

Employment, Mental Health, Internalized Stigma, and Coping With Transphobia Among Transgender Individuals

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Transgender individuals encounter stigma related to nonconforming gender identity, contributing to elevated symptoms of depression, anxiety, and suicidality. Stigma toward transgender individuals (i.e., transphobia) poses significant barriers to employment and other areas of functioning. Transgender individuals with a history of mental health concerns may encounter double stigma. The present 2-part study was conducted to investigate experiences of double stigma, internalized stigma, and coping strategies for dealing with transphobia. In Study 1, quantitative findings with 55 transgender participants indicated that employed participants reported higher levels of stigma (both internalized and external). Higher levels of coping with stigma were associated with lower levels of stigma (both internalized and external). Higher levels of coping were reported by participants utilizing psychiatric medication, with lower levels of coping with mental health stigma in particular found among those receiving outpatient mental health services. In Study 2, a grounded theory analysis was conducted with 45 of these participants to identify coping strategies that transgender individuals use to deal with transphobia. Coping strategies were categorized into individual factors (gender normative coping, self-affirmative coping, emotional regulation coping, cognitive reframe coping); interpersonal factors (social-relational coping, preventative-preparative coping, disengagement coping); and systemic factors (resource access coping, spiritual and religious coping, and political empowerment coping). Findings of Study 2 also revealed the presence of *disclosure strategies*—decisions to reveal or conceal one’s transgender identity, and *anticipatory stigma*—expecting and preparing for prejudice and discrimination. Results suggest the need for interventions for transgender individuals to enhance coping with stigma and reduce internalized stigma.

Keywords: transgender, coping, qualitative, internalized stigma, transphobia

Transgender individuals face significant stigma or transphobia—prejudice, discrimination, and gender-related violence due to negative beliefs, attitudes, irrational fear, and aversion to transgender people (Hill & Willoughby, 2005; Mizock & Lewis, 2008). Research has indicated that transphobia contributes to barriers to employment, elevated symptoms of depression, anxiety, and suicidality (Budge, Tebbe, & Howard, 2010; Chope & Strom, 2008; Kidd, Veltman, Gately, Chan, & Cohen, 2011; Sánchez & Vilain, 2009). Moreover, transgender individuals who also experience a mental health problem may encounter the additional challenge of mental health stigma, which is termed *double stigma* (Mizock, 2012). In the context of the present study, mental health problems exclude the diagnosis of Gender Dysphoria. Further research is needed on the experiences of stigma in general and in the work-

place among transgender individuals with mental health problems, as well as the incidence of internalized stigma (stigma directed at oneself). In addition, investigation is needed of the coping strategies used by transgender participants to deal with double stigma and internalized stigma (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Nuttbrock et al., 2010; Poteat, Germna, & Kerrigan, 2013; Sánchez & Vilain, 2009). The present two-part study was conducted to investigate these research questions utilizing quantitative analysis in Study 1 and qualitative analysis in Study 2.

Mental Health and Transgender Individuals

Transphobia has been identified as a key contributor to elevated rates of mental health problems and suicidality among transgender individuals (Hellman, Sudderth, & Avery, 2002; Kidd et al., 2011). Suicidality has been noted in one third to one half of some samples (Clements-Nolle, Marx, & Katz, 2006; Reisner, Perkovich, & Mimiaga, 2010). High rates of suicidal ideation (54%), lifetime suicide plans (35%), and suicide attempts (28%) have been found (Nuttbrock et al., 2010). In addition, high rates of other mental health problems have been identified among transgender individuals. For example, one estimate of the incidence of major depression among transgender individuals was three times that of the general population (54%; Nuttbrock et al., 2010). In another study,

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This research was funded by the Dudley Allen Sargent Research Fund of Sargent College at Boston University.

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more than half of transgender participants met criteria for clinical depression, (56%, $n = 16$) (Reisner et al., 2010). Increased rates of suicidality (61%), serious mental illness (43%), medical and psychiatric disabilities (>50%), and depression (20%) were noted in a study of transgender veterans (McDuffie & Brown, 2010). Higher rates of substance abuse, sexual risk taking, and suicidality have also been found among transgender individuals compared to cisgender counterparts (Mustanski, Garofalo, & Emerson, 2010; Reisner et al., 2010). These findings reflect the need for additional study of the impact of transphobia on transgender individuals.

Employment and Transphobia

Mental health problems have been associated with higher rates of unemployment despite interests in working among individuals with mental health problems (Drake, Skinner, Bond, & Goldman, 2009; Mueser, Salyers, & Mueser, 2001). Moreover, transgender people with mental health problems are more likely to be unemployed and underemployed given experiences with workplace stigma and discrimination, despite an interest in working (Mizock & Fleming, 2011; Chope & Strom, 2008; Lucksted, 2004; Vance et al., 2010). Impairment in vocational functioning for transgender people has been found to create a negative cycle of unemployment, financial problems, social isolation, psychiatric symptoms, and suicidal ideation (Hellman & Klein, 2004; Kidd et al., 2011; Meyer-Bahlburg, 2010; Nuttbrock et al., 2010; Sánchez & Vilain, 2009; Toomey, Ryan, Diaz, Card, & Russell, 2010).

Budge and colleagues (2010) conducted a qualitative study to identify occupational barriers and experiences with work among transgender individuals. These participants reported experiences with overt discrimination, loss of job, difficulty gaining employment, restroom discrimination, and gender stereotypes in the workplace. In addition, this study found that many transgender individuals face barriers while transitioning at work. Participants often compensated for job barriers by working harder in their professions or working in LGBT-related activist roles. This study suggested the role of active coping in dealing with stigma in order to reduce the effects of mental health issues among employed transgender individuals.

However, encounters with transphobia in the workplace may lower confidence and invoke psychiatric distress (Chope & Strom, 2008). Problems with employment may lead to financial problems that further interfere with accessing mental health services (Willing, Salvador, & Kano, 2006). Addressing harassment and discrimination in the workplace is essential (Chope & Strom, 2008). Additional research is needed to identify the impact of coping with employment-related stigma among transgender individuals (Budge et al., 2010).

