participants reported experiencing trauma, whether it was sexual violence, domestic violence, bullying, or physical violence. They reported experiencing these traumatic experiences in their childhood and their adulthood. Participants described being beat, jumped, abused and how direct experiences created fear and anxiety with leaving the house. Family members, partners, as well as strangers in the community inflicted harm on the participants. Participants frequently disclosed having “trust issues” and feeling vulnerable in the community. One participant further described the discrimination transgender individuals experience:

“Every second, every hour, every minute of the day...and I’m not saying that nobody else gets that discrimination, but working, walking down the street, just trying to do normal activities, just trying to go... do you think I would have chosen this lifestyle? I don’t think anyone would have chosen this lifestyle... Who in their right mind would want to choose the hardest lifestyle to live in their lifetime... like who would want to be discriminated against, who would want to get beat up, who would want to get spit at or spit on, who would want to be treated like a less than...”

**Isolation.** Isolation occurred as an outcome of trauma and rejection participants experienced. With family members, some participants described how they “didn’t want them to see me.” They described their choice as a means of preserving their safety, in which one participant stated how she “[wanted] to disappear.” There was a distinction between participants dealing with the “outside world” and their desire to “connect with the world.” The decision to isolate appeared to be closely related to their trauma history. One disclosed being “jumped by 15-20” men, and another described feeling “tormented by men.” Participants described their fear of being their true selves because they anticipated more violence or harm would happen.

With isolation, some participants described how they did not have anyone to turn to for support. One participant stated, “the less people I deal with, the better I am mentally.” The preference for isolation was evident with some of the participants' relationships. Participants described how some of their friendships remained intact, while other friendships ended. The friendships that ended were a result of the individual being unable to accept the participant for who they were and their decisions. One participant described how her friends judged her based on her choices, rather than understanding her for who she was. Another participant explained how she had “sat alone for years.” Participants described how they do not need people who are or feel the need to judge their identity.

**Autonomy.** Out of isolation, participants appeared to present with the need to be autonomous in their transformation. Participants frequently stated that they had “done their research,” whether it was in regards to “figuring it out or trying to Google” *transgender*. Also, by doing their research, participants described feeling empowered by it. Participants expressed experiences where they needed to educate their providers when they decided to seek help. By

informing their providers, some participants questioned the provider's expertise, other participants believed that it was an opportunity to build rapport with the providers.

### **Acceptance and Hopefulness**

Throughout the interviews, participants appeared to speak with a sense of optimism and hope regarding their journey towards their transformation. Participants described their want and need to be who they were. They spoke with confidence regarding their self-identity, emphasizing that there was "nothing wrong" with them. While some stated that they would have thrived with more support from their biological families, others described how "support is great no matter where it comes from." Furthermore, another participant stated that the "more [she] accepts being [herself], the less [the pain, discrimination] affects me. One participant also seemed to recognize that she could not "change the way society thinks;" however, "all [she] can do is change [herself]."

When posed with the question of what happens after the "complete transition," one participant described how everyone is in "constant transition" and that the process is "never-ending." Other participants described their motivation to continue to work towards self-actualization by becoming a better person internally. Participants described how they would like to return to work, to go back to school to get their degree, and to above all find ways to help others. Participants described the hope of rebuilding relationships with their family and believing that the "good outweighs the bad" as they get closer to their definition of feeling complete as they are as a person.

### **Discussion**

Based on this study's findings, the prevalence of mental health, specifically depression, anxiety, and suicidal ideations was consistent with previous research (Bockting et al., 2013;

Budge et al., 2012; Budge et al., 2013; McCann, 2015; Pflum et al., 2015). Low self-esteem, dealing with loneliness, and stigma around negative societal attitudes also appeared to be correlated with the participant's transition stage and the impact of their experiences when they initially came out as transgender (Budge et al., 2012; McCann, 2015). Reported experiences of acceptance were observed to improve somewhat within the community, in general; participants, however, identified the need for access to better trans-health where they can feel safe and accepted among their providers.

