THE RELATIONSHIP OF SELF-COMPASSION AND LEVEL OF OUTNESS WITH EMOTIONAL DISTRESS IN TRANSGENDER INDIVIDUALS

By

CHRISTOPHER D. ALLEN

Bachelor of Science in Parks and Recreation Management
Southwestern Oklahoma State University
Weatherford, OK
2007

Master of Education in School Guidance Counseling
Southwestern Oklahoma State University
Weatherford, OK
2009

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Dissertation Approved:

Carrie Winterowd, Ph.D.

Dissertation Adviser

Alfred Carlozzi, Ph.D.

John Romans, Ph.D.

Valerie McGaha, Ph.D.

Laura Barnes, Ph.D.

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Abstract: The purpose of this study was to explore the relationship of self-compassion and level of outness, as well as influential demographics of transgender individuals with emotional distress in a sample of 234 transgender individuals. Participants completed an on-line survey including a demographics page as well as information on their status of their transition, along with the Self-Compassion Scale, an adapted version of the Outness Inventory, and the Depression Anxiety, and Stress Scale-21.

The results of this study indicated that overall self-compassion as well as outness as transgender were significantly and negatively related to emotional distress. Higher levels of self-compassion and outness as transgender were associated with less emotional distress for the transgender people in this study. Aspects of self-compassion including self-kindness, common humanity, and mindfulness subscales were significantly and negatively related to emotional distress. Self-judgment, isolation, and over-identification subscales were significantly and positively related to emotional distress. Demographic characteristics of the sample including age, income, educational level, and sexual orientation were significant predictors of emotional distress in this sample and accounted for approximately 26% of the variance in emotional distress scores. Being older, more educated, having more income, and identifying as heterosexual was associated with less emotional distress. Of interest, sex at birth and race were not significantly related to emotional distress for this sample. After statistically controlling for the demographic variables that were significantly related to emotional distress, overall self-compassion was a significant predictor of emotional distress, accounting for approximately 28% of the variance, but outness as a transgender person was not a significant predictor of emotional distress. Self-compassion was also significantly and positively related to outness as transgender. The six aspects of self-compassion accounted for 10% of the variance in outness in the regression findings.

Transgender individuals may benefit from mindfulness-based and self-compassionate interventions, with less emphasis on the coming out process, depending on the needs of the client, to help them cope with their emotions such as depression, anxiety, and stress. Implications for further research include more qualitative and quantitative studies to better understand the importance of self-compassion in transgender people's lives and to explore the complexities of the coming out process as a transgender individual, including how the coming out process impacts the emotional distress of transgender individuals given the discrimination and pressure they experience in society.

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INTRODUCTION

The transgender community is an underserved and understudied population (Boehmer, 2002; Fredriksen-Goldsen, 2014; Grant et al., 2011; Horvath, Iantaffi, Grey & Bockting, 2012) who often endure discrimination, hatred, and negativity (Gainor, 2000; Tebbe & Moradi, 2012). The lives of most transgender individuals are characterized by elevated life stressors from experiencing social stigma and violence to basic civil rights violations, such as gaining employment, obtaining housing (Bradford, Reisner, Honnold, & Xavier, 2013; Grant et al., 2011), and access to public facilities due to transgender identity (Taylor, 2007). Transgender individuals suffer from lack of community compassion by a misinformed society that has stigmatized, marginalized, and pathologized them (Carrol & Gilroy, 2002). While society has become more accepting of sexual orientation, many states have now passed laws providing protection of sexual orientation from discrimination, gender identity issues have not been protected by law. An individual's decision to disclose his/her gender identity to the world, to feel authentic, means becoming open to the impact of potential social stigma and other risks that accompany that decision (Levitt & Ippolito, 2014), including issues of safety that arise from transphobia (Bettcher, 2007; Mizock & Mueser, 2014).

Coming Out as Transgender

Gender identity and sexual orientation are considered by many to be one in the same; however, they are two very different constructs that are often conflated (APA, 2015). Gender identity is defined as how deeply a person self-identifies with masculine traits experienced as a boy, a man or male, or feminine traits, experienced as a girl, woman or female, or experiences/expresses themselves somewhere along a continuum between masculine and feminine characteristics given their cultural understanding of what it means to be masculine or feminine (Egan & Perry, 2001; Tobin et al., 2010, Wood & Eagly, 2009). On the other hand, sexual orientation relates to a person's emotional and sexual attraction to another (Shively & De Cecco, 1977). Many informally describe sexual orientation as who a person wants to go to bed with, and gender identity as who a person goes to bed as.

For a transgender person, coming out may have nothing to do with one's sexual orientation, but rather one's gender identity. Many transgender people who come out continue with their previous partners if they desire and when it is agreeable to their partner. After a transition, some male to female (MTF) transgender individuals may begin to identify as heterosexual if they were previously attracted to men. Or if they were previously attracted to females and maintain that attraction, they may begin to identify as lesbian. Likewise, female to male (FTM) may begin to identify as heterosexual if they were previously attracted to females and that attraction remains. However, FTM individuals may begin to identify as gay if they were previously attracted to males or have begun to feel an attraction toward men. Their transition is directly related to changing the outside of themselves to reflect what they experience on the inside.

Usually, this "coming out process" with gender identity is described in stages (Devor, 2004; Lev, 2004), and typically this happens first with intimate partners, then family and friends, starting with those thought most likely to be supportive first, and then working toward revealing their transition to others to whom they may experience rejection. However, during every day public life, there is no way to selectively reveal one's gender identity once a transition has occurred.

There is some research evidence to support that coming out as transgender benefits individuals in several ways, such as better psychological well-being, including higher self-esteem as well as less depression and anxiety (Gagne, Tewksbury & McGaughey 1997; Kosciw, Greytak, & Diaz, 2010; Strain & Shuff, 2010). Although initially, there are challenging events that mostly relate to social stigma about transgender identity, often, after a little time passes, there are feelings of happiness and contentment reported by those who come out (Mullen & Moane, 2013).

Additionally, there is evidence to support the risks of coming out, including alienation, harsh criticism, physical abuse, social humiliation, and employment difficulty (Bradford, Reisner, Honnold, & Xavier, 2013; Grant et al., 2011; Lombardi, Wilchens, Priesling, & Malouf, 2002; Rachlin, 2002), which can develop into internalized transphobia, wherein the transgender individual begins to believe they are undeserving of fair treatment (Clements-Nolle et al., 2006; Kidd et al., 2011; Mizock & Lewis, 2008). Mental health practitioners are being encouraged to assist transgender clients in coming out when they are ready by balancing the use of positive psychology and minority stress models, instilling hope for the future and creating positive expectations for therapy, and modeling support and positivity within the primary support system (Budge, 2014).

One of the purposes of the present study is to explore the relationship between outness as a transgender individual and overall well-being. The research on factors related to emotional distress among transgender individuals will be discussed next.

Emotional Distress among Transgender Individuals

Transgender individuals are becoming more visible, and seeking community mental health services more frequently than in the past (Budge, Tebbe, & Howard, 2010). Yet, many mental health care providers lack adequate knowledge about transgender client issues, do not understand their mental healthcare needs, and/or do not realize the diversity they represent (Bess & Staab, 2009; Bidell, 2013; Carroll & Gilroy, 2002; Carroll, Gilroy, & Ryan, 2002).

Despite the fact that transgender individuals experience many of the same issues in psychotherapy as the general population (e.g., identity, self, self-in-relation, identity, intimacy, autonomy and connection; Fraser, 2009), in comparison, they suffer from higher rates of mental health issues, including depression, anxiety, low self-esteem, internalized transphobia, suicidal ideation, and distress from social stigma (Bockting, Miner, Romine, Hamilton, & Coleman, 2013; Carmel, Hopwood & dickey, 2014; Nuttbrock et al., 2012; Samons, 2001) believed to be exacerbated by minority stress (Meyer, 2003). The distress that transgender men and women experience can contribute to high levels of depression and anxiety and rates of mental health concerns that exceed heterosexual as well as lesbian, gay, and bisexual (LGB) populations (Budge, Adelson, & Howard, 2013). In a study of 28,000 transgender and gender non-conforming individuals who had negative experiences with

unsupportive families, 54% of them attempted suicide, and 50% of them were currently experiencing serious psychological distress (James et al., 2016).

Transgender people may experience shame for feeling different, experience seclusion, lack of community encouragement, and suffer from discrimination, for example, in finding housing, gaining financial security, and addressing employment concerns (Borden, 2015). Moreover, these stressors are often managed with coping behaviors that are unhealthy (Hepp, Kraemer, Schnyder, Miller, & Delsignore, 2005); for example, cutting, burning, severe scratching, hitting, and interfering with wound healing (Klonsky, 2007). In one study (dickey, Reisner & Juntunen, 2015), approximately 42% of transgender individuals had a history of non-suicidal self-injury (NSSI), and for many, their NSSI persisted throughout their lives.

In general, the emotional distress transgender individuals experience may be related to some of their unique challenges (Budge, Tebbe, & Howard, 2010; Levitt & Ippolito, 2014), such as obtaining legal documentation that reflects their gender identity rather than their sex at birth, as well as vocational and economic challenges that result from lack of laws to protect transgender people from employment discrimination, contributing to high unemployment, and low annual income (Badgett, Lau, Sears, & Ho, 2007).

There is some research to support the relationship between social support and emotional distress (Budge, 2011; Budge et al., 2013; Budge, Rossman, & Howard, 2014). Transgender individuals experience higher levels of well-being when they have higher levels of social support (Davey, Bouman, Arcelus & Meyer, 2014), and more involvement with the transgender community (Budge et al., 2013). Despite the elevated amount of stress and hardship experienced in the lives of most transgender individuals, positive coping behaviors

buffer the effects of negative life experiences. In one study, transgender men reported positive emotions through their transition, including confidence, comfort, connection, feeling alive, amazement, pride, happiness, and interpersonal reactionary emotions (Budge, Orovecz, & Thai, 2015).

While there is some emerging research focused on the emotional distress and well-being of transgender individuals, this research is still in stages of infancy, and research findings are not yet routinely implemented (Chavez-Korell & Johnson, 2010; Nemoto, Operario, & Keatley, 2005; Sperber, Landers, & Lawrence, 2005; Taylor, Jantzen, & Clow 2013). Of interest, no researchers to date have explored how positive psychology variables such as self-compassion relate to emotional distress in transgender individuals, which is one of the purposes of the present study. The research on self-compassion will be explored next.

Self-Compassion

The Eastern philosophical concept of self-compassion, which is rooted in principles of Buddhism, has become more commonly integrated into Western psychology much by way of the interests of research psychologists during the mid to late 1990's, (e.g., Epstein, 1995: Molino, 1998; Rubin, 1996; Watson, Batchelor, & Claxton, 1999), leading to a better understanding of well-being, and inviting others to develop mindfulness-based interventions (Neff, 2003a). Self-compassion is defined as "being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness" (Neff, 2003b, p. 87.) Self-compassion includes "offering nonjudgmental understanding to one's pain, inadequacies, and failures ... as part of the larger human experience" (Neff, 2003b, p. 87.)

The six dimensions of self-compassion fall along three continua: Self-kindness versus Self-judgment, feelings of common humanity versus isolation, and mindfulness versus over-identification with one's thoughts and emotions (Neff, 2011). Self-kindness is demonstrated by people who have resolved to be loving and considerate toward themselves, rather than harsh and disparaging when faced with challenging life events. Self-judgment, in contrast, is harsh and critical judgment of the self for having inadequacies and personal flaws. Common Humanity involves the recognition that all people share in the struggles of life and failures that accompany being human. Isolation, on the other hand, is the tendency to feel alone and disconnected from others when experiencing hardship and suffering. Lastly, mindfulness is the ability to take a nonjudgmental stance toward one's painful thoughts and feelings and examine them without changing or ignoring them. Over-identification occurs when an individual's storyline of pain gets caught up in negative self-relevant, exaggerated, and obsessive thoughts and emotions (Neff, 2011).

Research indicates that self-compassion is linked to positive mental welfare and functioning among predominantly White, heterosexual samples (Neff, 2004; Neff & Lamb, 2009; Neff, Kirkpatrick, & Rude, 2007; Neff, Rude, & Kirkpatrick, 2007). Developing self-compassion may be a very important goal in treatment for transgender individuals, as they try to navigate a society that has been misled by stereotypes and misinformation. Self-compassion has been explored primarily in heterosexual samples, with some emerging research with gay, lesbian, and bisexual individuals, which will be discussed shortly. In a first of a two-part study examining self-compassion and adaptive psychological functioning, Neff, Kirkpatrick, and Rude (2007) found that self-compassion served as a buffer against anxiety when an ego-threat was presented, and was also linked to the use of connected versus

separate language when writing about weaknesses. In the second study, they found that self-compassion positively correlated with psychological well-being, and that there were positive correlations between clients' reports of self-compassion and therapists' reports of clients' self-compassion. In another study, the same researchers (Neff, Rude, & Kirkpatrick, 2007) examined self-compassion, positive psychological functioning, and added personality traits. They found that self-compassion was a far better predictor of positive psychological strengths than personality, and that approaching painful feelings with self-compassion is linked to happiness and optimism, and may assist in the ability to grow, explore, and better understand self and others.

In yet another study, self-compassion was found to be ten times more accurate as a predictor of anxiety and depression symptom severity, and quality of life than mindfulness (Van Dam, Sheppard, Forsyth, & Earlywine, 2010). In a study among individuals living with HIV/AIDS, (Eller, Rivero-Mendez, Voss, Chen, Chaiphibalsarisdi, Iipinge, & Brion, 2014), those who reported more negative self-schemas were more vulnerable to depression, and those with depressive symptoms were more likely to be female or transgender, to report lower self-kindness as well as higher self-judgment. The strongest predictor of depressive symptoms was self-judgment for this sample.

In heterosexual samples, self-compassion has been positively associated with social connectedness, maternal support, positive family functioning, and attachment styles (Neff & McGehee, 2010) and negatively correlated with depression and anxiety (Neff & McGehee, 2010), including attachment anxiety (Wei, Liao, Ku, & Shaffer, 2011) and anger (Winterowd, Magruder, Shaw, & Sneed, 2015). Self-compassion has also been found to

mediate the relationship between attachment anxiety and subjective well-being (Wei, Liao, Ku, & Shaffer, 2011).

To date, there has been only a couple of research studies conducted to explore self-compassion and emotional distress within the LGBT population. In one study (Marks, Winterowd, & Crethar, 2017), researchers explored parental attachment, support, and acceptance of LGB identity, and level of outness with self-compassion and emotional distress in participants in the LGB community. Results indicated that self-compassion and outness as LGB were negatively correlated with and predictive of emotional distress for LGB individuals. In addition, self-compassion was positively related to level of outness for LGB individuals in this study.

Crews and Crawford (2015) sought to understand the role of being out on a queer person's self-compassion and found those who were totally out did have more self-compassion compared to those who were not out. However, the study was directed toward outness of sexual orientation and their definition of queer clustered all sexual minorities together including lesbian, gay, bisexual, transgender, questioning/queer, intersex, and others. The authors explained that sexual orientation and gender identity were indeed different, yet those included in the study that identified as intersex or transgender answered questions about sexual orientation only, and were devoid of any gender specific questions. Additionally, the researchers of this study failed to look at the well-being of the sample, and yet, most implications of gender identity and sexual orientation studies implore researchers to find ways to improve the well-being of this population due to the elevated rates of emotional distress for transgender individuals.

It is important to understand how self-compassion and level of outness could be related to the emotional distress of transgender and gender non-conforming populations. Being self-compassionate could very well be an important part of coping strategies that are desperately needed, given the impact of social stigma and transphobia on the transgender population. For example, research indicates that self-compassion affords more emotional resilience and stability than self-esteem (Neff, 2011). Leary et al. (2007) found that self-compassion helped people accept negative self-relevant emotions with emotional calmness whereas self-esteem did not. Neff & Vonk (2009) found self-compassion to offer similar benefits as self-esteem without the drawbacks of self-evaluation, ego-defensiveness, and self-enhancement. Neff contended that self-compassion correlates with social connectedness, being more satisfied with life, happiness, hopefulness, emotional intelligence, positive affect, insight, personal creativity, and learning goals, together with less depression, anxiety, self-criticism, perfectionism, performance goals and disordered eating (as cited in Neff, 2009, pp. 561-573; Neff, 2011) and less anger (Winterowd, Magruder, Shaw, & Sneed, 2015).

In summary, self-compassion is believed to be a psychological construct that may serve as a protective factor for transgender individuals who choose to openly live every day in their perceived gender. Self-compassion has the potential to greatly improve the well-being and quality of life of transgender individuals and serve as a buffer against the effects of being out as well as overall emotional distress. Further research on self-compassion with transgender individuals is needed. However, there have been no studies to date conducted with transgender individuals to explore how self-compassion and outness as transgender relates to their emotional distress.