Stigma

Many transgender individuals encounter stigma—negative attitudes, prejudice, and discrimination toward individuals with mental illness, transgender identity, and other marginalized backgrounds (Link & Phelan, 2001). Stigma may contribute to impairment in social and vocational functioning, prolong mental health symptoms, increase hospitalizations, and delay treatment-seeking (Link & Phelan, 2001; Russinova, Griffin, Bloch, Wewiorski, & Rosoklija, 2011; Sirey et al., 2001). Transgender

individuals may face both external stigma (prejudice and discrimination by others) and internalized stigma (self-stigma) that interfere with vocational functioning and increase depression and suicidality (Clements-Nolle et al., 2006; Grossman & D'Augelli, 2007; Kidd et al., 2011; Mustanski et al., 2010; Sánchez & Vilain, 2009). However, little is known as to how internalized and external stigma specifically impact vocational functioning and coping for transgender people.

Stigma may present a significant barrier to care for transgender individuals in the mental health system (Shipherd, Green, & Abramovitz, 2010). Stigma may interfere with accessing medical and mental health services (Lucksted, 2004; Shipherd et al., 2010). Transgender individuals are often underrepresented in mental health programs (Hellman, Klein, Huygen, Chew, & Uttaro, 2010; Shipherd et al., 2010), as these programs might exclude or fail to address the needs of transgender clients (Cook, 2000; Kidd et al., 2011). Transgender individuals have described needing to be hypervigilant about stigma in mental health services given reported experiences of discrimination, prejudice, alienation, hostility, and even danger within mental health systems (Lucksted, 2004). Evidence suggests less satisfaction with treatment as a result of encounters with providers who lack sensitivity, knowledge, and training in transgender care (Kidd et al., 2011; Colton Meier, Fitzgerald, Pardo, & Babcock, 2011). Furthermore, internalized stigma may reduce the access of emergency and inpatient services when needed due to reduced help-seeking and self-care to address mental health problems as they occur (Hellman et al., 2010; Ziguris, Klimidis, Lewis, & Stuart, 2003).

Resilience

Resilience refers to internal resources that enhance coping. In other words, resilience “emerges from a system of specific beliefs that interact with environmental stressors to determine an individual’s coping skills” (Jew, Green, & Kroger, 1999, p. 75). A number of internal factors of resilience have been identified that reduce the effects of stigma on mental health among transgender individuals. For example, a sense of personal mastery, self-esteem, and problem-focused coping predicted positive mental health outcomes among transgender youth in one study (Grossman, D'Augelli, & Frank, 2011). In another study, a sense of self-worth, hope, activism, and serving as a role model were identified as sources of resilience among transgender participants (Singh, Hays, & Watson, 2011). Bockting and colleagues (2013) identified identity pride and peer support as protective factors against the psychological distress that can result from experiences with stigma among adults. In addition, awareness of stigma has been found to protect self-esteem in the case of blatant discrimination among transgender groups (Kosenko, Rintamaki, Raney, & Maness, 2013). However, stigma awareness has not been found to protect against more subtle discrimination, reflecting the need for further research on coping with stigma among transgender groups (Kosenko et al., 2013).

Social support is a recurrent resilience factor found in the literature (Grossman et al., 2011; Singh et al., 2011; Stieglitz, 2010). Specifically, family and peer support have been identified as having protective effects against suicide and HIV infection among transgender populations (Grant et al., 2011). Peer support has been found to moderate the relationship between stigma and

mental distress, allowing for self-affirmation and questioning of stigma among the broader public (Bockting et al., 2013).

Coping

Coping with transphobia may also occur through concealing one's transgender identity to promote passing. This coping strategy may differ between trans women and trans men given the effects of masculinizing versus feminizing hormones on the ability to pass as one's affirmed gender (Bockting et al., 2013). However, passing does not necessarily reduce the psychiatric distress associated with transphobia given that concealment may contribute to hypervigilance and preoccupation with passing (Bockting et al., 2013).

Additional researchers have investigated how other marginalized populations cope with stigma in general. Compas and colleagues defined coping as "conscious volitional efforts to regulate emotion, thought, behavior, physiology, and the environment in response to stressful events or circumstances" (Compas, Connor-Smith, Saltzman, Thomsen, & Wadsworth, 2001, p. 89). These authors described coping to include the use of voluntary and involuntary coping responses of engagement or disengagement from the stressor (Compas et al., 2001). For example, an article on African American college students found psychological disengagement of self-esteem in prejudicial contexts to be a form of coping with discrimination to reduce the emotional injury of stigma (Major & Schmader, 1998). In another theoretical article, efforts to prevent, reduce, and educate about the effects of stigma were highlighted as key coping strategies for responding to this experience (Kunreuther & Solovic, 1999).

Effective coping with stigma has been found to reduce stress, improve functioning, and reduce the impact of stigma on mental health and occupational functioning across a number of groups (Franke, 1999; Miller & Kaiser, 2001; Perlick et al., 2011). However, additional study is needed with regard to how transgender people with mental health problems cope with internalized and external stigma in order to enhance vocational functioning and reduce related psychiatric problems among this population. The present study addresses the research gap on the impact of stigma and coping among transgender individuals with mental health problems.

Study 1

The goal of this study was to expand the knowledge base about experiences of transphobia, mental health stigma, and internalized stigma among transgender individuals with mental health problems. Moreover, differences in stigma levels and coping with stigma between employed and unemployed transgender individuals were assessed in order to identify variations in the impact of stigma on vocational functioning.

A number of hypotheses were identified to test relationships among variables of internalized/external stigma, coping, and work functioning. These hypotheses included the following: a) Participants who are working will report lower levels of internalized stigma than participants who are not working. b) Participants who are working will report lower levels of external stigma than participants who are not working. c) Participants who are working will report using more effective coping strategies than participants who are not working. d) Participants with lower levels of inter-

nalized stigma will report more effective coping strategies than those with higher levels of internalized stigma. e) Participants with lower levels of external stigma will report more effective coping strategies than individuals with higher levels of external stigma. f) Participants who utilize mental health services and resources show higher levels of coping.

