AN ABSTRACT OF THE DISSERTATION OF

Liesl M. Farnsworth for the degree of Doctor of Philosophy in Counseling presented on November 22, 2013.

Title: An Assessment of Intrapersonal and Interpersonal Resilience Factors Among Trans People: A Literature Review and Quantitative Investigation.

Abstract approved:

_____

Daniel Stroud

The purpose of this dissertation was to demonstrate research scholarship using the American Psychological Association (APA) manuscript-style dissertation format, in accordance with Oregon State University Graduate School and Counseling Academic Unit guidelines.

Chapter 1 provides explanation for how Chapters 2 and 3 are thematically linked manuscripts intended to extend professional literature in Counseling. Chapter 2 is a review of related literature titled: *Shame, Thwarted Belonging, Self-Harm, and the Moderating Influence Resilience Protective Factors May Serve for Trans People: A Literature Review*.

From the foundation established in Chapter 2, Chapter 3 details a cross-sectional survey descriptive design titled: *Assessing Intrapersonal and Interpersonal Resilience Factors among Trans People: A Descriptive Study*. The purpose of this study was to examine the intrapersonal and interpersonal protective factors of resilience among trans people.

Resilience of a diverse cross-section of trans people ($N = 151$) was measured by the Resiliency Scale for Adults (RSA). This 33-item, 5-point Likert scale, with response options ranging from 1 = strongly disagree to 5 = strongly agree, is comprised of three intrapersonal factors: Social Competence, Personal Competence, Structured Style; and two interpersonal factors: Social Resource and Family Cohesion. Findings indicate participants' intrapersonal factors scores ($M = 3.81$, $SD = 06$) were significantly higher than their interpersonal factors scores ($M = 3.47$, $SD = .48$); $t(301) = 14.06$, $p < .001$ ($d = .95$).

Results from this study, coupled with previous study findings, form a foundation upon which future studies of resilience among trans people may inform development and delivery of effective trans-specific support services and gender-affirming treatment approaches.

An Assessment of Intrapersonal and Interpersonal Resilience Factors Among Trans People: A Literature Review and Quantitative Investigation

by
Liesl M. Farnsworth

A DISSERTATION

Submitted to

Oregon State University

in partial fulfillment of
the requirements for the
degree of

Doctor of Philosophy

Presented November 22, 2013
Commencement June 2014

Doctor of Philosophy dissertation of Liesl M. Farnsworth presented on November 22, 2013.

APPROVED:

_____

Major Professor, representing Counseling

_____

Dean of the College of Education

_____

Dean of the Graduate School

I understand that my dissertation will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my dissertation to any reader upon request.

_____

Liesl M. Farnsworth, Author

ACKNOWLEDGEMENTS

There are many who have helped me personally and professionally with this dissertation. I have received support, encouragement, and patience from my community of friends and family, as well as the professionals who provided knowledge, experience, and encouragement. This was a project made possible by many.

I want to thank my committee: Dr. Lori Blackman, for her encouragement and advisement on the dissertation process; Dr. Amy Ford, for her ready support in editing and steadiness; Dr. Teri Strong, for her passion for social justice and steady encouragement; Dr. Karen Elliot, graduate representative, for her encouragement to expand this research to include community involvement and collaboration; and especially, Dr. Daniel Stroud, my major advisor, for his enthusiasm, warmth, skilled feedback, encouragement, and genuine care for my professional growth. I would like to acknowledge his patience in helping me understand statistics, as well as his ability to bring research alive. Dr. Stroud supported my ideas and desire to explore the lived experience of trans people without question. I could not have completed this project without him.

I want to thank my clients who challenge me to stretch and grow personally and professionally. Witnessing clients' courage and willingness to face past and current pain with the goal of wholeness and peace is an incredible honor.

And finally, I want to express my love to my supportive family and friends. To my parents, who have never wavered in their belief in me and supported me in every way possible. To my uncle Roger and aunt Judy, who offered emotional support, laughter, and great food. To Mariya Hammond, for her steady friendship and love. To Alexis Scharff,

whose encouragement and support kept me going. To Erin, Paul, Peter, Sam, and Laurie, my created family, who have supported me with shared dinners, dog walks, and other forms of distraction that provided renewed energy. To Gordon Cumming, my beloved, for giving me companionship, love, and amazing formatting skills.

TABLE OF CONTENTS

TABLE OF CONTENTS (Continued)

Page

TABLE OF CONTENTS (Continued)

LIST OF TABLES

CHAPTER 1: GENERAL INTRODUCTION

The purpose of this dissertation study was to demonstrate research scholarship using the American Psychological Association (APA) manuscript-style dissertation format, in accordance with Oregon State University Graduate School and Counseling Academic Unit guidelines.

Dissertation Overview

Chapter 1 provides explanation of how Chapters 2 and 3 are thematically linked manuscripts intended to extend professional literature in counseling. Chapter 2 is a review of related literature entitled, *Shame, Thwarted Belonging, Self-Harm, and the Moderating Influence Resilience Protective Factors may serve for Trans People: A Literature Review: A Literature Review*. Chapter 3 details a cross-sectional survey descriptive design, in manuscript form, titled, *Assessing Intrapersonal and Interpersonal Resilience Factors Among Trans People: A Descriptive Study*.

Both manuscripts focus on contributing factors, evidenced in the literature, of intrapersonal and interpersonal factors of resilience in relation to known psychological distress effects, such as shame, thwarted belonging, and self-harming behaviors.

Chapter 2 points to currently known and not yet known intrapersonal and interpersonal resiliency protective factors, both general and specific to trans people, as evidenced in research. Chapter 2 relates to Chapter 3 by providing the process by which existing, clearly identified variables were selected for testing in this quantitative investigation. In doing so, an incremental advancement in understanding the counseling profession may occur.

Thematic Introduction

Transgender is an umbrella term intended to represent those whose experience and identification cannot be captured by a dichotomous male or female category. Conceptual and empirical literature has only recently begun to focus on this population and agreement can be found as to the particularly high-risk and vulnerable existence of trans people in terms of suicide ideation and completion rates (Bockting, Miner, Romine, Hamilton, & Coleman, 2013; Mathy, 2002; Mathy, Lehmann, & Kerr, 2003). However, research specific to trans people currently lags, somewhat, in identifying contributing factors, as well as protective factors, specific to these rates for this unique population (Mathy et al., 2003); and the distance the body of directly related research needs to cover in empirically investigating that which is identified as contributing or predictive factors is considerable (Carroll, Gilroy, & Ryan, 2002). One such factor is shame, operationalized to mean a core self-evaluation as being damaged, inadequate, or worthless (Gilbert et al., 2010; Mann, 2010). Well-researched across samples other than trans people, much support exists regarding its relation to not just self-harm, but a sense of un-belonging as well. Experience of not belonging or thwarted belonging has emerged as a contributor to self-harming behaviors (Anestis & Joiner, 2011; Joiner & Van Orden, 2008). Thwarted refers to attempts at connection being rejected, in turn, often leading one to isolate as a protective coping mechanism. Indeed, both felt experience of shame and thwarted belonging have been linked to self-isolating behavior—a strong predictor of suicidal ideation and completion (Freedenthal, Lamis, Osman, Kahlo, & Gutierrez, 2011). Protective factors of resilience have yet to be explored in depth with trans people in

relation to the aforementioned challenges. Protective factors would address community and family support as protection against isolation and not belonging, as well as shame and self-harming behaviors. A gap appears to currently exist in the literature; a means for beginning to fill it will be to investigate resilience of trans people, for whom current statistics show as a vulnerable population with a high risk of self-harming behaviors and thwarted belonging.

The first manuscript, a literature review, provides a more in-depth assessment of shame, thwarted belonging, and self-harm by first introducing each construct, and then highlighting ways in which it has or has not been linked to trans people. It then offers an assessment of resilience and the protective factors of resilience as highlighted in the Resilience Scale for Adults in relation to trans people (Jowkar, Friborg, & Hjemdal, 2010).

The second manuscript, a research study, begins with a synopsis drawn from the first chapter to provide background and establish rationale for this proposed study and the findings it generates.

Chapter 4 provides a general conclusion to this dissertation. Findings provide the counseling profession evidence to support increased incremental understanding as to the relationship, or lack thereof, among high-risk factors potentially embodied in a vulnerable population.

Glossary of Terms

Assigned gender. Assigned gender at time of birth (Coolhart, Provancher, Hager, & Wang, 2008).

Coming out. Processes whereby gay men, lesbians, or bisexuals inform others of their sexual identity; and may include sexual preference, sexual identity, and gender identity (Gagne, Tewksbury, & McGaughey, 1997).

Cross-dresser. Individual who dresses in clothing that is culturally associated with members of the other sex. Most cross-dressers are heterosexual and conduct their cross-dressing on a part-time basis. Cross-dressers cross-dress for a variety of reasons, including pleasure, a relief from stress, and a desire to express "opposite" sex feelings to the larger society (Carroll et al., 2002).

Gender and gender identity. That which a society deems "masculine" or "feminine." Gender identity refers to an individual's self-identification as a man, woman, transgender, or other identity category (Carroll et al., 2002). For many, gender is considered a social construct and can be self-defined, and consider being transgender as a natural and normal variation of gender identity (Coolhart et al., 2008).

Gender confirmation surgery. Known as gender or sexual reassignment surgery.

Gender dysphoria. Radical incongruence between individual's birth sex and their gender identity. Many in the transgender community find this term offensive or insulting because it often pathologizes the transpeople due to its association with the DSM-IV (Carroll et al., 2002).

Gender queer. Individuals who "queer" the notion of gender in a given society. Gender queer may also refer to people who identify as both transgender and queer (i.e., individuals who challenge both gender and sexual orientation as overlapping and interconnected; Carroll et al., 2002). It refers to gender identification other than that of "man" or "woman." It often involves a politically motivated blending of gendered presentations, pronouns, and self-concepts (Connell, 2010).

Gender variant. Individuals who stray from socially accepted gender roles in a given culture. This term may be used in tandem with other group labels, such as gender-variant gay men and women (Carroll et al., 2002). Presents with patterns of intense, pervasive, and persistent interests and behaviors characterized as typical of the other gender as defined by the culture in which one resides (Perrin, Smith, Davis, Spack, & Stein, 2010).

Natal sex. "Male" or "female" coded sex organs of the individual's birth.

Passing. The chosen gender that is different from the natal or birth sex of the individual. There are other means of passing besides surgery or hormone replacement, and they include packing, binding, voice coaching, and hair removal (Coolhart et al., 2008).

Perceived burdensomeness. Perceived burdensomeness is a sense of being a burden and having little value as well as viewing oneself as a liability in society who offers no meaningful contribution to society (Anestis & Joiner, 2011; Selby et al., 2010).

Preferred gender. The gender the person experiences internally and wishes to transition to externally (Coolhart et al., 2008).

Queer. Queer is a term that has been reclaimed by members of the gay, lesbian, bisexual, and transgender communities to refer to people who transgress culturally imposed norms of heterosexuality and gender traditionalism. Although still often an abusive epithet when used by heterosexuals, many queer-identified people have taken back the word to use as a symbol of pride and affirmation of differences and diversity (Carroll et al., 2002).

Queer theorist. An individual, usually an academic, who uses feminism and psychoanalysis.

Resiliency. Resilience is "the ability of individuals to adapt successfully in the face of acute stress, trauma, or chronic adversity, maintaining or rapidly regaining psychological well-being and physiological homeostasis" (Rose et al., 2013, p.107).

Sexual orientation. The gender(s) to which a person is emotionally, physically, romantically, and erotically attracted. Examples of sexual orientation include homosexual, bisexual, heterosexual, and asexual. Transgender and gender-variant people may identify with any sexual orientation, and their sexual orientation may or may not change during or after gender transition (Carroll et al., 2002).

Self-harm. Behaviors that result in physical self-injury, typically involving soft tissue damage (e.g. cutting) self-hitting, and other forms of self-mutilation; to include forms that result in hospitalization (Gratz & Tull, 2011).

Shame. A global self-evaluation of being a failure, damaged, inadequate, and worthless. It is connected to identity and creates feelings of helplessness, weakness and inferiority (Gilbert et al., 2010; Mann, 2010; Montgomery, 2006).

Thwarted belongingness. The inability to experience positive social connections and being cared for by others (Selby et al., 2010).

Trans. An umbrella term referencing to cross-dressers, transgenderists, transsexuals, and others who permanently or periodically dis-identify with the sex they were assigned at birth. Trans is preferable to "transgender" to some in the community because it does not minimize the experiential specificities of transsexuals (Carroll et al., 2002).

Transgender. A range of behaviors, expressions, and identifications that challenge the pervasive binary gender system in a given culture. This, like trans, is an umbrella term that includes a vast array of differing identity categories such as transsexual, drag queen, drag king, cross-dresser, transgenderist, bi-gendered, and a myriad of other identities (Carroll et al., 2002). This term is used regardless of surgical or medical status (Connell, 2010).

Transgenderist. An individual who dis-identifies with their assigned birth sex and lives full time in congruence with their gender identity. This may include a regime of hormone therapy, but usually transgenderists do not seek or want sex reassignment surgery (Carroll et al., 2002).

Transman. Natal female who presents as male.

Trans people. The generic category used to describe everyone in the various gender categories (Connell, 2010).

Transsexual. An individual who strongly dis-identifies with their birth sex and wishes to use hormones and sex reassignment surgery (or gender confirmation surgery) as a way to align their physical body with their internal gender identity (Carroll et al., 2002).

Transvestite. An older term, synonymous with the more politically correct term cross-dresser, that refers to individuals who have an internal drive to wear clothing associated with a gender other than the one that they were assigned at birth. The term transvestite has fallen out of favor due to its psychiatric, clinical, and fetishistic connotations (Carroll et al., 2002).

Transwoman. Natal male who presents as female.

World Professional Association for Transgender Health (WPATH). provides Standards of Care (SOC) to offer insight and instruction regarding concerns, questions, and appropriate actions for serving transpeople. Formerly known as The Harry Benjamin International Gender Dysphoria Association (Coolhart et al., 2008).

Chapter 1 References

Anestis, M. D., & Joiner, T. E. (2011). Examining the role of emotion in suicidality: Negative urgency as an amplifier of the relationship between components of the interpersonal-psychological theory of suicidal behavior and lifetime number of suicide attempts. *Journal of Affective Disorders, 129*, 261-269.

Bockting, W. O., Miner, M. H., Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience among an online sample of the U.S. transgender population. *American Journal of Public Health, 103*(5), 943-951. doi: 10.2105/AJPH.2013.301241

Carroll, L., Gilroy, P. J., & Ryan, J. (2002). Counseling transgendered, transsexual, and gender-variant clients. *Journal of Counseling and Development, 80*, 131-139.

Connell, C. (2010). Doing, undoing, or redoing gender? Learning experiences from the workplace experiences of transpeople. *Gender & Society, 24*(1), 31-55.

Coolhart, D., Provancher, N., Hager, A., & Wang, M. (2008). Recommending transsexual clients for gender transition: A therapeutic tool for assessing readiness. *Journal of GLBT Family Studies, 4*(3), 301-324.

Freedenthal, S., Lamis, D. A., Osman, A., Kahlo, D., & Gutierrez, P. M. (2011). Evaluation of the psychometric properties of the Interpersonal Needs Questionnaire-12 in samples of men and women. *Journal of Clinical Psychology, 67*(6), 609-623.

Gagne, P., Tewksbury, R., & McGaughey, D. (1997). Coming out and crossing over: Identity formation and proclamation in a transgender community. *Gender & Society, 11*(4), 478-508.

Gilbert, P., McEwan, K., Irons, C., Bhundia, R., Christie, R., Broomhead, C., & Rockliff, H. (2010). Self-harm in a mixed clinical population: The roles of self-criticism, shame, and social rank. *British Journal of Clinical Psychology, 49*, 563-576.

Gratz, K. L., & Tull, M. T. (2011). Extending research on the utility of an adjunctive emotion regulation group therapy for deliberate self-harm among women with borderline personality pathology. *American Psychological Association, 2*(4), 316-326.

Joiner, T. E., & Van Orden, K. A. (2008). The interpersonal-psychological theory of suicidal behavior indicates specific and crucial psychotherapeutic targets. *International Journal of Cognitive Therapy, 1*(1), 80-89.

Jowkar, B., Friborg, O., & Hjemdal, O. (2010). Cross-cultural validation of the Resilience Scale for Adults (RSA) in Iran. *Scandinavian Journal of Psychology, 51*, 418-425.

Mann, M. (2010). Shame veiled and unveiled: The shame affect and its re-emergence in the clinical setting. *The American Journal of Psychoanalysis, 70*, 270-281.

Mathy, R. M. (2002). Transgender identity and suicidality in a nonclinical sample: Sexual orientation, psychiatric history, and compulsive behaviors. *Journal of Psychology and Human Sexuality, 14*(4), 47-65.