The purpose of this study was to explore the relationship of self-compassion and level of outness as correlates and predictors of overall emotional distress (including depression, anxiety, and stress) in a convenience sample of transgender individuals. In addition, the relationship between self-compassion (total and subscales as predictors) with level of outness for this transgender sample was also explored.

Research Questions and Hypotheses

The research questions for this study were as follows: 1) what is the relationship between some of the demographic variables of transgender individuals with their level of emotional distress (these demographic variables are representative of multicultural complexities and intersectionality), 2a) what are the bivariate relationships between self-compassion (total score and the six subscales including self-kindness, self-judgment, common humanity, mindfulness, over-identification), level of outness (total score), and emotional distress (i.e., total score) among transgender individuals? 2b) What is the linear relationship of self-compassion (total score) and outness (total score) with emotional distress (overall score), 3) what is the linear relationship of self-compassion (subscale scores) with emotional distress (total score)? and 4) what is the linear relationship of self-compassion (subscale scores) with level of outness as transgender (total score)?

Hypothesis 1. It was hypothesized that the demographic variables of age, annual income, education level, sexual orientation, and sex assigned at birth would have significant relevance to the level of emotional distress experienced among transgender individuals. It was expected that these demographics would represent the multicultural diversity present in

this transgender sample and would have significant relevance to their level of emotional distress.

Hypothesis 2a. It was hypothesized that overall self-compassion would be significantly and negatively related to overall emotional distress (including depression, anxiety, and stress). It was also hypothesized that the self-compassion subscales of self-kindness, common humanity, and mindfulness would be significantly and negatively related to overall emotional distress whereas the self-compassion subscales of self-judgment, isolation, and over-identification would be significantly and positively related to emotional distress in transgender individuals. It was also hypothesized that self-compassion (total score) would be significantly and positively related to level of outness among transgender individuals. It was expected that the self-compassion subscales of self-kindness, common humanity, and mindfulness would be significantly and positively related to level of outness whereas the self-compassion subscales of self-judgment, isolation, and over-identification would be significantly and negatively related to level of outness in transgender individuals. It was also hypothesized that level of outness would be significantly and negatively related to emotional distress (overall score) in transgender individuals.

Hypothesis 2b. It was hypothesized that overall levels of self-compassion and outness as transgender would be significant predictors of emotional distress and that both would load negatively in the regression findings.

Hypothesis 3. It was hypothesized that self-compassion subscale scores would be significant predictors of emotional distress in transgender individuals. It was expected that the self-compassion subscales of self-kindness, common humanity, and mindfulness would

significantly and negatively predict emotional distress; the self-compassion subscales of self-judgment, isolation, and overidentification would significantly and positively predict emotional distress.

Hypothesis 4. It was hypothesized that self-compassion subscale scores would be significant predictors of outness in transgender individuals. It was expected that the self-compassion subscales of self-kindness, common humanity, and mindfulness would significantly and positively predict outness as a transgender individual and the self-compassion subscales of self-judgment, isolation, and overidentification would significantly and negatively predict outness as a transgender individual.

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CHAPTER II

METHODOLOGY

Participants

A total of 301 individuals who identified as transgender initially participated in this study. Two participants were not included in the analyses of this study because they reported they were under the age of 18. Sixty-seven individuals were removed due to missing a significant amount of data (missing more than 10% of the items on an individual questionnaire), which could have potentially impacted the findings of this study.

The final sample of participants were 234 self-identified adult transgender individuals, who completed an on-line survey exploring factors related to emotional distress. The mean age of the participants was 33.91 years old, (sd = 13.79). They reported a mean age of discovery of gender incongruence as 22.80 years of age (sd = 9.70). The participants included a fairly equal number of individuals whose sex (gender) assigned at birth were male (56.8%, n = 133) and female (43.2%, n = 101). These individuals reported their gender identity as MTF (41%, n = 96), FTM (27.4%, n = 64), other (17.1% n = 40), male (5.6%, n = 13), female (8.5%, n = 20), and intersex (.4%, n = 1). The specific text of those participants who indicated their gender identity as "other" are listed in Table 1.

Participants indicated they either planned to take steps to transition (91%, n = 213) or had no plans to transition (9%, n = 21). Some participants intended to live stealth, or undetected as transgender (60.15, n = 140), while others reported they would not (39.9%, n = 93). Participants indicated education levels of college degree (47.9%, n = 112), some college (38%, n = 89), and high school or less (14.1%, n = 33). The participants were predominantly Caucasian (81.5%, n = 190). Other races represented in this sample were bi-racial (7.7%, n = 18), multi-racial (3.4%, n = 8), Hispanic (2.6%, n = 6), Native American (2.6%, n = 6), Asian American (1.3%, n = 3), and Black or African American (.9%, n = 2).

Participants indicated that their sexual or affectional orientation was heterosexual (16.7%, n = 39), other (15.8%, n = 37), Queer (15.4%, n = 36), lesbian (15.4%, n = 36), bisexual (7.7%, n = 18), asexual (7.3%, n = 17), questioning (6.8%, n = 16), or gay (4.7%, n = 11). The relationship status of participants included people who identified as single (35.5%, n = 83), married (21.8%, n = 51), partnered (16.2%, n = 38), divorced (8.1%, n = 19), polyamorous (7.7%, n = 18), other (5.6%, n = 13), and engaged (5.1%, n = 12). The demographics of this sample are provided in Table 1.

Measures

Participants completed an on-line survey including a demographics questionnaire, the Self-Compassion Scale (SCS; Neff, 2003a), the Depression, Anxiety, and Stress Scale (DASS-21; Lovibond & Lovibond, 1996) and an adapted version of the Outness Inventory (OI; Mohr & Fassinger, 2000) for transgender individuals (Allen & Winterowd, 2016).

Demographic Page. Participants were asked to complete a demographics questionnaire requesting the participant's age, gender identity, sexual orientation, race/ethnicity, relationship status, level of education, work status, transition status, and socioeconomic status. (There were other questions asked and these should be included here, including some of the demographics were used in our analyses.)

Self-compassion Scale. (SCS; Neff, 2003a). The SCS is a 26 item scale which includes six subscales: the 5-item Self-kindness subscale (i.e., being kind to oneself; e.g., "I try to be loving toward myself when I am feeling emotional pain."), the 5-item Self-judgment subscale (i.e., being judgmental towards onself; e.g., "I'm disproving and judgmental about my own flaws and inadequacies."), the 4-item Common Humanity subscale (i.e., realizing that we are not alone with our experience; e.g., "When things are going badly for me, I see the difficulties as part of life that everyone has to go through."), the 4-item Isolation subscale (i.e., feeling disconnected and different from others; e.g., "When I fail at something that's important to me, I tend to feel alone in my failure."), the 4-item Mindfulness subscale (i.e., awareness of one's thoughts and feelings without judgment; e.g., "When something upsets me, I try to keep my emotions in balance."), and the 4-item Over-identification subscale (e.g., judging one's thoughts and feelings; "When I'm down, I tend to obsess and fixate on everything that's wrong.").

Participants responded to statements that indicated the frequency with which they acted in the way described in each of the items on a Likert-scale of 1 (almost never) to 5 (almost always). To calculate the SCS total score, the negative subscale items from the Self-judgment, Isolation, and Over-identification subscales were reverse scored and totaled along with the Self-kindness, Common Humanity, and Mindfulness subscales.

Higher scores on the SCS indicate more self-compassion; lower scores on the SCS indicate less self-compassion. For the purposes of this study, the SCS total and subscale scores were used in the correlational and regression analyses (see original research questions for this study).

The SCS has been demonstrated to have good test-retest reliability (.85-.93 over 3-week timeframe; Neff, 2003a), and good internal consistency reliability for the overall scores and subscale scores (i.e., Cronbach alphas of .92 for the overall score and .78 for the Self-kindness subscale; .77 for the Self-judgment subscale; .80 for the Common Humanity subscale; .79 for the Isolation subscale; .75 for the Mindfulness subscale; and .81 for the Over-identification subscale; Neff, Kirkpatrick, & Rude, 2007).

In Neff's original study (2003a), factor analyses were conducted and items loading lower than .40 were omitted and the remaining 26 items created the construct of self-compassion, consisting of six factors which became the six subscales of the SCS. A confirmatory factor analysis (CFA) was conducted to assess the fit of the six inter-correlated factors to the 26 items, which was found to be adequate (Non-Normed Fit Index (NNFI = .90; Comparative Fit Index (CFI) = .91), each loading significantly different from zero ($p < .001$). Additionally, a higher order CFA was conducted to ascertain if a single higher-order factor would further elucidate the inter-correlations between the six factors. The model fit marginally well (NNFI) = .88; CFI= .90.

Convergent validity of the SCS is firmly established in that self-compassion has been significantly and positively correlated with social connectedness, $r = .41$, $p < .01$, as well as significantly and negatively correlated with self-criticism as measured by the Depressive Experiences Questionnaire, $r = -.65$, $p < .01$ (Neff, 2003a). In addition, self-

compassion has shown to be positively related to self-esteem (r = .59), self-acceptance (r = .62), self-determination (r = .43), autonomy (r = .42), competence (r = .52), and relatedness (r = .25; Neff, 2003a). Self-reported self-compassion significantly correlated (r = .32) with therapists' ratings of participants' self-compassion, even on their first meeting (Neff et al., 2007).

The internal consistency reliability estimate for the SCS total score was .96 for this transgender sample. The internal consistency reliability estimates for the SCS subscale for this transgender sample are as follows: .88 for Self-Kindness, .82 for Common Humanity, .86 for Mindfulness, .89 for Self-Judgment, .86 for Isolation, and .84 for Over-identification.

Depression Anxiety Stress Scales. (DASS-21; Lovibond & Lovibond, 1996). The DASS-21 is a 21-item self-report questionnaire, which is the shortened version of the DASS-42 item rating scale. The DASS-21 is designed to measure levels of emotional distress in terms of depression, anxiety, and tension/stress. There are 7 items in each of the three subscales. The DASS-21 Stress Scale measures difficulty relaxing, nervous arousal, and being easily upset or agitated, irritable, or over reactive, and impatient (e.g., "I found myself getting agitated"). The DASS-21 Depression Scale measures dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest or involvement, anhedonia, and inertia (e.g., "I felt that I had nothing to look forward to."). The DASS-21 Anxiety Scale measures autonomic arousal, skeletal musculature effects, situational anxiety, and subjective experience of anxious affect (e.g., "I felt scared without any good reason.") Participants respond to each statement using a 4 point Likert-scale of 0 ("Did not apply to me at all,") to 3 ("Applies to me very much, or most of the time."). The

overall score has been found to be more reliable, although some studies have used the subscale scores (e.g., Clark & Winterowd, 2012; Marks et al 2015). For the purposes of this study, the overall score was used.

The DASS-21 has good test-retest reliability as indicated by the results from the Lovibond (1998) study in which 3540 participants completed the DASS and it was later re-administered to 882 of these participants, with time lapsing from 3-5 years. Time 2 scales were best predicted by Time 1 scales.

In this same study, an exploratory factor analysis of the DASS-21 was conducted for Time 1 and Time 2, and a three-factor solution emerged which became the subscales of depression, anxiety, and stress. At each measurement, all subscale scores were constrained to their corresponding factor and each loaded positively. These results support the longitudinal nature of depression, anxiety, and stress, with a distinction between anxiety symptoms and tension-stress symptoms, demonstrating convergent validity and supportive of the existence of syndrome-specific vulnerabilities (Lovibond, 1998).

The DASS-21 has demonstrated adequate convergent and discriminant validity when compared to other scales designed to differentiate between anxiety and depression (Lovibond & Lovibond, 1995). In a comparison sample of N = 717 who were administered the Beck Depression Inventory (BDI) and the Beck Anxiety Inventory (BAI; Steer & Beck, 1997), the DASS-21 Anxiety scale correlated .81 with the BAI, and the DASS-21 depression scale correlated .74 with the BDI (Lovibond & Lovibond, 1995).

Internal consistency reliability estimates for each of the three subscales were as follows: .91 for Depression, .84 for Anxiety, and .90 for Stress (n = 2914; Lovibond & Lovibond, 1995). In another study (Clark & Winterowd, 2012), the internal consistency estimate for the DASS-21 total scale score was .93.

In the present study, the internal consistency reliability estimate for the DASS-21 total score was .95 for this transgender sample. The internal consistency reliability estimates for the DASS-21 subscales for this transgender sample are as follows: .88 for Stress, .93 for Depression, and .85 for Anxiety.

Outness Inventory (OI; Mohr & Fassinger, 2000). The OI assesses the degree respondents are open to different groups of people in their lives about their sexual orientation, including family, coworkers, and friends. The OI consists of 11 items that are rated using a 7-point Likert scale. The OI includes a total score as well as three subscales: 1) Out to Family, 2) Out to World, and 3) Out to Religion.

Research on the original version of this measure has indicated good internal reliability estimates for the subscales range from .74 to .97 (Mohr & Fassinger, 2000) and .92 for the overall score (Belmonte, 2011). Convergent validity for public outness is noticeable by being associated with the need for a certain degree of interaction with heterosexual individuals as well as the need for privacy (Mohr & Fassinger, 2000). Also, discriminant validity is clearly existent in that participants whose parents practiced anti-gay religions did not differ in their level of public outness, but differed in their level of outness to their family when compared to those who did not have parents practicing such religions (Mohr & Fassinger, 2003).

For the purposes of this study, the OI was adapted to measure the degree to which a person was out about his/her transgender identity. To achieve this, the words "sexual orientation" in each question were replaced with "transgender identity," and four additional questions concerning old and new lesbian, gay, and bisexual friends, and old and new transgender friends were added to the original 11 items. For example, participants would indicate their rating for their level of outness to persons listed separately in questions 1 through 15 (i.e., mother, father, siblings, extended family/relatives, my old heterosexual friends, my new heterosexual friends, my work peers, my work supervisor, members of my religious community, leaders of my religious community, strangers/new acquaintances, and old LGB friends, new LGB friends, old transgender friends, and new transgender friends), with a Likert scale rating of 1 = person definitely does not know about your transgender identity, 2 = person might know about your transgender identity, but it is NEVER talked about, 3 = person probably knows about your transgender identity, but it is NEVER talked about, 4 = person probably knows about your transgender identity, but it is RARELY talked about, 5 = person definitely knows about your transgender identity, but it is RARELY talked about, 6 = person definitely knows about your transgender identity, and it is SOMETIMES talked about, 7 = person definitely knows about your transgender identity, and it is OPENLY talked about, 0 = not applicable to your situation; there is no such person or group of people in your life. Given that this measure is being adapted for level of outness about one's transgender identity, no reliability and validity information is currently available. In the present study, the internal consistency reliability estimate for the OI overall score was .83 for this transgender sample. For the purposes of this study, the overall score was

used given that the majority of researchers using the original OI also use the overall score rather than the subscale scores.

Procedure

Participants were recruited using a snowball method of data collection. E-mail solicitation inviting transgender individuals to participate in the study was sent to listservs used to connect the transgender community throughout a Midwestern state as well as a listserv for professional counseling and psychology association division members who were dedicated to gender identity and sexual orientation issues (e.g., Div. 44 of APA, ALGBTC of ACA).

Participants were invited to participate in a study on transgender experiences and were informed that participation in the study would take no more than 30 minutes of their time. Participation in the study was voluntary, and participants were informed they could withdraw from the survey at any point. Participants were also informed that all survey responses were anonymous, and they were not to write any identifying information on their survey responses. If participants were interested in being included in a drawing for a $50.00 gift certificate/card, they were guided to a separate website to enter their email address for being contacted in the event they were a winner.

Participants were asked to read an informed consent page prior to completing the survey. If transgender individuals chose to participate, they completed a demographic page and three questionnaires including the DASS-21, the SCS, and the OI. At the end of the survey, they were guided to a separate website thanking them for their participation and asking them if they wanted to be entered into the drawing.

CHAPTER III

RESULTS

Descriptive Statistics

Examination of the descriptive statistics for self-compassion revealed that, on average, the transgender participants in this study were moderately self-compassionate (m = 70), however there was fairly large variation in scores around the mean (sd = 21.82). These findings may or may not reflect the experiences of self-compassion for all transgender individuals in the population at large.

Examination of the descriptive statistics for the outness scale revealed that, on average, the transgender participants in this study were somewhat out to people in their lives (m = 51.89), with some considerable variation in scores around the mean (sd = 20.48). This indicates some level of outness that may or may not reflect the level of outness of transgender individuals across the U.S. or even globally. While researchers do use the overall outness score in studies across the board, certainly looking at the unique individual profiles of outness when working with clients in individual counseling who are transgender will be very important to provide the best services possible. In reviewing the frequency distribution of scores for the individual items of the OI for this sample of transgender individuals, participants were typically out more to their new and old transgender friends, new and old LGB friends, and old heterosexual friends moreso than.

their parents. Over half of the sample were out to one or both parents/guardians. This sample of transgender individuals was less out in their work circles, and the least out to strangers in the community, and people in religious/spiritual communities.