Method

Participants. The sample in Study 1 included 55 transgender individuals, with 45 of these participants electing to complete qualitative interviews with results featured in Study 2. Demographic data is presented in Table 1 and key information is discussed here. Participants identified their transgender identity as trans women or male-to-female ([MTF], $n = 24$), trans men or female-to-male ([FTM], $n = 20$), gender queer or gender fluid ($n = 7$), undecided ($n = 2$), with two participants who did not respond to this item. This sample included 32 employed participants, 16 unemployed, and seven participants who did not respond to this item. The unemployment rate was very high for the sample (29%), over three times the national average (7.9%) at the time of data collection (U.S. Bureau of Labor Statistics, 2014). However, the unemployment rate of the present was lower than the average rate 60–80% unemployment rate for individuals with psychiatric disabilities (National Alliance on Mental Illness, 2010). In addition, the majority of participants were receiving outpatient mental health services (73%, $n = 40$). Current students made up 29.1% ($n = 16$) of the sample. The sample was predominantly White ($n = 44$, 80%). The age of participants ranged from 21 to 50, with the average age of 46 years ($SD = 15.5$). There were significant differences in average age depending on sex at birth,

Table 1
Summary of Demographic Information ($N = 55$)

Variable	n	(%)
Gender		
Trans women/MTF	24	(43.6)
Trans men/FTM	20	(36.4)
Gender queer/gender fluid	7	(12.7)
Undecided	2	(3.6)
No response	2	(3.6)
Sex assigned at birth		
Male	37	(67.3)
Female	17	(30.9)
No response	1	(1.8)
Psychiatric medication		
Yes	28	(50.9)
No	27	(49.1)
Highest level of education		
Graduate program	24	(44)
College	20	(36)
High school	9	(16)
10th Grade	1	(2)
No response	1	(2)
Ethnicity		
White	44	(80)
African American	1	(1.8)
Asian/Asian American	1	(1.8)
Latino/Hispanic	1	(1.8)
Native American	1	(1.8)
Biracial	7	(12.7)

$t(55) = -5.730, p < .01$. The average age of FTM participants was 31.76 ($SD = 13.53$) and for MTF was 53.30 ($SD = 53.30$).

Data collection and recruitment. Participants were recruited from a conference in the northeastern United States for transgender individuals. Selection criteria included age 18 years and older, history of receipt of mental health services, and history of diagnosis of a mental health disorder. This diagnosis did not include the controversial diagnosis of gender dysphoria. This diagnosis was not considered relevant to the study's aim of investigating the broader issue of mental health problems and coping with stigma among transgender individuals. In addition, gender dysphoria combines issues of mental health and gender identity, which were distinct selection criteria in the present study.

Measures

Background data questionnaire. A background questionnaire was used to gather demographic information (gender identity, age, race/ethnicity, relationship status, number of children, education, use of mental health services, use of psychiatric medications, and employment status).

Internalized stigma. Internalized Stigma of Mental Illness Scale ([ISMI], Ritscher, Otilingam, & Grajales, 2003). The ISMI was used to measure levels of internalized stigma. This scale includes 28 items rated on a 4-point Likert scale, ranging from 1 (*strongly disagree*) to 4 (*strongly agree*). Subscales include Alienation (e.g., "I feel out of place in the world because I have a mental health problem"), Stereotype Endorsement (e.g., "Stereotypes about people with mental health problems apply to me"), Perceived Discrimination (e.g., "People discriminate against me because I have mental health problem"), Social Withdrawal (e.g., "I don't talk about myself much because I don't want to burden others with my mental health problem"), and Stigma Resistance (e.g., "People with mental health problems make important contributions to society"). High internal consistency ($\alpha = .90$) and test-retest reliability ($r = .92$) for the scale have been demonstrated (Ritscher et al., 2003). Reliability for this measure in the present study was high with a Cronbach's alpha coefficient of .90. Reliability of the factors on this scale in the present study was as follows: Alienation ($\alpha = .83$), Stereotype Endorsement ($\alpha = .72$), Perceived Discrimination ($\alpha = .88$), Social Withdrawal ($\alpha = .92$), and Stigma Resistance ($\alpha = .10$).

Internalized Transphobia Scale ([ITS], Healy, 2011). The ITS was used to measure internalized stigma toward transgender identity. Healy (2011) adapted the Internalized Homophobia Scale (Ross & Rossner, 1996) for use with a transgender population. The ITS includes 24 items rated on a 4-point Likert scale, ranging from 1 (*strongly disagree*) to 4 (*strongly agree*). The scale is comprised of four subscales: Public Identification (e.g., "I feel comfortable discussing being transgender in public), Perception of Stigma (e.g., "Most people have negative reactions to transgender people"), Social Comfort with Transgender People (e.g., "Being around other transgender people makes me uncomfortable"), and Moral and Religious Acceptability (e.g., "Being transgender is not against the will of God"). A modified version of the scale was utilized without the Moral and Religious Acceptability given lack of relevance of moral and religious acceptability to the focus of coping with societal stigma in the present study, resulting in 20 items retained from the original 24. Reliability for this measure in

the present study was represented by a Cronbach's alpha coefficient of .53. Reliability of the individuals subscales included Public Identification ($\alpha = .29$), Perception of Stigma ($\alpha = .62$), and Social Comfort with Transgender People ($\alpha = .54$).

