Published in final edited form as:
J Couns Psychol. 2009 January 1; 56(1): 202–209. doi:10.1037/a0014573.

Collective Self-Esteem as a Coping Resource for Male-to-Female Transsexuals

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Abstract

The fear of experiencing discrimination often provokes symptoms of psychological distress. One coping resource is positive identification with one's social group—known as collective self-esteem. This preliminary study investigated whether collective self-esteem was related to fears regarding a transsexual identity and psychological distress among 53 self-identified male-to-female transsexuals (mean age = 50.79). Participants were recruited from transgender events held in Arizona and California. The majority (81%) reported living full-time as women (mean length of time living as a woman = 6.33 years). Negative feelings about the transsexual community and fears regarding the impact of a transsexual identity were positively related to psychological distress. A regression model revealed that the fear of how a transsexual identity would affect one's life was the best predictor of the severity of psychological distress. These results are consistent with findings from other historically marginalized groups whereby the stress of being stigmatized by society adversely affects mental health.

Keywords

Transgender; Gender Identity Disorder; Brief Symptom Inventory; Minority stress; Gender dysphoria

The transgender community is an extremely diverse group. While definitions and labels vary across time and cross-culturally (Lev, 2007), transgender is typically used as an umbrella term for people whose gender expression significantly differs from traditional notions of maleness and femaleness (Davidson, 2007). Underneath this umbrella are people who identify in a variety of ways including transsexual, crossdresser, "gender-queer," and "third sex." However, not all individuals who may fit these descriptors will choose to identify with these terms or this community (for an overview, see Korell & Lorah, 2007).

In mainstream culture, the transgender community is often associated with the lesbian, gay, and bisexual (LGB) community; however, the concerns of the transgender community are not necessarily tied to sexual orientation. Rather, members of the transgender community are unified by the fact that they are discriminated against because of their gender expression. This

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"violation" of social norms has resulted in transgender people being the victims of hate crimes at proportionately higher rates than LGB people (Patton, 2007). This constant discrimination and marginalization that transgender people face likely undermines their psychological functioning (Clements-Nolle, Marx, & Katz, 2006).

Given that public awareness of the transgender community has been growing and that transgender individuals are becoming more visible (Zucker et al., 2008), it is important that counseling psychologists expand their multicultural competence to include the experience of transgender people. A relatively large body of empirical articles is available for psychologists seeking to better understand this community. Most of the research has focused on etiology and psychopathology, which has been useful for medical and diagnostic purposes. However, many feel that this focus has presented a very narrow view of the experience of being transgender, and that it has contributed to the stigmatization of the community—a strong sentiment that has been reflected in the controversy surrounding the composition of the *DSM-V*'s Sexual and Gender Identity Disorders Work Group (American Psychiatric Association [ApA], 2008; Alexander, 2008). Furthermore, the focus on dysfunction overlooks the challenges that are faced by transgender people including discrimination and social isolation (Hill, 2005).

In order to further our understanding of transgender people, we conducted a survey examining how fears regarding one's identity and feelings about the community are related to psychological distress. We will focus on the experience of male-to-female (MTF) transsexuals because space limitation prohibits us from adequately addressing the complex issues specific to all segments of the transgender community—especially children. Given the nature of this Special Issue and given that this is the first article in the *Journal of Counseling Psychology* focused on transgender people (determined by running a keyword and title search on *PsycInfo*), we will briefly provide some basic information before focusing on the preliminary results from this survey. First, we will review prevalence data and the limited research that has investigated what contributes to the development of this unique identity. Second, we will discuss the role that psychologists may play in the transitioning process and concerns over diagnosis. Finally, we will review the literature on the effect of discrimination and the role that collective self-esteem can play as a coping mechanism. In this brief overview, we have included some controversial topics for informative purposes as they have been a source of tension between segments of the transgender community and mental health professionals.

Prevalence and Development

Most research on the transgender community has focused on MTF transsexuals, which may be because they are more common than other transgender people (Bakker, van Kesteren, Gooren, & Bezemer, 1993; Garrels et al., 2000; Olsson & Möller, 2003). While no epidemiological study has been conducted in the U.S., the *DSM-IV-TR* suggests that the prevalence is 1:30,000 (ApA, 2000). However, the estimated prevalence of MTF transsexualism in European and Asian countries has been reported to range from 1:100,000 to as high as 1:2,900 (see de Cuypere et al., 2006).