Demographic Findings for Emotional Distress in Transgender Individuals

Research Question 1. What is the relationship between some of the demographic variables of transgender individuals with their level of emotional distress?

To answer research question 1, correlational and t-test analyses were conducted to see if some of the demographic variables were related to or had an impact on the outcome variable of emotional distress (DASS-21 overall score) for this transgender sample.

Age was significantly and negatively correlated with emotional distress (r = -.43, $p < .001$). The older the participants were, the less emotional distress they experienced. Annual income was significantly and negatively correlated with emotional distress (r = -.32, $p < .001$). The more money participants made, the less emotional distress they experienced.

T-tests were conducted to explore demographic group differences (i.e., assigned sex at birth—Male versus Female, race—People of Color and Caucasian participants, education level—High School versus College, sexual orientation—heterosexual versus LGBQQA) in overall emotional distress and outness. Correlational analyses were also conducted to explore the relationship of continuous demographic variables with emotional distress (i.e., age and income level).

A t-test was conducted to compare emotional distress in transgender individuals whose sex assigned at birth was male with those whose sex assigned at birth was female.

There was not a significant difference in the scores of males (m = 41.73, sd = 13.43) and females (m = 41.63, sd = 14.29), t (231) = .05, p > .05. These results suggest that transgender individuals whose sex assigned at birth was male or female experience similar levels of emotional distress.

Another t-test was conducted to compare emotional distress in transgender individuals who identified as Caucasian with those who identified as culturally diverse. There were no significant racial group differences in emotional distress scores (Caucasian participants, m = 42.02, sd = 13.84, and participants of color, m = 40.33, sd = 13.69), t (227) = .70, p > .05. These results suggest that culturally diverse transgender individuals do not differ from Caucasian transgender individuals in their levels of emotional distress.

A t-test was conducted to compare emotional distress in transgender individuals whose education level was a high school diploma or less compared to those participants who had a 4 year or more years of college or a college degree. There was a significant education group difference in emotional distress for transgender individuals with a high school diploma or less education (m = 49.91, sd = 13.71) compared to those transgender individuals with a 4-year college degree or more college education experience (m = 40.33, sd = 13.34), t (231) = 3.81, p < .001. These results suggest that the more educated transgender people are, the less emotional distress they experience.

A t-test was conducted to compare levels of emotional distress for transgender individuals whose sexual orientation was heterosexual with those who identify as other than heterosexual. There was a significant sexual orientation group difference in the scores of those that identify as heterosexual (m = 36.16, sd 11.24) and those who identify as other than heterosexual (m = 42.76, sd = 13.99), t (231) = -2.74, p < .05. These results

suggest that transgender individuals who identify as heterosexual experience less emotional distress than those who identify as LGBQQA.

Based on the findings of these analyses, the demographic variables that were statistically controlled for in the multiple regression analyses to follow to address research questions 2b, and 3 were age, annual income, sexual orientation, and education level.

Correlational Analyses

Research question 2a: What are the bivariate relationships between self-compassion (total score and the six subscales including self-kindness, self-judgment, common humanity, mindfulness, over-identification), level of outness (total score), and emotional distress (total score) among transgender individuals?

To answer research question 2a, Pearson correlational analyses were used to explore the bivariate relationships between and among self-compassion, level of outness, and emotional distress. The total scores on the SCS, OI, and DASS-21 were used for these analyses. Self-compassion and outness as a transgender person ($r = .32$, $p < .001$) were significantly and negatively related to emotional distress for this transgender sample. The more out transgender people are, the less emotional distress they experience.

Additionally, self-compassion and emotional distress were significantly and negatively related to one another ($r = -.66$, $p < .01$). As self-compassion increased, emotional distress decreased for this transgender sample. Outness and emotional distress were significantly and negatively related to one another ($r = -.30$, $p < .01$). The more out transgender people are, the less emotional distress they experience.

Emotional distress was significantly and negatively related to the positive self-compassion subscales of self-kindness (r = -.49, p < .001), common humanity (r = -.47, p < .001), and mindfulness (r = -.50, p < .001). More self-compassion was associated with less emotional distress. The more transgender individuals could be kind to themselves, to see themselves sharing similar life struggles and failures as others, and to take a non-judgmental stance toward their painful thoughts and feelings, without trying to change or ignore them, the less emotional distress they were in general.

The negative self-compassion subscales of self-judgment (r = .57, p < .001), isolation (r = .65, p < .001), and over-identification (r = .63 p < .001) with one's thoughts and feelings were positively related to emotional distress. Self-judgment, isolation, and over-identifying with negative thoughts and feelings was associated with more emotional distress. The more critical and harsh transgender people are towards themselves for having inadequacies and personal flaws, the more they tended to feel alone and disconnected from others when experiencing hardship and suffering, and the more their stories of personal pain contained negative, exaggerated, and obsessive thoughts and emotions, the more emotional distress they experience. See Table 5 for the correlation matrix.

Regression Analyses

2b) What is the linear relationship of self-compassion (total score) and outness (total score) with emotional distress (overall score) for this sample of transgender individuals?

To answer research question 2b, a multiple regression analysis was conducted to explore the linear relationship of self-compassion and level of outness as a transgender

person with overall level of emotional distress among transgender individuals. Given that the demographic variables of age, income level, sexual orientation, and education level were significantly related to emotional distress for this sample, these demographic variables were controlled for statistically in the following multiple regression analyses by entered them in the first step (Block 1) of the analysis. In model 1, age, income level, sexual orientation, and education were found to be significant predictors of emotional distress when considered together, $F(4,228) = 17.91$, $p < .001$. Examination of the standardized beta weights revealed that Education level ($\beta = -.151$, $t = -2.51$, $p < .05$); Sexual orientation ($\beta = .155$, $t = 2.67$, $p < .01$); and Age ($\beta = -.328$, $t = -4.88$, $p < .001$) were the significant individual contributors to the understanding of emotional distress for the transgender individuals in this study. Participants who were older, had more education, and identified as heterosexual reported experiencing less emotional distress.

In the second step of the analysis (Block 2), self-compassion and outness were entered into the equation and found to be significant predictors of emotional distress when considered together, $F(6, 226) = 42.15$, $p < .001$. Examination of the standardized beta weights, revealed that Self-compassion, ($\beta = -.54$, $t = -10.73$, $p < .001$) was also a significant individual contributor to the understanding of emotional distress for the transgender individuals in this study. These results suggest that the more self-compassionate transgender individuals are, the less emotional distress they report feeling.

Results of a follow-up sequential regression revealed that self-compassion accounted for an additional 28.3% of the variance in emotional distress scores after statistically controlling for the demographic variables ($B = -.560$, $t = -11.59$, $p < .001$. Outness as a transgender person only accounted for an additional 6% of the variance in

emotional distress scores above and beyond what was accounted for by demographic variables and self-compassion ($B = -.083, t = -1.70, p > .05$).

While both self-compassion and outness as a transgender person are important correlates of the emotional distress of transgender individuals, self-compassion is really the variable that accounts for much of the emotional distress of transgender individuals in this study (28.3%), above and beyond demographic contributors, and not outness as a transgender individual. Thus, the correlational findings indicated that more self-compassionate transgender individuals are, the less emotional distress they experience. In addition, the more out a transgender person is, the less emotional distress they experience. However, the regression findings indicated that self-compassion was the significant individual predictor of emotional distress for transgender individuals in this study above and beyond demographic characteristics, and that outness as transgender was not a significant individual predictor of emotional distress for this sample.

Demographic variables of age, sexual orientation, educational level, and income were related to the emotional distress of transgender individuals (collectively accounting for 23.9% of the variance). Being older, having more income, being more educated, and identifying as heterosexual were associated with less emotional distress for the transgender individuals in this study. Being younger, having less income, being less educated, and identifying as LGBQQA as a transgender person was associated with more emotional distress for these participants.

Research question 3: What is the linear relationship of self-compassion (subscale scores) with emotional well-being (total score)?

To answer research question 3, a multiple regression analysis was conducted to explore the linear relationship of self-compassion (subscales) with emotional distress among transgender individuals in this study.

Given that the demographic variables of age, income level, sexual orientation, and education level were significantly related to emotional distress for this sample, these demographic variables were controlled for statistically in the multiple regression analyses by entered them in the first step (Block 1) of the analysis. Age, income level, sexual orientation, and education were found to be significant predictors of emotional distress when considered together, $F(4,228) = 17.91$ $p < .001$. Examination of the standardized beta weights revealed that Age ($\beta = -.328$, $t = -4.88$, $p < .001$), Sexual orientation ($\beta = .155$, $t = 2.67$, $p < .05$) and education ($\beta = -.151$, $t = -2.51$ $p < .05$) were significant contributors to the understanding of emotional distress for transgender individuals in this study, accounting for 23.9% of the variance in emotional distress scores.

In the second step of the analysis (Block 2), the six self-compassion subscales were entered into the equation and were found to be significant predictors of emotional distress when considered together, $F(10, 222) = 27.94$, $p < .001$. Examination of the standardized beta weights revealed that Isolation ($\beta = .320$, $t = 4.11$ $p < .001$) and Overidentification ($\beta = .243$, $t = 2.75$, $p < .01$) were significant individual contributors to the understanding of outness for the transgender individuals in this study. Feeling alone and disconnected from others when experiencing hardship and suffering and getting caught up in negative self-relevant, exaggerated, and obsessive thoughts and emotions was associated with more emotional distress. The self-compassion subscales accounted for an additional 31.8% of the variance in emotional distress scores.

The demographic variables of age, income level, sexual orientation, and education level were related to the level of emotional distress of transgender individual's experiences, and collectively accounted for 23.9% of the variance, while self-compassion accounted for another 31.8%.

Research question 4. What is the linear relationship of self-compassion (subscale scores) with level of outness (total score)?

To answer research question 4, a multiple regression analysis was conducted to explore the linear relationship of self-compassion (subscales) with level of outness among transgender individuals.

Analyses were conducted to explore the impact to demographic variables on level of outness prior to running the multiple regression analysis to answer question 3.

Pearson correlational analyses were used to explore the bivariate relationships between age and level of outness. The total scores on the OI, and DASS-21 were used for these analyses. Age and outness as a transgender person ($r = .11$, $p > .5$) were not significantly related to emotional distress for this transgender sample.

A t-test was conducted to compare outness in transgender individuals whose sex assigned at birth was male with those whose sex assigned at birth was female. There was a significant difference in the scores of males ($m = 47.89$, $sd = 20.83$) and females ($m = 57.48$, $sd = 18.90$), $t(232) = -3.63$, $p < .001$. These results suggest that transgender individuals assigned female at birth were more likely to be out.

A t-test was conducted to compare outness in transgender individuals who identified as Caucasian with those who identified as culturally diverse. There were no significant racial group differences in emotional distress scores (Caucasian participants, $m = 50.88$, $sd = 20.67$, and participants of color, $m = 56.72$, $sd = 20.33$), $t(228) = -1.61$, $p > .05$. These results suggest that culturally diverse transgender individuals do not differ from Caucasian transgender individuals in their levels of outness.

A t-test was conducted to compare outness in transgender individuals whose education level was a high school diploma or less compared to those participants who had a 4 year or more years of college or a college degree. There was not a significant education group difference in outness for transgender individuals with a high school diploma or less education ($m = 48.30$, $sd = 21.89$) compared to those transgender individuals with a 4-year college degree or more college education experience ($m = 52.64$, $sd = 20.30$), $t(232) = -1.12$, $p > .05$. These results suggest that transgender people who are less educated experience outness about the same as those who are more educated.

A t-test was conducted to compare levels of outness for transgender individuals whose sexual orientation was heterosexual with those who identify as other than heterosexual. There was a significant sexual orientation group difference in the scores of those that identify as heterosexual ($m = 61.54$, sd 18.81) and those who identify as other than heterosexual ($m = 50.12$, $sd = 20.39$), $t(232) = 3.23$, $p < .01$. These results suggest that transgender individuals who identify as heterosexual experience higher levels of outness than those who identify as LGBQQA.

For question 4, based on the findings of these preliminary analyses, the demographic variables that were statistically controlled for in the multiple regression analyses were sexual orientation and sex assigned at birth. Age and income were not significantly correlated with outness.

In model 1, Sexual orientation and sex assigned at birth were found to be significant predictors of outness $F(2,231) = 10.47$, $p < .001$. Examination of the standardized beta weights revealed that Sexual orientation ($\beta = -.174$, $t = -2.72$, $p < .01$) and Sex assigned at birth ($\beta = .203$, $t = 3.18$, $p < .01$) were significant contributors to the understanding of outness for transgender individuals in this study. Transgender participants in this study who identify as heterosexual were more out than those who identify as LGBTQQA. Those individuals assigned female at birth were more likely to be out as transgender compared to transgender individuals whose sex assigned at birth were male.

In the second step of the analysis (Block 2), the six self-compassion subscales were found to be significant predictors of outness when considered together, $F(8, 225) = 6.13$, $p < .001$. Examination of the standardized beta weights revealed that none of the self-compassion subscales were significant individual contributors to the understanding of outness for the transgender individuals in this study.

The demographic variables of sexual orientation and sex assigned at birth related to the level of outness of transgender individuals, collectively accounted for 8.3% of the variance, while the six aspects of self-compassion collectively accounted for 9.6% of the variance in outness as transgender scores.

CHAPTER IV

DISCUSSION

In this study, self-compassion and outness as a transgender person were significantly and negatively related to emotional distress for transgender identifying individuals in this study. Being kinder to oneself, being mindfulness of one's thoughts and feelings without over-identifying with them, and realizing one is not alone with his/her/their experience are all associated with less depression, anxiety, and stress for transgender individuals. These correlational findings from the present study were in line with previous research with heterosexual samples (Neff, 2004; Neff & Lamb, 2009; Neff, Kirkpatrick & Rudd, 2007; Neff, Rude & Kirkpatrick, 2007) and LGB samples (Marks et al., 2017) on the significant negative relationship between self-compassion and emotional distress.

However, it should be noted that key demographic variables (education, sex assigned at birth, and sexual orientation) and overall self-compassion were more predictive of the emotional distress experienced by transgender individuals than their actual outness as transgender individuals. Interestingly, this finding is not in line with previous research with LGB individuals, in that self-compassion and outness as LGB were significant predictors of emotional distress for LGB individuals (Marks et al, 2017).

While outness for some transgender individuals may be very important in relation to their overall emotional well-being, for others it may not be. Once transgender individuals go through their transition, they may not feel the need to be out given the benefits of living stealth in our society. Transgender individuals may realize the benefits and risks of outness, but, at the same time, may not view their outness as critical to their overall emotional well-being compared to their inner/internal process of self-acceptance, self-kindness, mindfulness, and existential realizations that they are not alone with their experiences. If transgender individuals are able to pass as their experienced gender without others' knowledge, it is usually what was desired from a young age, and giving that up may not even be a consideration, even if there are psychological benefits. Historically, transgender individuals disappear after transition, making it hard to find willing research participants.

Another significant finding of the present study was that self-compassion was significantly and positively correlated with outness for transgender individuals in this study. Interestingly, all the unique aspects of self-compassion were significantly related to outness as a transgender person, but no one aspect of self-compassion was a unique predictor of outness as transgender. These correlational findings were also consistent with one previous study with an LGB sample indicating that self-compassion was negatively correlated with emotional distress and was positively correlated with outness (Marks et al., 2017).

There is evidence in the previous research that transgender individuals experience higher levels of emotional distress, which are believed to contribute to elevated mental health concerns, that exceed both heterosexual (Grant et al., 2011) and LGB populations

(Budge, Adelson, & Howard, 2013). This may be due to the discrimination and oppression that transgender individuals experience in our societies compared to heterosexual and LGB individuals.