### **Transition Stage**

Among the participants, trans individuals' transition stage appeared consistent with their degree of confidence and optimism. For example, individuals who were seeking sex re-assignment surgery presented with the most optimism and hope regarding their future. Similar findings in Budge et al. (2012) were discussed, in which participants "could not imagine their lives being any other way" and being able to live as their "true selves" (p. 36). They presented with beliefs that once their surgeries took place, they can go back to school or work and achieve higher self-identified goals. Hopes and aspirations were also vocalized by participants in Budge et al. (2012), Budge et al. (2013) and McCann (2015)'s research regarding the ability to pass as their identified gender. One participant, whom recently began to identify as female, appeared to be developing confidence with her identification as a woman; she, however, presented with hesitation and fears about how members of the community would perceive her. Her worries were demonstrated by her presentation, in which she wore gender-neutral clothing and verbalized her experiences of trauma and strained relationships with family and in the community. One participant identified as a woman, rejecting the trans-identity, and appeared to present with a

sense of actualization and complacency. This participant reported that she had completed sex re-assignment surgery nearly thirty years ago.

Trans individuals' transition stage may also influence how they are affected by direct and internal experiences as identified within the minority stress model. For the participant that identified as a woman, rather than a transwoman, she described how she had encountered some discrimination in the community she lives in now, such as being laughed at by another customer. Her response to this situation appeared to demonstrate a degree of resiliency as well as her interest in blending into society. She described how she moved on from the incident by overlooking the person and proceeding with what she needed to do. By integrating into society, she explained how the community is giving her permission to be herself rather than a spectacle. From her response, one can infer that she does not experience significant amounts of internal stress regarding the expectation or anticipation of harm because of her trans identity. Overall, participants that were further in their transition presented with the perspective that their struggles will be worth it.

### **Prevalence of Mental Health Co-Morbidities**

Participants disclosed their struggles within themselves, such as suicide ideations, depression, and anxiety. From the interviews, participants appeared to experience the most severe mental health symptoms in the initial and adjustment phases of their trans-identity. Budge et al. (2013) found a similar finding in which participants experienced more distress in the beginning stages of their transition. Also, Budge et al. (2013) indicated that trans women might endure heightened stress, discrimination, and more concern over their physical appearance as a woman, compared to trans men. When trans individuals are dealing with these mental health symptoms in the early stages of transition, they may be less likely to seek out services.

Thus, outreach from community organizations may improve engagement with mental health services during this transition stage. On the contrary of community organizations' outreach efforts, trans individuals' participation in the early transition stages may pose as a challenge because of the heightened need or belief for social isolation. With the heightened mental health symptoms, social isolation appeared to be a significant behavior described among most of the participants.

### **Resiliency**

A possible solution to overcome social isolation not only trans individuals, but for the general population experiencing mental health symptoms is to promote resiliency skills across learning environments for all age groups, such as daycares, school, and work environments. Bariola et al. (2015) discuss the how positive personal and communal relationships increase individuals' resiliency. Positive relationships and social support presented as protective factors to decrease the impact of mental health symptoms and seemed to progress trans individuals' identity development. For most of the participants, their relationships with their immediate families appeared to have a detrimental impact on their health and increase their distress. Thus, more research is needed in order to identify characteristics that may improve these interpersonal relationships. For trans youth, resiliency may develop out of a better understanding of their meaning of gender, gender roles and to foster self-acceptance. When self-acceptance and support from family members is present, trans youth develop more self-worth and protective factors to reduce the effects of possible depression, anxiety, suicidal symptoms as well as family isolation. With additional research, trans individuals and the general population may benefit from the exploration of resiliency building within the individual to become stronger from adverse experiences.

All of the participants had participated in mental health counseling at various stages of their lives. For some, meeting with a counselor began when the participants started identifying as a female, and their parents intervened. For others, participation in counseling was required to move forward with their sex-reassignment surgery and process gender identity development. Also, the majority of the participants described their interest in continuing counseling to work through their previous traumas, build self-awareness, and feel stronger in regards to their mental health and stability.

From counselors, participants described how they valued necessary counseling skills, such as eye contact, being engaged, and actively listening. Participants expressed their struggle with trusting counselors and feeling comfortable. From the counseling relationship, participants wished to become more secure, reassured, and feeling heard. Participants emphasized that while they are “different, they are just like everyone else.” They described their search for freedom and being able to go as they please without being pegged as a spectacle. Participants throughout the interviews emphasized that there is more to them than being labeled as a transgender individual. One participant stated, “people see transgenders as whatever they want to see it as, they don’t see us as people, like being tranny is only one part of me.” Also, participants described how there is more to them than their gender identity and the importance of being able to address other facets of their life.