Mathy, R. M., Lehmann, B. A., & Kerr, D. L. (2003). Bisexual and transgender identities in a nonclinical sample of North Americans: Suicidal intent, behavioral

difficulties, and mental health treatment. *Journal of Bisexuality, 3*(3-4), 93-109.

Montgomery, C. (2006). The virtue of depression in the secret life of shame: A group-analytic perspective. *Group Analysis, 39*(1), 73-85.

Perrin, E., Smilth, N., Davis, C., Spack, N., & Stein, M. T. (2010). Gender variant and gender dysphoria in two young children. *Journal of Developmental and Behavioral Pediatrics, 31*(2), 161-164.

Rose, R. D., Buckly, J. C., Jr., Zbozinek, T. D., Motivala, S. J., Glenn, D. E., Caftreine, J. A., & Craske, M. G. (2013). A randomized controlled study of a self-guided, multimedia, stress management and resilience training program. *Behavioral Research and Therapy, 51*, 106-112.

Selby, E. A., Anestis, M. D., Bender, T. W., Ribeiro, J. D., Nock, M. K., Rudd, M. D., & Joiner, T. E., Jr. (2010). Overcoming the fear of lethal injury: Evaluating suicidal behavior in the military through the lens of the Interpersonal-Psychological Theory of Suicide. *Clinical Psychology Review, 30*, 298-307.

CHAPTER 2: A REVIEW OF RELATED LITERATURE

Shame, Thwarted Belonging, Self-Harm, and the Moderating Influence Resilience Protective Factors may serve for Trans People: A Literature Review.

Liesl M. Farnsworth

Oregon State University

Daniel Stroud

Oregon State University-Cascades

Abstract

This review of relevant literature serves to connect intrapersonal and interpersonal resiliency protective factors with shame, thwarted belonging, and self-harm in relation to individuals who identify as trans. Relationships exist between thwarted belonging, shame, isolation, and the detrimental effects these factors can have on psychological health and well-being (Choma et al., 2010). Current research demonstrates the moderating influence of resilience when associated with psychological distress (Bockting, Miner, Romine, Hamilton, & Coleman, 2013; Orbkes & Smith, 2013). Research focused on trans people is limited, most of which has occurred in the past decade (Hanssmann, Morrison, & Russian, 2008; Hughes & Eliason, 2002). Most recently, resiliency and psychological distress studies specific to subgroups of the trans population offer future research directions (Bockting et al., 2013; Reicherzer & Spillman, 2011; Singh, Hayes, & Watson, 2011). Important support and treatment services for this marginalized population can be more effective if interpersonal and intrapersonal protective factors are identified and ultimately used to support and empower trans individuals (Mizock & Lewis, 2008).

Key words: *Shame; Thwarted Belonging; Self-harm; Resilience*; *Trans*

Introduction

What is known regarding lived experiences of those who identify as transgender is perhaps better framed as what is not known. Research focused on persons who identify as transgender is limited (Hanssmann et al., 2008; Hughes & Eliason, 2002). Assumptions can be made regarding collective attributes of this population based on research concentrated on lesbian, gay, bisexual, and trans samples. Often grouped under a rather broad sexual minority umbrella, this practice fails to account for between group differences. Given this limitation, generalizability to trans people may not be appropriate, as distinct differences exist between one's sexual orientation and one's gender identification and expression (Hanssmann et al., 2008; Hughes & Eliason, 2002; Mathy, Lehmann, & Kerr, 2003). The current lack of research specific to trans people served as impetus for this review of relevant literature.

Given a shortfall of trans-specific empirical research literature upon which to draw, we chose to review relevant literature beginning with a focus on trans people. With that foundation, we transitioned to the challenges and struggles often befalling transgender individuals that may present barriers to resilience, such as shame, thwarted belonging, and self-harm. After examining the challenges, we looked at the construct of protective intrapersonal and interpersonal resilience that many trans people may utilize to combat the challenges.

Transgender

Transgender, broadly defined, identifies people who do not fit into culture's male-female, masculine-feminine classifications, in terms of identification and/or role. Varying

expressions of gender identity come under the umbrella of transgender and include, but are not limited to, heterosexual or gay cross-dressers; those living full time as the other gender whether or not they are taking hormone replacement or preparing for surgery; and those who demonstrate fluidity on a gender continuum adopting both female and male gender roles (Hughes & Eliason, 2002). Sexual orientation, on the other hand, is experienced with trans people in the same way it is with other subgroups of the general population: heterosexual, bisexual, gay, or lesbian.

Transgender is a relatively new term, coined in the 1980s, to highlight and honor the complex nature of gender (Carroll, Gilroy, & Ryan, 2002; Coolhart, Provancher, Hager, & Wang, 2008). Until this time, gender variant individuals were commonly referred to as transvestite or transsexual. Transvestite was replaced with cross-dressing, as a way to de-pathologize individuals who dress in a manner other than their biologically coded sex (Coolhart et al.). The transgender community has fought against the DSM diagnosis of transvestite, because it has been classified as a paraphilia disorder (American Psychiatric Association, 2000). The term transsexual, once used to identify gender variant individuals, assumes that individuals desire to become, through surgery or hormones, one of the binary genders. Many with cross-sex identification, however, have no intention of altering their external genitalia and, thus, do not fit under transsexual identification (Carroll et al.). The umbrella terms “transgender” and “trans people” allow for any and all expressions of gender and are non-pathological in definition to include all individuals who experience self, outside of culture’s binary system; to include those who fluidly

move between the two genders (Hanssmann et al., 2008). Thus, many therapists, activists, and queer advocates subscribe to this more inclusive terminology.

Marginalization and Discrimination

Spanning some ten years, which almost completely encompasses the history of transgender research literature to date, findings have remained consistent that trans people experience more marginalization and violence than same-sex oriented individuals, with whom trans people share sexual minority designation (Bockting et al., 2013; Hughes & Eliason, 2002; Nuttbrock et al., 2010). For the purpose of understanding their marginalization further, scholars have reported those with gender variant manifestation or who experience gender dysphoria tend to also experience marginalization sooner than those who identify as lesbian, gay, or bisexual (Perrin, Smilth, Davis, Spack, & Stein, 2010). In addition to separation effect within the multi-dimensional sexual minority population, conflict also arises within the otherwise seemingly homogeneous trans-community. Conflict occurs between those who identify as transsexual and cross-dressers, as discussed by Schrock, Holden, and Reid (2004), wherein cross-dressers are sometimes criticized by transsexuals as being in denial of their transgender status. Cross-dressers, however, see things differently by viewing themselves as experiencing more fluidity across gender identification to encompass both, as opposed to either, male-female gender. Thus, viewing this population as homogeneous has limitations, similar to non-specific sexual minority samples. As such, additional perspectives should be considered.

Queer theorists and other post-modern deconstructionists posit gender is a culturally and socially created concept (McKensie, 2010). An individual's biological sex

and social, cultural setting have a deep impact on one's sense of self (McKensie). Trans people challenge society's belief that biological sex, sex category, and gender correspond cohesively (Connell, 2010). For example, cispeople, or "gender normals" (Schilt & Westbrook, 2009, p. 441), behave in socially normative ways that correspond to assigned birth sex and behave in a gender normative fashion as defined by cultural norms. Trans people disrupt this assumption and invite the exploration of gender fluidity across the current binary system (Connell; Coolhart et al., 2008). The disruption on cultural norms and subsequent ambiguity can cause internal and external backlash with both the gender variant individual and the general population (Mizock & Lewis, 2008). Western cultures are threatened by the introduction of more than two gender expressions (Connell; Coolhart et al.). Whether threatened or misinformed, helping professions have room for improvement. Limited training options for mental health and medical providers regarding this population sends the message to consumers and providers alike that knowledge and expertise in this area is discretionary (Hanssmann et al., 2008). Concern over subjective understanding and a clinician's expertise points to the debate and history of gender identity as a disorder.

Diagnostic History Overview

There are several schools of thought regarding the diagnosis of Gender Identity Disorder (GID). Some contemporary theorists and practitioners view the diagnosis as pathologizing, while others view it as a necessary step toward addressing the complexity of cross-sex identification (Kulish, 2010, Mathy, 2002; Mizock & Lewis, 2008). The accuracy of a GID diagnoses and subsequent action must improve in order to offer best

practice for gender variant individuals seeking sexual reassignment. Currently, a diagnosis rests on the subjectivity of the identified trans person and subjectivity of the mental health practitioner (Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008; Hanssmann et al., 2008). The introduction of the DSM V, in effect October 2014, attempts to address these concerns. Questions remain, though, for mental health practitioners, medical providers, and trans people regarding the most effective and honoring way to support this population.

Gender Identity Disorder was added to the DSM in 1980. Like the previously unfounded pathology of homosexuality, this diagnosis continues to be supported in many professional realms despite the absence of empirical evidence to support it (Hughes & Eliason, 2002; Kulish, 2010). Many trans people and clinicians are advocating to de-pathologize transgenderism and move away from the GID diagnosis (Carroll et al., 2002; Mathy, 2002; Mizock & Lewis, 2008). Contemporary theorists challenge the assumptions of what is considered normal in this culture and what is pathological (Kulish, 2010). Many members of society and mental health practitioners, as well as the DSM IV guidelines, support a rigid interpretation of gender. In fact, recent research notes the emotional distress suffered by gender variant people may be less about internal struggles regarding the development of gender identity and more about the struggle of living in an unsafe and unfriendly social environment (Mizock & Lewis, 2008; Nuttbrock et al., 2010).

Authenticity and gender flexibility has been challenged by the diagnosis of GID. The act of diagnosing a trans person pathologizes the individual and implies the

pathology can be "cured" through surgery (Schrock et al., 2004, p. 67). In many cases, the trans-individual, in a quest toward authenticity, must identify as pathological in order to experience their body as matching inner knowing and experience. However, many trans people do not consider surgery as an option and forego mainstream understanding and expression of the binary gender system (Carroll et al., 2002). Choosing to proceed with hormones or surgery in order to match internal knowing with external expression first requires the individual to adhere to the medical model by being diagnosed with a mental illness (Butler, 2009; Gagne, Tewksbury, & McGaughey, 1997). The DSM V addressed this concern by stating it "aims to avoid stigma and ensure clinical care" (APA, 2013, p. 1) by removing the Gender Identity Disorder, which assumes a mental disorder, with Gender Dysphoria. However, current controversy over the DSM V makes its suggestions less than stable.

Some practitioners, both mental health and medical, highlight the need to work with the diagnosis in order to offer best practice. In fact, debate and research in the Netherlands and Boston in the U.S. posit early diagnosis and treatment of GID, before puberty, may lessen the psychological distress of the developing body as different from the internal sense of self and underscore the importance of early detection and action (Cohen-Kettenis et al., 2008). Many in the mental health and medical profession, however, resist diagnosing an adolescent with unrelenting GID until after puberty when the brain has been exposed to natal sex hormones (Cohen-Kettenis et al.). Countering, some researchers argue that early detection and intervention reduces social and psychological stress, as well as physiological problems of transitioning later in life

(Cohen-Kettenis et al.). Caution in diagnosing children with GID is warranted, however, as highlighted by Cohen-Kettenis et al., as current research suggests between 80-95% of GID symptoms in prepubescent children decrease or disappear by puberty. Whether diagnosed or not and whether the struggle originates within the individual or more a result of the individual in relation to and with a two-gender normed culture and society, the individual's internal, felt experience can be impacted.

Shame

Numerous studies identify shame as having a central role in self-harming behaviors, suicidal ideations and attempts, depression, isolation, minimization of abuse, anger proneness, and decreased self-esteem (McDermott, Roen, & Scourfield, 2008; Rizvi, 2010). Shame is defined as a global self-evaluation of being a failure, damaged, inadequate, and worthless (Gilbert et al., 2010; Mann, 2010; Montgomery, 2006). It is connected to identity and creates feelings of helplessness, weakness, and inferiority (Gilbert et al., 2010; Mann, 2010; Montgomery, 2006). According to Pinto-Gouveia and Matos (2011), shame plays a significant role in self-identity and one's beliefs and emotions regarding social suitability and desirability. When believed to be unsuitable and undesirable, shame can be experienced such that methods for coping, to include avoidance, social withdrawal, attempts to escape, or otherwise hide, are deemed necessary (Bennett, Sullivan, & Lewis, 2010). However, for gender variant people, there is often no escape (Proyer, Platt, & Ruch, 2010). As such, defenses or coping mechanisms are needed in order to offer a sense of protection in an environment experienced as unsafe (Livingston, 2006).

Shame has been extensively researched across numerous sample populations (Gilbert et al., 2010; Mann, 2010; McDermott et al., 2008; Montgomery, 2006; Rizvi, 2010). Experiencing the self as damaged or flawed causes an individual to seek coping strategies, some which have been documented to include: self-harming behaviors, displays of anger, and isolation (McDermott et al., 2008; Rizvi, 2010). Moving from behavioral expressions to affect, felt shame has been identified in mental health disturbances such as depression and anxiety (Pinto-Gouveia & Matos, 2011; Proyer et al., 2010). A sense of belonging is essential for mental health and is blocked by one's experience of shame.

Thwarted Belongingness

"These people looked like they knew where they belonged. There was no place for me to feel comfortable with anybody or anything." (Joiner & Van Orden, 2008, p. 86) To belong is a fundamental human need. Gilbert (2010) highlighted the importance of belonging this way:

> We are all born with the need to connect to other minds and feel cared for. This blossoms into desires to socially connect in one's group; to find acceptance and social belonging to facilitate helpful relationships; to be wanted, appreciated and valued. If we achieve this then our worlds are much safer (and our threat systems settle) in contrast to not being valued or wanted, rejected or struggling alone. Helpful relationships are physiologically regulating. (p. 83)

Social support shields and protects individuals with suicidal ideations and self-harming behaviors and appears to be related to increased resilience (Hjemdal et al., 2011; Selby et al., 2010; Wu, Stewart, Huang, Prince, & Liu, 2011). Researchers have identified thwarted belongingness as a psychological predictor of suicidal and self-

harming behaviors (Anestis & Joiner, 2011; Joiner & Van Orden, 2008; Mathy et al., 2003). Selby et al. (2010) defined thwarted belongingness is the inability to experience positive social connections and be cared for by others, with thwarted implying an attempt to connect that is met with rejection. Thwarted belongingness can also be activated by feeling deeply misunderstood by those close (Anestis & Joiner). Two of the three protective factors of resilience include family support and social support outside of one's family (Hjemdal et al.). Indeed, being both seen and understood is a basic human need that cultivates internal awareness and connection with others and contributes to feelings of resilience (Gilbert, 2010; Hjemdal et al., 2011). However, being deeply and accurately seen and understood can be a challenge for trans people beginning early in life (Mizock & Lewis, 2008).

Development of gender identity and sense of belonging seem to go hand in hand, as feelings of separateness and being different can be experienced as a young child. Gender variant expressions are often noted before age 3, and children begin to notice differences by kindergarten when behaviors of other students differ from theirs, and children are divided by gender ranging from sports to bathroom use or forming lines (Perrin et al., 2010).

Thus, in an attempt to fit in and avoid stigmatization and marginalization, trans people may hide their true identity, which can result in feelings and experiences of being inauthentic, which can lead to isolation, and ultimately, maladaptive behaviors as means for coping (Craig, Tucker, & Wagner, 2008; Nuttbrock et al., 2009; Schrock et al., 2004).

Accordingly, isolating and masking one's true self may be risk factors to the protection offered by resilience.

Self-Harm

Disagreement over the operational definition of self-harm exists. Some define deliberate self-harm as behavior not necessarily indicative of suicidal intent (Brown & Chapman, 2007; Daigle, Pouliot, Chagnon, Greenfield, & Mishara, 2011; Gratz & Tull, 2011; Lewis, Rosenrot, & Santor, 2011; Skegg, 2005; Wu et al., 2011). Others include suicidal intent in assessing self-harming behaviors (Boyce, Oakley-Browne, & Hatcher, 2001). Interpersonal Psychology tenets suggest self-harming behaviors, whether or not suicide intent is present, increases physical pain tolerance, decreases the fear of dying, and overrides the human drive toward self-preservation, thus moving the individual closer to the possibility of completed suicide (Joiner & Van Orden, 2008; Joiner, Van Orden, Witte, & Rudd, 2009; Ougrin & Latif, 2011).