MTF transsexuals are individuals who at birth were assigned the sex of male (henceforth referred to as birth sex) and typically possess male primary and secondary sexual characteristics. However, they report that neither their birth sex nor anatomy reflects their true gender identity. Consequently, they may engage in an arduous process in order to actualize their sense of self. The degree to which one will go through this process—which may include hormone replacement therapy, electrolysis to remove unwanted body hair, and sex reassignment surgery—can be affected by a number of factors including medical risks, relationship concerns, personal preference, and discriminatory medical systems (Dean et al., 2000). Furthermore, the prohibitive costs of sex reassignment surgery and the lack of coverage

by third party payers prevents many from accessing this treatment (Gehi & Arkles, 2007; Gordon, 1991).

Early in the transitioning process, many MTF transsexuals want to understand what has contributed to their identity (Lev, 2004). While both social and life scientists have investigated this question, it remains unclear which factors contribute to a transsexual identity and to what degree. Many theories from the social sciences have been proposed (e.g., absent fathers [Stoller, 1979] and enmeshed mothers [Loeb & Shane, 1982]), yet most have no empirical support. The most supported yet contentious claim comes from the field of sexology: Some males transition because of an extreme form of transvestic fetishism or a paraphilia known as autogynephilia (essentially meaning self-female-love; Blanchard, 1989, 1991, 2005). While numerous reports were published throughout the 1980s and 1990s, this concept did not receive much attention until the mass-market release of a controversial book by Bailey (2003). The merits of autogynephilia continue to be debated (see the special issue of *Archives of Sexual Behavior*, volume 37, issue 3) as many feel it makes gross generalizations and minimizes the experience of MTF transsexuals (e.g., Bockting, 2005; McCloskey, 2008). However, there are MTF transsexuals who feel it is an accurate description for some transsexuals (e.g., Lawrence, 2004, 2007) and counseling psychologists should at least be aware of this concept.

The life sciences have provided some insight, which we will briefly review here (for an updated review, see Sánchez, Bocklandt, and Vilain, 2009). First, it was hypothesized that hormonal anomalies—especially elevated levels of cross-sex hormones during embryonic development—led to a transgender identity (Kester, Green, Finch, & Williams, 1980; Slipjer, 1984). However, human experiments that would test this casual link have not been conducted as such studies would be unethical. Second, compelling reports have suggested that MTF transsexuals have “feminized” brain regions (Berglund, Lindstöm, Dhejne-Helmy, & Savic, 2008; Kruijver et al., 2002; Lüders et al., 2009; Zhou et al., 1995). Yet, many confounds in these studies (e.g., small samples sizes and high degrees of unsystematic variability) make the findings equivocal and further investigation is needed. Finally, there is tentative evidence that MTF transsexuals may have rare genetic variations that affect hormonal receptors necessary for the developing brain to “masculinize” (Hare et al., 2009; Henningsson et al., 2005). These findings will need to be replicated using larger samples. Overall, while the life sciences may be honing in on the specific biological underpinnings of gender identity, there are no definitive answers at this time.

Regardless of why a transsexual identity may develop, MTF transsexuals are likely to seek mental health services. In part, this is because MTF transsexuals experience many stressors related to their identity and transition (e.g., the fear of losing significant relationships and their job). However, the biggest reason that MTF transsexuals will seek out psychologists is that the accepted standards of care specify that individuals who are seeking to transition must be in therapy (Meyer et al., 2001). We will briefly review the role that psychologists play in this process, which includes diagnosing Gender Identity Disorder.

WPATH Standards of Care and Gender Identity Disorder

While the American Psychological Association (APA) has yet to adopted practice guidelines for working with transsexual clients, the World Professional Association for Transgender Health (WPATH) has developed standards of care to guide health professionals (Meyer et al., 2001). These guidelines are intended to help in the determination of readiness for transition related treatments. As part of this process, MTF transsexuals must be evaluated and cleared for treatment by one mental health professional in order to receive hormone therapy, and by two mental health professionals in order to receive sex reassignment surgery. While these guidelines were intended to increase the likelihood of a positive outcome, the need for a mental

health evaluation has been seen as pathologizing (Bockting, Robinson, Benner, & Scheltema, 2004). Further fueling these criticisms is that the individual must be diagnosed with Gender Identity Disorder (GID)—a controversial diagnosis (Lev, 2005; Zucker & Spitzer, 2005).