Throughout the interviews, participants subliminally described their desire to build up their resiliency, such as becoming better advocates, improving themselves as well as identifying positive relationships. Participants also indicated the value of counselors having some cultural competence in trans issues; however, it is also important to note that the counselor cannot fully

understand their experiences. Thus, it is more valuable for clinicians to have the willingness to develop their cultural awareness in order to be more informed. To promote cultural awareness, mental health professionals need to understand gender identity affirmation to begin to address trans health holistically, as well as, the barriers to trans clients seeking services. Clinicians can also further demonstrate their support by participating in advocacy and outreach. The visibility and word-of-mouth are two strategies that reduce the barriers that present for individuals seeking mental health services. This population has “little faith that the majority of mental health practitioners have adequate ability to work with transgender clients” (Benson, 2015, p. 35). In addition to advocacy and outreach, clinicians can seek out gender affirmative training.

Aside from cultural competence, trauma-informed care and Meyer’s Minority Stress Model with trans individuals is paramount because of higher correlations of individuals experiencing physical and sexual violence as well as harassment and discrimination in the community.

Furthermore, social connectedness is significant to trans individuals’ mental health. Participants discussed their experiences with isolation and how having or not having primary supports, such as mentors, family members, or friends, shaped their transition process. For counselors, trans individuals and their families may benefit from family counseling and psychoeducation sessions to increase awareness and promote healthy communication among them. In addition to educating trans individuals’ direct support systems and developing within-group solidarity, mental health practitioners, can be a resource for promoting a “client’s psychological well-being, quality of life and self-fulfillment” (McCann, 2015, p. 80).

Trans individuals, who are not connected to community resources or are in the beginning stages of their transition, may benefit from within-group supports, such as support groups, to

foster connections and gain an understanding of who they are. When referring to community resources, one participant discussed the importance of safety. For counselors, it would be beneficial to have background knowledge of these resources to provide referrals where these individuals can feel safe, connected to the community, and afford the services. For mental health practitioners, trans individuals' ability to afford services can be addressed by promoting sliding scale for services and identifying insurance panel participation as well as helping them get linked with additional support services (Shipherd et al., 2012).

### **Community Relations**

There have been some improvements in the way the community interacts with individuals from the trans community. One participant described her positive and negative experiences with employment, specifically the use of her legal versus chosen names. She recounted how it was dependent upon the management and how she was addressed. When employers refused to use her chosen name, the participant described how the work environment became more negative. She was susceptible to judgment and harassment by other employees and was put in a situation to come out to the staff. Also, she described how a more recent employer held a staff training on gender identity. While she was excited that the employer wanted to educate the staff, she felt that this put a "target on her back" because she was open about being trans. As a result, she felt that employees were "walking on eggshells" when around her. This participant suggested that employers make efforts to include gender identity training during new employee orientation. By holding having a mandatory training for new staff members, employers would have the opportunity to address gender identity, affirming conversations, and create an open dialogue.

### **Limitations**

Participants had described their desire to help others. As a result, the themes identified may not be representative of the transgender community overall because these individuals were motivated to share their story. Also, these individuals were already established with the community organization for counseling supports and healthcare. All of the participants identified as female or transfemale; therefore, it is undetermined whether these themes would be consistent for individuals that identified as male or transmale. Participants were all linked to the same community health organization; therefore, findings may be influenced by their specific experience, and it is not known how trans individuals experience other community organizations.

### **Recommendations for Future Research**

For future research, it is recommended to explore the benefits of intrapersonal versus interpersonal resiliency among trans individuals and the general population. By developing resiliency skills within themselves, it may be beneficial to investigate whether or not there is a change in the severity of their mental health symptoms, need for social isolation, and if the quality of relationships improves among their immediate social supports. By identifying specific resiliency-building skills, individual and group counseling approaches can potentially enhance the individual's overall health. Also, resiliency building skills may be examined among counselors who provide trans individuals with permission to change their minds about their gender identity and affirmation of the person first, rather than specific to the gender identity. Other areas of exploration may include if resiliency skill building is a preventative in regards to dealing with varying degrees of loss, such as their hopes and aspirations are not achieved regarding their appearance, grieving relationships, etc.

An additional recommendation for future research would be to explore the mental health and quality of relationships among transmen in the community. Across research, it seems that

transwomen are more likely to participate in studies compared to transmen. By increasing transmen's participation in research, socialization from early childhood may be further explored as it relates to the quality of relationships.