Many who engage in deliberate self-harm lack problem-solving skills and tend to use passive or avoidant styles in response to problems (Brown & Chapman, 2007). On the other hand, traits of those considered resilient, such as positive self-perception, internal locus of control, and social and familial support, offer protection from self-harm (Hjemdal et al., 2011). The experimental avoidance model posits individuals who engage in self-harm are attempting to avoid or escape unwanted emotions, thoughts, and struggles as opposed to seeking support from family or friends (Brown & Chapman). Furthermore, self-harm has been related to early childhood shaming and abuse experiences (Skegg, 2005); emotional, physical, and sexual abuse often lead to feelings

of self-hatred and shame, which may influence the avoidance of help seeking behaviors, while increasing the likelihood of engaging in self-harming behaviors (Gilbert et al., 2010). Intrapersonal and interpersonal protective factors of resiliency support healthy adaptation and increase hardiness, which may combat self-harming behaviors (Jowkar, Friborg, & Hjemdal, 2010). Sixteen to thirty-seven percent of transgender research participants reported attempting suicide, while as many as 64% of participants reported suicidal ideations (Mizock & Lewis, 2008). While the experience of shame may cause transgender individuals to engage in coping strategies that make them among the highest in self-harming behaviors, it may be speculated that many are able to access the protective factors of resiliency and engage in self-affirming coping mechanisms.

Resiliency

The origins of resiliency are found in the field of medicine. In the 1950s, resiliency was adopted by the social and behavioral sciences as investigations began to identify resiliency attributes noted in children raised in adverse environments (Reicherzer & Spillman, 2011). The construct of resilience has experienced much iteration of human focus, such as, but not limited to, youth, veterans, childhood survivors of sexual abuse, Romanian adoptees victims of bullying, and those individuals with learning disabilities (Zolkoski & Bullock, 2012).

The study of resilience provides several challenges for researchers due to differing definitions and terminology (Reicherzer & Spillman, 2011). Smith et al. (2008) operationalized resilience as the "ability to bounce back or recover from stress, to adapt to stressful circumstances, to not become ill despite significant adversity, and to function

above the norm in spite of stress or adversity" (p. 194). According to Zolkoski and Bullock (2012), "resilience is not a one-dimensional dichotomous attribute that an individual has or does not have" (p. 2296). Resilience is "the ability of individuals to adapt successfully in the face of acute stress, trauma, or chronic adversity, maintaining or rapidly regaining psychological well-being and physiological homeostasis" (Rose et al., 2013, p. 107).

Resilience may be context and content specific depending on one's response to differing stressors (Zolkoski & Bullock, 2012). Herrick, Stall, Goldhammer, Egan, and Mayer (2013) offered a fitting definition, "the process of overcoming the negative effects of risk exposure, coping successfully with traumatic experiences, and avoiding the negative trajectories associated with risk" (p. 2). In addition, Herrick et al. viewed resilience as a learned process developed over time, where protective factors are created in response to adversity.

Resilience is a process that is learned through adversity and is not experienced in the absence of a significant stressor and/or stressors; risk must be discernible (Orbkes & Smith, 2013; Zolkoski & Bullock, 2012). According to Jowkar et al. (2010), the study of resiliency is integrative and examines vulnerabilities, stressors, risks to mental health, as well as strengths and protective factors, and is preventative in nature. However, there is debate as to whether resiliency is a process (Jackson, Wolven, & Aguilara, 2013) or a personality trait. According to Zolkoski and Bullock, all humans are born with the capacity for resilience, which is part of the basic adaptive process of humans. Many resiliency researchers agree there appears to be some protective factors to stressors that

include individual characteristics or attributes, a healthy and supportive family environment, and support outside of the family of origin (Hash & Rogers, 2013; Herrick et al., 2013; Hjemdal et al., 2011; Orbkes & Smith). However, identifying a set of universal protective factors may be challenging in light of content and context specificity (Anthony & Robbins, 2012; Zolkoski & Bullock).

Researchers identified three main stages in resiliency development in children and adolescence (Zolkoski & Bullock, 2012). First, researchers sought to understand resilience and prevent psychopathology. Second, researchers explored the protective factors of resiliency. And finally, researchers addressed the needs of children growing up in adverse environments and focused on prevention, intervention, and policy (Zolkoski & Bullock). Internalized symptoms, such as depression and anxiety, were markedly higher in youth exposed to chronic stressors in disorganized and emotionally unstable home environments, divorce, domestic teen pregnancy, as well as biological stressors, such as congenital defects; the daily changes experienced during puberty also increased anxiety and depression in adolescents (Sheidow, Henry, Tolan, & Strachan, 2013; Zolkoski & Bullock). In addition, domestic violence has been shown to diminish resiliency in youth (Sirikantraporn, 2013). Resiliency is also affected by minority status and discrimination (Zolkoski & Bullock). However, according to Orbkes and Smith (2013), one-third of children exposed to the aforementioned stressors become functional and competent adults. It is important to understand not only what places children and youth at risk but also the protective factors that increase resilience (Zolkoski & Bullock). Family functioning, nurturing and caring parents, and family relationships play an important role

in resiliency outcomes in youth with high functioning families offering a buffer to stress exposure (Anthony & Robbins, 2012; Sheidow et al., 2013; Sirikantraporn, 2013). Sheidow et al. and Sirikantraporn suggested bolstering services for parenting as a way to increase resiliency in youth.

Protective factors of resilience in children and adolescents are similar to what has been shown as protective factors of resilience for adults. These protective factors include, but are not limited to, social competence, ability to solve problems, critical consciousness, autonomy, and a sense of purpose (Anthony & Robbins, 2012; Hash & Rogers, 2013; Herrick et al., 2013; Zolkoski & Bullock, 2012). Resiliency is affected both intrapersonally and interpersonally (Orbkes & Smith, 2013). Examples of intrapersonal and interpersonal protective factors of resiliency are:

1. Psychological/dispositional skills and attributes of the individual;
2. Family support and a family climate of cohesion; and
3. Presence of external support systems that reinforce efficient coping and adjustment. (Jowkar et al., 2010, p. 418; see also Hjemdal et al., 2011; Smith et al., 2008)

Many studies of resiliency focus on intrapersonal strengths and protective factors (Hash & Rogers, 2013; Jowkar et al., 2010; Sheidow et al., 2013). Some assess the ability to bounce back from stress as opposed to focusing on the protective factors of resilience (Smith et al., 2008). While this approach is important, stress for transgender individuals is possibly chronic, thus exploring a more complete experience of internal and external vulnerabilities, stressors, strengths, and protective factors is more fitting.

"There have been numerous empirical studies of resilience, but few are sensitive to community and cultural factors that contextualize how resilience is manifested and understood within diverse populations" (Jackson et al., 2013, p. 216). As a marginalized population, transgender studies would be most effective if the interpersonal impact of protective factors, such as family cohesion and social resources, were examined. This assessment may reveal key components lacking with transgender individuals (Mizock & Lewis, 2008). In fact, Hjemdal et al. (2011) noted that resilient individuals turn to social support and their families in times of crisis, which may not be possible for individuals who identify as transgender. So what factors conserve mental health despite exposure to health and safety hazards or psychosocial adversity? The Resilience Scale for Adults (RSA) was developed to answer such a question (Hjemdal et al., 2011).

The Resilience Scale for Adults (RSA) is a multidimensional scale created to measure the general characteristics of resilience, which include the protective factors believed to enhance resilience (Jowkar et al., 2010). Unlike many scales preceding it, the RSA highlights the social and family aspects of resilience, as well as personal competence and personal structure (Jowkar et al.). Higher levels of the aforementioned protective factors have been found to be correlated with lower levels of psychological disturbances and pathology (Friborg, Hjemdal, Martinussen, & Rosenvinge, 2009; Hjemdal, Friborg, Stiles, Rosenvinge, & Martinussen, 2006). The authors of the RSA aimed to identify these protective factors.

Several differences appeared in RSA outcomes with regard to gender (Hjemdal et al., 2011). This outcome may be of particular interest in exploring the experience of

resilience with transgender individuals. Of the five factors of resiliency studied, Social Competency, Social Resources, Family Cohesion, Personal Competency, and Structured Style, male participants rated higher on Perception of Self and women scored rated themselves higher on Structured Style and Social Resources (Hjemdal et al., 2011). Differences supported by previous studies stated men as feeling more personally competent than women, while women identified more closely with social support. According to the Belgian samples of the RSA, women rated themselves as more structured than men (Hjemdal et al.).

An extensive body of research has been dedicated to the study of resilience. However, what appears to be lacking is how these findings relate to specific populations and contexts (Anthony & Robbins, 2012). Research centered on gay and bisexual men HIV prevention efforts notes the efficacy of focusing on resilience as opposed to deficit-based approaches that has long been the focus of study (Smith & Grey, 2009; Herrick et al., 2013). King and Orel (2012) noted a correlation between higher resiliency and decreased mental health disturbance, which included less clinical depression and a decrease in suicidal ideations and attempts in midlife and older gay men with HIV/AIDS.

Research has been conducted to explore the experience of resilience with other minority groups, such as Mexican-Americans. Ethnic discrimination is characterized by negative stereotypes, negative behaviors directed at the individual with minority status, and prejudicial comments, all of which are similarly experienced with trans people (Jackson et al., 2013). As with ethnic and mixed ethnic minorities, trans people often have to field questions about what and who they are that would not be asked of

individuals who clearly meet the culture's definition. Participants demonstrated a link between negative identity and identity experiences to "feelings of identity confusion, isolation, and exclusion" (Jackson et al., p. 218).

Several qualitative studies have examined the lived experiences of trans people in relation to resilience. Reicherzer and Spillman (2011) examined how resilience manifested with three transgender women of Mexican origin who worked as entertainers. Resiliency factors noted in this study were community involvement and giving back, as well as recognizing accountability, knowing what was their responsibility and what was others', self-acceptance, and family cohesiveness. In addition, spirituality played an important role with each participant (Reicherzer & Spillman).

Singh et al. (2011) explored resiliency as it relates to trans people in a qualitative study of 21 participants. Resiliency factors identified included social activism and supporting other trans people. Additional factors included community support, an optimistic attitude about the future, understanding of oppression, and self-worth and knowledge (Singh et al.).

Bockting et al. (2013) analyzed data from a previous study ($N = 1093$) to determine associations between depression, anxiety, somatization, and stigma, as well as resiliency among trans people. Four questions addressed the impact family and peers had on moderating psychological distress. Findings suggested family and peer support as necessary in order to ameliorate psychological distress.

The challenge of being true to self, when risk of social rejection exists, places a gender nonconforming trans person in a quandary: live authentically and risk societal and

familial rejection, even violence, or attempt inauthenticity by presenting an incongruent persona. Supporting this dichotomy, previous study findings indicate emotional distress suffered by trans people may be less about internal gender identity struggles and more about the struggle of living in an unaccepting, sometimes unsafe social environment (Mizock & Lewis, 2008; Nuttbrock et al., 2010). Gaining increased understanding and awareness about intrapersonal and interpersonal pressures and resilience of trans people will help providers offer more complete support in order to decrease the current statistics that identify this population with the highest rates of self-harm and suicide completions of the general population (Mizock & Lewis). Studying resiliency of trans people will further inform practitioners on strengths and offer guidance on how to increase resiliency in those individuals struggling to belong or engulfed in shame and self-loathing. Likewise, resiliency interventions on a macro level may help advocates support societal change (Craig et al., 2008; Mizock & Lewis).

Implications

While the experience of shame and thwarted belonging may cause trans people to engage in maladaptive coping strategies that make them among the highest in self-harming behaviors, it may be supposed that many are able to access the protective factors of resiliency and engage in self-affirming coping mechanisms. Similar to public health field, psychotherapy has tended to focus on the associations with mental illness as opposed to protective factors that promote health (Mizock & Lewis, 2008; Smith & Grey, 2009). However, according to Herrick et al. (2013), gay and bisexual men have been able to overcome internalized homophobia despite continued experiences of discrimination

and marginalization that promotes self-loathing. While much of the current research focus is on behavioral modification, the focus on strengths and building community seems of value considering issues transgender people face. Capitalizing on skills and strengths could greatly improve support for trans people (Mizock & Lewis).

A broad descriptive study of trans people and resiliency has not been conducted to highlight current strengths, as well as provide guidance in increasing resilience. Findings from such a study would offer increased understanding of protective factors of trans people, as well as resiliency factors that need to be cultivated with this population.

In reviewing relevant literature on resilience, conclusions can be drawn. A correlation exists between resilience and family and friend or community support as well as individual characteristics (Hjemdal et al., 2011; Orbkes & Smith, 2013). Trans people often do not have the support of family and the culture (Craig et al., 2008; Mizock & Lewis, 2008; Nuttbrock et al., 2009; Perrin et al., 2010). In light of current findings on resiliency and statistics pointing to high suicide ideations and completion with trans people, future research is necessary in order to assess a sample of trans people's experience of resiliency (Mizock & Lewis). Researchers will do well to capture unique participant characteristics so as to allow for more precise interpretation of findings to address both the struggles, as well as highlight the strengths of trans people and guide the development of strength-based approaches (Mizock & Lewis).

Conclusion

Trans people are considered a marginalized population in this culture's binary gender system; challenges to a culturally and socially accepted binary gender system

often place the transgender individual on the periphery of society. The cultural and social expectation, enforced by systems such as, but not limited to, families, institutions, politics, and religion, leave little leeway for the gender-fluid individual (Gagne et al., 1997). Due to the culture's discrimination and lack of knowledge, many trans people are viewed as vulnerable and fragile, unable to make decisions for gender expression on their own (Carroll et al., 2002). There are considerable psychological challenges with being a member of a social minority (Craig et al., 2008). While deficit-based research and intervention is important, what should also be noted are the incredible strengths and resiliency needed in order to survive and thrive as a marginalized population (Mizock & Lewis, 2008).

Trans people may play a significant role in understanding resilience. A wellness focus could lead to better community services as well as counter the focus on deficits. Research focusing on the lived experiences of midlife and older gay men with HIV/AIDS revealed that stigma and internalized homophobia and discrimination based on sexual orientation decreased resiliency (King & Orel, 2012). Reicherzer and Spillman (2011) noted strength and resiliency focus corresponds with the wellness focus stressed in the World Professional Association of Transgender Heath (WPATH, 2011) Standards of Care.

Chapter 2 References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. text revision). Washington, DC: Author.

American Psychiatric Association. (2013). Gender dyphoria. Retrieved from www.psychiatry.org

Anestis, M. D., & Joiner, T. E. (2011). Examining the role of emotion in suicidality: Negative urgency as an amplifier of the relationship between components of the interpersonal-psychological theory of suicidal behavior and lifetime number of suicide attempts. *Journal of Affective Disorders, 129*, 261-269.

Anthony, E. K., & Robbins, D. E. (2012). A latent class analysis of resilient development among early adolescents living in public housing. *Child and Youth Services Review, 35*, 82-90.

Bennett, D. S., Sullivan, M. W., & Lewis, M. (2010). Neglected children, shame proneness, and depressive symptoms. *Child Maltreatment, 15*(4), 305-314.

Bockting, W. O., Miner, M. H., Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience among an online sample of the U.S. transgender population. *American Journal of Public Health, 103*(5), 943-951. doi: 10.2105/AJPH.2013.301241

Boyce, P., Oakley-Browne, M. A., & Hatcher, S. (2001). The problem with deliberate self-harm. *Current Opinion in Psychiatry, 14*(2), 107-111.

Brown, M. Z., & Chapman, A. L. (2007). Stopping self-harm once and for all: Relapse prevention in Dialectical Behavior Therapy. *Therapist's Guide to Evidence-Based Relapse Prevention, 3*, 191-214.

Butler, C. (2009). Sexual and gender minority therapy and systemic practice. *The Association for Family Therapy, 31*, 338-358.

Carroll, L., Gilroy, P. J., & Ryan, J. (2002). Counseling transgendered, transsexual, and gender-variant clients. *Journal of Counseling and Development, 80*, 131-139.

Cohen-Kettenis, P. T., Delemarre-van de Waal, H., & Gooren, L. J. (2008). The treatment of adolescent transsexuals: Changing insights. *International Society for Sexual Medicine, 5*(8), 1892-1897.

Choma , B. L., Visser, B. A., Pozzebon, J. A., Bogaert, A. F., Busseri, M. A., & Sadava, S. W. (2010). Self-objectification, self-esteem, and gender: Testing a moderated mediation model. *Sex Roles, 63*, 645-656.

Connell, C. (2010). Doing, undoing, or redoing gender? Learning experiences from the workplace experiences of transpeople. *Gender & Society, 24*(1), 31-55.

Coolhart, D., Provancher, N., Hager, A., & Wang, M. (2008). Recommending transsexual clients for gender transition: A therapeutic tool for assessing readiness. *Journal of GLBT Family Studies, 4*(3), 301-324.

Craig, S. L., Tucker, E. W., & Wagner, E. F. (2008). Empowering lesbian, gay, bisexual, and transgender youth: Lessons learned from a safe schools summit. *Journal of Gay and Lesbian Social Services, 20*(3), 237-252.