This was the first study of its kind that explored correlates of self-compassion among transgender individuals. It was our aim that the findings from this study would help narrow the gap in research specific to transgender populations. They often face unique obstacles related to coming out with their gender identity that are different from, but may include, concerns of sexual orientation (Cass, 1979, 1984, 1990; Devor, 2004). In this study, the positive self-compassion subscales of self-kindness, common humanity, and mindfulness were negatively related to emotional distress. Thus, transgender individuals who were kind to themselves, viewed their failures and struggles as common to humanity, and who could avoid judging their painful thoughts and feelings without trying to change them, experienced less emotional distress. Isolation and over-identification with one's problems were both significant predictors of psychological distress. The negative self-compassion subscales of self-judgment, isolation, and over-identification with one's thoughts and feelings were positively related to emotional distress. Thus, transgender individuals who were more harsh and self-critical for personal flaws and short-comings felt more alone and socially disconnected during hard times. They also reported more personal narratives containing negative, exaggerated, and obsessive thoughts and emotions, and tended to experience more emotional distress. Similar research has been conducted with LGB populations and findings included self-kindness, isolation and overidentification as significant predictors of emotional distress (Beard, Eames &Withers, 2017; Crews and Crawford, 2015; Marks et al., 2017). Our

findings were in line with other studies of self-compassion with heteronormative samples as well, that suggest self-compassion served as a buffer against anxiety and correlated significantly and negatively with depression and anxiety (Neff, Kirkpatrick & Rude, 2007; Neff & McGehee, 2010).

Demographic findings from this study suggested that transgender individuals who were older, had higher annual income, identified as heterosexual, and had a college education, experienced less emotional distress. Those who had a 4-year college education or higher experienced less emotional distress. This was consistent with other previous research with transgender individuals who had a high school education or less (Haas, Rogers & Herman, 2014). Transgender individuals who identified their sexual orientation as heterosexual tended to experience less emotional distress in the present study, which was paralleled by similar findings of existing stereotypes and heterosexuals' negative attitudes that connect homosexuality to a violation of gender norms (Herek, 2000; Norton & Herek, 2013; Nagoshi et al., 2008). Older transgender individuals in this study reported less emotional distress, which may imply that as transgender people progress in their transition, emotional distress tended to level out or reduce with the passing of time, which lined up with some research (Mullen & Moane, 2013). In the present study, transgender individuals that had higher annual incomes reported less emotional distress. Those who earned higher annual incomes experienced less emotional distress than those who had lower incomes. The more money they made, the less distress they reported. It is interesting to note that of the 234 participants in this study, 111 reported incomes of $20,000 or less. This may or may not be representative of

transgender individuals in general. However, it is important to note that having less than 20,000 a year for about half of the sample appeared to be a significant stressor for them.

Findings from this study suggested transgender individuals whose sex assigned at birth was male experienced similar levels of emotional distress as those whose sex assigned at birth was female. This was in line with some other previous mental health findings (Clements-Nolle, Marx, Guzman, & Katz, 2001; Clements-Nolle, Marx, & Katz, 2006). However, other studies indicated heteronormative attitudes that were significantly more negative toward transgender individuals than LGB individuals, particularly those whose sex assigned at birth were male (Norton & Herek, 2013).

Transgender individuals in this study who identified as culturally diverse reported experiencing about the same level of emotional distress as those who identified as Caucasian. This was a finding that is not generally paralleled by other research that indicates that stigma and discrimination do contribute to higher levels of mental health concerns, and people of color experienced compounding effects of discrimination, as well as poverty, unemployment, and greater health disparities (James et al., 2016).

In this study, self-compassion and level of outness as a transgender individual were significantly and negatively related to emotional distress. Transgender individuals who report more self-compassion and who were out in more areas of life or to more people tend to experience less emotional distress. The more self-compassion increased, the more emotional distress decreased. The more out a person was, the less emotional distress they experienced. These findings matched up with previous research on outness and emotional distress, indicating the more out a person is, the better emotional well-

being they experienced (Gagne, Tewksbury & McGaughey 1997; Kosciw et al., 2010; Strain & Shuff, 2010). The Outness Inventory total score was not designed to completely capture the unique, and sometimes, difficult decisions related to coming out to different groups of people and how coming out impacts emotional distress for transgender individuals. In this sample, many participants indicated that others who definitely knew and openly talked about their transgender identity with them were their new and old LGBT and heterosexual friends, and to a little lesser degree their mothers, siblings, extended family and fathers, respectively. Over half of the sample responded that being out to spiritual friends and leaders was not relevant to their lives.

When the self-compassion subscales were considered together, they were found to be significant predictors of outness after the demographic variables of age, sexual orientation, income, and education were statistically controlled. However, there were no significant individual predictors of outness for that analysis. The demographics were significantly related to outness when considered together, however, sexual orientation was found to be the only significant individual contributor to the understanding of transgender outness for this sample. Those who identified as heterosexual were more likely to be out as transgender than those who identified as lesbian, gay, bisexual, queer, questioning, or asexual.

Overall, for both transgender and LGB populations, self-compassion and outness were and important in understanding emotional distress among these oppressed and underserved populations, however, self-compassion was the significant predictor, and outness was not. This has interesting implications for counseling and advocacy services for transgender individuals, which will be discussed next.

Implications for Practice

Findings from this present study suggest that self-compassion is a significant protective factor against emotional distress. Negative aspects of self-compassion such as feeling isolated and over-identifying with one's thoughts and feelings predicted emotional distress for transgender individuals in this study. By becoming more mindful of painful thoughts and feelings without over-identifying with them, transgender clients can begin to attain a healthier level of emotional well-being. Health service practitioners are encouraged to commit to assisting transgender clients make improvements using positive psychology and mindfulness-based therapies and CBT therapy to instill hope for the future and creating positive expectations, and focus on teaching facilitative rather than avoidant coping mechanisms and support (Budge et al., 2013; Budge, 2014).

Counselors and psychologists can help transgender clients enhancer their emotional well-being by introducing them to concepts of self-compassion, and helping them learn how to become their own best friend internally, challenging negative and critical self-talk, and generally learning how to nurture the ability to offer kindness and understanding to themselves—just noticing and acknowledging their thoughts and feelings as experiences to attend to and observe, rather than to judge themselves internally. Counselors and psychologists could also introduce transgender clients to ways of feeling connected to others through life's challenges, and learn to view their problems as common to humankind, rather than seeing themselves as unique, isolated, or lonely. Many of us are searching and finding our true, authentic selves, internally as well as externally. Seeking congruence in our outer and inner selves is important for all of us. The struggle to understand and truly love ourselves comes from external as well as

internal sources and forces, including our relationships with others and societal messages at large. We all experience a certain level of oppression, discrimination, and misunderstanding. Acknowledging those challenges can help us realize the importance of being heard and understood. In summary, seeing our common humanity—our common connections—can also be a protective factor against emotional distress for all of us whether we are transgender individuals or not.

Outness was not found to be an important predictor of emotional distress for transgender individuals in this study. Although developing plans to come out to others may be considered important in the process of counseling and psychotherapy, it does not appear to be nearly as important as helping transgender clients learn how to become their own source of support via self-compassion based on the findings of the present study. Rather than solely focusing on helping transgender clients develop a plan to come out to others, counselors and psychologists might have a greater impact on their transgender clients by enhancing their clients' self-compassion and mindfulness.

Many transgender individuals face the loss of social support and community compassion when they begin to transition (Carrol & Gilroy, 2002). This can result in monetary losses that are socially connected as well, such as the loss of jobs, money, and resources. Providing for basic human needs are the most fundamental needs of sound emotional well-being (Maslow, 1943). Almost half of the participants in this study reported annual earnings of $20,000 or less. This has implications for practice in that counselors and psychologists may need to broaden their focus of counseling and psychotherapy for transgender individuals who lack financial resources. Quality of life has an impact on emotional well-being, and connecting transgender clients to financial

resources could play a vital role in therapy for this population. Providing information related to academic or career services may be also beneficial, as well as information about getting connected other mentors and people in their communities who can support their educational and career goals.

Learning how to be practice self-kindness when faced with potential rejection from society and loss of support from family and friends could be an important part of counseling and psychotherapy with transgender individuals. Helping transgender clients find resources within the community to replace or enhance their social support systems is very much needed. Counselors and psychologists can also encourage transgender clients to become more connected with other transgender individuals involved in community programs (e.g., yoga and other social events through LGBTQQA resource centers).

Working with individuals in therapy involves working with their authentic selves. With transgender individuals, therapists work will be with a person who identifies as their true self, not the false self they have perhaps presented to the world for sometimes many years. Living as if you are someone else does not allow authenticity and congruence to be a prominent part of your identity (Rogers, 1959). When transgender individuals decide to live stealth, that means they have been able to illuminate the physical features that identified them as the gender with which they did not feel congruent. Sometimes the effects of puberty and hormones are not erasable, and this is especially true if there are no resources to make changes medically. Living openly as a transgender individual is a choice that many transgender individuals make, knowing that society will impose their disdain for violation of gender norms, which can put them at risk for discrimination, violence and, even death. It becomes clear how important it is to be known as you know

yourself. It is not that being out makes things easier, but it makes you more authentic, and that should be the aim of counseling—to be your true, authentic self.

Limitations

The sample for this study predominantly self-identified as Caucasian. There were a number of participants that identified as multi- or bi-racial, and this could have had an impact on the outcomes of this study, overshadowing the experiences of people of color. This research study was also dependent on the recruitment of research participants via the internet. This could limit the researcher's ability to achieve a random sample, and pose as an obstacle to participate for those in the community that do not have access to the internet. However, since many in the transgender community are not willing to be highly visible, the anonymity of internet research may free them up to share their voice without the risk of exposure to researchers and those involved.

The Outness Inventory was adapted to be used with transgender individuals for this study, and was not able to capture the unique experiences of those that participated in this study.

Different geographical locations were not known, and this can have an impact on the amount of social stigma that a transgender individual may experience. This can further be a different experience when rural is compared to urban. This study did not explore separately an individual's level of well-being for those who pass in public and those who do not, which may have resulted in different outcomes.

Future Research

This was the first study of its kind to explore the unique and positive experiences of transgender individuals, and aimed to fill a gap of knowledge concerned with

developing resources for transgender individuals through counseling psychology research. Transgender individuals experience higher rates of mental health concerns than the general and LGB population, and seek mental healthcare for those needs, as well as a requirement to begin transitioning. Once a person decides to transition, usually, it cannot be hidden from others. According to World Professional Association for Transgender Health (WPATH) Standards of Care (SOC), it is a clinical guideline to have a patient have 12 continuous months of hormone therapy in the desired gender roles prior to being provided with a letter of recommendation for any medical or hormonal interventions (Coleman et al., 2011). It could be beneficial to conduct further research exploring transgender individuals' self-compassion in relation to where they are at in their transition and to evaluate if it would be advantageous for practitioners to implement self-compassion interventions early in their treatment planning to help buffer against negative impacts that often accompany a transition.

Further research is needed to explore self-compassion, outness as a transgender individual, and emotional distress for those transgender individuals who identify as male-to-female compared to female-to-male. Due to differing societal expectations and acceptance for males who would give up their masculinity, in comparison to societal expectations and acceptance of females who would give up their femininity, it is likely their transition experiences could be very different, and that this could impact their self-compassion, outness, and emotional distress. This study is only a snapshot of a community of transgender individuals who may or may not be representative of the larger transgender population. Future researchers should explore how these relationships between self-compassion, outness, and emotional distress may differ for those whose sex

assigned at birth was male from those whose sex assigned at birth was female, due to differing social norms and gender role expectations. It would also be important for researchers use qualitative research methods to reveal on the unique individual experiences of transgender individuals, as they are a very diverse population, and have many different and intersecting identities. Researchers need to continue to explore the similar and unique experiences of those transgender individuals who identify as gay, lesbian, bisexual or otherwise may likely be quite different than those who identify as heterosexual in terms of the factors that influence their emotional well-being. Given that self-compassion can be predictive of emotional well-being for transgender individuals, it could be worth exploring self-compassion as a buffer against social stigma and transphobia in future research studies.

Counselors and psychologists can indeed help transgender individuals live meaningful and authentic lives and help them find ways to cope during different times in their lives, at various stages of transition, and thereafter. In summary, self-compassion is a relevant and meaning psychological construct in understanding the experiences of transgender individuals, especially given the stressors that they may experience psychologically as well as in response to societal pressures/forces. It is hoped that being more self-compassionate will not only help transgender individuals cope with their emotional distress, but also help them live more congruent, authentic lives, with the much needed support and advocacy they so deserve.

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APPENDICES

Appendix A: Tables

Table 1

Demographics of the Sample: Descriptive Statistics and Frequency Distributions

Descriptive Statistics

Variable	M	Sd	Range
Age	33.91	13.79	18 - 74
Age at discovery of Gender incongruence	22.8	13.79	0 – 54

Frequency Distributions

Group	Variable	n	%
Gender Assigned at Birth	Male	133	56.8
	Female	101	43.2
Gender Identity	Male	13	5.6
	Female	20	8.5
	Male to Female	96	41.0
	Female to Male	64	27.4
(Other)	Agender	4	1.6
	Androgynous	1	.4
	Demigirl	1	.4
	Gender Fluid	9	3.8
	Gender Queer	4	1.7
	Neuter	1	.4
	Non-binary	9	3.7

	Queer	1	.4
	Trans	1	.4
	Trans Masculine	2	.8
	Trans Woman	1	.4
	Two Spirit	2	.8
Transition	Plan to transition	213	91
	No plan to transition	21	9
Plan to live	Yes	140	60.1
Stealth	No	93	39.9
Education level	< High School	4	1.7
	High School/GED	29	12.4
	Some College	89	38
	2 year Degree	22	9.4
	4 year Degree	49	20.9
	Master's Degree	26	11.1
	Doctoral Degree	9	3.8
	Professional Degree	6	2.6
Race/Ethnicity	White	190	81.5

	Black	2	.9
	Hispanic	6	2.6
	Asian/American	3	1.3
	Native American	6	2.6
	Bi-racial	18	7.7
	Multi-racial	8	3.4
Sexual	Heterosexual	39	16.7
Orientation	Gay	11	4.7
	Lesbian	36	15.4
	Bi-sexual	18	7.7
	Queer	36	15.4
	Questioning	16	6.8
	Asexual	17	7.3
	Other	37	15.8
Relationship	Single	83	35.5
Status	Engaged	12	5.1
	Partnered	38	16.2
	Married	51	21.8
	Divorced	19	8.1
	Polyamorous	18	7.7
	Other	13	5.6
Annual Income	Below $20,000	111	47.4
	$20,000-29,999	26	11.1

	$30,000-39,999	20	8.5
	$40,000-49,999	27	11.5
	$50,000-59,999	11	4.7
	$60,000-69,000	10	4.3
	$70,000-79,999	5	2.1
	$80,000-89,999	5	2.1
	$90,000 or more	19	8.1

Table 2

Means, Standard Deviations, Actual scores and possible ranges for the Self-compassion Scale, Depression, Anxiety, and Stress Scale – 21, and the Outness Inventory

Categorical Variable(s)	**m**	**sd**	**Actual Score Low - High**	**Possible range**
SCS	70	21.82	28 - 125	26 - 130
DASS-21	41.67	13.77	21 - 81	0 - 63
OI	51.89	20.48	7 - 98	0 - 105

m = mean; sd = standard deviation; SCS = Self-compassion Scale; DASS-21 = Depression Anxiety Stress Scale-21; OI = Outness Inventory

Table 3

Preliminary T-Tests Findings for Demographic Variables with Outcome Variables

Outcome Variable	**Categorical Variable(s)**	**N**	**M**	**Sd**	**T**	**Df**
Emotional Distress	Sex Assigned at Birth				.054	231
	Male	133	41.73	13.43		
	Female	101	41.63	14.29		
	Education Group				3.81***	231
	High school or less education	33	49.91	13.71		
	4 Year college degree or more	200	40.33	13.34		
	Race Group				.695	227
	White	190	42.02	13.84		
	Other than White	39	40.33	13.69		
	Categorical Variable(s)	n	m	sd	t	df
	Sexual Orientation Group				-2.74**	231
	Heterosexual	38	36.16	11.24		
	Not heterosexual	195	42.76	13.99		
Outcome Variable	**Categorical Variable(s)**	**N**	**M**	**Sd**	**T**	**Df**
Outness	Sex Assigned at Birth				-3.63***	232
	Male	133	47.89	20.83		
	Female	101	57.48	18.91		
	Education Group				-1.12**	232
	High school or less education	33	48.30	21.89		
	4 Year college degree or more	201	52.64	20.30		
	Race Group				-1.61	228
	White	191	50.88	20.67		
	Other than White	39	56.72	20.33		
	Categorical Variable(s)	n	m	sd	t	df
	Sexual Orientation Group				3.23**	232
	Heterosexual	39	61.54	18.81		
	Not heterosexual	195	50.12	20.39		

** = p < .01; *** = p < .001; n = number of participants; m = mean; sd = standard deviation; t= t-value, size of variance; df = degrees of freedom

Table 4

Preliminary Bivariate Correlations between and among Demographic Variables and Emotional Distress

	Age	Annual Income	DASS Tot
Age	1	.49**	-.43**
Annual Income		1	-.32**
DASS Tot			1

** = p < .01; DASS Tot = Depression Anxiety Stress Scale-21 Total

Preliminary Bivariate Correlations between and among Demographic Variables and Outness