External stigma. The Stigma Scale ([SS], King et al., 2007). The Stigma Scale (SS) was adapted for the present study to measure the experience of discrimination and stigma of psychiatric disability and mental illness. This scale includes 27 items rated on a 5-point Likert scale, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). This scale is comprised of three factors: Discrimination (e.g., "I have been discriminated against in education because of my mental health problems"), Disclosure (e.g., "I worry about telling people I receive psychological treatment"), and Positive Aspects of Mental Illness (e.g., "Having had mental health problems has made me a stronger person"). The scale has demonstrated strong internal consistency ($\alpha = .87$; King et al., 2007). Reliability for this measure in the present study was adequate with a Cronbach's alpha coefficient of .89. Reliability of the factors on this scale in the present study was as follows: Discrimination ($\alpha = .88$), Disclosure ($\alpha = .80$), and Positive Aspects of Mental Illness ($\alpha = .52$).

The Transgender Stigma Scale (TSS) was adapted from the Stigma Scale (King et al., 2007) to assess experiences of stigma or transphobia among transgender individuals. This scale includes 27 items rated on the same 5-point Likert scale comprised of similar factors as the Stigma Scale: Discrimination (e.g., "I have been discriminated against in education because of being transgender"), Disclosure (e.g., "I worry about telling people I am transgender"), and Positive Aspects of Transgender Identity (e.g., "Having been transgender has made me a stronger person"). Cronbach's alpha for the adapted measure in this sample was .83. For the specific factors on the scale, reliability was Discrimination ($\alpha = .90$), Disclosure ($\alpha = .63$), and Positive Aspects of Transgender Identity ($\alpha = .62$).

Coping. Coping Skills Interview (CSI; Mueser, Valentin, & Agresta, 1997). There is no currently available quantitative scale to measure effective coping with transgender and mental health-related stigma and vocational functioning. Therefore, coping strategies for stigma related to transgender identity and psychiatric disability were measured using Mueser and colleagues' (1997) flexible Coping Skills Interview (CSI). Participants were asked in a follow-up interview to the quantitative survey to report coping strategies and self-rate them in terms of perceived effectiveness on a 5-point Likert scale, with high numbers corresponding to better coping efficacy. Coping strategies and effectiveness were elicited with regard to dealing with transgender stigma related to work goals and experiences. Then, participants were asked to list and rate coping with mental health-related stigma in work goals and experiences. Participants were asked about their use of coping strategies with an open-ended question, as opposed to selecting specific strategies from a list in order to offer flexibility. If the participant could not identify any coping strategies for a particular problem, the participant was asked to rate their overall ability to cope with the problem. The CSI gathers data on the total number of coping strategies provided by the participant, and the perceived effectiveness of coping strategies. Reliability has been demonstrated for the CSI ($\alpha = .62 - .85$) (Mueser et al., 1997).

Statistical analysis. Survey data were analyzed using descriptive and inferential statistical analyses using the statistical pro-

gram, IBM SPSS Statistics Version 22. Analysis was conducted of the following variables: internalized stigma (Internalized Transphobia Scale, Internalized Stigma of Mental Illness Scale), external stigma (The Stigma Scale for mental illness, adapted Stigma Scale for transgender identity), coping (Coping Skills Interview), and vocational functioning (employment status). Descriptive data were generated for these variables as well as demographic data (means, medians, modes, frequency tables) to summarize characteristics of the participant demographics and distributions of variables of interest. To examine differences between the employed and unemployed study participants across the different stigma and coping variables, multivariate analyses of variance (MANOVA) were performed on the subscales of each of the five measures, with employment status as the independent variable. Significant multivariate F tests ($p < .05$) were followed up by examination of the univariate analyses to determine which specific subscales differed significantly between the two groups. Exploratory correlations were also computed to examine relationships between number of coping strategies reported as well as stigma (external and internalized).

Results

Hypotheses were validated, partially validated, or contradicted. Contrary to Hypothesis 1, participants who were working reported higher levels of internalized stigma (internalized transphobia) than participants who are not working. Contrary to Hypothesis 2, participants who were working reported higher levels of external mental health stigma on the Disclosure subscale (fear of disclosing a mental health problem) than participants who were not working. Contrary to Hypothesis 3, there was no multivariate effect for employment and coping strategies (number or effectiveness). In support of Hypothesis 4, lower levels of internalized stigma (transphobia and mental illness stigma) were associated with more effective coping strategies or higher numbers of coping strategies. Hypothesis 5 was partially supported, with lower levels of external stigma (experiences of transgender-related discrimination) associated with higher numbers of coping strategies. In support of Hypothesis 6, participants who reported outpatient mental health services and psychiatric medication reported higher levels of coping effectiveness for all coping strategies (mental health and transgender-related stigma). Additional analyses indicated that internalized stigma could be statistically predicted by employment, external stigma, and coping with stigma.

Hypothesis 1: Internalized stigma and employment. Significant multivariate effects are presented in Table 2. A significant main effect was found for the Internalized Transphobia Scale total score, $F(1, 48) = 8.72, p < .01$. Employed participants had higher levels of internalized transphobia (employed $M = 2.61, SD = .38$; unemployed $M = 2.28, SD = .33$). No significant effects were found for internalized mental health stigma between employed and unemployed participants.

Hypothesis 2: External stigma and employment. A significant main effect was found for employed participants versus unemployed participants on the Stigma Scale measuring experiences of mental health stigma for the subscale of Disclosure, $F(1, 48) = 5.22, p < .05$, which pertains to fear of disclosing a mental health problem in various settings. Employed participants reported higher levels of external mental health stigma (employed $M =$

Table 2
Multivariate Results ($N = 55$)

Outcome variable	Employed	Unemployed
Transgender Stigma Scale (TSS)	2.90	2.89
Discrimination Subscale	3.02	3.23
Disclosure Subscale	3.19	2.92
Positive Aspects Subscale	2.29	2.15
Internalized Transphobia Scale (ITS)*	2.61	2.28
Public Identification Subscale*	2.63	2.13
Perception of Stigma Subscale	2.93	2.80
Social Comfort Subscale	2.04	1.69
Mental Illness Stigma Scale (SS)	2.91	2.80
Discrimination Subscale	2.83	2.95
Disclosure Subscale**	3.33	2.90
Positive Aspects Subscale	2.61	2.42
Internalized Stigma Mental Illness Scale (ISMI)	1.80	1.86
Alienation Subscale	2.08	1.97
Stereotype Subscale	1.47	1.52
Discrimination Subscale	1.83	1.95
Social Withdrawal Subscale	1.82	2.00
Stigma Resistance Subscale	1.88	1.98

* $p < .01$. ** $p < .05$, # based on $N = 55$.