Daigle, M. S., Pouliot, L., Chagnon, F., Greenfield, B., & Mishara, B. (2011). Suicide attempts: Prevention of repetition. *The Canadian Journal of Psychiatry, 56*(10), 621-629.

Friborg, O., Hjemdal, O., Martinussen, M., & Rosenvinge, J. H. (2009). Empirical support for resilience as more than the counterpart and absence of vulnerability and symptoms of mental disorder. *Journal of Individual Differences, 30*(3), 138-151.

Gagne, P., Tewksbury, R., & McGaughey, D. (1997). Coming out and crossing over: Identity formation and proclamation in a transgender community. *Gender & Society, 11*(4), 478-508.

Gilbert, P. (2010). *Compassion focused therapy.* New York, NY: Routledge.

Gilbert, P., McEwan, K., Irons, C., Bhundia, R., Christie, R., Broomhead, C., & Rockliff, H. (2010). Self-harm in a mixed clinical population: The roles of self-criticism, shame, and social rank. *British Journal of Clinical Psychology, 49*, 563-576.

Gratz, K. L., & Tull, M. T. (2011). Extending research on the utility of an adjunctive emotion regulation group therapy for deliberate self-harm among women with borderline personality pathology. *American Psychological Association, 2*(4), 316-326.

Hanssmann, C., Morrison, D., & Russian, E. (2008). Talking, gawking, or getting it done: Provider trainings to increase cultural and clinical competence for transgender and gender-nonconforming patients and clients. *Sexuality Research and Social Policy, 5*(1), 5-23.

Hash, K. M., & Rogers, A. (2013). Clinical practice with older LGBT clients: Overcoming lifelong stigma through strength and resilience. *Journal of Clinical Social Work.* doi:10.1007/s10615-013-0437-2

Herrick, A. L., Stall, R., Goldhammer, H., Egan, J. E., & Mayer, K. H. (2013). Resilience as a research framework and as a cornerstone of prevention research for gay and bisexual men: Theory and evidence. *AIDS Behavioral.* doi:10.1007/s10461-012-0384-x

Hjemdal, O., Friborg, O., Braun, S., Kempenaers, C., Linkowski, P., & Fossion, P. (2011). The Resiliency Scale for Adults: Construct validity and measurement in a Belgian sample. *International Journal of Testing,* 11, 53-70.

Hjemdal, O., Friborg, O., Stiles, T., Rosenvinge, J. H., & Martinussen, M. (2006). Resilience predicting psychiatric symptoms: A prospective study of protective factors and their role in adjustment to stressful life events. *Clinical Psychology and Psychotherapy, 13*, 194-201.

Hughes, T. L., & Eliason, M. (2002). Substance use and abuse in lesbian, gay, bisexual, and transgender populations. *The Journal of Primary Prevention, 22*(3), 263-298.

Jackson, K. F., Wolven, T., & Aguilara, K. (2013). Mixed resilience: A study of multiethnic Mexican American stress and coping in Arizona. *Interdisciplinary Journal of Applied Family Studies, 62*, 212-225.

Joiner, T. E., & Van Orden, K. A. (2008). The interpersonal-psychological theory of suicidal behavior indicates specific and crucial psychotherapeutic targets. *International Journal of Cognitive Therapy, 1*(1), 80-89.

Joiner, T. E., Van Orden, K. A., Witte, T. K., & Rudd, M. D. (2009). *The interpersonal theory of suicide: Guidance for working with suicidal clients.* Washington, DC: American Psychological Association.

Jowkar, B., Friborg, O., & Hjemdal, O. (2010). Cross-cultural validation of the Resilience Scale for Adults (RSA) in Iran. *Scandinavian Journal of Psychology, 51*, 418-425.

King, S. D., & Orel, N. (2012). Midlife and older gay men living with HIV/AIDS: The influence of resiliency and psychological stress factors on health needs. *Journal of Gay and Lesbian Social Services, 24*, 346-370.

Kulish, N. (2010). Clinical implications of contemporary gender theory. *Journal of the American Psychoanalytic Association, 58*(2), 231-258.

Lewis, S. P., Rosenrot, S. A., & Santor, D. A. (2011). An integrated model of self-harm: Identifying predictors of intent. *Canadian Journal of Behavioral Science, 43*(1), 20-29. doi:10/1037/a0022076

Livingston, L. R. (2006). No place to hide: The group leader's moments of shame. *International Journal of Group Psychotherapy, 56*(3), 307-323.

Mann, M. (2010). Shame veiled and unveiled: The shame affect and its re-emergence in the clinical setting. *The American Journal of Psychoanalysis, 70*, 270-281.

Mathy, R. M. (2002). Transgender identity and suicidality in a nonclinical sample: Sexual orientation, psychiatric history, and compulsive behaviors. *Journal of Psychology and Human Sexuality, 14*(4), 47-65.

Mathy, R. M., Lehmann, B. A., & Kerr, D. L. (2003). Bisexual and transgender identities in a nonclinical sample of North Americans: Suicidal intent, behavioral difficulties, and mental health treatment. *Journal of Bisexuality, 3*(3-4), 93-109.

McDermott, E., Roen, K., & Scourfield, J. (2008). Avoiding shame: Young LGBT people, homophobia and self-destructive behaviors. *Culture, Health and Sexuality, 10*(8), 815-829.

McKensie, S. (2010). Genders and sexualities in individuation: Theoretical and clinical explorations. *Journal of Analytical Psychology, 55*, 91-111.

Mizock, L., & Lewis, T. K. (2008). Trauma in transgender populations: Risk, resilience, and clinical care. *Journal of Emotional Abuse, 8*(3), 335-354.

Montgomery, C. (2006). The virtue of depression in the secret life of shame: A group-analytic perspective. *Group Analysis, 39*(1), 73-85.

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.

Nuttbrock, L., Hwahng, S., Bockting, W., Rosenblum, A., Mason, M., Marci, M., & Becker, J. (2010). Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons. *Journal of Sex Research, 47*(1), 12-23.

Orbkes, S., & Smith, H. L. (2013). A developmental framework for enhancing resiliency in adult survivors of child abuse. *International Journal for Advanced Counseling, 35*, 46-56.

Ougrin, D., & Latif, S. (2011). Specific psychological treatment versus treatment as usual in adolescents with self-harm: Systematic review and meta-analysis. *Crisis, 32*(2), 74-80.

Perrin, E., Smilth, N., Davis, C., Spack, N., & Stein, M. T. (2010). Gender variant and gender dysphoria in two young children. *Journal of Developmental and Behavioral Pediatrics, 31*(2), 161-164.

Pinto-Gouveia, J., & Matos, M. (2011). Can shame memories become a key to identity? The centrality of shame memories predicts psychopathology. *Applied Cognitive Psychology, 25*(2), 281-290.

Proyer, R. T., Platt, T., & Ruch, W. (2010). Self-conscious emotions and ridicule: Shameful gelotophobes and guilt free katagelasticists. *Personality and Individual Differences, 49*, 54-58.

Reicherzer, S., & Spillman, J. (2011). A Multiple case study examination of resiliency factors for Transgenderism, *International Journal of Transgenderism, 13*, 147-164.

Rizvi, S. L. (2010). Development and preliminary validation of a new measure to assess shame: The Shame Inventory. *Psychopathological Behavioral Assessment, 32*, 438-447.

Rose, R. D., Buckly, J. C., Jr., Zbozinek, T. D., Motivala, S. J., Glenn, D. E., Caftreine, J. A., & Craske, M. G. (2013). A randomized controlled study of a self-guided, multimedia, stress management, and resilience training program. *Behavioral Research and Therapy, 51*, 106-112.

Schilt, K., & Westbrook, L. (2009). Doing gender, doing heteronormativity, "gender normals," transgender people, and the social maintenance of heterosexuality. *Gender & Society, 23*(4), 440-464.

Schrock, D., Holden, D., & Reid, L. (2004). Creating emotional resonance: Interpersonal emotion work and motivational framing in a transgender community. *Social Problems, 51*(1), 61-81.

Selby, E. A., Anestis, M. D., Bender, T. W., Ribeiro, J. D., Nock, M. K., Rudd, M. D., & Joiner, T. E., Jr. (2010). Overcoming the fear of lethal injury: Evaluating suicidal behavior in the military through the lens of the Interpersonal-Psychological Theory of Suicide. *Clinical Psychology Review, 30*, 298-307.

Sheidow, A. J., Henry, D. B., Tolan, P. H., & Strachan, M. K. (2013). The role of stress exposure and family functioning in internalizing outcomes of urban families. *Journal of Child and Family Studies*. doi:10.1007/s10826-103-9793-3

Singh, A. A., Hays, D. G., & Watson, L. S. (2011). Strength in the face of adversity: Resilience strategies of transgender individuals. *Journal of Counseling and Development, 89*, 20-27.

Sirikantraporn, S. (2013). Biculturalism as a protective factor: An exploratory study on resilience and the bicultural level of acculturation among Southeast Asian American youth who have witnessed domestic violence. *Asian American Journal of Psychology, 4*(2), 109-115.

Skegg, K. (2005). Self-harm. *Lancet, 366*(9495), 1471-1483. Retrieved from www.thelancet.com

Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The Brief Resilience Scale: Assessing the ability to bounce back. *International Journal of Behavioral Medicine, 15*, 194-200.

Smith, M. S., & Gray, S. W. (2009). The courage to challenge: A new measure of hardiness in LGBT adults. *Journal of Gay and Lesbian Social Studies, 21,* 73-89.

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner, T. E. (2010). The Interpersonal Theory of Suicide. *Psychological Review, 117*(2), 575-600.

World Professional Association for Transgender Health (WPATH). *Standards of care (SOC)*. Retrieved from www.psychiatry.org

Wu, C.-Y., Stewart, R., Huang, H.-C., Prince, M., & Liu, S.-I. (2011). The impact of quality and quantity of social support on help-seeking behavior prior to deliberate self-harm. *General Hospital Psychiatry, 33*, 37-44.

Zolkoski, S. M., & Bullock, L. M. (2012). Resilience in children: A review. *Children and Youth Services Review, 34*, 2295-2303.

CHAPTER 3: DISSERTATION STUDY

Assessing Intrapersonal and Interpersonal Resilience Factors Among Trans People: A Descriptive Study.

Liesl M. Farnsworth

Oregon State University

Daniel Stroud

Oregon State University – Cascade

Abstract

Resilience has been researched extensively; however, resilience research specific to trans people is limited. What studies have been conducted highlight need for more (Bockting, Miner, Romine, Hamilton, & Coleman, 2013; Hill, 2007; Mizock & Lewis, 2008; Reicherzer & Spillman, 2011; Singh, Hays, & Watson, 2011). The purpose of this descriptive study was to assess resiliency among a diverse cross-section of trans people (N = 151). Participants completed demographic questionnaire items and the Resilience Scale for Adults (RSA). The RSA is a multidimensional measure composed of three intrapersonal factors: Social Competence, Personal Competence, Structured Style; and two interpersonal factors: Social Resource and Family Cohesion. Findings suggest trans people score highest on Personal Competence (M = 3.99*, SD* = .93*)* and lowest on Family Cohesion (M = 3.14, SD = 1.27). In addition, participants' overall intrapersonal factors scores (M = 3.81, SD = .16) were significantly higher than their overall interpersonal factors scores (M = 3.47, SD =.48); $t(301) = 14.06$, $p < .001$ (d = .95). Detailed findings are presented and implications discussed.

Key words: Resiliency; shame; thwarted belongingness; deliberate self-harm; trans people.

Introduction

Transgender is an umbrella term intended to include those for whom a binary gender identification system does not fit: be it lack of identification with one's natal sex, gender role, or other form of embodiment or expression (Carroll, Gilroy, & Ryan, 2002; Connell, 2010). Literature in this area illustrates challenges for trans people above and beyond what many individuals and subgroups of the general population experience (Hanssmann, Morrison, & Russian, 2008; Hughes & Eliason, 2002). If these challenges are not met well, the consequence could be devastating, as suicide rates of trans people are among the highest in the nation (Eliason, 2011; Mathy, 2002; Mathy, Lehmann, & Kerr, 2003; Walls, Freedenthal, & Wisneski, 2008). However, research on protective factors, such as resiliency, specific to trans people, is lacking. In setting the foundation for this study, we discuss resiliency as a protective factor against shame, thwarted belongingness, and self-harm related to concerning aspects of trans people's lived experience.

Risk factors, such as shame, have been researched in varying degree and form (Eliason, 2011; Mathy et al., 2003; McDermott, Roen, & Scourfield, 2008; Nuttbrock et al., 2010; Walls et al., 2008). Operationalized as global self-evaluation of being a failure, damaged, inadequate, and worthless, shame, in turn, contributes to feelings of helplessness and inferiority (Gilbert et al., 2010; Mann, 2010; Montgomery, 2006). Pinto-Gouveia and Matos (2011) highlighted shame, by way of shame-central memories, as influential in identity development as one's beliefs and emotions regarding self-suitability and desirability are being formed and present as a potential predictor of psychopathology.

Feeling and believing one is neither suitable nor desirable can be experienced from a young age for many reasons: race, ethnicity, religion, culture, language, age, and gender, to name a few. Researchers have identified gender variant expressions, often before age three (Perrin, Smilth, Davis, Spack, & Stein, 2010). As children grow, as early as pre-school or kindergarten, differences are noticed—by self and others—when behaviors of other children differ from their own. A potential consequence occurs as friendships, often of the same-sex, are being cultivated; and genders are being separated for reasons ranging from sports to bathroom use (Perrin et al.). A child may struggle when attempting to figure out developmental questions, such as *who am I; who am I in relation with others; and who am I in relation to the world in general*, when a sense of gender group identification, and the sense of belonging it can provide, are missing (Pinto-Gouveia & Matos, 2011). Indeed, identification with and expression of one's gender involves social learning—through interactions and cultural influence—and when internal experience is not congruent with dichotomous female or male status with which to identify, a sense of un-belonging and isolation can result (Gagne, Tewksbury, & McGaughey, 1997).

The importance of a sense of belonging cannot be overstated and is well captured by Gilbert (2010) who wrote:

> We are all born with the need to connect to other minds and feel cared for. This blossoms into desires to socially connect in one's group; to find acceptance and social belonging to facilitate helpful relationships; to be wanted, appreciated and valued. If we achieve this then our worlds are much safer (and our threat systems settle) in contrast to not being valued or wanted, rejected or struggling alone. Helpful relationships are physiologically regulating. (p. 83)

Lack of belonging, or thwarted belongingness as it has been termed, refers to one's inability to experience positive social interactions and care from others and can be activated by feeling misunderstood, or otherwise rejected, by those close, such as family and community (Selby et al., 2010). When perceived as rejection from those close, vulnerability to, and likelihood of, deliberate self-harming behavior may increase (Bockting et al., 2013; Wu, Stewart, Huang, Prince, & Liu, 2011).

Research related to trans people has focused mostly on vulnerabilities and pathologies (Hill, 2005; Hughes & Eliason, 2002; Mizock & Lewis, 2008; Nuttbrock et al., 2010; Perrin et al., 2010). However, a shift in focus is beginning to show in the literature as calls have been made for researchers to broaden focus to explore strengths and wellness attributes, such as resiliency of trans people. (Hill; Mizock & Lewis; Singh et al., 2011). Shift in focus is important as depathologizing transgenderism is considered a necessary step in supporting trans people (Mathy, 2002; Mizock & Lewis). To date, what has previously been viewed as pathological may be less about intrapersonal struggles regarding gender identity and more about the struggle of living on the fringes of society (Bockting et al., 2013; Mizock & Lewis; Nuttbrock et al.).

Resilience as a construct has been defined as a set of learned behaviors evolving from an individual's system of beliefs that precedes one's ability to cope (Jew, Green, & Kroger, 1999). Resiliency pertains to the resources an individual has available to be able to deal with stressful situations (Singh et al., 2011). Essentially, resiliency is a process learned through adversity (Orbkes & Smith, 2013; Zolkoski & Bullock, 2012). Drawing

upon some 30 years research, three broad categories of the protective factors of resiliency were identified:

1. Psychological/dispositional skills and attributes of the individual;
2. Family support and a family climate of cohesion; and
3. Presence of external support systems that reinforce efficient coping and adjustment. (Jowkar, Friborg, & Hjemdal, 2010, p. 418)

Further, resiliency scales typically overlook social and family aspects of resilience, as they were designed to focus on individuals' dispositional attributes (Jowkar et al.). In contrast, the Resiliency Scale for Adults (RSA) was designed to measure multidimensional aspects of resilience.