	Age	Annual Income	Outness Tot
Age	1	.49**	.11
Annual Income		1	.07
DASS Tot			1

** = p < .01; Outness Tot = Outness Inventory Total

Table 5

Correlation matrix for Self-compassion, Outness, and Emotional Distress

	SCS total	DASS total	OI total	SK	SJ	CH	I	M	O
SCS total	1	-.66**	.32**	.87**	-.87**	.77**	-.84**	.84**	-.86**
DASS total		1	-.30**	-.49**	.57**	-.47**	.65**	-.50**	.63**
OI total			1	.29**	-.28**	.25**	-.29**	.23**	-.23**
SK				1	-.71**	.68**	-.61**	.77**	-.60**
SJ					1	-.52**	.75**	-.58**	.79**
CH						1	-.52**	.72**	-.50**
I							1	-.60**	.78**
M								1	-.65**
O									1

** = $p < .01$; SCS total = Self-compassion Scale total; DASS total = Depression Anxiety Stress Scale-21 total; OI total = Outness Inventory total; SK = Self-kindness: SJ = Self-judgement: CH = Common humanity, I = Isolation: M = Mindfulness: O = Overidentification

Table 6

Multiple Regression findings for Self-compassion and Outness as Predictors of Emotional Distress

Model 1

Criterion Variable	Predictor Variable(s)	R	R^2	F	β	t
DASS total	Demographics	.489	.239	17.907		
	Sexual Orientation				.155	2.67**
	Education				-.151	-2.51*
	Age				-.328	-4.88***
	Annual income				-.110	-1.64

Model 2

Criterion Variable	Predictor Variable(s)	R	R^2	F	β	t
DASS total	SCStot/Outness tot	.727	.528	69.204		
	Outness total				-.083	-1.70
	SCS total				-.536	-10.73***

* = p < .01; ** = p < .01; *** = p < .001; R^2 = R-Squared; β = Standardized Beta Weight SCStot/total = Self-compassion Scale total; DASS total = Depression Anxiety Stress Scale-21 total: Outness tot = Outness Inventory total

Table 7

Multiple Regression findings for Self-compassion subscales as Predictors of Emotional Distress

Model 1						
Criterion Variable	Predictor Variable(s)	R	R^2	F	β	t
DASS total	Demographics	.489	.239	17.907		
	Sexual Orientation				.155	2.66**
	Education				-.151	-2.51*
	Age				-.328	-4.88***
	Annual Income				-.110	-1.64
Model 2						
Criterion Variable	Predictor Variable(s)	R	R^2	F	β	t
DASS total	SCS subscale total	.746	.557	26.54		
	Self-kindness				-.079	-.92
	Self-judgement				-.058	-.66
	Common Humanity				-.103	-1.51
	Isolation				.320	4.11***
	Mindful				.008	.10
	Overidentification				.243	2.75**

* = p < .05; ** = p < .01; *** = p < .001; R^2 = R-Squared; β = Standardized Beta Weight SCStot/total = Self-compassion Scale total; DASS total = Depression, Anxiety, Stress Scale-21 total:

Table 8

Multiple Regression findings for Self-compassion subscales as Predictors of Outness

Model 1						
Criterion Variable	Predictor Variable(s)	R	R^2	F	β	t
Outness total	Demographics	.288	.083	10.446		
	Sexual Orientation				-.174	-2.72**
	Sex assigned at birth				.203	3.18**
Model 2						
Criterion Variable	Predictor Variable(s)	R	R^2	F	β	t
Outness total	SCS subscale total	.423	.179	4.381		
	Self-kindness				.119	1.04
	Self-judgement				.021	.179
	Common Humanity				.097	1.06
	Isolation				-.186	-1.75
	Mindful				.077	.68
	Overidentification				.119	.98

** = $p < .01$; ** = $p < .01$; *** = $p < .001$; R^2 = R-Squared; β = Standardized Beta Weight; SCS subscale total = Self-compassion Scale total

Table 9

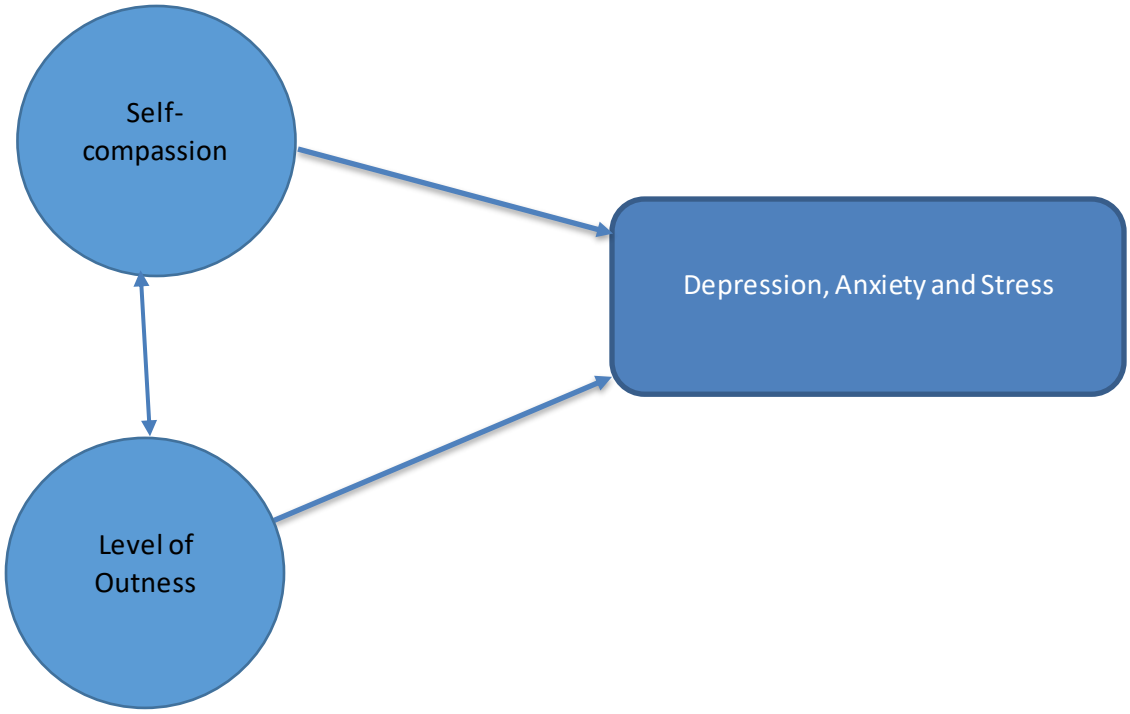
Means, and Standard Deviations for the Outness Inventory (n =234)

Item	m	sd
1 Mother	4.14	2.536
2 Father	3.04	2.585
3 Siblings	4.02	2.614
4 Extended family	3.37	2.257
5 Old heterosexual friends	4.31	2.325
6 New heterosexual friends	4.18	2.581
7 Work Peers	2.91	2.380
8 Work Supervisor(s)	2.69	2.493
9 Members of religious community	1.30	2.295
10 Leaders of religious community	1.26	2.312
11 strangers	2.42	1.852
12 old LGB friends	4.47	2.839
13 new LGB friends	5.15	2.644
14 old transgender friends	3.46	3.304
15 new transgender friends	5.32	2.815

Appendix B: List of Figures

Figure 1.

Structural Relationship Model. Circles depict the Predictor Variables, and the rectangle depicts the Outcome Variable. The arrows represent the direction of associations between the variables.



Appendix C: Review of Literature

REVIEW OF LITERATURE

Research for this dissertation was obtained through various means utilizing Oklahoma State University's electronic databases including PsycINFO, PsycArticles, PsycTEST, ERIC, ProQuest, Sociological Abstracts, and PILOT. ProQuest was used to retrieve doctoral dissertations within similar areas of research. PsycINFO was the primary source used for retrieval of peer reviewed articles. PsycTEST was the primary source used for retrieval of tests and measures. Keyword terms used to search data bases for transgender related information included *transgender identity, gender identity, transgender identity development, coming out,* and *level of outness.* For information, specific to the mental health care of transgender individuals, keyword terms used were *stress, mental health, depression, anxiety, self-injury, and non-suicidal self-injury.* Additionally, health and wellness literature keywords used were *self-compassion, well-being, and resilience*. Electronic as well as print versions of journal articles were secured for reviewing the current literature. In addition, several books and supplementary electronic government information provided the necessary tools for examination of interrelated research.

This chapter will begin with a review of the literature of the history of transgender individuals and gender identity, followed by factors related to their development; the well-being of this population in terms of depression, anxiety, and stress; and how self-compassion and well-being interact with level of outness.

Transgender History

There have been historical accounts of transgender individuals living within various civilizations throughout recorded history (Coleman, Colgan, & Gooren, 1992).

The earliest documented cases of people desiring to transform one's gender go back as far as Greek mythology (Koh, 2012). Before Europeans came to America, there were known to be among the American Native tribes a third gender of people whom they referred to as "berache" or "Two-Spirited" (Callender et al., 1983). Transgender research literature began to appear in the early 20th century (Jones, 2004). In 1910, Mangus Hirschfield noted in a book he wrote entitled *Transvestites*, a distinction between those he called transvestites from those he considered homosexual, and he was of the opinion that transsexuality occurred far more often than most believed. In the early 1920's and 30's, European doctors performed the first complete genital transformation surgeries (Stein, 2004). In 1949, David O. Cauldwell first identified transsexualism as people who wanted to change their sex (Meyerowitz, 2002). If a client's incongruence with their gender identity was to the extent that they desired to be born a different sex or desired to change their sex, clinicians responded with attempts to increase comfort with their birth sex.

Later, mental and behavioral health practitioners focused on trying to help transgender individuals reduce discomfort and incongruence between their gender assigned at birth and the gender they identified with (Blumer et al., 2012).Eventually, they began to assist those clients who were considered truly transsexual to obtain hormone therapy and sex reassignment. Likewise, research on transgender identity and gender variance was very clinical and positivistic (APA, 2009), and generally focused on Sex Reassignment Surgery (SRS), or issues pertaining to sexual health. Early gender identity was interpreted through Freud's psychoanalytic view and represented the core idea that there was a clear cut psychological differences between male and female that was natural and enduring (Shields & Dicicco, 2011). This reflected the dominant male,

Caucasian, European view from a time in history that any deviations from the binary model was interpreted as pathological, that the stages of normal development had been interrupted, and the person who identified with the other gender was considered an anomaly.

By the late 1960's, feminist psychologists began to focus on gender differences, shifting from a biological approach to that of socialization. They also began to challenge female-deficit-models. In the early 1970's, unidimensional bipolar male/female measures were challenged by Bem's creation of an androgynous measurement of gender and the elements of masculinity and femininity were hypothesized to be orthogonal and each were individually expressed on a low to high continuum (Hollander, Renfrow & Howard, 2011; Shields & Dicicco, 2011). Around 1985, there was a paradigm shift in transgender healthcare and efforts to move away from the disease-focused model (i.e., something went wrong developmentally and needed to be corrected), to that of an identity-based model with less of a focus on the individual, and more focus on the problem of health disparities connected with the social stigma of gender variance (Bockting, 2009).

Transgender Identity Development

Social psychologists study people, their individual behavior, and the way they interact with their social environment (Hollander, Renfrow & Howard, 2011; Fiske, Gilbert & Lindzey, 2010). These psychologists have concurrently failed to recognize the influence of gender, and yet have been profoundly influenced by it (Hollander, Renfrow & Howard, 2011). Most social psychologists agree that a multifaceted approach and integration of theories is required to gain a clear understanding of the construction of gender identity (Eagan & Perry, 2001; Tobin, 2010; Wood & Ridgeway, 2010), which

must be acknowledge the internal perspective of how a person experiences their own gender, and an external perspective that recognizes the cultural expectations in a society toward gender and the impact it has on the construction of gender roles (Hollander, Renfrow & Howard, 2011; Wood & Eagly, 2010; Wood & Ridgeway, 2010). Looking at the world through a gendered lens means understanding that gender plays a central role in social life, considering the assumptions that are pervasive about gender, and showing how these assumptions continue to be perpetuated regardless of their reality, and how they promote inequality and maintain gender differences (Howard & Hollander, 1997).

Transgender identity has challenged major theories of gender from early in the 20th century, and attracted only the attention of researchers interested in the outliers (Benjamin, Lal, Green & Masters, 1966: Hirshfield, 1952). The transgender community is an underserved and understudied population (Boehmer, 2002; Fredriksen-Goldsen, 2014; Grant et al., 2011; Horvath, Iantaffi, Grey & Bockting, 2012) who often endure discrimination, hatred, and negativity (Drescher, 2002; Gainor, 2000; Tebbe & Moradi, 2012). Additionally, transgender theory is perceived by some feminist theorists as an affront against women, conceptualized primarily as male-to-female transsexualism. For example, Richard Raskins, an ophthalmologist from Manhattan who underwent sex reassignment surgery and surfaced on the tennis court as Renee Richards in the mid 1970's, was perceived as a masculine, manufactured woman pushing her way into a women's professional sport; flaunting how the male-dominated medical and legal professions dared to construct and legitimate what is female (Hausman, 2001; Nagoshi & Brzuzy, 2010). Billie Jean King however, was not detoured by physical remnants of Richard's maleness, and boldly met Richards on the court (Piper, 2012), winning one for

the "girls." This high profile event fueled the controversy surrounding what legitimizes "being female" and who has the right to claim that as a gender role. Additionally, Queer Theory takes the usualness of "man" and "woman" and destabilizes it, toppling the idea of a transsexual's desire or ultimately need for the "right body" of a binary gender system. So, will it be that feminist and queer theorists extend a hand of compassion toward transgender and transsexual individuals despite the collision of theories, or will they further separate the LGBT acronym by refuting the legitimacy of transgender individuals that strive daily against medical, mental, and societal structures just to be the person they believe themselves to be? *Gender Identity* and *Sexual Orientation* are considered by many to be one in the same; however, they are two very different constructs that are often conflated (APA, 2015). *Gender Identity* is defined as how deeply a person self-identifies with masculine traits experienced as a boy, a man or male; or feminine traits, experienced as a girl, woman or female; or experienced and expressed somewhere along a continuum of masculine and feminine characteristics given their cultural understanding of what it means to be masculine or feminine (Egan & Perry, 2001; Tobin et al., 2010, Wood & Eagly, 2009). *Sexual Orientation*, on the other hand, relates to a person's emotional and sexual attraction to another (Shively & De Cecco, 1977). In other words, sexual orientation describes who a person wants to go to bed with; gender identity clarifies who a person goes to bed as.

Transgender identity affirmation is defined as the extent gender identity is performed in the presence of others to be recognized, responded to, and offered support by others. In a preliminary research sample of 43 transgender women researchers, Nuttbrock, Rosenblum, & Blumenstein, (2002) measured depression and identity support,

with findings that indicated that participants reported their spouses or partners as 96% seeing their female attire as a natural part of them. Concerning friends, 79% of the participants reported one or more friends that knew they wore female attire and respecting their use of female attire, and 97% of participants said they had at least one family member that was aware of their female attire with about 55% being supportive. The high levels of support could be that the partners and friends they chose share positive attitudes toward transgender individuals. However, the results indicated transgender identity support had a negative and statistically significant association with depressive symptoms, in the social context of family support ($r = .38$; $p = .01$) and support of friends ($r = -.26$; $p = .05$). Mental health functioning appears to be strengthened by incorporating transgender identity into social life and it appears that validation of identity and personal empowerment are vitally important to good mental health. The sample in this study, however, was taken from one location, and the participants were all sex workers that used drugs heavily to cope with their challenges. Also, it did not include transgender men. Further studies were indicated to further understand the social psychological processes with identity affirmation and transgender mental health.

Coming Out as Transgender

For a transgender person, coming out may have nothing to do with one's sexual orientation, but rather one's gender identity. Many transgender people who come out continue on with their previous partners if they desire and when it is agreeable to their partner. After a transition, some male to female (MTF) transgender individuals may begin to identify as heterosexual if they were previously attracted to men**.** Or if they were previously attracted to females and maintain that attraction, they may begin to

identify as lesbian. Likewise, female to male (FTM) may begin to identify as heterosexual if they were previously attracted to females and that attraction remains; or they may begin to identify as gay if they were previously attracted to males or have begun to feel an attraction toward men. However, their transition is directly related to changing the outside of that person to reflect what they experience on the inside, and in the midst of everyday public life, there is no way to selectively reveal one's gender identity once a transition has occurred.