The full criteria for GID can be reviewed in the *DSM-IV-TR* (ApA, 2000). However, the key characteristic is the persistent experience of gender dysphoria—a strong feeling that one's birth sex does not reflect her inner sense of gender. Opponents of this diagnosis argue that GID pahtologizes normal variation in gender expression (Hill, Rozanski, Carfagnini, & Willouhby, 2005). While behaviors that simply conflict with societal norms are not diagnosable (ApA, 2000, pp. xxx–xxxi), the *DSM* criteria are criticized for being too vague and subjective in practice (Widiger & Samuel, 2005). Opponents also argue that GID stigmatizes people, which exacerbates the harm that they already experience in society, and that GID provides a reason to withhold civil rights (e.g., custody of children; Hill et al., 2005; Winter, 2005).

Proponents of the diagnosis argue that—while there is a need to update the language and criteria in the *DSM*—the experience of gender dysphoria is a real concern and not simply the result of societal discrimination (Zucker, 2006). That is, even if society was open to a variety of gender expressions, the individual will still experience significant distress because her anatomy does not reflect her inner sense of gender (Bockting & Ehrbar, 2005). Furthermore, the existence of the diagnosis provides access to treatment (Spitzer, 2005), and access to rights under specific laws (Dasti, 2002; Levi, 2006).

The debate over GID's place in the *DSM* continues. In the meantime, the APA Task Force on Gender Identity and Gender Variance (2008) opined

> Whether gender identity disorder belongs in the *DSM* is a point of contention. What is not in contention is that gender dysphoria is often a source of psychological distress, above and beyond the influence of societal attitudes, and as such must be addressed with some form of treatment or intervention (p. 57).

Consequently, counseling psychologists may find themselves in a difficult position where they are called upon as "gatekeepers" to treatment while having to treat their client's psychological distress without further making them feel stigmatized.

Psychological Distress and Coping

Movies such as *Boys Don't Cry* (Pierce, 1999) and *Soldier's Girl* (Pierson, 2003) have vividly depicted the type of discrimination that transgender people and their loved ones encounter. While they have served to heighten public awareness, the incidence of transgender-related discrimination remains high considering the proportion of the population that they represent. For instance, a survey of 515 transgender people in San Francisco found that 83% reported some form of gender-based victimization (Clements-Nolle et al., 2006), and a review of Los Angeles police reports from 2002–2006 yielded 49 documented violent crimes against transgender people (Stotzer, 2008). Consequently, the high incidence of discrimination experienced by transgender people negatively affects their psychological functioning whether or not they have been victimized (Clements-Nolle et al., 2006; Lombardi, Wilchin, Priesing, Malouf, 2001; Patton, 2007).

When it comes to other historically marginalized groups, the experience of discrimination based on personal characteristics instills fear of future discrimination, which provokes psychological distress (e.g., Jackson et al., 1996). Yet, one does not have to directly experience discrimination to be adversely affected by it. Merely witnessing or knowing that one's group is the target of discrimination is sufficient to provoke distress. This overall concept has been termed as *minority stress* by some scholars (see Frost & Meyer, 2009).

When coping with this type of stress, one source of strength seems to be a person's feelings and connection with other individuals who are stigmatized for the same characteristic. In particular, positive identification with one's social group—known as collective self-esteem (Crocker & Luhtanen, 1990)—has been negatively related to psychological distress among racial/ethnic minorities (e.g., Kim & Omizo, 2005; Liang & Fassinger, 2008), sexual minorities (e.g., Zea, Reisen, & Poppen, 1999), and women (e.g., Corning, 2002; Fischer & Holz, 2007). Thus, positive identification with one's group may help buffer the effects of societal oppression.

Given the discrimination faced by transgender people, we sought to investigate whether collective self-esteem served as a coping resource for MTF transsexuals by reducing their fears about a transsexual identity and symptoms of psychological distress. In addition, we investigated whether aspects of one's transsexual identity served as predictors of psychological distress.