To date, several studies highlighting resiliency and trans people precede this one (Bockting et al., 2013; Reicherzer & Spillman, 2011; Singh et al., 2011). Singh et al. identified five primary themes and two additional factors of resiliency among the 21 participants in their phenomenological study. These themes included definition of self, self-worth, awareness of oppression, connection with a supportive community, hope for the future, as well as factors of social activism and being a positive role model for other trans people. Participants in the study proved resilient in facing discrimination and prejudice through a blend of individual strengths and community support (Singh et al.). This small but diverse (racial/ethnic, age, and educational background) sample presented several limitations. First, the majority of participants identified as male-to-female (MtF). Future research suggestions include an equal representation of female-to-male (FtM). The

authors suggest future researchers use a variety of research methods in exploring resiliency with trans people such as mixed methods and quantitative designs.

Published the same year, Reicherzer and Spillman (2011) used a case study approach to explore resiliency of Mexican-American transsexual women ($N = 3$). Findings suggest resiliency thematically connected across participants around the constructs of accountability, spirituality, family cohesion, and self-acceptance. Some limitations of this study included the small sample size, participants were natal males who identified as cross-dressers and did not desire gender reassignment surgery. Singh et al. (2011) reiterated assertions about the importance of strength identification in the counseling process as well as in research, and recommended future studies explore the lived experience of trans people involved in support groups and examine the influence of resources such as family and/or friends (Reicherzer & Spillman, 2011).

To this end, Bockting et al. (2013) analyzed cross-sectional data from a previous study ($N = 1093$) to assess moderating effects of resiliency on psychological distress associated with depression, anxiety, somatization, and stigma. Their data came from a larger cross-sectional study that examined the influence gender identity has on gender related stigma and HIV risk specific to MtF and FtM trans people. Based on their findings, Bockting et al. concluded family and peer support are necessary in order to ameliorate psychological distress. However, Bockting et al. noted their use of just two items for each resulting in their measure not being as strong as it could have been, as it did not allow for a broader assessment of social and emotional support elements. Despite noted limitations with the previous studies (Bockting et al., 2013; Reicherzer & Spillman,

2011, Singh et al., 2011), a compelling consensus has begun to emerge. Findings from these studies combine to provide support for further study of resilience specific to trans people.

In short, the relationship between thwarted belonging, shame, and isolation and the detrimental effects these experiences can have on psychological health and well-being is well represented among the literature (Choma et al., 2010; Giner-Sorolla & Espinosa, 2011; Hadar, 2008; Joiner, Van Orden, Witte, & Rudd, 2009; Rizvi, 2010; Schrock, Holden, & Reid, 2004; Van Orden, Cukrowicz, Witte, & Joiner, 2011; Van Orden, Lynam, Hollar, & Joiner, 2006). The moderating effects of resiliency on psychological distress is also known (Bockting et al., 2013; Orbkes & Smith, 2013; Rose et al., 2013; Zolkoski & Bullock, 2012). It is the beginning of understanding resiliency specific to subgroups of the trans population (Bockting et al., 2013; Reicherzer & Spillman, 2011; Singh et al., 2011). However, what it not yet known are levels of resiliency across a diverse sample of the trans population. Answering this question is important given resiliency's potential for moderating psychological distress. Increased understanding of intrapersonal and interpersonal resilience levels can contribute to improved support and treatment services specific to trans people and professionals charged with their care (Butler, 2009).

The purpose of this study was to assess intrapersonal and interpersonal factors of resilience for individuals who identify as trans. We also wanted to determine if within-group difference exists between participants' intrapersonal and interpersonal factors.

Finally, for between-group differences, we tested for difference in overall resilience comparing this study's participants to an overall population estimate.

Method

For this study, a cross-sectional survey descriptive design was used to assess intrapersonal and interpersonal factors of resilience among a diverse sample of individuals who identify as trans. Descriptive statistics were used to detail intrapersonal and interpersonal factors scores. A paired *t*-test was used to test for within-group difference between intrapersonal and interpersonal mean scores. This design was chosen for its utility in assessing behaviors, attitudes, beliefs, or experiences of a specific population at one moment in time (Gay, Mills, & Airasian, 2009). A paired *t*-test was chosen for its appropriateness testing within-group difference between two different variables based on scores from one sample (Gravetter & Wallnau, 2013).

Sample

Upon Institutional Review Board approval (Appendix A), participants were recruited via e-mail distribution of this study's flyer to 119 agencies throughout the United States that provide advocacy, support, or counseling services to trans people. The initial recruitment yielded 172 participants. Of these, a convenience sample ($N = 151$) completed all study materials. Participant's ages ranged from 19-74 years old ($M = 43.15$, $SD = 15.25$). One hundred thirty participants (86.09%) identified as "Caucasian/white." Eight participants (5%) identified as "mixed race". Two individuals (1.3%) indicated African-American, Asian-American, Native American, and Latino/Hispanic, respectively. Five participants (3%) selected the response option "Other".

Materials

Handling and Reporting Data

Participants' responses were anonymous and data calculations were made using Excel. Missing data (e.g., non-response items) were identified and attended to in accordance with the established survey research procedures (George & Mallery, 2006), as follows: Participants who accessed study materials and indicated consent to participate, yet did not complete all study materials, were removed from the sample ($N = 21$). Four participants did not indicate "age". To remedy, age of the 147 participants who did respond were averaged and the sample mean age was substituted for each missing cell. For the RSA, 26 total items had no response, though no one participant or item had more than four empty cells. Because these missing values were less than 15% of the sample (RSA missing values: by item/by participant = < 3%), responses were averaged and sample means substituted (George & Mallery).

Demographic Questionnaire

Participant information was collected to illustrate sample characteristics. In addition to age and ethnicity, we also asked "How do you self-identify?"; "How long have you identified in this way?"; and "At what age, do you recall becoming aware of your self-identification?" to allow a more thorough description of sample characteristics.

Resiliency Scale for Adults (RSA)

Intrapersonal and interpersonal resilience factors were measured using the Resiliency Scale for Adults (RSA). The RSA was developed to measure the presence of protective factors specific to self and self in relation with others (Hjemdal, Friborg,

Martinussen & Rosenvinge, 2001; Jowkar et al., 2010). Unlike other commonly used and well-established resilience measures, the RSA was developed based upon three decades of research on protective resiliency factors (Hjemdal et al., 2011). From these studies, agreement exists around three categories of resiliency protective factors:

1. Psychological/dispositional skills and attributes of the individual;
2. Family support and a family climate of cohesion; and
3. Presence of external support systems that reinforce efficient coping and adjustment. (Jowkar et al., 2010, p. 418)

These categories are translated into the RSA's five-factor composition: Social Competency measures levels of social warmth, flexibility, and the positive use of humor, as well as the ability to establish friendships; Social Resources measures the availability of social support, whether they have a confidante outside the family, such as friends or other family members that appreciate and encourage them, and whether they turn to someone outside the family for help if needed; Family Cohesion measures whether values are shared or discordant in the family and whether family members enjoy spending time with each other, have an optimistic view of the future, have loyalty toward each other, and have the feeling of mutual appreciation and support; Personal Competency is a combination of previous factors of perception of self and planned future and contains items that measure confidence in one's abilities and judgments, self-efficacy and realistic expectations, the ability to plan ahead, have a positive outlook, and be goal oriented; and Structured Style measures the preference of having and following routines, being organized, and the preference of clear goals and plans before undertaking activities

(Hjemdal et al., 2011). The RSA is comprised of 33 total items, with 5-point Likert response options ranging from 1 = strongly disagree to 5 = strongly agree.

RSA Validity and Reliability

The RSA has been extensively researched through a series of exploratory and confirmatory factor analyses and normed across diverse cultural and ethnic samples. The RSA's psychometric properties are sound (Hjedmal et al., 2011; Jowkar et al., 2010). Hjedmal et al. (2011) found the RSA to be reliable (α = .84) by looking at two samples that included a French-speaking Belgian sample of students (N = 363) and a Norwegian student sample (N = 315). Jowkar et al. (2010) examined the cross-cultural validity of the RSA by looking at Iranian college students (N = 373; r = .76-.84), as well as a matched pair of run-away girls (N = 30). Jowkar et al. used this step to test the RSA's construct validity by way of differentiating a subsample from a poorer psychosocial environment (run-away girls) compared with findings from a more stable psychosocial environment subsample. Jowkar et al. noted the internal consistency of the RSA subscales were adequate across subscales (α range .23-.58). The group mean differences of the RSA evidenced construct validity by "differentiating girls in a poorer psychosocial situation (run-away from home) from girls in a psychosocially more healthy situation (living at home with their family). Effect sizes were all greater (> .80)" (Jowkar et al., 2010, p. 418).

Ultimately, we chose the RSA for its multidimensional focus on well-supported intrapersonal and interpersonal protective factors. These factors were also found in three

trans-specific resiliency-focused studies (Bockting et al., 2013; Reicherzer & Spillman, 2011; Singh et al., 2011).

Data Collection

Study materials were combined into one survey using Oregon State University administered Qualtrics survey software in the following order: (a) cover letter explaining the purpose of the study (Appendix B); (b) participant informed consent (Appendix C); (c) demographic questionnaire (Appendix D); and (d) the Resiliency Scale for Adults (RSA; Appendix E).

Results

For the three trans identification demographic questions, we opted for open-ended response options. As such, responses varied to the question, "*How do you self-identify?"* Thirty-eight participants (25%) identified as "trans woman" or "trans female". Twenty-eight (19%) identified as "trans male" or "trans man". Twenty-four individuals (16%) identified as "transgender". Fourteen participants identified as "trans" (9%). Eleven participants identified as "female" (7%) and two participants identified as "male" (1%). Ten individuals identified as "transsexual" (7%) and six participants as "gender queer" (4%). Four participants identified as "FtM" (3%) and three as "MtF" (2%). Three participants identified as "cross-dressers" (2%) and three participants as "queer" (2%). Two participants identified as "transmasculine" (1%) and two participants as "bi-gender" (1%). The remaining participants had varying ways of identifying such as "intersex", "two-spirit", "surgically re-engineered hybrid", "woman with postoperative transsexual history", "trans-lesbian", "biologically XXY male", "gender queer transmasculine dyke",

"woman with a transitional history", "agender", "gender", "tranny", and "gay man that happens to be transgender".

Varied responses were also evidenced for the demographic question "*How long have you identified this way?"* Responses ranged from "all my life" to as recent as "one year". Many reported identifying in early childhood, as a teenager, or when they became introduced to the concept; some reported their identity as "shifting" throughout their lives. Some participants identified as "gender queer" before identifying as "transgender". One participant stated, "As a term? Ten years. As a being? My whole life."

The demographic question, "*At what age do you recall becoming aware of your self-identification?"* resulted in varying responses from the participants. The ages at which participants identified as transgender varied from age 2-60 years. Ninety-seven participants (64%) reported ages 12 years and younger as the beginning of identification. Forty-six ranged from ages 20-60 years, and 22 participants reported identification at ages 13-19 years. Some reported being aware of their felt gender differences but waited to identify until later in life. For example, one participant noted awareness of being transgender at 29 years but did not "come out" until age 33. Many reported cross-dressing at a young age but not publically identifying or even having the terminology to identify until later. One individual reported cross-dressing at age 12 but did not identify as transgender until age 35. Some reported focusing on sexual orientation or being gay as initial identification prior to acknowledging gender.

Resiliency Scale for Adults (RSA) Descriptive Statistics

Table 1 displays mean, standard deviation, and Cronbach's alpha for Social Competency, Social Resource, Family Cohesion, Personal Competency, and Structured Style factors.

Table 1

Resiliency Scale for Adults: Mean, Standard Deviation, and Cronbach's Alpha by Factor

Factor	*M*	*SD*	α
Social Competence (6 items)	3.75	1.06	.80
Social Resources (7 items)	3.81	1.17	.82
Family Cohesion (6 items)	3.14	1.27	.81
Personal Competence (10 items)	3.99	.93	.78
Structured Style (4 items)	3.68	.96	.78
RSA Total Score (33 items)	**124.26**	**9.59**	**.89**

Note. *Response options ranged from 1 = strongly disagree to 5 = strongly agree.* (*N = 151*).

The mean response rate for the Social Competency factor was (*M* = 3.75, *SD* = 1.06). The highest mean response rate for the items comprising the Social Competence factor was item 12: "Enjoy being with other people" (*M* = 3.73, *SD* = 1.05). The lowest mean response rate was item 10: "Easy to find subjects to talk about with others" (*M* = 3.57, *SD* = 1.12).

The mean response rate for the Social Resource factor was (*M* = 3.81, *SD* = 1.17). The highest mean response rate was for item 7 "Have friends/family members who appreciate one's abilities" (*M* = 4.20; *SD* = .98). The lowest mean response rate was item 13 "Being quickly informed when a family member has a problem: (*M* = 3.04, *SD* = 1.25).

The mean response rate for the Family Cohesion factor was (*M* = 3.14, *SD* = 1.27). The highest mean response rate was for item 18: "Enjoy being with my family" (*M*

= 3.44, *SD* = 1.23). The lowest mean response rate was item 17: "My family agrees on important affairs in life" (*M* = 2.78, *SD* = 1.23).

The mean response rate for the Personal Competency factor was (*M* = 3.99, *SD* = .93). The highest mean response rate was for item 20 "I believe in my abilities" (*M* = 4.19, *SD* = .85). The lowest mean response rate was item 28 "Know there is a better future in difficult situations" (*M* = 3.76, *SD* = .95).

The mean response rate for the Structured Style factor was (*M* = 3.68, *SD* = .96). The highest mean response rate was for item 32: "When I have a goal, I do my best to attain it" (*M* = 4.22, *SD* = .74). The lowest mean response rate was for item 31: "Maintain daily rules even in difficult situations" (*M* = 3.36, *SD* = 1.02).

Finally, a paired sample *t*-test was conducted to compare the aggregate mean score of Intrapersonal factors (Personal Competence, Social Competence, and Structured Style) and the score of Interpersonal factors (Social Resource and Family Cohesion). There was a significant difference between Intrapersonal (*M* = 3.81, *SD* = .16) and Interpersonal (*M* = 3.47, *SD* = .48) scores; $t(301) = 14.06$, $p < .001$. Mean difference and standard deviations were used to conduct an effect size estimate; which exceeded .80 necessary for "large" effect (*d* = .95).

Discussion

Studying resilience specific to trans people is important as protective factors shown to decrease psychological distress could inform development of specific support and treatment services for practitioners (Bockting et al., 2013; Hill, 2005; Mizock & Lewis, 2008; Reicherzer & Spillman, 2011; Singh et al., 2011).

The few previous studies specific to resilience and trans people noted limitations of either small sample size (e.g., $N = 21$; Singh et al., 2011; and $N = 3$, Reicherzer & Spillman, 2011); or potentially limited homogenous sample inclusion criteria (e.g., MtF and FtM; Bockting et al., 2013; Singh et al., 2011); or transsexual professional entertainers (Reicherzer & Spillman). Our study design was influenced by these scholars' recommendations.

We sought a broad representation of trans people without narrow inclusion parameters, such as including only those taking hormones or intending to have gender reassignment surgery, in hopes of forming a diverse sample (Carroll et al., 2002; Coolhart, Provancher, Hager, & Wang, 2008; Hughes & Eliason, 2002). Of the participants ($N = 151$), the majority (69%) identified as either "trans woman", "trans man", "transgender", or "trans". The remaining participants self-identified with a variety of terms that indicated fluidity on gender identification. This diverse sample illustrates ways in which such things as lack of identification with one's natal sex, gender role, or other form of embodiment or expression—outside binary gender classification—seemingly becomes grouped under the umbrella term "transgender" (Carroll et al., 2002; Connell, 2010).

In answering the demographic question, "*How long have you identified this way?"* answers varied considerably. Responses ranged from "all my life" to "one year". Many reported identifying in early childhood, as a teenager, or when they became introduced to the concept; some reported their identity as shifting throughout their lives.

Some participants identified as gender queer before identifying as transgender. One participant stated, "As a term? Ten years. As a being? My whole life."

The final trans-specific demographic question, "*At what age do you recall becoming aware of your self-identification?"* also resulted in a wide array of participant responses. The ages at which participants recalled initial awareness varied from age 2-60 years. The majority of participants (64%) reported ages 12 years and younger as the beginning of identification. The next most commonly cited age range (20-60 years) included much of the remaining participants (30%). Ages of the remaining 6% were between 13 and 19 years. Age ranges presented here were formed based on participant responses. The actual survey response option was open-ended, and responses are worth noting. Some reported being aware of their felt gender differences but waited to identify until later in life. For example, one participant noted an awareness of being transgender at age 29 but did not come out until age 33. Many reported cross-dressing at a young age but not publically identifying or even having the terminology to identify until later in life. One individual reported cross-dressing at age 12 but not identifying as transgender until age 35. Some reported focusing on sexual orientation or being gay as initial identification prior to acknowledging gender.