3.11, $SD = .11$; unemployed $M = 2.59, SD = .15$). No significant main effects were found for subscales on the Transgender Stigma Scale or other subscales of the Stigma Scale.

Hypothesis 3: Employment and coping. MANOVA analyses found no significant effects for coping strategies (number of coping strategies, effectiveness of coping strategies) with regard to employment.

Hypothesis 4: Internalized stigma and coping. Correlational analyses found a significant, negative correlation between the Internalized Stigma of Mental Illness scale and overall effectiveness rating for all coping strategies (mental health and transgender-related stigma) ($r = -.31, p < .05$). A significant, negative correlation was found for the Social Comfort subscale of the Internalized Transphobia scale and the overall effectiveness rating for all coping strategies ($r = -.32, p < .05$). A significant, positive correlation was found for the Public Identification subscale of the Internalized Transphobia Scale and the number of coping strategies for mental health-related stigma ($r = .33, p < .05$). No other significant main effects were found for the additional subscales or the Internalized Stigma of Mental Illness scale nor the additional subscales of the Internalized Transphobia Scale.

Hypothesis 5: External stigma and coping. Correlational analyses found a significant, positive correlation between the subscale of Discrimination on the Transgender Stigma Scale and total number of coping strategies for all coping strategies (mental health and transgender-related stigma) ($r = .34, p < .05$). No significant correlations were found between the Stigma Scale and coping.

Hypothesis 6: Mental health service access and coping. People receiving outpatient mental health services had lower means of effectiveness of mental health stigma coping strategies ($M = 1.49, SD = 1.85$) than those not receiving mental health services ($M = 2.32, SD = 2.33$), $F(1, 43) = 4.97, p < .05$. In addition, people taking psychiatric medication reported higher means of effectiveness of mental health stigma coping strategies

($M = 2.40$, $SD = 2.10$) than those not taking psychiatric medication ($M = .98$, $SD = 1.62$), $F(1, 43) = 8.56$, $p < .01$.

Additional analyses: Coping, stigma, and internalized stigma. Given correlations between coping, stigma, and internalized stigma, multiple regressions were conducted to test whether internalized stigma could be predicted by coping and experiences of external stigma. Two multiple regressions were conducted to examine models that predicted internalized transphobia and internalized mental health stigma, respectively. The first regression analysis attempted to predict internalized transphobia from employment, transgender stigma, and the four measures of coping—transgender stigma coping strategy number and effectiveness, as well as mental health stigma coping strategy number and effectiveness. The same model was repeated with internalized mental illness stigma as the criterion variable, with mental health stigma added as a predictor to the model instead of transgender stigma.

Significant results were demonstrated for both regression models. Internalized transphobia was statistically predicted by six of these predictor variables, $F(6, 31) = 10.59$, $p < .01$, $R^2 = .61$. These variables included transgender stigma, number of mental health coping strategies, employment, effectiveness of transphobia coping strategies, number of transphobia coping strategies, and effectiveness of mental health coping strategies. The variables of employment ($\beta = -.27$, $p < .001$), $p = .001$), transgender stigma ($\beta = .38$, $p < .001$), and number of mental health coping strategies ($\beta = .15$, $p < .05$) significantly added to the prediction. In the second analysis, internalized mental health stigma was statistically predicted by six of the predictor variables, $F(6, 31) = 4.71$, $p < .01$, $R^2 = .48$. The variable of mental health stigma significantly added to the prediction ($\beta = .77$, $p < .001$). The variable of mental health stigma coping strategy number ($\beta = .31$) was trending toward significant at ($p = .053$) but was not significant. The mental health stigma coping strategy effectiveness score was also trending toward significant ($\beta = -.13$, $p = .06$) but was not significant.

Discussion

Results indicated that internalized transphobia was predicted by employment, external stigma, and coping with stigma. Internalized mental health stigma was predicted by mental health stigma. Employment among transgender participants was associated with higher levels of internalized transphobia. Employed participants reported higher levels of fear of disclosing a mental health problem. It was hypothesized that employed transgender participants would have encountered less stigma given higher levels of functioning in the vocational realm. However, these results suggest that transgender participants who were working were more likely to report experiences of internalized and external stigma.

Employed participants had higher levels of stigma associated with disclosure of mental health problems in particular, confirming follow-up qualitative analysis of this research (Mizock, 2014). Follow-up qualitative data indicated that transgender participants who were working often avoided disclosure of a mental health problem in the workplace given that they were already managing transphobia in that setting and wished to avoid encounters with further stigma.

Higher levels of coping were associated with lower levels of transphobia as well as internalized stigma, confirming hypotheses. Additionally, coping was associated with lower levels of internalized stigma and external stigma. Lastly, psychiatric medication was associated with higher levels of coping effectiveness for both mental health stigma and transphobia, while receipt of outpatient mental health services was associated with lower levels of coping with mental health stigma. These divergent results may be explained by the preferences of some for psychiatric medication over outpatient psychotherapy due to lack of time for therapy or avoidance of stigma associated with therapy as found in the general public. (Dwight-Johnson, Sherbourne, Liao, & Wells, 2000; Wiechers, Leslie, & Rosenheck, 2013). As a result, individuals using outpatient mental health services may experience added stigma of receiving these services in contrast to those taking medication. In addition, perception and detection of mental health stigma may be higher among individuals with an active mental health problem who are receiving mental health services that may make them aware of stigma (Golberstein, Eisenberg, & Gollust, 2008; Russinova et al., 2014).