Usually, this "coming out process" with gender identity is described in stages (Devor, 2004; Lev, 2004), and typically this happens first with intimate partners, then family and friends, starting with those thought most likely to be supportive first and then working toward revealing the transition to others to whom they may experience rejection. Devor (2004) proposed a 14 stage model that extended the framework of Cass's model of homosexual identity formation (Cass, 1979, 1984, 1990) and the role exit work of Ebaugh (1988). These stages are not all inclusive of what all transgender individuals will experience, and everyone will most likely go through the process in varying and personal ways rather than following a prescribed method. The stages are:1) Abiding anxiety, 2) Identity confusion of gender and sex assignment at birth 3) Identity comparisons about gender and sex assigned at birth 4) Discovery of Transsexualism or Transgenderism 5) Confusion about Transsexualism or Transgenderism 6) Identity Comparison of Transsexualism or Transgenderism 7) Tolerance of Transsexualism or Transgenderism 8) Delay before acceptance of Transsexualism or Transgenderism 9) Acceptance of Transsexualism or Transgenderism 10) Delay before Transition 11) Transition 12)

Acceptance of Post-transition Gender and Sex identities, for inclusion sake, 13) Integration, and 14) Pride (Devor, 2004).

There is ample evidence of the risks involved with coming out, including alienation, harsh criticism, physical abuse, social humiliation, and employment difficulty (Bradford, Reisner, Honnold, & Xavier, 2013; Grant et al., 2011; Lombardi et al., 2002; Rachlin, 2001), which can develop into internalized transphobia, wherein transgender individuals begin to believe they are undeserving of fair treatment (Clements-Nolle et al., 2006; Kidd et al., 2011; Mizock & Lewis, 2008). However, there are mental health risks involved with concealing one's true identity from the world. Additionally, there is research evidence to support that coming out as transgender benefits individuals in a number of ways, such as better psychological well-being, including higher self-esteem as well as less depression and anxiety (Gagne, Tewksbury, McGaughey, 1997; Kosciw, Greytak, & Diaz, 2010; Strain & Shuff, 2010). Although early on, there are challenging events that mostly relate to social stigma about transgender identity, often after a little time has passed, there are feelings of happiness and contentment reported by those who come out (Mullen & Moane, 2013). The invisibility of the body/mind mismatch and social stigma of gender variance creates tension between transgender individuals need to be acknowledged by their core identity, the desire to be authentic to the self, and trying to elude social stigma (Fraser, 2009). Some individuals that chose sex reassignment, over time, have recognized that their transition to the other gender role did not gain them the sense of belonging they were looking for. Rather, that need to belong was found by embracing a transgender identity and others in the transgender community (Bockting, 2009).

In 2007, Maguen, Shipherd, Harris, & Welch conducted research that examined the prevalence and predictors of transgender identity disclosure with a sample of 156 participants from a New England transgender conference. Eighty one percent were born male at birth. They were recruited from a regional transgender conference and responded to a self-report questionnaires that took 20-25 minute to complete. The survey included questions concerning demographics, self-esteem, amount of cross-dressing, passing (not identified as others as transgender) disclosure, and support. They found that transgender disclosure rates were lower than LGB individuals, and those who disclosed to a larger number of people reported more social support than those who disclosed to fewer people. This was done in an order that disclosed to the most supportive first, and many chose not to inform co-workers, although when they did co-workers were the second most supportive group they disclosed to. Significant predictors of disclosure included age of the transgender group, the amount of time dressing in referred gender clothing, and involvement in the transgender community. Findings also included that 62% of the sample were predominantly attracted to females. Younger participants disclosed at higher rates. Limitations include use of a convenience sample, which may not generalize to the transgender community. Also, the sample collection was from a conference and may have not included a large demographic. Additional studies would benefit from measuring participants at different levels of identity development, such as Devor's 14-stage model.

Stigma, Violence, and Discrimination

The lives of most transgender individuals are characterized by elevated life stressors from experiencing social stigma and violence to basic civil rights violations,

such as gaining employment, obtaining housing (Grant et.al., 2011), and access to public facilities due to transgender identity (Taylor, 2007). The minority stress model (Meyer, 2003) would suggest that psychological distress in the transgender population is exacerbated by stress associated with stigma, prejudice, and discrimination experienced by minorities at levels beyond that of the general stressors felt by all people. In addition, this stress is socially based and chronic, stemming from social structures and norms that are firm constructions and overpower the individual. This happens externally (i.e., actual experiences of rejection and discrimination otherwise known as enacted stigma) as well as internally (i.e., perceived rejection and expectations of being stereotyped or discriminated against otherwise known as felt stigma). Social stigma interferes with the development of self, and aspects of attachment and intimacy (Bockting, 2015), and distress can vary depending on the transition process, coping mechanisms used, and the level of support received (Nuttbrock et al. 2010; Budge et al. 2012).

According to Grant et al. (2011), the combination of anti-transgender bias and persistent structural and interpersonal acts of racism has had devastating effects on multiracial transgender people and other people of color, including suicide attempts (54% of multiracial transgender people) (Grant et al., 2011). In conjunction with the previously mentioned hardships transgender people face is the shame they feel for being different. Manifestations of social stigma, transphobia, and the internalization of negative perceptions toward transgender individuals can result in shame they feel for being different; seclusion and lack of community encouragement; and the fallout from discrimination, such as housing, financial, and employment issues (Borden, 2015).

Although the transgender and gender non-conforming communities are very diverse, gender minority people from all backgrounds face common experiences of discrimination in a wide array of settings across the United States today, and the consequences of discrimination can be quite severe. Statistics of transgender deaths are believed to be underreported, and an individual's decision to disclose their gender identity to the world, in order to feel authentic, means becoming open to the impact of potential social stigma and other risks that accompany that decision (Levitt & Ippolito, 2014; Testa et al., 2012), including issues of safety that arise from transphobia (Bettcher, 2007; Mizock & Mueser, 2014). Every November 20th, in remembrance of Rita Hester, a transgender woman who was murdered in Allston, Massachusetts on November 28th, 1998, the Transgender Day of Remembrance (TDOR) serves as a reminder of hate crimes carried out against transgender individuals, and their violent deaths by holding candlelight vigils and reading each name in honor of the victims.

If as believed, statistics do not correctly reflect the deaths of transgender, transsexual, and gender non-conforming individuals, then the true picture of transphobia and hate crimes may be far worse (Hill & Willoughby, 2005) than originally believed and still reflect a very dangerous path for those who brave a life transition, even if a desired "stealth existence" (living in the perceived gender without being detected by others) never transpires. According to the National Coalition of Anti-Violence Programs (NCAVP, (2015), on August 15th, 36 year old Tamara Dominguez of Kansas City, Missouri, was the 17th reported homicide of a transgender or gender non-conforming person this year. She was reported by the local media to have been run over multiple times by a vehicle.

According to the National Transgender Discrimination Survey (Grant et al., 2011) administered to over 6400 transgender and gender non-conforming people, widespread discrimination was reported by all who participated. Key findings included that because of discrimination, 28% of participants postponed medical care when sick or injured, while 48% postponed because of the inability to afford healthcare. Concerning obstacles to healthcare, 19% reported service refusal, and 28% were experienced harassment in medical settings and another 2% in doctors' offices. Moreover, 50% of participants reported having to teach their providers about transgender care. The majority of participants wanted to have transition-related surgery, but had not had any at that time. If providers were aware of their transgender status, the probability of discrimination increased.

Grant highlighted in his report that the majority of survey participants have had some level of transition related medical care, and the majority reported a desire to have surgery, but had not had any surgeries yet. If the medical providers knew of the patient's transgender status, they were more likely to experience discrimination. The cost involved with undergoing a transition that involves any surgical procedures are extremely expensive and most often are out of pocket expenses. Participants reported rates of HIV infection four times more than the national average; 2.6% in Grants sample, as compared to .6% in the general population. Transgender women reported a rate of 3.76% HIV infection; transgender women that were unemployed 4.7% HIV infection, and those transgender women who have engaged in sex work were even higher at 15.32%. Those who had had an infection rate of 15.32%. Over 25% of the survey respondents misused drugs or alcohol just to handle the discrimination they experienced because of their

gender identity or expression. The attempted suicide rate was 41% compared to 1.6% of the general population, and over half (54%) of multiracial respondents had attempted suicide. Unemployment, low income and sexual and physical assault were among the contributing factors to suicide attempts.

Hill and Willoughby (2005) aimed to develop and validate the Genderism and Transphobia Scale in response to research that indicated denial of a strong anti-transgender sentiment in Western culture, and reflected an abundance of acceptance of gender non-conforming individuals, in contrast to the prevalence of hate crimes toward transgender and gender non-conforming individuals. The measure consisted of 32 statements related to thoughts, feelings, actions, and reactions toward gender and sexual minorities. It was designed to detect violence, harassment and discrimination toward transsexuals, crossdressers, and transgender individuals. The second study was conducted with parents to predict their reaction to their gender conforming and gender nonconforming children. Correlations with other scales designed to evaluate homophobia and gender role ideologies indicated good discriminant and convergent validity, and reasonable internal consistency that could detect gender differences in attitudes toward gender non-conformity. The measure was the first of its kind and no valid measure of anti-trans views existed at the time that could reveal discriminating behaviors and prejudicial attitudes. Findings from a diverse sample of university students indicated that anti-trans views were not rare or hard to elicit, and that some participants harbored far more intolerant and negative attitudes than was expected in the study site of Montreal, considered to be populated with well-educated city dwellers known for their liberal attitudes about sexuality and gender.

In a different study, using data gathered in 2005-2006 from a statewide study in Virginia, Testa et al. (2012) explored the psychological effects of violence on a sample of 350 self-identified transgender people, 18 years or older who wished to transition from their sex assigned at birth. Participants were recruited from health clinics, transgender support groups, and through peer networks. Survey questionnaires, developed from qualitative data gathered from focus groups of transgender individuals in a previous stage of the study, pertaining to the exposure to physical and sexual violence, suicidal ideation and attempts, and alcohol and substance use were distributed in both paper and internet versions in English and a paper version in Spanish. Findings indicated that both transmen and transwomen were at high risk for physical and sexual violence, and those who had experienced violence were at a much higher risk of suicidal ideation, suicide attempts, and substance abuse. Additionally, they found a high prevalence of victimization because of their gender identity or expression. The perpetrators were from varied sources, with only a small percentage of the violence reported to the police. Implications included a call to researchers and clinicians to develop programs and policies that can be used to help educate police departments and increase knowledge and comfort in working with transgender people. Limitations of this study included the use of self-report and the potential for error, and the inability to create a probability sample due to lack of information about transgender people in Virginia. Also findings cannot be generalized to those who do not intend to transition, due to exclusion criteria designed to target those believed to be most at-risk. Also, those who do not utilize the services used to recruit participants from may be underrepresented, and causal relationships cannot be determined due to the use of correlational analysis.

Social support is known to be widely lacking for transgender individuals, and although tolerance for sexual orientation has improved in recent years, there seems to be a persistent disdain for those that identify as transgender or gender nonconforming. In 2012, Tebbe & Moradi evaluated the associations of anti—transgender prejudice with sexual orientation and gender role specific attitudes, and also with broader individual difference correlates of prejudicial attitudes. The study was conducted with 250 undergraduate students from a large Midwestern university. The participants completed instruments to measure anti-transgender attitudes, using the Transphobia Scale (TS; Nagoshi et al., 2008), anti-LGB attitudes measure using the Attitudes Toward Lesbians and Gay Men Scale (ATLG; Herek, 1988) and the Attitudes Regarding Bisexuality Scale –Female/Male Version (ARBS-FM; Mohr& Rochlen, 1999), traditional gender role attitudes using the Attitudes Toward Women Scale (AWS; Spence & Helmreic.1978) and the Gender Role Beliefs Scale I(GRBS; Kerr & Holden, 199), need for closure measured by the Need For Closure Scale (NFCS; Webster & Kruglanskj, 1994), social dominance orientation measured with the Social Dominance Scale (SDO: Prato et al., 1994), and finally social desirability measured by the Marlowe-Crowne Social Desirability Scale (MCSD; Crowne & Marlowe, 1960). Participants completed self-report surveys through an online data collection system described as a study on feelings toward different groups of people. They found unique positive relationships with anti-LGB prejudice, traditional gender role attitudes, and a need for closure, with anti-transgender prejudice, while also controlling for social desirability as a covariate, Social dominance orientation did not have a unique relationship to anti-transgender prejudice, and findings with women were similar to men in regard to prejudice, although with a lower mean. Unidimensional

structure was supported by confirmatory factor analysis, operationalized by Nagoshi's Transphobia Scale (Nagoshi et al., 2008). Limitations of the study include demographics that were all White and heterosexual, having similar levels of education and socioeconomic status. Also, the study focused only on individual differences in attitude and cognitive style, whereas interpersonal and contextual factors are likely important as well for future studies.

Many transgender individuals, activists, and service providers to transgender people realize the ultimate harm of stigma and the pathologizing that has dominated the psychology world. In a 13 year content analysis study of articles concerning transgender issues in marriage/couples, and family therapy (M/CFT) journals, Blumer et al. (2012) noted that in1997 a much needed update to LGB issues in the field was presented at a state conference, however, it did not include issues of the transgender population, nor has there been much inclusion of the "T" in current M/CFT literature, resulting in further ignorance and invisibility (Israel & Tarver, 1997). The study focused on the degree transgender issues were addressed, and those instances where journals claimed to be attentive to these issues, but in reality are not. From 17 journals, and 10,739 articles, only nine (0.0008%) focused on transgender issues or used gender variance as a variable. Their finding reinforced the claim that the issues of this population were further ignored and marginalized by M/CFT professionals.

In the United States as well as other countries of the western world, universities are where new concepts and ideas are generated, shared, and tested. This is true regarding contemporary thoughts and concepts of gender and sexuality as well. Even in the most conservative states, it is possible for transgender individuals to find others who at least

share social justice concerns of the underprivileged and underserved. Most universities have developed declarations concerning gender identity and expression, what is expected and acceptable on their campuses, and proclamations of respect for diversity among their faculty, administration, and students. In the United States on a daily basis, transgender youth who do not fit into a binary system of recognized gender, struggle with rejection and harassment (Reicherzer, 2006). Rejection in adolescents has also been found to predict negative health outcomes for gay, lesbian, and bisexual adults (Ryan, Huebner, Diaz, & Sanchez, 2009; Dietert & Dentice, 2013). Many transgender individuals never reach the classrooms of a university to see that there are others that can extend compassion toward them.

Emotional Distress among Transgender Individuals

Transgender people have historically been more susceptible to mental health issues and psychological distress (Nuttbrock, Rosenblum, & Blumenstein, 2002), and they report higher levels of distress, anxiety and depression than the general population Clements-Nolle, Marx, Guzman, & Katz, 2001; Hepp, Kraemer, Schnyder, Miller, & Delsignore, 2005: Kessler, Berglund, Demler, Jin, &Waters, 2005; Mustanski, Garofalo, & Emerson, 2010; Nemoto, Bodeker, & Iwamoto, 2011). According to the 2011 National Healthcare Disparities Report, transgender people, particularly those who are visibly gender non-conforming, are more likely to experience violence in the home, on the street, and in health care settings. Violence perpetrated against transmen and transwomen has been shown to be associated with suicidal ideation, suicide attempts and higher numbers of attempts, as well as substance abuse (Testa et.al, 2012). Clements-Nolle et al., (2001) found suicide attempts were indicated at 32%. Suicide attempts among transgender

individuals have been found to be 41 percent as compared to 4.6 % of the overall population in the U.S., and higher than the 10 -20 % reported of lesbian, gay, and bisexual individuals (Grant et al., 2011). Key findings from a study conducted in 2015, with 28,000 transgender and gender non-conforming individuals reported that of those who had negative experiences with unsupportive families, 54% attempted suicide, and 50% were currently experiencing serious psychological distress (James et al, 2016).

Clements-Nolle, Marx, Guzman, & Katz, (2001) conducted research in San Francisco that explored HIV prevalence, risk behavior, healthcare, and mental health among 392 MTF and 123 FTM transgender individuals. Participants were recruited through agency referrals, and targeted and response-driven samples. HIV prevalence rates were 35% for MTF and 2% for FTM. Mental health findings included depression rates of 62% for MTF and 55% for FTM participants. Limitations include use of nonprobability sampling, which may not generalize to urban areas, and internal validity may have been compromised if high risk individuals were over-represented. Additional research is needed to further confirm these findings. Implications are that the need exists for depression and suicidality screening by health care professionals for male-to-female/female-to-male transgender individuals due to a much higher rate of suicide attempts among transgender individuals in this sample than the average U.S. household, as well as a population-based sample of men reporting same-sex partners.