Much more information would certainly need to be gathered from these participants in order to form meaningful hypotheses about participants' experiences with gender self-identity awareness in relation to authentic self-expression and embodiment processes. Research regarding early assessment and gender-affirming treatment is limited. However, studies in the U.S. and the Netherlands suggest early intervention may

help decrease psychological distress resulting from gender dysphoria (Cohen-Kettenis, Wolf, Panter, & Katz, 2008). Findings from gender-affirming treatment and psychological stress are interesting when considering nearly two-thirds of participants in our study indicated early awareness (age 12 or younger) of their felt gender difference—paired with what appears to be a time delay trend between age of first awareness and age of congruent identification.

From responses to the trans specific demographic questions asked of participants in this study, we are somewhat confident our aim to form a diverse trans sample to assess intrapersonal and interpersonal protective resiliency factors was accomplished.

To this end, RSA findings from this study provide additional understanding of resilience in trans people. Five factors comprise the RSA, with three designed to measure one's personal attributes, or intrapersonal protective factors (Personal Competence, Social Competence, and Structured Style); while two measure self in relation to and with others—interpersonal protective factors (Social Resource and Family Cohesion).

Participants in this study scored highest on questions comprising the Personal Competency factor ($M = 3.99$, $SD = .93$). This factor measures self-confidence, efficacy, realistic expectations, as well as ability to plan ahead with a goal-oriented positive outlook (Hjemdal et al., 2011). These results seem to be on par with qualitative study findings that highlighted the importance of self-acceptance and accountability, defined as the ability to articulate who one is and not internalize oppression or marginalization (Reicherzer & Spillman, 2011). Awareness of oppression was an indicator of resiliency in Singh et al.'s (2011) study, which matched the results in our study regarding trusting

one's judgment. Singh et al.'s findings suggest a self-generated definition of self, coupled with embracing one's self-worth, as indicators of resilience. Providing additional evidence, Bockting et al.'s (2013) outcomes support self-acceptance—to include identity pride—as a protective factor against psychological distress. Taken together, these findings inform the importance of authentic self-identification and self-acceptance for trans individuals.

Following Personal Competence, Social Resource was the next highest score factor (M = 3.81, SD = 1.17). This factor measures social support availability, which is accepting and encouraging (Hjemdal et. al., 2011). Participants' relatively high levels of social resources are synonymous with qualitative findings noted by Reicherzer and Spillman (2011) and Singh et al.'s (2011) findings and discussion on the importance connection with a supportive community plays in resilience. Indeed, trans people often combat the rejection of families by adopting new families comprised from friends and other trans people (Sanchez & Viain, 2009), which supports the assertion that peer support mitigates psychological distress (Bockting et al., 2013).

Next in magnitude were participants' scores on the Social Competency factor (M = 3.75, SD = 1.06). Items measure one's social skills, sense of humor, and ability to establish and be flexible in relationships (Hjemdal et al., 2011). Perhaps what is most compelling about these findings is how it relates to past research on the importance of being connected with a supportive community that is accepting and encouraging (Bockting et al., 2013; Hjemdal et al., 2011; Reicherzer & Spillman, 2011; Singh et al., 2011). Indeed, this outcome is important as those commonly coming together and

forming relationships that ultimately provide peer and community support and connection are in fact trans individuals.

Shifting from social competence to more of a focus solely on the individual, the fourth lowest of the five RSA factors assessed was Structured Style ($M = 3.68$, $SD = .96$). These items measured preference for having routines and being organized and goal-oriented (Hjemdal et al., 2011). Participants' responses to these items most closely aligned with previous study findings, which highlights the importance of one cultivating hope for the future (Singh et al., 2011).

Interestingly, participants' scores on the Family Cohesion factor ($M = 3.14$, $SD = 1.27$) were far below all other RSA factors. This factor measures familial appreciation and encouragement, loyalty, communication, and whether or not similar shared values are present (Hjemdal et al., 2011). From visual inspection of the data, we noticed disparity between this factor and the next lowest RSA factor Structured Style (mean diff = .54). This mean difference contrast becomes sharper considering lesser variation exists between the combined mean differences across the other four RSA factors assessed (combined mean diff = .31). In light of the structured style outcomes, though not the primary purpose of this study, we decided to assess mean difference effect size estimates comparing the Family Cohesion factor with the other four RSA factors. In doing so, effect sizes were of medium magnitude (> .50), with the one exception being mean difference between Family Cohesion and Structured Style ($d = -.48$). This finding provides quantitative support to Reicherzer and Spillman's (2011) qualitative finding on

the importance of family connection and Bockting et al.'s (2013) finding of a negative association (β= -.164, p < .001) between family support and psychological distress.

Finally, the significant result from comparing participants' intrapersonal RSA factor scores (Personal Competence, Social Competence, and Structured Style) with their interpersonal factor scores (Social Resource and Family Cohesion) are concerning—while at the same time quite encouraging. The sharp contrast between intrapersonal and interpersonal protective factors suggest trans people possess high levels of sense-of-self and personal determination, which can serve as necessary, positive, adaptive attributes, when one perceives a need to improve a dismal situation (Jowkar et al., 2010).

Findings from the trans-specific demographic questions coupled with descriptive findings from the RSA can help inform and guide future directions for resilience studies composed of trans participant samples.

Limitations and Recommendations for Future Research

In light of these findings, study limitations are noted. First, this cross-sectional survey design was not intended to highlight trends or development over time, but rather provide a snapshot of participants' self-reported experiences (Gay et al., 2011). As such, stability of participants' RSA scores over time cannot be inferred. Future studies could assess resiliency in trans people at multiple points to gather a more thorough, stable baseline assessment.

This study's use of volunteer participant self-report data limits generalizability as differences can certainly exist between characteristics of those who volunteer to participate and those who do not (Erford, 2008). Also, because a 5-point Likert scale was

used for response options, potential exists for the occurrence of participant response ceiling effect, as response options that may have limited upper-end response options, and ultimately, limited our ability to accurately assess participant report (Breakwell, 2006). Future studies may better be served by 7-point response scale. Regarding RSA factors, we were concerned with how similar wording is for items in the Social Resource and Family Cohesion factors. Specifically, four Social Resource items reference "friends/family members", which could confuse participants depending on how each one chose to define what constitutes friend/family (e.g., not family of origin, but someone considered very close). Future users of the RSA may wish to remove "family member" from social resource items, for clarity, since family is well assessed in the Family Cohesion factor.

Those who identify as transgender are as diverse as the general population. Participants of this study demonstrated a diversity of age, self-identification, age of awareness, and age of internally and externally identifying as transgender. However, our study did not draw a diverse representation based on race and ethnicity.

According to Smith and Grey (2009), LGBT scores on resiliency scales need to be further researched as psychometric properties of measures have, at best, only begun to be normed on LGBT samples. Future research could compare LGB RSA scores to RSA trans scores; or RSA scores could be assessed across LGBT presumed homogenous subsamples to better understand LGBT within-group differences.

Future studies will also do well to assess participant length of time involved in support groups or counseling services to better understand associations between involvement in counseling or support services and resilience.

Conclusion

The purpose of this descriptive study was to assess intrapersonal and interpersonal factors of resilience for a diverse cross-section of people who identify as trans. Studies preceding this one highlighted the multidimensional nature of resilience, as well as the mitigating influence resilience has when associated with psychological distress. Findings from this study suggest trans people tend to possess higher overall levels of intrapersonal protective factors than interpersonal factors. However, despite this difference, it appears the two most influential resilience sub factors—Personal Competence and Social Resource—highlight the importance of both intrapersonal and interpersonal factors. Results from this study, coupled with previous findings, provide a foundation upon which future studies of resilience among trans people may be designed to inform development and delivery of effective trans-specific support services and gender-affirming treatment approaches.

Chapter 3 References

Bockting, W. O., Miner, M. H., Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience among an online sample of the U.S. transgender population. *American Journal of Public Health, 103*(5), 943-951. doi: 10.2105/AJPH.2013.301241

Breakwell, G. M. (2006). *Research methods in psychology* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Butler, C. (2009). Sexual and gender minority therapy and systemic practice. *The Association for Family Therapy, 31*, 338-358.

Carroll, L., Gilroy, P. J., & Ryan, J. (2002). Counseling transgendered, transsexual, and gender-variant clients. *Journal of Counseling and Development, 80*, 131-139.

Choma , B. L., Visser, B. A., Pozzebon, J. A., Bogaert, A. F., Busseri, M. A., & Sadava, S. W. (2010). Self-objectification, self-esteem, and gender: Testing a moderated mediation model. *Sex Roles, 63*, 645-656.

Cohen-Kettenis, P. T., Delemarre-van de Waal, H., & Gooren, L. J. (2008). The treatment of adolescent transsexuals: Changing insights. *International Society for Sexual Medicine, 5*(8), 1892-1897.

Connell, C. (2010). Doing, undoing, or redoing gender? Learning experiences from the workplace experiences of transpeople. *Gender & Society, 24*(1), 31-55.

Coolhart, D., Provancher, N., Hager, A., & Wang, M. (2008). Recommending transsexual clients for gender transition: A therapeutic tool for assessing readiness. *Journal of GLBT Family Studies, 4*(3), 301-324.

Eliason, M. (2011). Introduction to special issue on suicide, mental health, and youth development. *Journal of Homosexuality, 58*, 4-9.

Erford, B. T. (2008). *Research and evaluation in counseling* (1st ed.). Boston, MA: Lahaska Press.

Gagne, P., Tewksbury, R., & McGaughey, D. (1997). Coming out and crossing over. Identity formation and proclamation in a transgender community. *Gender & Society, 11*(4), 478-508.

Gay, L., Mills, G., & Airasian, P. (2011). *Educational research: Competencies for analysis and applications* (10th ed.). Upper Saddle River, NJ: Merrill Prentice Hall.

George, D., & Mallery, P. (2006) *SPSS for Windows: Step by step* (6th ed.). Boston, MA: Pearson Education.

Gilbert, P. (2010). *Compassion focused therapy.* New York, NY: Routledge.

Gilbert, P., McEwan, K., Irons, C., Bhundia, R., Christie, R., Broomhead, C., & Rockliff, H. (2010). Self-harm in a mixed clinical population: The roles of self-criticism, shame, and social rank. *British Journal of Clinical Psychology, 49*, 563-576.

Giner-Sorolla, R., & Espinosa, P. (2011). Social cuing of guilt by anger and of shame by disgust. *Psychological Science, 22*(1), 49-53.

Gravetter, F., & Wallnau, L. (2013). *Statistics for the behavioral sciences* (9th ed.). Belmost, CA: Thomson/Wadsworth.

Hadar, B. (2008). The body of shame in the circle of a group. *Group Analysis, 41*(2), 163-179.

Hanssmann, C., Morrison, D., & Russian, E. (2008). Talking, gawking, or getting it done: Provider trainings to increase cultural and clinical competence for transgender and gender-nonconforming patients and clients. *Sexuality Research and Social Policy, 5*(1), 5-23.

Hill, D. B. (2005). Trans/Gender/Sexuality: A research agenda. *Journal of Gay and Lesbian Social Services, 18*(2), 101-109.

Hjemdal, O., Friborg, O., Braun, S., Kempenaers, C., Linkowski, P., & Fossion, P. (2011). The Resiliency Scale for Adults: Construct validity and measurement in a Belgian sample. *International Journal of Testing, 11*, 53-70.

Hjemdal, O., Friborg, O., Martinussen, M., & Rosenvinge, J. H. (2001). Preliminary results from the development and validation of a Norwegian scale for measuring adult resilience. *Journal of the Norwegian Psychological Association, 38*(4), 310-317.

Hughes, T. L., & Eliason, M. (2002). Substance use and abuse in lesbian, gay, bisexual and transgender populations. *The Journal of Primary Prevention, 22*(3), 263-298.

Jew, C. L., Green, K. E., & Kroger, J. (1999). Development and validation of a measure of resiliency. *Measurement and Evaluation in Counseling and Development, 32*(2), 75-89.

Joiner, T. E., Van Orden, K. A., Witte, T. K., & Rudd, M. D. (2009). *The interpersonal theory of suicide: Guidance for working with suicidal clients.* Washington, DC: American Psychological Association.

Jowkar, B., Friborg, O., & Hjemdal, O. (2010). Cross-cultural validation of the Resilience Scale for Adults (RSA) in Iran. *Scandinavian Journal of Psychology, 51*, 418-425.

Mann, M. (2010). Shame veiled and unveiled: The shame affect and its re-emergence in the clinical setting. *The American Journal of Psychoanalysis, 70*, 270-281.

Mathy, R. M. (2002). Transgender identity and suicidality in a nonclinical sample: Sexual orientation, psychiatric history, and compulsive behaviors. *Journal of Psychology and Human Sexuality, 14*(4), 47-65.

Mathy, R. M., Lehmann, B. A., & Kerr, D. L. (2003). Bisexual and transgender identities in a nonclinical sample of North Americans: Suicidal intent, behavioral difficulties, and mental health treatment. *Journal of Bisexuality, 3*(3-4), 93-109.

McDermott, E., Roen, K., & Scourfield, J. (2008). Avoiding shame: Young LGBT people, homophobia and self-destructive behaviors. *Culture, Health and Sexuality, 10*(8), 815-829.

Mizock, L., & Lewis, T. K. (2008). Trauma in transgender populations: Risk, resilience, and clinical care. *Journal of Emotional Abuse, 8*(3), 335-354.

Montgomery, C. (2006). The virtue of depression in the secret life of shame: A group-analytic perspective. *Group Analysis, 39*(1), 73-85.

Nuttbrock, L., Hwahng, S., Bockting, W., Rosenblum, A., Mason, M., Marci, M., & Becker, J. (2010). Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons. *Journal of Sex Research, 47*(1),

12-23.
Orbkes, S., & Smith, H. L. (2013). A developmental framework for enhancing resiliency in adult survivors of child abuse. *International Journal for Advanced Counseling, 35*, 46-56.
Perrin, E., Smilth, N., Davis, C., Spack, N., & Stein, M. T. (2010). Gender variant and gender dysphoria in two young children. *Journal of Developmental and Behavioral Pediatrics, 31*(2), 161-164.
Pinto-Gouveia, J., & Matos, M. (2011). Can shame memories become a key to identity? The centrality of shame memories predicts psychopathology. *Applied Cognitive Psychology, 25*(2), 281-290.
Reicherzer, S., & Spillman, J. (2011). A Multiple case study examination of resiliency factors for Mexican and Mexican-American transsexual women. *International Journal of Transgenderism, 13*, 147-164.
Rizvi, S. L. (2010). Development and preliminary validation of a new measure to assess shame: The Shame Inventory. *Psychopathological Behavioral Assessment, 32*, 438-447.
Rose, R. D., Buckly, J. C., Jr., Zbozinek, T. D., Motivala, S. J., Glenn, D. E., Caftreine, J. A., & Craske, M. G. (2013). A randomized controlled study of a self-guided, multimedia, stress management and resilience training program. *Behavioral Research and Therapy, 51*, 106-112.
Sanchez, F. J., & Vilain, E. (2009). Collective self-esteem as a coping resource for male-to-female transsexuals. *Journal of Counseling Psychology, 56*(1), 202-209.
Schrock, D., Holden, D., & Reid, L. (2004). Creating emotional resonance: Interpersonal emotion work and motivational framing in a transgender community. *Social Problems, 51*(1), 61-81.
Selby, E. A., Anestis, M. D., Bender, T. W., Ribeiro, J. D., Nock, M. K., Rudd, M. D., Joiner, T. E., Jr. (2010). Overcoming the fear of lethal injury: Evaluating suicidal behavior in the military through the lens of the Interpersonal-Psychological Theory of Suicide. *Clinical Psychology Review, 30*, 298-307.
Singh, A. A., Hays, D. G., & Watson, L. S. (2011). Strength in the face of adversity: Resilience strategies of transgender individuals. *Journal of Counseling and Development, 89*, 20-27.
Smith, M. S., & Gray, S. W. (2009). The courage to challenge: A new measure of hardiness in LGBT adults. *Journal of Gay and Lesbian Social Studies, 21*, 73-89.
Van Orden, K. A., Cukrowicz, K. C., Witte, T. K., & Joiner, T. E. (2011). Thwarted belongingness and perceived burdensomeness: Construct validity and psychometric properties of the Interpersonal Needs Questionnaire. *Psychological Assessment, 24*(1), 197-215. doi:10.1037/a0025358
Van Orden, K. A., Lynam, M. E., Hollar, D., & Joiner, T. E., Jr. (2006). Perceived burdensomeness as an indicator of suicidal symptoms. *Cognitive Therapy and Research, 30*, 457-467.
Walls, N. E., Freedenthal, S., & Wisneski, H. (2008). Suicidal ideation and attempts among sexual minority youths receiving social services. *Social Work, 53*(1), 21-29.

Wu, C.-Y., Stewart, R., Huang, H.-C., Prince, M., & Liu, S.-I. (2011). The impact of quality and quantity of social support on help-seeking behavior prior to deliberate self-harm. *General Hospital Psychiatry, 33*, 37-44.