Method

Participants

The participants were 53 self-identified MTF transsexuals recruited at two separate events: the International Foundation for Gender Education Conference (Tucson, AZ), and the California Dreamin' Transgender Conference (San Jose, CA). Both of these educational, social, and supportive events were targeted at the whole transgender community and their allies. The average age of the participants was 50.79 (*SD* = 11.62; range = 21–77 years-old) with 77% (*n* = 41) currently undergoing estrogen treatment. The majority of the participants (*n* = 43; 81%) reported living full-time as a woman: The average number of years since beginning to live full-time as a woman for this subset was 6.33 (*SD* = 6.82; range up to 37 years). The majority of the sample identified as White (non-Latino; *n* = 46, 86%), with three (6%) identifying as Asian American, two as African American (4%), and two as Pacific-Islander (4%). Furthermore, the majority of the participants had at least a bachelor's degree (*n* = 37; 70%) and the median individual annual income bracket was $60,000–$69,999.

In terms of sexual orientation, the participants' self-reports presented a mixed picture. Based on the Kinsey Scale (Kinsey, Pomeroy, & Martin, 1948/1975) described in more detail below, we coded their sexual orientation as follows: attracted to women (*n* = 28; 53%), bisexual (*n* = 20; 38%), attracted to men (*n* = 4; 8%), and asexual (*n* = 1; 2%). Of the group, 25 (47%) reported being in a significant romantic relationship (mean length = 10.39 years; *SD* = 12.54; range = 0.25–40 years), with 14 being in a relationship with a non-transgender woman, 4 with a non-transgender man, and 7 with another MTF transsexual. Additionally, 70% (*n* = 37) of the sample reported a history of being married to a woman and 76% (*n* = 40) reported that their ideal partner was not a man.

Measures

Collective Self-Esteem Scale (CSES)—The CSES (Luhtanen & Crocker, 1992) is a 16-item self-report measure that assesses one's thoughts and feelings regarding her social group. Using a seven-point scale, participants indicate the degree to which they agree or disagree with the statements: 1 = strongly disagree; 2 = disagree; 3 = disagree somewhat; 4 = neutral; 5 = agree somewhat; 6 = agree; and 7 = strongly agree. The CSES is divided into four subscales; each subscale consists of four questions. The Membership CSE subscale items assess how "good or worthy" one feels about being in a particular social group (e.g., "I am a worthy member of the social groups I belong to"). Items from the Private CSE subscale assess how good one views her social group (e.g., "I feel good about the social groups I belong to"). The Public CSE subscale items assess how one believes others outside the social group judge her group (e.g.,

"In general, others respect the social groups that I am a member of"). Finally, items in the Identity CSE subscale assess how important one's social group is to her self-concept (e.g., "The social groups I belong to are an important reflection of who I am").

In Luhtanen and Crocker's (1992) scale development report, they found internal consistencies ranged from .71 to .88 for all four subscales over a series of three studies consisting of college students. While the original scale was designed to capture a global assessment regarding one's social groups, Luhtanen and Crocker (1992) demonstrated that wording the questions for a specific group would not compromise its psychometric properties. Subsequently, studies that have altered the scale for specific social groups have reported sound validity and reliability data (e.g., Fisher & Holz, 2007; Liang & Fassinger, 2008). For instance, Kim and Omizo (2005) reported alphas of .72–.86 with a sample of Asian American college students; and Downie, Mageau, Koestner, and Liodeden (2006) reported alphas of .78–.92 with a sample of multiethnic Canadians. Thus, items were worded to indicate that the transsexual community was the social group of interest for this study. In the current study, Cronbach's alphas were . 70, .83, .71, and .77, for the Membership, Private, Public, and Identity subscales respectively.

Transgender Adaptation and Integration Measure (TG-AIM)—Sjoberg, Walch, and Stanny (2006) developed the TG-AIM to assess the adjustment experience of transgender adults and particular concerns they experience due to their gender identity. Participants use a four-point scale to respond to each item: 0 = never; 1 = rarely; 2 = occasionally; and 3 = frequently. The original 15-item measure consists of four subscales: 1) Coping and Gender Reorientation Efforts subscale, 2) Gender Locus of Control subscale, 3) Gender-Related Fears subscale, and 4) Psychosocial Impact of Gender Status subscale. For the purposes of this study, only the latter two subscales were used. Furthermore, the word transsexual was substituted for transgender in order to be more specific.