Stressors are often managed with coping behaviors that are unhealthy (Hepp, Kraemer, Schnyder, Miller, & Delsignore, 2005), for example; cutting, burning, severe scratching, hitting, and interfering with wound healing (Klonsky, 2007). In an online study, dickey, Reisner, & Juntunen, (2015) explored Non-Suicidal Self-Injury with a

sample of 773 transgender adults. Participants completed an on-line survey including the Depression Anxiety Stress Scales (DASS—21), Body Investment Scale (BIS), and the Non-suicidal Self-injury Inventory and Inventory (ISAS). Results indicated that roughly 42% of transgender individuals had a history of NSSI. Limitations of the study included problems associated with self-report surveys, such as recall bias, or how the participants made meaning of questions. The sample was overly weighted with FTM participants who were predominantly white, highly educated, and the researcher's identification with the population sampled may have swayed the results. Also, an internet convenience sample could limit generalization. Implications of this study are that distress and expression of distress are key issues to address in counseling transgender individuals.

Mental health practitioners are now encouraged to commit to assisting transgender individuals in coming out by balancing the use of positive psychology and minority stress models, instilling hope for the future and creating positive expectations for therapy, and modeling support and positivity within the primary support system (Budge, 2014).

Social Support and Coping

Transgender individuals experience higher levels of well-being when they have higher levels of social support, (Davey, Bouman, Arcelus & Meyer, 2014). Because they suffer from lack of community compassion (Carrol & Gilroy, 2002) they are also more vulnerable than some other marginalized groups. While society has become more accepting of sexual orientation and many states have now passed laws providing protection of sexual orientation from discrimination, gender identity issues have not been

protected by law uniformly among the states, while relatively few list gender identity in their statements of protection (Currah, & Minter, 2000; Spade, 2011a).

In a qualitative study seeking to understand emotional and coping processes experienced by transgender individuals during the transition process, Budge, Katz-Wise, Tebbe, Howard, Schneider, & Rodriquez (2013) conducted semi-structured interviews with 18 transgender participants, and utilized grounded theory analyses to theorize and interpret the findings. Emotional and coping experienced emerged in three phases of the process: pre-transition, during the transition, and post-transition. The themes that emerged included descriptions of coping mechanisms, emotional hardship, lack of support, positive social support, and affirmative emotional experiences. Through discoveries of this research, the authors were able to describe the role of coping mechanisms and support. As participants progressed through transition, emotional hardships lessened and facilitative coping use increased, which led to confirming emotional experiences. The results of this study indicated the importance of guiding transgender individuals through facilitative coping and the importance of social support. Limitations included the use of qualitative research does not allow to generalize to other transgender individuals, however it can be used to inform theory. The study also used a convenience sample that was mostly MTF transsexuals recruited from the same LGBT resource. Racial demographics were mostly homogenous, and the participants were all considered "out." Implications are that counseling psychologists need to understand the emotional and coping processes of transgender individuals to assess what phase of transition clients are in to determine appropriate facilitative coping mechanisms and encourage support.

In a study designed to examine depression and anxiety in transgender individuals, Budge, Adelson, and Howard (2013) explored facilitative and avoidant coping as potential mediators between distress (depression and anxiety) and transition status, loss, and social support for transgender individuals. Participants included 351 FTMs and MTFs, and they completed demographic questions, the Multidimensional Scale of Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988), Ways of Coping (Revised) (WC-R; Folkman, Lazarus, Dunkel-Schetter, DeLongis & Gruen, 1986), Burns Anxiety Inventory (BAI; Burns, 1998), Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977), and the Transgender Perception of Loss Scale (Budge et al., 2012). Results concluded that transgender men and women experience high levels of emotional distress that contributes to rates of depression and anxiety and other mental health concerns that exceed heterosexual as well as lesbian, gay, and bisexual (LGB) populations. Also, avoidant coping was found to be used more at the beginning of the transition, and was significantly and positively related to depression and anxiety in transgender individuals. Implications were that counselors and psychologists need to help transgender clients with ways to reduce avoidant coping while increasing social support to help alleviate depression and anxiety. The research indicated the relationship between social support and emotional well-being was clearly relevant in that the more social support a transgender person has, the less distress they will exhibit.

Gender Dysphoria

In the early years of transgender care, mental and behavioral health practitioners concentrated on easing the discomfort and incongruence between one's felt gender and their sex assigned at birth (Bockting, 2009). Outcomes to reconcile gender identity with

assigned sex, were not very effective, so the focus of assistance was shifted to help the body become more aligned with the mind and the individual's gender perception (Bockting, 2009). Afterward, the diagnosis attached to the transgender experience – *Gender Identity Disorder* (GID) was first included in the third edition of the *Diagnostic and Statistical Manual (DSM;* American Psychiatric Association; APA, 1980). This was intended to be helpful for the individual's medical and psychological needs that required a validity marker to code for health services rendered, however, the pathology of classifying it as a disorder is believed by many to have had contributed to a dominant pathological view from the psychology profession (Lombardi & Davis, 2006).

Transgender people, professionals working with them, and activists have expressed their discontent with transgenderism being viewed as pathology through the disease model, and have begun to embrace and promote gender diversity as an alternative gender from the concept of gender as a spectrum that more accurately reflected the transgender experience (Bockting, 2009; Lombardi & Davis, 2006). G*ender Identity Disorder* was maintained in the DSM-IV-TR, for a diagnosis that was both needed for justification of medical intervention, and unwanted by those it was applied to as a disorder that indicated pathology from within, yet clearly social stigma was the bigger perpetrator, and it was considered an unfounded diagnosis due to distress and pressure that came from without, forged by social constructs, and deemed inaccurate for a diagnosis, even by the DSM authors definition (Barbachano, 2007).

The *Diagnostic and Statistical Manual of Mental Disorders DSM-5* (DSM5) (American Psychiatric Association, 2013) (APA) made it clear that a diagnostic manual should not include a psychological disorder diagnosis in which the criteria did not

originate from within the individual. *Gender Dysphoria* is now listed in the replacing the previous disorder, and many who study psychology are unaware that..."*Gender Dysphoria* refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender...and focuses on dysphoria as the clinical problem, not identity per se" (APA, 2013, p.451). Research has indicated that two primary reasons that transgender individuals seek therapy are for personal growth and help with the transition process (Rachlin, 2002). The World Professional Association of Transgender Healthcare (WPATH) requires physicians to defer to psychologists the task of determining if a client is a fit candidate for sex reassignment surgery or transitioning. *Standards of Care* (SOC) guidelines for treatment of *Gender Dysphoria* may include living full time in the desired gender for a year. Options for psychological and medical treatment for *Gender Dysphoria* vary from person to person, and could include a change in gender expression or role. This sometimes involves living a predetermined amount of time in the gender role consistent with their experienced identity (Bockting, Knudson, 2011). Not being able to change documentation may lead to being outed by someone doing the hiring or administrative help. This eludes anonymity and ultimately an individual does not get to choose if and how to out themselves, but rather that takes place at the hands of personnel that do not honor confidentiality, therefore making them vulnerable to discrimination. Often, finding themselves at a point where the need to be authentic about their internal gender experience, and determining if they have the resources and fortitude available to move forward with a transition, is the point in which many transgender individuals arrive at a decision to expose their gender identity (Levitt & Ippolito, 2014).

Anxiety and Depression

For reasons that may or may not be related to gender dysphoria, transgender individuals, suffer from elevated rates of mental health issues, including depression, anxiety, low self-esteem, internalized transphobia, suicidal ideation, distress from social stigma with reports ranging anywhere from 10 to 30 % higher than the population as a whole (Clements-Nolle, Marx, Guzman, & Katz, 2001; Hepp, Kraemer, Schnyder, Miller, & Delsignore, 2005: Kessler, Berglund, Demler, Jin, &Waters, 2005:Mustanski, Garofalo, & Emerson, 2010; Nemoto, Bodeker, & Iwamoto, 2011; (Bockting, Miner, Romine, Hamilton, & Coleman, 2013; Carmel, Hopwood & dickey, 2014; Nuttbrock et al., 2012; Samons, 2001) believed to be exacerbated by the experience of minority stress (Meyer, 2003). Transgender people also experience many of the same issues as the general population (Fraser, 2009), and are becoming more visible, and seeking community mental health services more frequently than in the past (Budge, Tebbe, & Howard, 2010). Yet, many mental health care providers lack adequate knowledge about transgender client issues, do not understand their mental healthcare needs, and/or realize the diversity they represent (Carroll & Gilroy, 2002; Carroll, Gilroy, & Ryan, 2002).

In one study, that examined the relationship between depression, anxiety, self-esteem, and level of outness, Strain & Shuff (2010) participants were administered the Beck Depression Inventory-II BDI-II; Beck, Steer, & Brown, 1996), the Beck Anxiety Inventory (BAI; Steer & Beck, 1997), and the Rosenberg Self-Esteem Scale (RSES: Rosenburg, 1965) as predictor variables, and for criterion variables; the outness demographics questionnaire designed for this study, an adapted version of the Outness Attitude Scale, Openness Scale (Frank & Leary, 1991). However, this study was limited

in generalizability because the it was a small convenience sample (105) of mostly white, well-educated, higher income transsexual women attending an annual transgender conference in Atlanta, GA, and may not generalize to other transgender individuals. They found that for transsexual women, coming out negatively correlates with depression and anxiety, and positively correlates with self-esteem. The research concerning these variables and outcomes are sparse, and these findings need to be replicated.

In general, the emotional distress transgender individuals experience may be related to some of their unique challenges (Budge, Tebbe, & Howard, 2010; Levitt & Ippolito, 2014), such as, obtaining legal documentation that reflects their gender identity rather than their sex at birth, as well as vocational and economic challenges that result from lack of laws to protect transgender people from employment discrimination, contributing to high unemployment, and low annual income (Badgett, Lau, Sears, & Ho, 2007).

While there is some research that has focused on the emotional distress and well-being of transgender individuals, this research is still in stages of infancy, and research findings are not yet routinely implemented (Chavez-Korell & Johnson, 2010; Nemoto, Operario, & Keatley, 2005; Sperber, Landers, & Lawrence, 2005; Taylor & Jantzen, & Clow, 2013). Budge, Rossman, & Howard (2014) examined the relationships of social support, coping, depression and anxiety with another marginalized group: 64 individuals who identified as *genderqueer*, (i.e., their gender identity is outside of the male/female binary construct). They are known to be an overlooked population, in much the same way as bisexuals (Bilodeau, 2005) Meyer, 2003and typically prefer to be referred to with gender neutral pronouns. Participants that were over 18 and identifies as transgender or

gender-variant were recruited from e-mails sent to community and university LGBT centers, support groups, and social networking groups. They completed demographic information, the Multidimensional Scale of Social Support (MSPSS) (Zimet, Dahlem, Zimet, & Farley, 1988), the Center for Epidemiologic Studies Depression Scale, (CES-D) (Radloff, 1977) Burns Anxiety Inventory, (BAI) (Burns, 1998), and Ways of Coping (Revised). Findings indicated 53% reported clinical levels of depression and 39% reported clinical levels of anxiety. Findings also revealed a negative relationship between social support and depression and anxiety when controlling for coping factors, with more facilitative coping (seeking help) being related to less anxiety, whereas more avoidant coping (avoiding emotions) had a positive relationship with depression and anxiety. A significant interaction existed between social supports and coping factors when predicting anxiety, (i.e., the more social support, the more facilitative coping, which was associated with lower anxiety). Additionally, those who reported less support indicated higher avoidant coping were associated with more anxiety. Limitations to this study included a small sample size, and a more in-depth understanding of how social support and coping interact. This study is the first of its kind with genderqueer individuals, and future studies should focus on inclusion of all types of identities for better generalizability. Implications include the need for counselors to be familiar with genderqueer issues to apply the right approach, and coping should be a focus as well.

The way in which a person copes with psychological stressors is believed to have a buffering effect on distress that stems from transphobia, stigma, and violence and discrimination (Meyer, 2003), and contributing factors include social stressors and ostracism. Despite the elevated amount of stress and hardship experienced in the lives of

most transgender individuals, positive coping behaviors buffer the effects of negative life experiences. In one study, transgender men reported positive emotions through their transition, including confidence, comfort, connection, feeling alive, amazement, pride, happiness, and interpersonal reactionary emotions (Budge, Orovecz, & Thai, 2015). Moreover, these stressors are often managed with coping behaviors that are unhealthy (Hepp, Kraemer, Schnyder, Miller, & Delsignore, 2005), for example; cutting, burning, severe scratching, hitting, and interfering with wound healing (Klonsky, 2007).

Self-Compassion

The Eastern philosophical concept of self-compassion, which is rooted in principles of Buddhism, has become more commonly integrated into Western psychology much by way of the interests of research psychologists during the mid to late 1990's, (e.g., Epstein, 1995: Molino, 1998; Rubin, 1996; Watson, Batchelor, & Claxton, 1999) leading to a better understanding of well-being, and inviting others to develop mindfulness-based interventions (Neff, 2003a). Self-compassion is defined as "being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness" (Neff, 2003b, p. 87.) Self-compassion includes "offering nonjudgmental understanding to one's pain, inadequacies, and failures ... as part of the larger human experience" (Neff, 2003b, p. 87.)

The three main elements of self-compassion intersect and equally intermingle: Self-kindness versus self-judgment, feelings of common humanity versus isolation, and mindfulness versus over-identification (Neff, 2011). Self-kindness is demonstrated by

people who have resolved to be loving and considerate with themselves, rather than harsh and disparaging when faced with challenging life events. Self-judgment, in contrast, is harsh and critical judgment of the self for having inadequacies and personal flaws. An understanding of common humanity entails a recognition that all people share in the struggles of life and failures that accompany being human. Isolation, on the other hand, is the tendency to feel alone and disconnected from others when experiencing hardship and suffering. Lastly, mindfulness is the ability to take a nonjudgmental stance toward one's painful thoughts and feelings and examine them without changing or ignoring them. Over-identification occurs when an individual's storyline of pain gets caught up in negative self-relevant, exaggerated, and obsessive thoughts and emotions (Neff, 2011). Research indicates that self-compassion is linked to positive mental welfare and functioning in heterosexual samples (Neff, 2004; Neff, 2009; Neff, Kirkpatrick, & Rude, 2007; Neff, Rude, & Kirkpatrick, 2007).

In a two-part study examining self-compassion and adaptive psychological functioning, Neff, Kirkpatrick, and Rude (2007) used a laboratory setting with a sample of 91 educational psychology students from a Southwestern University. In groups of 10-20, they first filled out a series of self-report measures including demographics, self-compassion, self-esteem, negative affect, and anxiety. They were asked to answer two questions in a mock job interview about their greatest weakness and an example of a time or situation when this weakness had affected them. Afterwards, they again filled out an anxiety measure and were allowed to answer the questions again, and informed it was an opportunity to make changes or improvements. Scales used were the 26-item Self-Compassion Scale (SCS; Neff, 2003a), the 10-item Rosenberg self-esteem scale (RSE;

Rosenberg, 1965), Positive and Negative Affect Schedule (PANAS; Watson, Clark, & Tellegen, 1988), the 20-item Speilberger State-Trait Anxiety Inventory—State form (Speilberger, Gorsuch, & Lushene, 1970), text analyses using the Linguistic Inquiry and Word Count (LIWC; Pennebaker et al., 2001). Results of this first study found that self-compassion served as a buffer against anxiety when an ego-threat was presented, and was also linked to the use of connected verses separate language when writing about weaknesses, i.e., more plural pronouns used such as we, and with social references such as friends, family, communication, and other humans, supporting the idea that self-compassion indicates a more interconnected and less separate view of the self when personal weaknesses are revealed.

The second study was conducted with 40 undergraduate students from an educational psychology subject pool from a Southwestern university, led to believe they were participating in two different studies, with the first part presented as an investigation into self-attitudes, and the SCS was completed along with some other measures on-line, one week prior to the study, and three weeks afterward. The second part was a Gestalt two-chair dialogue exercise presented as a conflict resolution, however, the intervention was designed to assist clients in challenging maladaptive beliefs and self-criticism, and ultimately allowing them to become more empathic towards the self. Therapists rated the level of self-compassion they thought the participants displayed at the start and end of the exercise on a scale of 1 (not self-compassionate at all) to 5 (Very self-compassionate). Measures used in this part of the study were the 26-item Self-Compassion Scale (SCS; Neff, 2003a), the Social Connectedness Scale (Lee & Robbins, 1995), the 20-item Speilberger State-Trait Anxiety Inventory—State form (Speilberger, Gorsuch, &

Lushene, 1970), the 21-item Beck Depression Inventory (Beck, Ward, Mendelson, Mock & Erbaugh, 1961), the 10-item Ruminative Responses Scale (Butler & Nolen-Hoeksema, 1994), the 15-item White Bear Suppression Inventory (Wegner & Zanakos, 1994). They found that increases in self-compassion over the next month correlated with increased psychological well-being, as well as correlations between self-reports and therapist reports of self-compassion. Limitations of this study were that experimental designs should be conducted to help support the link between self-compassion and well-being, and the exploration of the individual components of self-compassion to see if they are present in differing populations, and also including participants from differing socioeconomic, ethnic and racial, and educational backgrounds.