Further research is needed to better understand these contradictory findings. Bockting and colleagues (2013) discuss the high levels of employment discrimination reported by transgender individuals (37%). It may be that employed transgender individuals have higher exposure to stigma in the context of work, and thus more internalization of this stigma. Employment barriers have been found to be manifold, including overt discrimination, job threats, restroom discrimination, gender stereotypes, lack of promotion, demotion, lack of training opportunities, gossip, and social distancing (Budge et al., 2010; Sangganjanavanich, 2009). Additionally, transgender individuals with mental health problems may experience hypervigilance in the workplace to reduce the likelihood of workplace discrimination or termination for double stigma of transgender identity and mental health concerns. It is also possible that concealing one's transgender identity in the workplace may contribute to psychiatric distress as discussed by Bockting and colleagues (2013), enhancing mental health problems of anxiety or depressed mood.

Study 2

Study 1 indicated that coping strategies were associated with lower levels of internalized stigma (transphobia and mental illness stigma). However, little is known about the types of coping strategies transgender individuals utilize to deal with transphobia (Bockting et al., 2013; Nuttbrock et al., 2010; Poteat et al., 2013; Sánchez & Vilain, 2009). To better understand the types of coping strategies transgender individuals with mental health problems utilize, the present qualitative study was conducted to interview transgender and gender nonconforming individuals about experiences with stigma and coping. Study 2 was conducted using follow-up interviews with participants from Study 1.

Method

Participants. Participants included 45 transgender- and gender variant-identified individuals from Study 1 who elected to complete follow-up qualitative interviews. This sample in-

cluded 21 trans women/male-to-female (MTF), 17 trans men/female-to-male (MTF), and seven gender queer or gender fluid participants. Average age of participants was 46 years ($SD = 16.5$) with a range between 21 and 71 years of age. The racial ethnic makeup of the sample was predominantly White (34 participants), with seven biracial participants, one African American participant, one Asian American participant, one Latino American participant, and one Native American participant. With regard to employment, 28 participants were employed, 16 were unemployed, and one was retired. In addition, 31 participants were attending an outpatient therapy program at the time of the study.

Procedure. Participants were recruited from a conference in the Northeast for transgender individuals (See Study 1 procedure) to participate in semistructured follow-up interviews. The interviews lasted approximately 60 minutes and took place by phone or in a private research space on the university campus. The interview covered the following topics: internalized and external stigma, coping strategies to deal with stigma and enhance vocational functioning, as well as recommendations for rehabilitation services. Interview questions were developed by the research team with consultation from content experts in transgender research and clinical care to best address these topics (see Appendix). In addition, a questionnaire was used to gather demographic information. Audio recordings of the interviews were transcribed verbatim. Each participant signed a consent form to participate and be recorded, per the institutional review board.

Data analysis. The grounded theory approach was utilized for data analysis (Corbin & Strauss, 2008; Miles & Huberman, 1994). The grounded theory method of qualitative research is recognized for building theory (Corbin & Strauss, 2008). Data analysis was conducted by two researchers including the first author. In addition, a data auditor and content expert in transgender clinical care and research reviewed the codebook that was established by these researchers. The researchers independently read and coded an initially purposive sample of five interviews prior to coding all of the remaining interviews in order to develop the initial codebook. Per the standards of qualitative analysis, this sample of interviews were selected by the research team given that they were assessed to provide an information-rich source of data on the topic of coping with transphobia in order to establish the code book (Corbin & Strauss, 2008).

A new code (i.e., category label) was created for each new concept that emerged from participant responses during the initial review of text. After coding this sample of interviews, the research team established an initial list of codes. The coders proceeded to recode the remaining interviews according to this code list, meeting regularly to reach consensus, established by equitable discussion from each team member (Hill, Knox, Thompson, Williams, & Hess, 2005). Axial coding was conducted (Corbin & Strauss, 2008). Once a comprehensive list of codes were gathered from all 45 interview transcripts, codes were further aggregated by relating codes to one another and grouping under broader concepts. Data pertaining to coping with stigma is presented here.

Data quality. Data quality in the present study was maintained through a number of validity strategies to reduce re-

searcher bias. 1) Multiple coding of interview themes by the researchers enabled the comparison and revision of themes to enhance validity (Barbour, 2001). 2) Investigator triangulation was utilized through the use of research team members and a data auditor to provide complementary perspectives on development of the codes in the present study (Barbour, 2001). 3) The use of this data auditor was another validity strategy (Hill et al., 2005). The data auditor is a content expert in the area of transgender mental health care who was also experienced in qualitative research. The data auditor reviewed the codes generated by the researchers and made suggestions to refine areas of the codebook. 4) Cross-checking of the coding in the interview transcripts was conducted by the research team to ensure consistency and reliability (Polkinghorne, 2007). 5) Memos of research team meetings were kept and redistributed to the research team over the course of the four months of data analysis to keep a record of themes, key quotes from the interviews, and interpretation of data to enhance reflexivity in the present study (Corbin & Strauss, 2008). 6) Consensus among research team members was used in the development of the research interview, in data analysis, and in the rare cases when disagreement arose with regard to coding themes. Consensus is a research strategy often used in qualitative research to reduce bias and enhance validity (Edwards, Dattilio, & Bromley, 2004).

Results

Coding of participant responses led to identification of a number of coping skills utilized to deal with experiences of stigma that emerged at the individual, interpersonal, and systemic levels (see Table 3). Individual factors included gender-normative coping, self-affirmative coping, emotional-regulation coping, cognitive-reframe coping, and spiritual and religious coping. Interpersonal factors included social-relational coping, preventative-preparative coping, and disengagement coping. Systemic factors included resource-access coping and political-empowerment coping.

Coping strategies at the individual level

Gender-normative coping. One category of coping that emerged was gender normative coping strategies, the modification of gender presentation and utilization of traditional gender coping styles to deal with experiences of transphobia. For example, when asked how she coped with transphobia, one trans woman indicated:

Something that I remember from my mom and genetic females [is] where they just kind of hold their head high and go about their business . . . but for most of the time I will just kind of be non-confrontational, because women tend to not be confrontational . . . That's more of a male trait to fire off and do something. And I remember some situations, like I did come out and say that I would talk it over with my therapist. And she goes, "We don't do that. We hold our head high. We back off. We would say it a little gentler." And then I said, "Then you go home and cry in your pillow?" And she said, "Exactly. And then make a hot cup of tea, okay?" It's not going to be the same as a male style. And figuring out what that was took a while.