The five-item Gender-Related Fears subscale measures fears related to discrimination and potential social losses (e.g., "I fear discrimination," and "I fear abandonment if I told others"). The four-item Psychosocial Impact of Gender Status subscale measures the perceived impact of one's gender identity on her mental health and quality of life (e.g., "Being transsexual causes me relationship problems"). Higher scores on both these scales suggest more gender related fears and stress than lower scores. Based on their sample of 108 MTF transsexuals, Sjoberg et al. (2006) reported internal consistencies of .81 and .72 for the two subscales respectively. Validity was established by demonstrating negative correlations with personal self-esteem (Rosenberg, 1965) and quality of life (Huba & Melchior, 1996). To our knowledge, this is the second published study to use the TG-AIM. Cronbach's alphas in the current study were .81 and .72, for the Gender-Related Fears and Psychosocial Impact of Gender Status subscales respectively.

Brief Symptom Inventory–18 (BSI–18)—The BSI–18 (Derogatis, 2000) was used to assess primary symptoms of psychological distress. This 18-item self-report inventory was selected because it quickly and reliably assesses three common psychiatric syndromes—somatization (SOM), depression (DEP), and anxiety (ANX)—and the intensity of psychological distress attributed to these three syndromes (Global Severity Index; GSI). Using a five-point scale, participants indicate the degree to which they have been bothered by particular problems during the past seven days: 0 = not at all; 1 = a little bit; 2 = moderately; 3 = quite a bit; 4 = extremely. Validity for the BSI–18 was demonstrated by showing a strong correlation between this inventory and congruent subscales in the Symptom Checklist–90–R (Derogatis, 1994). Furthermore, Derogatis (2000) reported that internal reliability for the subscales ranged from .74–.89, and that test-retest reliability was estimated to range between . 68–.90. In this study, Cronbach's alphas for the BSI–18 subscales ranged from .73–.88.

Demographic Questionnaire—A demographic questionnaire designed for this study was used to collect personal information including age, educational level, individual annual income, relationship status, relationship history, medical history, and sexual interests and attitudes. The Kinsey Scale (Kinsey et al., 1948/1975) was used to assess sexual orientation. The scale ranges from 0–6 (0 = exclusively heterosexual; 1 = predominately heterosexual, but occasionally bisexual or gay; 2 = mostly heterosexual, but more than just occasionally bisexual or gay; 3 = bisexual; 4 = mostly gay, but more than just occasionally bisexual or heterosexual; 5 = predominately gay, but occasionally bisexual or heterosexual; 6 = exclusively gay) and takes into account a person's sexual attraction, fantasies, behavior, and identity. For descriptive purposes, individuals with a score of 0/1 were coded as being attracted to women; 5/6 as being attracted to men; and 2–4 as bisexual. This method for coding sexual orientation is commonly used by sex researchers (e.g., Rahman & Hull, 2005; Tiggemann, Martins, & Kirkbride, 2007).

Procedure

In order to solicit potential participants, a table was set up in areas with moderate traffic and with seating within 15 feet of the table. Solicitation signs calling for self-identified MTF transsexual research participants were posted in plastic table sign holders so that they were visible to people passing by. Interested participants were briefed on the purpose and procedure of the project. If still interested, they were handed a packet, which contained the informed consent form and the questionnaires in counterbalanced order. The forms were explained to the participants and space was offered to them where they could complete the questionnaires. The approximate time to complete the questionnaire was 15 minutes. Participants were offered a $5 compensation for their time.

Results

A preliminary review of the data was conducted to examine the distribution of predictor and criterion variables (Tabachnik & Fiddell, 2006). Scores on the BSI–18 were positively skewed ($p < .05$). Square root transformations were used to reduce the skew of the data to non-significant levels. These values were used in the subsequent analyses.

Table 1 provides the means and standard deviations for the variables (further descriptive statistics are available online). Three participants did not complete the BSI–18; however, their data were included for the correlational analysis. The BSI–18 means presented in Table 1 are the raw scores and not the transformed scores or standardized T-scores that are provided on the BSI–18 clinical profile forms. Nevertheless, we did compare the participants' scores to the community norms (Derogatis, 2000) to determine how many would reach a clinical threshold (i.e., a T-score of 60 or one standard deviation from the normative mean) for each dimension.

The standard BSI–18 clinical profile form provides results based on either female or male norms. When applying the male norms, more participants reached the clinical threshold for three of the subscales compared to the female norms: DEP = +22%; ANX = +18%; and GSI = +10%. Derogatis (2000) provided norms for the combined normative sample in Appendix A of the BSI–18 manual. Applying the combined norms, an intermediate compromise is reached whereby more participants reached the clinical threshold when compared to the female norms (+8%, +8%, and +4%, respectively) but less when compared to the male norms (–14%, –10%, and –6%, respectively). An online table is available for further analysis.