Following that study, Neff, Rude, and Kirkpatrick, (2007) examined self-compassion, positive psychological functioning, and personality traits. Participants were randomly assigned from educational-psychology students, enrolled at a large Southwestern university, with 68% of the sample female, and 56% Caucasian. In groups up to 30, the participants completed the 26-item SCS; Neff, 2003a, the 39-item Three-Dimensional Wisdom Scale (3D-WS; Ardelt, 2003), the 9-item Personal Growth Initiative Scale (PGIS; Robitscek, 1998)the Curiousity and Exploration Inventory, the 4item Subjective Happiness Scale (SHS; Lyubomirsky & Lepper, 1999), the 6-item Life Orientation Test-Revised (LOT-R; Scheier, Carver, & Bridgges, 1994), the Positive and Negative Affect Scale (PANAS; Watson, Clark, & Tellegen, 1998), and the 60-item NEO Five-Factor Inventory, Form S (NEO-FFI S; Costa & McRae, 1992). The study was correlational in design and overall the study not only supported the notion that self-compassion improved psychopathology, but also was capable of forecasting positive

psychological strengths, and was significantly and positively associated with happiness, optimism, positive affect, wisdom, personal initiative, curiosity and exploration, agreeableness, extroversion, and conscientiousness. Additionally, it was significantly and negatively associated with negative affect and neuroticism. Overall, self-compassion was a far better predictor of positive psychological strengths than personality, and approaching painful feelings with self-compassion is linked to happiness and optimism, and may assist in the ability to grow, explore, and better understand self and others.

Van Dam et al., (2010) investigated mindfulness and self-compassion in terms of predictive ability, to confirm if one was better able to assess symptom severity and quality of life in individuals diagnosed with mixed anxiety and depression. Participants included 504 individuals ranging in age from 18 to 73, mostly well-educated and employed, from the United States, Canada, Australia, and the United Kingdom, among a few other international individuals, with the majority identifying as Caucasian and female. Participants completed the 15-item Mindful Attention Awareness Scale (MAAS; Brown & Ryan, 2003), the 26-item SCS; (Neff, 2003b), the 21-item BAI; (Steer & Beck, 1997), the 21-item BDI; (Steer & Beck, 1997), the Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, Borkovec, 1990), and the quality of life inventory (QOLI; Frisch, 1994). Correlational, multivariate, and univariate analyses indicated that self-compassion, as a whole was a better predictor of anxiety and depression symptom severity than mindfulness, and accounting for as much as ten times more variance in the criterion variables, suggesting that self-compassion may be a key component of Mindfulness Based Interventions. Limitations include the need for longitudinal studies to be conducted as this was a cross-sectional study, and could be limited in generalizability

due to the majority of participants were from a Western culture. Additionally, all participants had used psychotherapeutic services before, which could indicate a unique population. Also there are now several measures that have unique qualities available to measure mindfulness. Self-compassion may have an advantage over mindfulness in prediction of emotional distress.

Eller et al. (2014) conducted a study to explore depressive symptoms, HIV symptom management self-efficacy, and self-compassion, comparing differences in self-schemas between persons living with HIV/AIDS that exhibit depressive symptoms, and those persons that live with HIV/AIDS but do not have depressive symptoms, to discover how predictive these self-schemas were with depressive symptoms. Self-schemas are the beliefs one holds about their self and include self-esteem, HIV symptom management self-efficacy, and self-compassion. The participants were recruited from HIV clinics or AIDS service organizations who were receiving routine care. The sample size was 1766 individuals, either from 10 sites among 6 states in the USA or from 1 place in Puerto Rico who were of legal age (18 years old in the USA, and 21 years old in Puerto Rico, were HIV-positive, and able to provide informed consent. The majority of participants were African American males with a high school education and were not employed. Measures used were sociodemographic data, the 20-item Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977), the 10-item Rosenberg Self-Esteem Scale (RSES: Rosenburg, 1965), the 10-item HIV System Management Self-Efficacy Scale, adapted from the 6-item Chronic Disease Self Efficacy Scale (Lorig, Sobel, Ritter, Laurent, & Hobbs, 2001), and the 12-item Self Compassion Short Scale (SCS-S; Neff, 2003a; Raes, Pommier, Neff, & Van Gucht, 2011). Rates of depression in this sample

were 65% and symptoms were significantly ($p \leq 0.05$), and negatively correlated with age (r = -0.154), education (r = -0.106), work status (r = -0.132), income adequacy (r = -0.204), self-esteem (r = -0.617), HIV symptom self-efficacy (r = -0.408), and self-kindness (r = 0.284); and they were significantly and positively correlated with gender (female/transgender) r – 0.061), white or Hispanic race/ethnicity r = 0.047) and self-judgement (r = 0.600). Additionally, 51% of the variance (F = 177.530 (df = 1524); p <0.00) in depressive symptoms were projected by all of those negatively correlated with exception of self-kindness, and the positively correlated symptom of self-judgement, with self-judgement being the strongest predictor. These findings were in agreement with Beck's theory that people with negative self-schemas are susceptible to depression and clinicians need to screen people in their care that are living with HIV/AIDS. Limitations include a cross-sectional design which does not allow inferences about causality to be made. It also was a convenience sample, and self-report, which could introduce bias into the results. Future interventions should be created for this population, informed by knowledge such as these results and other similar research. Future studies should test, and evaluate if changes in negative schema could be the key to improvement and verify causality in treatment of those living with HIV/AIDS suffering with depressive symptoms.

In heterosexual samples, self-compassion has been positively associated with social connectedness, maternal support, positive family functioning, and attachment styles (Neff & McGehee, 2010) and negatively correlated with depression and anxiety (Neff & McGehee, 2010), including attachment anxiety (Wei, Liao, Ku, & Shaffer,

2011). Self-compassion has also been found to mediate the relationship between attachment anxiety and subjective well-being (Wei, Liao, Ku, & Shaffer, 2011).

To date, there has been little research conducted with self-compassion and distress with the LGBT population. In one unpublished study (Marks, Winterowd, & Crethar, 2015) conducted with participants in the LGB community, researchers explored parental attachment, parental support, and parental acceptance of LGB identity and level of outness with self-compassion and emotional distress. Participants were 98 individuals who self-identified as lesbian, gay, or bisexual. Measures completed were an on-line survey including demographics, the Self-compassion Scale (SCS; Neff, 2003), the Depression, Anxiety, and Stress Scales (DASS; Lovibond, & Lovibond, 1995), the Inventory of Parent and Peer Attachment (IPPA; Armsden, & Greenberg, 1987), the Outness Inventory (OI; Mohr & Fassigner, 2000), and the Parental Support for Sexual Orientation Scale (PSSOS; Mohr & Fassinger, 1997). Results indicated self-compassion was negatively correlated with emotional distress and level of outness, parental attachment, parental support, and acceptance of LGB identity (by one's mother) as well as level of outness were positively correlated with self-compassion for LGB individuals and negatively correlated with emotional distress. Also, self-compassion was negatively correlated with emotional distress. Significant correlations with level of outness were found among levels of mother's ($r = .28$, $p < .01$) and father's ($r = .25$, $p < .01$) attachment, mother's ($r = .49$, $p < .001$) and father's ($r = .4$, $p < .001$) acceptance of participants' sexual orientation, as well as parental support ($r = .21$, $p < .05$).

Crews and Crawford (2015) sought to understand the role of being out on a queer person's self-compassion and found that those who were totally out did have more self-

compassion compared to those who were not out. However, the study was directed toward outness of sexual orientation and their definition of *queer* clustered all sexual minorities together including lesbian, gay, bisexual, transgender, questioning/queer, intersex, and others. The authors explained that sexual orientation and gender identity were indeed different, yet those included in the study that identified as intersex or transgender answered questions about sexual orientation only, and were devoid of any gender specific questions. Additionally, these latter researchers failed to look at the well-being of the sample, and yet, most implications of gender identity and sexual orientation studies implore researchers to find ways to improve the well-being of this population due to the elevated rates.

Counselors and psychologists understand that subtleties are important to practice competently with transgender individuals, and recognize the importance of language in counseling sexual and gender minorities, and the power of honoring people by accepting the gender they identify with whether male, female, or otherwise. If counselors and psychologists are sincere in the desire to honor aspirational ethics that beckon advocacy for underserved and underprivileged populations, it is imperative that researchers answer the call for information to inform practitioners and their practices with transgender and gender non-conforming clients, and develop and disseminate empirically driven interventions that improve the quality of life, while the mystery of human gender and sexuality continues to unfold and enlighten the field of counseling psychology.

The purpose of the present study was to explore the relationship of psychological variables, such as self-compassion, with levels of emotional distress, including depression, anxiety, and stress as well as levels of outness of one's transgender identity in a convenience sample of transgender individuals. In addition, the relationship between self-compassion and level of outness for this transgender sample was explored.

Appendix C: Demographic Sheet

DEMOGRAPHICS

What is your gender? _____ Female _____Male _____Intersex _____Transgender

What is your age? _____

What is your highest educational attainment?
___ Less than high school graduate
___ High school graduate or GED
___Current College freshman
___Current College sophomore
___Current College junior
___Current College senior
___College graduate
___Currently pursuing a master's degree
___Earned a master's degree
___Currently pursuing a PhD or professional degree (MD, JD, etc.)
___Earned a PhD or professional degree

What is your race/ethnicity? (Check all that apply)
___ African/African American/Black
___Alaska Native
___ Asian/Asian American
___Bi-racial
___Caucasian/White/European American
___Hispanic/Latino
___Multi-racial
___Native American Indian
___Native Hawaiian
___Other (please specify)_____
___Pacific Islander

What is your sexual/affectional orientation? (check one box)
___Asexual
___Bisexual
___Gay
___Heterosexual
___Lesbian
___Queer
___Questioning
___Other_(please specify)_____

What is your relationship/marital status?

___Divorced
___Engaged
___Married
___Never Married
___Other)_____
___Partnered
___Polyamorous
___Single
___Widowed

What is your estimated annual income?

____Less than $10,000
____$10,001 to $15,000
____$15,001 to $20,000
____$20,001 to $25,000
____$25,001to $30,000
____$30,001 to $40,000
____$40,001 to $50,000
____$50,001 to $60,000
____$60,001 to $70,000
____$70,001 to $80,000
____$80,001 to $100,000
____$100,001 or more

What is your employment status?

____ Employed (under 6 months)
____ Employed (over 6 months with the same employer)
____ Employed (over 6 months with different employers)
____ Employed (over 12 months with the same employer)
____ Employed (over 12 months with different employers)
____ Employed during transition
____ Never employed
____ Recently Fired
____ Unemployed (employed before transition)
____ Unemployed (employed during transition)
Unemployed (employed after transition)
Unreported or illegal work

Self-Compassion Scale (SCS)

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never				**Almost always**
1	**2**	**3**	**4**	**5**

_____ 1. I'm disapproving and judgmental about my own flaws and inadequacies.

_____ 2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.

_____ 3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.

_____ 4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.

_____ 5. I try to be loving towards myself when I'm feeling emotional pain.

_____ 6. When I fail at something important to me I become consumed by feelings of inadequacy.

_____ 7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.

_____ 8. When times are really difficult, I tend to be tough on myself.

_____ 9. When something upsets me I try to keep my emotions in balance.

_____ 10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

_____ 11. I'm intolerant and impatient towards those aspects of my personality I don't like.

_____ 12. When I'm going through a very hard time, I give myself the caring and tenderness I need.

_____ 13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

_____ 14. When something painful happens I try to take a balanced view of the situation.

_____ 15. I try to see my failings as part of the human condition.

_____ 16. When I see aspects of myself that I don't like, I get down on myself.

_____ 17. When I fail at something important to me I try to keep things in perspective.

_____ 18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.

_____ 19. I'm kind to myself when I'm experiencing suffering.

_____ 20. When something upsets me I get carried away with my feelings.

_____ 21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.

_____ 22. When I'm feeling down I try to approach my feelings with curiosity and openness.

_____ 23. I'm tolerant of my own flaws and inadequacies.

_____ 24. When something painful happens I tend to blow the incident out of proportion.

_____ 25. When I fail at something that's important to me, I tend to feel alone in my failure.

_____ 26. I try to be understanding and patient towards those aspects of my personality I don't like.

Depression Anxiety Stress Scales (DASS-21)

Please read each statement and select a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1. I found it hard to wind down.
   0 1 2 3
2. I was aware of dryness of my mouth
   0 1 2 3
3. I couldn't seem to experience any positive feeling at all.
   0 1 2 3
4. I experienced breathing difficulty (e.g. Excessively rapid breathing, breathlessness in the absence of physical exertion)
   0 1 2 3
5. I found it difficult to work up the initiative to do things
   0 1 2 3
6. I tend to over-react to situations
   0 1 2 3
7. I experienced trembling (e.g. In the hands)
   0 1 2 3
8. I felt that I was using a lot of nervous energy
   0 1 2 3
9. I was worried about situations in which I might panic and make a fool of myself.
   0 1 2 3

   I felt that I had nothing to look forward to.
   1 1 2 3
10. I found myself getting agitated.
    0 1 2 3

11. I found it difficult to relax.

0 1 2 3

12. I felt down-hearted and blue.

0 1 2 3

13. I was intolerant of anything that kept me from getting on with what I was doing.

0 1 2 3

14. I felt close to panic.

0 1 2 3

15. I was unable to become enthusiastic about anything.

0 1 2 3

16. I felt I wasn't worth much as a person

0 1 2 3

17. I felt that I was rather touchy.

0 1 2 3

18. I was aware of the action of my heart in the absence of physical exertion (e.g. Sense of heart rate increase, heart missing a beat.)

0 1 2 3

19. I felt scared without any good reason.

0 1 2 3

20. I felt that life was meaningless.

0 1 2 3

Outness Inventory

Use the following rating scale to indicate how open you are about your transgender identity to the people listed below. Try to respond to all of the items, but leave items blank if they do not apply to you.

1 = person definitely does NOT know about your transgender identity
2 = person might know about your transgender identity, but it is NEVER talked about
3 = person probably knows about your transgender identity, but it is NEVER talked about
4 = person probably knows about your transgender identity, but it is RARELY talked about
5 = person definitely knows about your transgender identity, but it is RARELY talked about
6 = person definitely knows about your transgender identity, and it is SOMETIMES talked about
7 = person definitely knows about your transgender identity, and it is OPENLY talked about
0 = not applicable to your situation; there is no such person or group of people in your life

1. mother	1	2	3	4	5	6	7	0
2. father	1	2	3	4	5	6	7	0
3. siblings (sisters, brothers)	1	2	3	4	5	6	7	0
4. extended family/relatives	1	2	3	4	5	6	7	0
5. my old heterosexual friends	1	2	3	4	5	6	7	0
6. my new heterosexual friends	1	2	3	4	5	6	7	0
7. my work peers	1	2	3	4	5	6	7	0
8. my work supervisor(s)	1	2	3	4	5	6	7	0
9. members of my religious community (e.g., church, temple)	1	2	3	4	5	6	7	0
10. leaders of my religious community (e.g., church, temple)	1	2	3	4	5	6	7	0
11. strangers, new acquaintances	1	2	3	4	5	6	7	0
12. my old LGB friends	1	2	3	4	5	6	7	0
13. my new LGB friends	1	2	3	4	5	6	7	0

14. my old transgender friends	1	2	3	4	5	6	7	0
15. my new transgender friends	1	2	3	4	5	6	7	0

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VITA

Christopher D. Allen

Candidate for the Degree of

Doctor of Philosophy/Education

Thesis: THE RELATIONSHIP OF SELF-COMPASSION AND LEVEL OF OUTNESS WITH EMOTIONAL DISTRESS IN TRANSGENDER INDIVIDUALS

Major Field: Educational Psychology, Specialization in Counseling Psychology

Biographical:

Education:

Completed the requirements for the Doctor of Philosophy in Educational Psychology, Specialization in Counseling Psychology at Oklahoma State University, Stillwater, Oklahoma in July, 2017 (projected).

Completed the requirements for the Master of Education in School Guidance Counseling at Southwestern Oklahoma State University, Weatherford, Oklahoma in 2009.

Completed the requirements for the Bachelor of Science in Parks and Recreation at Southwestern Oklahoma State University, Weatherford, Oklahoma in 2007.

Experience: Kansas State University, Counseling Services, Manhattan, Kansas, August 2016 – present

Oklahoma Juvenile Authority, Oklahoma City, Oklahoma, June 2015 – July 2016

Citizen Potawatomi Nation Behavioral Health Services, Shawnee, Oklahoma, August 2014 – May 2015

OSU Tulsa Counseling Center, Tulsa, Oklahoma, August 2013 – May 2014

Professional Memberships: American Psychological Association