In this excerpt, the participant described her use of stereotypic emotion-focused coping styles traditionally attributed to women. This excerpt not only demonstrates gender-normative coping but also the attempt of a cisgender female therapist to coach a trans-

Table 3
Transphobia Coping Strategies

Levels	Coping strategy	Definitions
Individual	Gender-normative coping	Modifying one's gender presentation and utilizing traditional gender coping styles to deal with transphobia.
	Self-affirmative coping	Coping with transphobia in ways that reinforce one's strengths and self-esteem.
	Emotional-regulation coping Cognitive-reframe coping	Managing and adapting one's emotions in response to the experience of transphobia. Using styles of thinking to cope with transphobia, including reframing, positive thinking, and understanding.
Interpersonal	Social-relational coping	Accessing relational supports and engaging interpersonally with others to cope with transphobia.
	Preventative-preparative coping	Readying for, precluding, and counteracting encounters with transphobia, often through the use of <i>disclosure strategies</i> and <i>anticipatory stigma</i> .
Systemic	Disengagement coping	Detaching and disconnecting from sources of transphobia
	Resource-access coping	Obtaining various services and information to cope with transphobia.
	Spiritual and religious coping	Connecting to the sacred or transcendent to cope with transphobia
	Political-empowerment coping	Engaging in activism, education, and advocacy to promote and protect the rights of transgender people.

gender client in gender-normative coping, suggesting traditional gender socialization may occur with some therapists.

Self-affirmative coping. Self-affirmative coping strategies were also described by participants. These strategies included ways of coping with transphobia that asserted one's strengths, sense of self, and self-esteem. This coping style included connecting to a sense of confidence, self-awareness, genuineness, authenticity, and perseverance in the face of stigma. For example, one participant stated:

I guess the first coping thing was just [to] keep being myself in the face of whatever people were dealing with and realize that if I said part of what I was trying to do was help educate and be there for people to talk to—I had to be there.

This participant's statement represents coping with transphobia through confidence, perseverance, and being true to oneself. In another example, a participant responded to a question about coping with transphobia with the statement, "It's not my problem if someone doesn't like who I am—who wants to make fun of me. That's not my problem. It's their problem. I guess it comes down to a little bit of self-awareness." Participants described self-awareness and other self-affirming experiences as valuable coping strategies for dealing with the distress posed by encounters with transphobia.

Emotional-regulation coping. Emotional-regulation coping was described as another important strategy for dealing with transphobia, involving managing one's emotions in response to the experience of transphobia. This coping strategy included keeping calm, using relaxation techniques, staying active, and managing one's health. For example, one participant coped with transphobia by using: "opposite actions, breathing exercises, and relaxation exercises." Another participant also described coping with an experience of transphobia:

I did a lot of going to the gym and working out [the] energy and anger and hurt. Yeah, so trying to do positive things. It was tempting sometimes, but sometimes I just wanted to forget about it all and move away. Live on a desert island. But I knew that wasn't realistic, and [it] didn't do any good. So, those are some of the things that I did.

This approach avoided disengaging or pushing aside these emotions. Participants described maintaining calm, working through difficult emotions, and other forms of emotional regulation as important coping strategies for the emotional challenges presented by experiences with transphobia.

Cognitive-reframe coping. Cognitive-reframe coping was a strategy that entailed using styles of thinking to cope with transphobia, including reframing the experience, thinking positively in the face of transphobia, and developing a sense of understanding of the perpetrator of the transphobia. In one instance, a participant described coping with transphobia by, "reframing the situation and changing it around so that it wasn't as hurtful to me and it wasn't as, you know, troubling." Another participant also described the importance of one's thinking style in coping with transphobia:

I tend to think positively . . . I'm going to do what I feel makes me happy and fulfilled as a person. If others don't agree with me, I just tend to say that it doesn't matter. It doesn't matter to me what others think if they don't agree with me, because it's my life.

As seen in this excerpt, positive thinking and other cognitive approaches to transphobia were described as helpful ways of dealing with this experience.

Coping strategies at the interpersonal level.

Social-relational coping. Another category included social-relational coping, involving accessing relational supports and engaging interpersonally with others to cope with transphobia. Social-relational coping strategies included seeking advocates, family support, peer support, friendliness, building relationships, as well as communicating about and confronting transphobia in others. One participant described dealing with transphobia in her community through relationship building. This participant spoke about overcoming stigma in her town by working for her town in various community leadership roles:

I guess [my community members] got used to [my gender] because [transphobia] hasn't happened in quite a long time now. Of course, I really worked to be out in the community doing positive things for the

community. So I think that that has done a lot to change the attitudes of my fellow townspeople.

Community engagement and relationship building was a way of dealing with transphobia in one's network. Another participant described coping with transphobic reactions through social-relational means, stating, "in public, you get people looking at you in a strange way and not accepting you at all. If I encounter that kind of a reaction—but it isn't very frequent anymore—but when I do I just sort of—I smile, I give someone the peace sign, and just go on." These examples highlight the different social-relational approaches to coping with transphobia discussed by participants.

Preventative-preparative coping. Preventative-preparative coping was a style of counteracting transphobia through *anticipatory stigma*—expecting and preparing for prejudice and discrimination. This strategy included assessing for and avoiding transphobia by selecting tolerant environments and making careful decisions about disclosing one's transgender identity. One participant stated, "I would say that another coping strategy is always hoping for the best and expecting the worst, because heaven is based on low expectations." In another example, a participant utilized *disclosure strategies*—decisions to reveal or conceal one's transgender identity depending on safety and likelihood of desired outcome of disclosure:

The big choice is how much information to disclose. Really. Who really needs to know every detail? They don't. It's sort of like you don't want to say too much. Does it matter to this person? You have to second-guess anybody that you're talking to. Does it really matter to them what I'm discussing about my private life? You have less of a private life than say the general public would have, I feel.