### **Conclusion**

This study presented with consistent findings regarding the prevalence of mental health and trauma. Variables that may have influenced their mental health, such as being most affected by their family relationships changing and social isolation, were countered by the value of religion and spirituality to understand their identity, finding ways to increase self-acceptance, and establishing harmony among positive supports. Transition stage appeared to influence the results, in which individuals that achieved more milestones physically and emotionally appeared to be more comfortable with sharing their narratives. Furthermore, trans individuals encounter counseling at least once in their lifetime, if they wish to participate in the sex-reassignment surgery; therefore, the counseling relationship is paramount. For counselors, it is vital to build up their cultural competence when working with trans-individuals and see the individual first as a person, rather than a label, number, or spectacle. The counseling relationship may be the first attempt to begin to rectify and understand the trauma and distress experienced as well as the loss of previous relationships. Unlike the counseling relationship, society is an unpredictable variable in the treatment of trans individuals. Thus, change begins with awareness. For counselors, the ability to build up trans individuals' resiliency is one opportunity to reduce the impacts of discrimination and anticipated threats of harm.

**References**

- Austin, A., Craig, S. L., & Alessi, E. J. (2017). Affirmative cognitive behavior therapy with transgender and gender nonconforming adults. *Psychiatric Clinics, 40*(1), 141-156. doi: 10.1016/j.psc.2016.10.003
- Bariola, E., Lyons, A., Leonard, W., Pitts, M., Badcock, P., & Couch, M. (2015). Demographic and psychosocial factors associated with psychological distress and resilience among transgender individuals. *American Journal of Public Health, 105*(10), 2108-2116. doi:10.2105/AJPH.2015.302763
- Benson, K. E. (2013). Seeking support: Transgender client experiences with mental health services. *Journal of Feminist Family Therapy, 25*(1), 17-40. doi:10.1080/08952833.2013.755081
- Biblarz, T. J., & Savci, E. (2010). Lesbian, gay, bisexual, and transgender families. *Journal of Marriage and Family, 72*(3), 480-497. doi:10.1111/j.1741-3737.2010.00714.x
- Bilodeau, B. L., & Renn, K. A. (2005). Analysis of LGBT identity development models and implications for practice. *New Directions for Student Services, 2005*(111), 25-39. doi:10.1002/ss.171
- Bockting, W. O., Miner, M. H., Swinburne Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience in an online sample of the US transgender population. *American Journal of Public Health, 103*(5), 943-951. doi: 10.2105/AJPH.2013.301241
- Budge, S. L., Katz-Wise, S. L., Tebbe, E. N., Howard, K. A., Schneider, C. L., & Rodriguez, A. (2012). Transgender emotional and coping processes facilitative and avoidant coping

- throughout gender transitioning. *The Counseling Psychologist*, 41(4), 601-647. doi: 10.1177/0011000011432753
- Budge, S. L., Adelson, J. L., & Howard, K. A. (2013). Anxiety and depression in transgender individuals: the roles of transition status, loss, social support, and coping. *Journal of Consulting and Clinical Psychology*, 81(3), 545-557. doi:10.1037/a0031774
- Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. *Professional Psychology-Research and Practice*, 43(5), 460-467. doi:10.1037/a0029597
- McCann, E. (2015). People who are transgender: mental health concerns. *Journal of Psychiatric and Mental Health Nursing*, 22(1), 76-81. doi: 10.1111/jpm.12190
- Pflum, S. R., Testa, R. J., Balsam, K. F., Goldblum, P. B., & Bongar, B. (2015). Social support, trans community connectedness, and mental health symptoms among transgender and gender nonconforming adults. *Psychology of Sexual Orientation and Gender Diversity*, 2(3), 281-286. doi: 10.1037/sgd0000122
- Nuttbrock, L. A., Bockting, W. O., Hwahng, S., Rosenblum, A., Mason, M., Macri, M., & Becker, J. (2009). Gender identity affirmation among male-to-female transgender persons: A life course analysis across types of relationships and cultural/lifestyle factors. *Sexual and Relationship Therapy*, 24(2), 108-125. doi: 10.1080/14681990902926764
- Shipherd, J. C., Green, K. E., & Abramovitz, S. (2010). Transgender clients: Identifying and minimizing barriers to mental health treatment. *Journal of Gay & Lesbian Mental Health*, 14(2), 94-108. doi: 10.1080/19359701003622875