Zolkoski, S. M., & Bullock, L. M. (2012). Resilience in children: A review. *Children and Youth Services Review, 34*, 2295-2303.

CHAPTER 4: GENERAL CONCLUSIONS

The purpose of this dissertation was to demonstrate research scholarship using the American Psychological Association (APA) manuscript-style dissertation format, in accordance with Oregon State University Graduate School and Counseling Academic Unit guidelines.

Chapter 1 provided explanation for how Chapters 2 and 3 are thematically linked manuscripts intended to extend professional literature in Counseling with a specific focus on trans people. Chapter 2 comprised a relevant literature critique titled; *Shame, Thwarted Belonging, Self-Harm, and the Moderating Influence Resilience Protective Factors may serve for Trans People: A Literature Review*.

From the foundation established in Chapter 2, Chapter 3 detailed a cross-sectional survey descriptive design titled; *Assessing Intrapersonal and Interpersonal Resilience Factors Among Trans People: A Descriptive Study*. The purpose of this study was to examine the intrapersonal and interpersonal protective factors of resilience among trans people.

Resilience of a diverse cross-section of trans people ($N = 151$) was measured by the Resiliency Scale for Adults (RSA). This 33-item, 5-point Likert scale, with response options ranging from 1 = strongly disagree to 5 = strongly agree, is comprised of three intrapersonal factors: Social Competence, Personal Competence, Structured Style; and two interpersonal factors: Social Resource and Family Cohesion. The RSA's strength is the evidenced multidimensional resilience construct foundation upon which it was

developed. Essentially, instead of sole focus on an individual's personal resilience attributes, the RSA measures both individual attributes and individual attributes in relation to other attributes.

Findings from this study indicate participants' intrapersonal factors scores (M = 3.81, SD = .16) were significantly higher than their interpersonal factors scores (M = 3.47, SD = .48); $t(301) = 14.06$, $p < .001$ (d = .95).

Results from this study, coupled with previous study findings, forms a foundation upon which future studies of resilience among trans people may inform development and delivery of effective trans-specific support services and gender-affirming treatment approaches.

Scientist-Practitioner: Some Reflections on My Process

As a clinician, my initial drive was to study the lived experience of trans people as it relates to resiliency. With reportedly high rates of suicide among this population, I sought to gain understanding and clarity about which trans-specific strength attributes could aid clinicians who work with gender identity issues. In my opinion, and based on my professional experience, some clinicians may benefit from increased understanding and awareness of trans individuals' embodied strength attributes so as to transcend a cultural bias view that being transgender is a disorder to be cured. Some, despite good intentions, may overly focus on struggles and challenges and/or focus solely on gender identity, forgetting to work with the whole person. Part of working with any client is to identify and accentuate strengths, and resiliency is one such strength that may help trans people better navigate a life of gender fluidity.

Reviewing the literature and investigating the protective factors of resilience among trans people was one of the most important aspects of this dissertation process. Both manuscripts highlight the vulnerabilities of trans people and speak to the possible risk factors of shame, thwarted belonging, and self-harm. However, the manuscript in Chapter 3 focused on the protective factors of resilience specific to trans people. Results highlight both current strengths, such as higher levels of Personal Competency and Social Resource, and areas for improvements, such as Family Cohesion and familial connection.

In my private practice, I have noticed what I consider to be high levels of resilience and inner strength in transgender clients. Trans people, in my view, must be highly resilient in order to not only thrive, but also survive, in a culture that at best misunderstands gender variance and at worst discriminates and marginalizes. This view is supported by prior qualitative research of resiliency and trans people (Reicherzer & Spillman, 2011; Singh et al., 2011). However, with high levels of psychological distress and the effects that accompany it, a question emerges: In what ways can resilience be increased?

Recommendations for Further Research

The three well-established dimensions of resilience, as measured by the Resiliency Scale for Adults, moderate negative effects often experienced by those individuals confronted with adversity, whether acute or chronic (Jowkar, Friborg, & Hjemdal, 2010). Continued research should explore intrapersonal and interpersonal stress factors in relation to resilience factors. More research regarding trans people's ability to thrive under stress would offer new insight into previously held beliefs regarding fragility

of this population. Future research addressing trans people's definition of family is necessary. Although only a portion of trans people seek hormone therapy or surgery, current standards are followed. And while these standards (WPATH, 2001) are highly regarded and respected, some trans people find the process offensive, claiming they are being treated with a mental illness and required to seek therapy before being allowed to alter their bodies. The argument is that, while some may have co-occurring struggles, not all trans people are experiencing intrapersonal conflict or believe they need therapy. Some argue that many in the mainstream are not required to attend counseling for a variety of plastic surgeries that drastically change one's body. Continued research in the area of resilience among this population may help shift the apparent assumption trans people are mostly homogenous, and in turn, provide rationale for more individualized assessments—as is the case across the mental health field in general.

More research regarding resiliency and trans people may help mental health practitioners be more curious and less afraid in working with gender variance. Looking for factors of resilience may assist trans clients in seeking alternatives to coping with the stress associated with marginalization and discrimination and help with the development and testing of strength-based approaches. As such, a quasi-experimental pre-post design; or multiple baseline, could be utilized to determine effects of trans specific interventions, like peer support groups, on interpersonal sub factor contributors to overall resilience.

This dissertation study drew its sample via agencies serving trans people recruitment. Results may differ if a sample were comprised of those individuals who do not access such agencies. Involvement in an agency may meet interpersonal needs, such

as sense of support and community connection, as measured by the RSA Social Resource factor. Important to measure would be the resilience of trans people not involved in agencies or trans specific gatherings. Certainly, recruiting a robust sample size could be challenging; therefore, a case study design may work well.

Future Uses of Results From This Study

The express purpose of this research study was to review the literature on both the psychological challenges and resilience strengths of trans people for the purpose of gaining insight into how best to support those individuals who identify as trans. Limited research on resilience attributes of trans people—a vulnerable high risk population—served as foundation for this dissertation. Further analyses of this data set could include a multivariate correlational design in which responses to the questions "at what age do you recall first becoming aware" and "how long have you identified this way" could be clustered by time duration (e.g., 12 years old or younger; or less than/more than 10 years ago) and then controlled for in order to determine explained resilience variance (r^2) levels across the five RSA subfactors above and beyond the influence of one's initial age of awareness and length of time since authentic self-identification. Qualitatively, either a phenomenological or grounded theory design could provide thick rich descriptions of trans individuals' perceptions (or the meaning behind perceptions, if using a grounded theory design) about their intrapersonal and interpersonal lived experiences in relation to, and framed by, the RSA subfactors. Findings from each of these methods could shed light on the role resilience plays in protecting trans people from intrapersonal and interpersonal stressors that they may experience. Future studies could also determine if a relationship

exists between resiliency levels and history of self-harming behaviors; for which a hypothesis could be: An inverse relationship exists between resiliency levels and history of self-harming behaviors, such that increases in resilience levels correlate with decreases in self-harming behaviors.

Finally, participant characteristics related to racial/ethnic identity were limited as 88% of identified as white. Moving forward, I believe it is important to control for potential racial/ethnic differences, in relation to the question: "what additional vulnerabilities exist for those who are not only marginalized because they are trans, but who are also racially/ethnically of a minority culture?" I believe access to services and community support may protect trans people from undue psychological distress. I am also alert to the possibility identifiable barriers may exist that keep non-white trans people from seeking services.

Summary

There is sufficient evidence to suggest that trans people possess intrapersonal and interpersonal protective factors of resilience. Possessing resilience may indeed protect trans people from succumbing to the intrapersonal and interpersonal pressures of being part of a binary gender culture, while not identifying with a culturally normed gender. Literature suggests factors such as family and community support serve a protective role associated with resilience and psychological distress. Therefore, efforts to increase multidimensional aspects of resilience in trans people may help protect them from undue effects of psychological distress.

Chapter 4 References

Jowkar, B., Friborg, O., & Hjemdal, O. (2010). Cross-cultural validation of the Resilience Scale for Adults (RSA) in Iran. *Scandinavian Journal of Psychology, 51*, 418-425.

Perrin, E., Smilth, N., Davis, C., Spack, N., & Stein, M. T. (2010). Gender variant and gender dysphoria in two young children. *Journal of Developmental and Behavioral Pediatrics, 31*(2), 161-164.

Reicherzer, S., & Spillman, J. (2011). A Multiple case study examination of resiliency factors for Mexican and Mexican-American transsexual women. *International Journal of Transgenderism, 13*, 147-164.

Singh, A. A., Hays, D. G., & Watson, L. S. (2011). Strength in the face of adversity: Resilience strategies of transgender individuals. *Journal of Counseling and Development, 89*, 20-27.

World Professional Association for Transgender Health (WPATH; 2001). *Standards of Care (SOC)*. Retrieved from www.psychiatry.org

BIBLIOGRAPHY

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. text revision). Washington, DC: Author.

American Psychiatric Association. (2013). Gender dyphoria. Retrieved from www.psychiatry.org

Anestis, M. D., & Joiner, T. E. (2011). Examining the role of emotion in suicidality: Negative urgency as an amplifier of the relationship between components of the interpersonal-psychological theory of suicidal behavior and lifetime number of suicide attempts. *Journal of Affective Disorders, 129*, 261-269.

Anthony, E. K., & Robbins, D. E. (2012). A latent class analysis of resilient development among early adolescents living in public housing. *Child and Youth Services Review, 35*, 82-90.

Bennett, D. S., Sullivan, M. W., & Lewis, M. (2010). Neglected children, shame-proneness, and depressive symptoms. *Child Maltreatment, 15*(4), 305-314.

Bockting, W. O., Miner, M. H., Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience among an online sample of the U.S. transgender population. *American Journal of Public Health, 103*(5), 943-951. doi: 10.2105/AJPH.2013.301241

Boyce, P., Oakley-Browne, M. A., & Hatcher, S. (2001). The problem with deliberate self-harm. *Current Opinion in Psychiatry, 14*(2), 107-111.

Breakwell, G. M. (2006). *Research methods in psychology* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Brown, M. Z., & Chapman, A. L. (2007). Stopping self-harm once and for all: Relapse prevention in Dialectical Behavior Therapy. *Therapist's guide to Evidence-Based Relapse Prevention, 3*, 191-214.

Butler, C. (2009). Sexual and gender minority therapy and systemic practice. *Journal of Family Therapy, 31*, 338-358.

Carroll, L., Gilroy, P. J., & Ryan, J. (2002). Counseling transgendered, transsexual, and gender-variant clients. *Journal of Counseling and Development, 80*, 131-139.

Choma , B. L., Visser, B. A., Pozzebon, J. A., Bogaert, A. F., Busseri, M. A., & Sadava, S. W. (2010). Self-objectification, self-esteem, and gender: Testing a moderated mediation model. *Sex Roles, 63*, 645-656.

Cohen-Kettenis, P. T., Delemarre-van de Waal, H., & Gooren, L. J. (2008). The treatment of adolescent transsexuals: Changing insights. *International Society for Sexual Medicine, 5*(8), 1892-1897.

Connell, C. (2010). Doing, undoing, or redoing gender? Learning from the workplace experiences of transpeople. *Gender and Society, 24*(1), 31-55.

Coolhart, D., Provancher, N., Hager, A., & Wang, M.-N. (2008). Recommending transsexual clients for gender transition: A therapeutic tool for assessing readiness. *Journal of GLBT Family Studies, 4*(3), 301-324.

Craig, S. L., Tucker, E. W., & Wagner, E. F. (2008). Empowering lesbian, gay, bisexual, and transgender youth: Lessons learned from a safe schools summit. *Journal of*

Gay and Lesbian Social Services, 20(3), 237-252.

Daigle, M. S., Pouliot, L., Chagnon, F., Greenfield, B., & Mishara, B. (2011). Suicide attempts: Prevention of repetition. *The Canadian Journal of Psychiatry, 56*(10), 621-629.

Eliason, M. (2011). Introduction to special issue on suicide, mental health, and youth development. *Journal of Homosexuality, 58*, 4-9.

Erford, B. T. (2008). *Research and evaluation in counseling* (1st ed.). Boston, MA: Lahaska Press.

Freedenthal, S., Lamis, D. A., Osman, A., Kahlo, D., & Gutierrez, P. M. (2011). Evaluation of the psychometric properties of the Interpersonal Needs Questionnaire-12 in samples of men and women. *Journal of Clinical Psychology, 67*(6), 609-623.

Friborg, O., Hjemdal, O., Martinussen, M., & Rosenvinge, J. H. (2009). Empirical support for resilience as more than the counterpart and absence of vulnerability and symptoms of mental disorder. *Journal of Individual Differences, 30*(3), 138-151.

Gagne, P., Tewksbury, R., & McGaughey, D. (1997). Coming out and crossing over: Identity formation and proclamation in a transgender community. *Gender & Society, 11*(4), 478-508.

Gay, L., Mills, G., & Airasian, P. (2011). *Educational research: Competencies for analysis and applications* (10th ed.). Upper Saddle River, NJ: Merrill Prentice Hall.

George, D., & Mallery, P. (2006) *SPSS for Windows: Step by step* (6th ed.). Boston, MA: Pearson Education.

Gilbert, P. (2010). *Compassion focused therapy.* New York, NY: Routledge.

Gilbert, P., McEwan, K., Irons, C., Bhundia, R., Christie, R., Broomhead, C., & Rockliff, H. (2010). Self-harm in a mixed clinical population: The roles of self-criticism, shame, and social rank. *British Journal of Clinical Psychology, 49*, 563-576.

Giner-Sorolla, R., & Espinosa, P. (2011). Social cuing of guilt by anger and of shame by disgust. *Psychological Science, 22*(1), 49-53.

Gratz, K. L., & Tull, M. T. (2011). Extending research on the utility of an adjunctive emotion regulation group therapy for deliberate self-harm among women with borderline personality pathology. *American Psychological Association, 2*(4), 316-326.

Gravetter, F., & Wallnau, L. (2013). *Statistics for the behavioral sciences* (9th ed.). Belmont, CA: Thomson/Wadsworth.

Hadar, B. (2008). The body of shame in the circle of the group. *Group Analysis, 41*(2), 163-179.

Hanssmann, C., Morrison, D., & Russian, E. (2008). Talking, gawking, or getting it done: Provider trainings to increase cultural and clinical competence for transgender and gender-nonconforming patients and clients. *Sexuality Research and Social Policy, 5*(1), 5-23.

Hash, K. M., & Rogers, A. (2013). Clinical practice with older LGBT clients: Overcoming lifelong stigma through strength and resilience. *Journal of Clinical*

Social Work. doi:10.1007/s10615-013-0437-2

Herrick, A. L., Stall, R., Goldhammer, H., Egan, J. E., & Mayer, K. H. (2013). Resilience as a research framework and as a cornerstone of prevention research for gay and bisexual men: Theory and evidence. *AIDS Behavioral.* doi:10.1007/s10461-012-0384-x

Hill, D. B. (2005). Trans/Gender/Sexuality: A research agenda. *Journal of Gay and Lesbian Social Services, 18*(2), 101-109.

Hjemdal, O., Friborg, O., Braun, S., Kempenaers, C., Linkowski, P., & Fossion, P. (2011). The Resiliency Scale for Adults: Construct validity and measurement in a Belgian sample. *International Journal of Testing, 11*, 53-70.

Hjemdal, O., Friborg, O., Martinussen, M., & Rosenvinge, J. H. (2001). Preliminary results from the development and validation of a Norwegian scale for measuring adult resilience. *Journal of the Norwegian Psychological Association, 38*(4), 310-317.

Hjemdal, O., Friborg, O., Stiles, T., Rosenvinge, J. H., & Martinussen, M. (2006). Resilience predicting psychiatric symptoms: A prospective study of protective factors and their role in adjustment to stressful life events. *Clinical Psychology and Psychotherapy, 13*, 194-201.

Hughes, T. L., & Eliason, M. (2002). Substance use and abuse in lesbian, gay, bisexual and transgender populations. *The Journal of Primary Prevention, 22*(3), 263-298.

Jackson, K. F., Wolven, T., & Aguilara, K. (2013). Mixed resilience: A study of multiethnic Mexican American stress and coping in Arizona. *Interdisciplinary Journal of Applied Family Studies, 62*, 212-225.

Jew, C. L., Green, K. E., & Kroger, J. (1999). Development and validation of a measure of resiliency. *Measurement and Evaluation in Counseling and Development, 32*(2), 75-89.

Joiner, T. E., & Van Orden, K. A. (2008). The interpersonal-psychological theory of suicidal behavior indicates specific and crucial psychotherapeutic targets. *International Journal of Cognitive Therapy, 1*(1), 80-89.

Joiner, T. E., Van Orden, K. A., Witte, T. K., & Rudd, M. D. (2009). *The interpersonal theory of suicide: Guidance for working with suicidal clients.* Washington, DC: American Psychological Association.