Table 1 presents the zero-order correlations between the measured variables (95% confidence intervals are available online). As a whole, the more positively one felt about being a part of the transsexual community, the less psychological distress that was reported. Specifically, feelings about being a member of the transsexual community accounted for 17% of the variance

in GSI scores and private feelings about the transsexual community accounted for 20%. Conversely, the more fear one felt because of her transsexual identity, the more distress she reported. Specifically, fears related to being transsexual accounted for 25% of the variance in GSI scores and the perceived impact of a transsexual identity accounted for 28%.

A simultaneous multiple regression analysis was conducted to determine which variables best predicted severity of psychological distress (see Table 2). The four collective self-esteem variables and the two variables related to one's transsexual experience were simultaneously entered as predictor variables with the GSI serving as the criterion variable. While the linear combination of these predictors accounted for 44% of the variance in GSI scores, only fears related to one's transsexual identity was a significant unique predictor of GSI.

Discussion

This preliminary study investigated how collective self-esteem was related to fears of transsexual-related discrimination and psychological distress. For this group of participants, the more positive one felt about the transsexual community the less psychological distress they reported. On the other hand, participants who were more fearful about the effect of their transsexual identity reported more psychological distress than those less fearful. Finally, a regression model showed that fears related to being transsexual best predicted the severity of psychological distress.

As a whole, two main findings stand out from these preliminary results. The first finding suggests that the internalization of negative feelings regarding a transsexual identity may be detrimental to her well-being. If true, this internalization of discriminatory views would be consistent with the experience of other historically marginalized people (Frost & Meyer, 2009; Szymanski, Kashubeck-West, & Meyer, 2008). For instance, Liang and Fassinger (2008) found that negative feelings about being Asian American among a sample of college students were negatively related to personal self-esteem and positively related to interpersonal problems. Fischer and Holz (2007) found that women who evaluated women as a social group more negatively reported more symptoms of depression than those who viewed women more positively. Similarly, MTF transsexuals may initially view themselves negatively as their group has been pathologized by the dominant culture. Such a hypothesis would also fit within the existing multicultural frameworks (e.g., Atkinson, 2006).

The second main finding in this preliminary study came from the regression analysis. It is common for MTF transsexuals to reports fears of losing significant relationships (e.g., with romantic partners, parents, and children), losing their job, and being victimized in public because of their gender identity (Gagné & Tewksbury, 1998). Such fears are realistic given the pervasiveness of crimes against gender variant people (Lombardi et al., 2001). Consequently, the more fearful that one is, the more distress that she will experience.

This also seems consistent with minority stress theory (Frost & Meyer, 2009). Specifically, people who are more fearful of discrimination report more symptoms of depression and anxiety than those who are less fearful (e.g., Fischer & Holz, 2007; Moradi & Risco, 2006). This can further affect well-being because if people expect to be discriminated by particular institutions (e.g., the healthcare system), then they may not seek out their services to address important needs (Gee, Ryan, Laflamme, & Holt, 2006).

Limitations

While this preliminary study focused on a unique group of women, several limitation should be kept in mind. First, given the cross-sectional and correlational nature of the data, causal relationships cannot be determined. Furthermore, in our regression model the severity of

psychological distress served as the criterion variable. It could be argued that it is psychological distress that leads to discrimination fears and lower collective self-esteem. Second, while the participants varied in terms of specific demographic characteristics (e.g., income, education, and stage of transition), this convenience sample recruited at two transgender specific events lacked racial/ethnic diversity as well as MTF transsexuals attracted to men. Thus, self-selection bias may limit how generalizable these results are. Third, while the alpha coefficients for the Collective Self Esteem Scale were good, this is the first published study to use this measure with MTF transsexuals. Further studies using this scale are needed to determine if it is a valid instrument to use with this population. Finally, even though MTF transsexuals represent a relatively small proportion of the general population, the small sample size may have affected the results of the regression model analyzed in this study.

Implications for Research and Practice

Notwithstanding the limitations, this preliminary study offers some implications for research and practice. First, regardless of why a transsexual identity may develop, counseling psychologists must respect the dignity and worth of transgender individuals and strive to conduct beneficial work—both through science and practice—within the scope of their competence (APA, 2002). In regards to empirical research, counseling psychologists can play an active role in understanding the experience of the transgender community. In particular, there is a need to conduct process and outcome research in order to determine effective counseling interventions with transgender clients. Future research can also examine what are effective coping strategies that are appropriate to the experience of transgender clients and investigate what factors foster psychological well-being.

In regards to clinical practice, it may be important to explore the client's experience with discrimination. In particular, has the client internalized negative messages regarding her identity? If so, how are those messages affecting both her connection with the transgender community and her well-being? While APA has yet to adopt practice guidelines for working with transgender clients, the WPATH Standards of Care (Meyer et al., 2001) may provide some help when working with those who seek to transition. Furthermore, it maybe helpful to review counseling suggestions from practitioners who specialize in working with the transgender community (e.g., Korell & Lorah, 2007; Lev, 2004). While appropriate interventions have yet to be empirically tested, the perspective of these practitioners may provide insight when developing therapeutic goals that can empower the client by enhancing feelings about her gender identity.

Given that discrimination is a real concern for the transgender community, counseling psychologists can also help develop coping strategies to buffer the negative experience of discrimination. For example, helping the client enhance her ability to use internal sources of validation (e.g., positive self-talk) and to utilize social support networks may lessen psychological distress related to discriminatory events. The client may also benefit from engaging with others struggling with their gender identity through group therapy.

One final implication relates to the use of self-report symptom inventories such as the BSI–18 in the assessment of a client's presenting concerns. Most inventories are normed on dichotomous samples of men and women. Consequently, psychologists have no clear basis for using either set of norms for their transsexual clients. Until norms for MTF transsexuals are reported, the most cautious practice would be to report comparisons between both sets of norms as we have done in this paper.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

Support for this study was provided by the first author's NIH training grant 5 T32 HD07228: 26 (Neural Regulation of Reproduction/Laboratory of Neuroendocrinology).

We thank Sven Bocklandt, Denise Leclair, Laura Marlowe, Rohan Spong, and Cat Turner for their assistance on this project.

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Table 1

Zero-Order Correlations

	Variables	*M*	*SD*	1	2	3	4	5	6	7	8	9
1	Membership CSE	23.64	4.71	—								
2	Private CSE	22.06	6.55	.55***	—							
3	Public CSE	17.53	4.89	.34*	.51***	—						
4	Identity CSE	14.64	6.40	.48***	.55***	.33*	—					
5	TR-Related Fears	6.32	4.54	−.07	−.17	−.23*	−.10	—				
6	TR Impact	4.92	3.05	−.28*	−.33*	−.10	−.07	.53***	—			
7	Somatization	2.50	3.25	−.33*	−.18	−.03	−.13	.37**	.40**	—		
8	Depression	4.20	4.39	−.34*	−.45**	−.31*	−.22	.37**	.43**	.15	—	
9	Anxiety	3.68	4.41	−.29*	−.30*	−.28	−.15	.41**	.32*	.35*	.56***	—
10	Global Severity	10.38	9.40	−.41**	−.45**	−.30*	−.23	.50***	.53***	.62***	.79***	.81***

Note: CSE = collective self-esteem; TR = transsexual.

* $p < .05$;

** $p < .01$;

*** $p < .001$

Table 2

Regression Coefficients on Global Severity of Psychological Distress

	Unstandardized				95% Confidence Interval		Correlation		
	B	***SE B***	**β**	***t***	**Lower**	**Upper**	**Zero-order**	**Partial**	**Part**
(Constant)	3.98	1.09		3.66**	1.784	6.167			
Membership CSE	−0.04	0.04	−.15	−0.97	−0.133	0.046	−.408	−.147	−.111
Private CSE	−0.04	0.03	−.22	−1.31	−0.113	0.024	−.449	−.195	−.150
Public CSE	−0.01	0.04	−.05	−0.37	−0.091	0.063	−.299	−.056	−.042
Identity CSE	0.01	.03	0.03	0.23	−0.056	0.070	−.230	.035	.026
TR-Related Fears	0.09	0.04	.30	2.18*	0.007	0.180	.498	.316	.250
TR Impact	0.10	0.07	.23	1.48	−0.036	0.238	.526	.220	.170

Note: $n = 50$; CSE = collective self-esteem; TR = transsexual; $R = .66$; $R^2 = .44$.

* $p < .05$;

** $p < .01$.