Jowkar, B., Friborg, O., & Hjemdal, O. (2010). Cross-cultural validation of the Resilience Scale for Adults (RSA) in Iran. *Scandinavian Journal of Psychology, 51*, 418-425.

King, S. D., & Orel, N. (2012). Midlife and older gay men living with HIV/AIDS: The influence of resiliency and psychological stress factors on health needs. *Journal of Gay and Lesbian Social Services, 24*, 346-370.

Kulish, N. (2010). Clinical implications of contemporary gender theory. *Journal of the American Psychoanalytic Association, 58*(2), 231-258.

Lewis, S. P., Rosenrot, S. A., & Santor, D. A. (2011). An integrated model of self-harm: Identifying predictors of intent. *Canadian Journal of Behavioral Science, 43*(1), 20-29. doi:10.1037/a0022076

Livingston, L. R. (2006). No place to hide: The group leader's moments of shame.

International Journal of Group Psychotherapy, 56(3), 307-323.
Mann, M. (2010). Shame veiled and unveiled: The shame affect and its re-emergence in the clinical setting. *The American Journal of Psychoanalysis, 70*, 270-281.
Mathy, R. M. (2002). Transgender identity and suicidality in a nonclinical sample: Sexual orientation, psychiatric history, and compulsive behaviors. *Journal of Psychology and Human Sexuality, 14*(4), 47-65.
Mathy, R. M., Lehmann, B. A., & Kerr, D. L. (2003). Bisexual and transgender identities in a nonclinical sample of North Americans: Suicidal intent, behavioral difficulties, and mental health treatment. *Journal of Bisexuality, 3*(3-4), 93-109.
McDermott, E., Roen, K., & Scourfield, J. (2008). Avoiding shame: Young LGBT people, homophobia and self-destructive behaviors. *Culture, Health and Sexuality, 10*(8), 815-829.
McKensie, S. (2010). Genders and sexualities in individuation: Theoretical and clinical explorations. *Journal of Analytical Psychology, 55*, 91-111.
Mizock, L., & Lewis, T. K. (2008). Trauma in transgender populations: Risk, resilience, and clinical care. *Journal of Emotional Abuse, 8*(3), 335-354.
Montgomery, C. (2006). The virtue of depression in the secret life of shame: A group-analytic perspective. *Group Analysis, 39*(1), 73-85.
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.
Nuttbrock, L., Hwahng, S., Bockting, W., Rosenblum, A., Mason, M., Marci, M., & Becker, J. (2010). Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons. *Journal of Sex Research, 47*(1), 12-23.
Orbkes, S., & Smith, H. L. (2013). A developmental framework for enhancing resiliency in adult survivors of child abuse. *International Journal for Advanced Counseling, 35*, 46-56.
Ougrin, D., & Latif, S. (2011). Specific psychological treatment versus treatment as usual in adolescents with self-harm: Systematic review and meta-analysis. *Crisis, 32*(2), 74-80.
Perrin, E., Smilth, N., Davis, C., Spack, N., & Stein, M. T. (2010). Gender variant and gender dysphoria in two young children. *Journal of Developmental and Behavioral Pediatrics, 31*(2), 161-164.
Pinto-Gouveia, J., & Matos, M. (2011). Can shame memories become a key to identity? The centralitiy of shame memories predicts psychopathology. *Applied Cognitive Psychology, 25*(2), 281-290.
Proyer, R. T., Platt, T., & Ruch, W. (2010). Self-conscious emotions and ridicule: Shameful gelotophobes and guilt free katagelasticists. *Personality and Individual Differences, 49*, 54-58.
Reicherzer, S., & Spillman, J. (2011). A Multiple case study examination of resiliency factors for Mexican and Mexican-American transsexual women. *International Journal of Transgenderism, 13*, 147-164.

Rizvi, S. L. (2010). Development and preliminary validation of a new measure to assess shame: The Shame Inventory. *Psychopathological Behavioral Assessment, 32*, 438-447.

Rose, R. D., Buckly, J. C., Jr., Zbozinek, T. D., Motivala, S. J., Glenn, D. E., Caftreine, J. A., & Craske, M. G. (2013). A randomized controlled study of a self-guided, multimedia, stress management and resilience training program. *Behavioral Research and Therapy, 51*, 106-112.

Sanchez, F. J., & Vilain, E. (2009). Collective self-esteem as a coping resource for male-to-female transsexuals. *Journal of Counseling Psychology, 56*(1), 202-209.

Schilt, K., & Westbrook, L. (2009). Doing gender, doing heteronormativity. "Gender normals," transgender people, and the social maintenance of heterosexuality. *Gender & Society, 23*(4), 440-464.

Schrock, D., Holden, D., & Reid, L. (2004). Creating emotional resonance: Interpersonal emotion work and motivational framing in a transgender community. *Social Problems, 51*(1), 61-81.

Selby, E. A., Antestis, M. D., Bender, T. W., Ribeiro, J. D., Nock, M. K., Rudd, M.D., & Joiner, T. E. (2010). Overcoming the fear of lethal injury: Evaluating suicidal behavior in the military through the lens of the Interpersonal-Psychological Theory of Suicide. *Clinical Psychology, 30*, 298-307.

Sheidow, A. J., Henry, D. B., Tolan, P. H., & Strachan, M. K. (2013). The role of stress exposure and family functioning in internalizing outcomes of urban families. *Journal of Child and Family Studies.* doi:10.1007/s10826-103-9793-3

Singh, A. A., Hays, D. G., & Watson, L. S. (2011). Strength in the face of adversity: Resilience strategies of transgender individuals. *Journal of Counseling and Development, 89*, 20-27.

Sirikantraporn, S. (2013). Biculturalism as a protective factor: An exploratory study on resilience and the bicultural level of acculturation among Southeast Asian American youth who have witnessed domestic violence. *Asian American Journal of Psychology, 4*(2), 109-115.

Skegg, K. (2005). Self-harm. *Lancet, 366*(9495), 1471-1483. Retrieved from www.thelancet.com

Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The Brief Resilience Scale: Assessing the ability to bounce back. *International Journal of Behavioral Medicine, 15*, 194-200.

Smith, M. S., & Gray, S. W. (2009). The courage to challenge: A new measure of hardiness in LGBT adults. *Journal of Gay and Lesbian Social Studies, 21*, 73-89.

Van Orden, K. A., Cukrowicz, K. C., Witte, T. K., & Joiner, T. E. (2011). Thwarted belongingness and perceived burdensomeness: Construct validity and psychometric properties of the Interpersonal Needs Questionnaire. *Psychological Assessment, 24*(1), 197-215. doi:10.1037/a0025358

Van Orden, K. A., Lynam, M. E., Hollar, D., & Joiner, T. E. (2006). Perceived burdensomeness as an indicator of suicidal symptoms. *Cognitive Therapy and Research, 30*, 457-467.

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., &

Joiner, T. E. (2010). The Interpersonal Theory of Suicide. *Psychological Review, 117*(2), 575-600.

Walls, N. E., Freedenthal, S., & Wisneski, H. (2008). Suicidal ideation and attempts among sexual minority youths receiving social services. *Social Work, 53*(1), 21-29.

World Professional Association for Transgender Health (WPATH; 2001). *Standards of Care (SOC)*. Retrieved from www.psychiatry.org

Wu, C.-Y., Stewart, R., Huang, H.-C., Prince, M., & Liu, S.-I. (2011). The impact of quality and quantity of social support on help-seeking behavior prior to deliberate self-harm. *General Hospital Psychiatry, 33*, 37-44.

Zolkoski, S. M., & Bullock, L. M. (2012). Resilience in children: A review. *Children and Youth Services Review, 34*, 2295-2303.

APPENDICIES

APPENDIX A:

IRB NOTICE OF APPROVAL

Institutional Review Board
Office of Research Integrity | Oregon State University
B308 Kerr Administration Building, Corvallis, OR 97331-2140
Telephone (541) 737-8008
irb@oregonstate.edu | http://oregonstate.edu/irb/

STUDY ID
5734

Notification Type	**EXEMPTION**		
Date of Notification	5/9/2013		
Study Title	Transpeople: An Assessment of Internal and External Resilience Factors		
Principal Investigator	Daniel Stroud, PhD		
Study Team Members	Liesl Farnsworth		
Submission Type	Initial Application		
Level	Exempt	Category(ies)	2
Number of Participants	165 *Do not exceed this number without prior IRB approval*		
Funding Source	None	Proposal #	N/A
PI on Grant or Contract	N/A		

The above referenced study was reviewed by the OSU Institutional Review Board (IRB) and determined to be exempt from full board review.

Expiration Date: 5/8/2018
*The exemption is valid for **5 years** from the date of approval.*

Annual renewals will not be required. If the research extends beyond the expiration date, the Investigator must request a new exemption. Investigators should submit a final report to the IRB if the project is completed prior to the 5 year term.

Documents included in this review:

☒ Protocol	☒ Recruiting tools	☐ External IRB approvals
☐ Consent forms	☒ Test instruments	☐ Translated documents
☐ Assent forms	☐ Attachment A: Radiation	☐ Attachment B: Human materials
☒ Alternative consent	☐ Alternative assent	☐ Grant/contract
☐ Letters of support	☐ Project revision(s)	☐ Other:

Comments:

Principal Investigator responsibilities:

- Amendments to this study must be submitted to the IRB for review prior to initiating the change. Amendments may include, but are not limited to, changes in funding, personnel, target enrollment, study population, study instruments, consent documents, recruitment material, sites of research, etc.
- All study team members should be kept informed of the status of the research.
- Reports of unanticipated problems involving risks to participants or others must be submitted to the IRB within three calendar days.
- The Principal Investigator is required to securely store all study related documents on the OSU campus for a minimum of three years post study termination.

APPENDIX B:

COVER LETTER

Invitation to participate in a research study titled:

Transpeople: An Assessment of Internal and External Resilience Factors

I'm Liesl Farnsworth, a doctoral student in Counseling at Oregon State University. I'm seeking participants for my dissertation study. This OSU-IRB approved study seeks to assess resiliency among transpeople. I'm focusing on, and very much passionate about, this topic area as I'm also a licensed clinician who works with and advocates for this population.

I'm currently contacting organizations, associations and coalitions related to sexual minorities and ask for your willingness to post, or otherwise share this request with those eligible to participate. My hope is findings from this study will increase awareness and understanding so as to further inform advocacy, support and counseling services transpeople receive.

To date, we know how resilience is experienced in the general population, as well as within some specific ethnic groups. However, very few studies have explored how resilience is experienced within other diverse populations and subgroups such as those who identify as Trans We know resiliency is both internally and externally influenced and includes protective factors such as psychological/dispositional skills, family support and cohesion and external support (Jowkar, Friborg, & Hjemdal, 2010; Hjemdal et al., 2011; Smith et al., 2008). What we don't yet know is much about resiliency factors among Transpeople.

Participants can access study materials via the following URL:
http://oregonstate.qualtrics.com/SE/?SID=SV_0e7qVKdZ8fC0aVv

Participation is anonymous and responses will be kept confidential—to include no identifying information linked to participants or organizations. If published, findings will be reported anonymously.

Thank you for any assistance you can provide in distributing this flyer, and feel free to contact me, or my dissertation chair: Daniel Stroud Ph.D., who is my academic advisor and this study's principal investigator, if you have any questions or concerns.

Daniel Stroud, Ph.D.
Assistant Professor, Counseling
Oregon State University
daniel.stroud@osucascades.edu
541.322.3155

Liesl Farnsworth, L.P.C.,
Ph.D. Candidate
Oregon State University
farnswol@onid.orst.edu
541.388.1261

APPENDIX C:

INFORMED CONSENT

Dear Participant,

This is a request for your participation in a dissertation research study led by Dr. Daniel Stroud, Assistant Professor of Counseling, Oregon State University. The purpose of this study (titled: Transpeople: An Assessment of Internal and External Resilience Factors) is to gain understanding of the internal and external experiences of transpeople. Eligible participants for this study are those age 18 or older, who identify as Transgender. Procedures entail anonymously completing a thirty-three-item resiliency survey and demographic questions. Participation will take approximately 20 minutes.

Extensive research has been conducted on resiliency. However few have explored how resilience is experienced among diverse populations. To date, the lived-experience of strength and resilience of those identifying as Transgender has received very little attention. Findings from this study may benefit transpeople and organizations that provide advocacy, support or counseling services. A potential risk of participating in this study could involve psychological discomfort resulting from reading and responding to questions assessing resiliency factors. If you experience discomfort and are in need of assistance, resources to help exist. The GLBT National Help Center can be reached by phone (1-888-843-4564) and on line (www.glnh.org).

The decision to participate in this study is voluntary and you may withdraw at any time. Your responses will be completely anonymous. If findings from this study are published, no individual answers will be reported; and any information you provide will have no

link to your identity. There is no financial compensation for your participation in this un-funded study.

Your completion of the question items will constitute your informed consent to participate in this study.

If you have any questions or concerns about this study, please contact Daniel Stroud (daniel.stroud@osucascades.edu). If you have any questions about your rights or welfare as a participant, please contact the Oregon State University Institutional Review Board (IRB) Office (541-737-8008) or by email (IRB@oregonstate.edu).

Daniel Stroud, Ph.D.
Oregon State University
daniel.stroud@osucascades.edu
541.322.3155

Liesl Farnsworth, L.P.C., Ph.D. Candidate
Oregon State University
farnswol@onid.orst.edu

APPENDIX D:

DEMOGRAPHIC FORM

1. What is your age?
2. What is your ethnicity?

African-American

Asian-American

Caucasian/White

Latino/Hispanic

Native American

Multi/Bi-Racial

Other

3. How do you self-identify (i.e. Trans-)?
4. How long have you identified in this way?
5. At what age do you recall becoming aware of your self-identification?
6. How do you rate your own resilience?

   (a) Very resilient; (b) Resilient; (c) Somewhat resilient; (d) Not resilient

APPENDIX E:

RSA DESCRIPTIVES BY ITEM

Table 2

Resiliency Scale for Adults

Item by Factor	Mean	Std. Deviation
Social Competency (6 items)		
1. It's easy to be flexible in social situations	3.72	0.99
2. Communicate well with new people	3.73	1.14
3. Establish friendly relationships easily	3.66	1.16
4. Easy to find subjects to talk about with others	3.59	1.12
5. Laugh easily	4.10	0.87
6. Enjoy being with other people	3.72	1.04
Social Resource (7 items)		
7. *Have friends/family members who appreciate my abilities*	4.20	0.96
8. Have friends/family members who encourage me	4.09	0.98
9. There are family members/friends who help me	4.13	0.99
10. Always someone who helps me when needed	3.53	1.19
11. Strong connections among my friends	3.79	1.11
12. . I can discuss personal issues with friends/family members	3.86	1.15
13. . Being quickly informed when a family member has a problem	3.04	1.26
Family Cohesion (6 items)		
14. Strong connections in my family	3.20	1.35
15. My family is honest with each other	3.07	1.26
16. My family enjoys finding a chance to have common activity	3.10	1.31
17. My family agrees on important affairs in life	2.78	1.24
18. Enjoy being with family	3.42	1.24
19. My family is optimistic in difficult situations	3.06	1.15
Personal Competency (10 items)		
20. I believe in my abilities	4.21	0.83
21. Can solve my personal problems	4.07	0.88
22. Know I will succeed if I continue	4.02	0.96
23. Know how to get to my aims	3.83	0.93

(continued)

Table 2 (continued)

Resiliency Scale for Adults

Item by Factor	Mean	Std. Deviation
24. Believe in my ability	4.14	0.90
25. I always find a way to solve problems regardless of what happens	3.89	0.89
26. A good future awaits me	3.90	1.02
27. . I trust my judgments and decisions	4.08	0.82
28. Know there is a better future in difficult situations	3.76	0.94
29. Realistic plans for the future	4.05	0.86
Structured Style (4 items)		
30. Prefer to have plans for my activities	3.73	0.87
31. Maintain daily rules even in difficult situations	3.34	1.03
32. When I have a goal I do my best to attain it	4.22	0.72
33. Regular rules make my daily life easier	3.40	0.95

Note. *Response options minimum 1.00 (strongly disagree) to maximum 5.00 (strongly agree). N = 151*

Table 3

Participants' Age Range, Mean, and Standard Deviation

Characteristic	Min	Max.	*M*	*SD*
Age	19	74	43.5	15.25

Note: *N* = 151

Table 4

Participant Ethnicity and Gender Frequency Distribution

Characteristic	Frequency	Percent
Ethnicity		
Caucasian	130	88.0
African America	2	1.3
Asian American	2	1.3
Native American	2	1.3
Hispanic	2	1.3
Multi/Bi-Racial	8	5.3
Other	5	3.3

Note: *N* = 151