Participants described making decisions about disclosure strategies as important to preventing and preparing for potential transphobia.

Disengagement coping. Disengagement coping included emotionally detaching, ignoring, and isolating oneself in response to transphobia. For instance, one participant described coping with encounters with transphobia: "I have to say ignore it and walk away—not to rise to the instigation." This use of disengagement to cope with transphobia appeared in another interview:

Usually I just avoid people, and I just don't talk to them because I'm afraid of rejection. So, I've come to realize that it's kind of like I reject them first, but I don't give the chance to really learn what they think about me.

In this excerpt, disengaging socially was a way of avoiding transphobia through disconnecting from others. Another participant was asked to describe coping with transphobia and provided the following response:

I've been a good one to hide about 90% of my feelings. You know, unless I start talking about it, I have a tendency to hide things a lot. So I try not to let anybody know that I'm feeling that way, you know. Or I focus on work so I could bury it. Ninety percent of the time, I try to bury it . . . I've learned over 30 years of hiding, 40 years of hiding, that I can hide it real well. I try not to allow it to come out unless I start talking about it. When I start talking about it, forget it. I lose it.

This participant found self-protection from transphobia through isolating and emotionally detaching, albeit with potentially harm-

ful side effects of repressing emotional expression. This quote also demonstrates the use of disclosure strategies in conjunction with disengagement coping by avoiding disclosure.

Systemic level: Systemic coping strategies.

Resource-access coping. Resource-access coping refers to the use of various services and information to cope with transphobia. This form of coping included seeking legal counsel, sharing information with peers, utilizing social media to connect with transgender organizations, and seeking mental health services. For example, one participant described coping with transphobia through resource access:

I know a couple of girls in the area. I know the coach that I work with over the phone . . . So, if people need to turn around and get ready for the gender thing and the family, and some understanding, I would point those in that direction. I have people that I know that live in the community—they have a websites and links. You know it's easy for people now because they can just go on and find [a transgender group], and set up a fake profile, and do something on Facebook.

As seen in this excerpt, participants discussed accessing social media and various community resources as important ways of coping with transphobia.

Spiritual and religious coping. Participants also used spiritual and religious strategies to cope with transphobia—connecting to the sacred or transcendent to cope with transphobia. These strategies included drawing from a sense of spiritual direction, engaging in religious study, experiencing a relationship with God, and connecting to a religious community. In fact, four of the 45 participants (~ 9%) had become religious leaders in their communities, which they often described as a way of overcoming transphobia in the religious organizations and making meaning of their gender variance through spiritual means. One trans man described coping through religious and spiritual means after experiencing transphobia in his church:

I didn't want anything to do with the Christian church, and so I started reading Buddhism . . . and Hinduism, and I started exploring all the other religious paths, spiritual paths . . . I think [I coped with this experience] with a lot of years of exploring other traditions and seeing where I am, and if I might fit in.

As seen in this quote, religious and spiritual coping strategies were used to deal with experiences of transphobia both within and outside of formal religious settings.

Political-empowerment coping. Political-empowerment coping was a tool for dealing with transphobia that was reported by transgender participants, involving engaging in activism and advocacy to educate others, promote, and protect the rights of transgender people. This type of coping included assisting with developing policy, becoming involved in transgender organizations, participating in transgender research to increase awareness, educating others, and serving as a role model for others. For example, when asked about coping with transphobia, one participant discussed her decision to start a transgender advocacy organization:

When I transitioned everything fell apart in my life, but I wasn't going to take it laying down. I mean, I did what I needed to do. I did my own research. I did my own advocacy. And because I saw

that I was strong enough to do that for myself with the toughest adversity that I was facing, homelessness and such, that I felt that someone needs to be able to provide services and information to other people in the community. Because there is no other organization that really [responds to people] on a personal level. Even though there are a lot of trans organizations that do advocate for the LGBTIQ community, I take it one step further and I make it personal to me when I'm helping somebody, when I'm reaching out to somebody or somebody is reaching out to me. They're reaching out to the organization through me.

In this case, participating in activism was personally rewarding and advanced a political cause. Activism served a dual purpose of facilitating the coping of the person, and offering assistance to the community. Political empowerment coping and activism were helpful means of dealing with transphobia at a systemic level while promoting social change.

Discussion

Coding of participant responses led to the identification of a number of coping skills utilized to deal with experiences of stigma that emerged at the individual, interpersonal, and systemic levels (see Table 3). These findings make a number of unique contributions to the literature. The present study sheds new light on the wide range of coping strategies used to deal with transphobia in particular. In addition, gender normative coping was unique to this study—ways of utilizing the stereotypical or traditional coping style of one's identified gender as new opportunities for coping following one's gender transition. This finding suggests that for some, transitioning genders may open up new avenues for coping. Another unique contribution of this study was the finding that these various coping strategies occur at individual, interpersonal, and systemic levels, suggesting a variety of levels at which transphobia can occur and be overcome.

In addition, the present study identified the use of *disclosure strategies* and *anticipatory stigma* in coping with transphobia. The use of disclosure strategies suggests that transgender individuals may make decisions regarding the tactical and desired outcomes involved in disclosing one's transgender identity, while assessing for safety. In addition, the finding on anticipatory stigma suggests that transgender individuals may deal with transphobia by expecting and preparing for stigma in order to prevent or counteract the stigma. As seen in Emler (2006) and Bridgewater (1997), anticipatory stigma and disclosure strategies, respectively, may also apply to other populations with stigmatized identities, such as individuals with serious mental illnesses and psychiatric disabilities as well as lesbian, gay, and bisexual populations. However, for those who may be visibly identifiable as transgender, there may be less of a choice to disclose or not.

This qualitative study links to the current literature in a number of ways. Some of the coping strategies used to deal with transphobia in the present study (i.e., self-affirmative coping, emotional-regulation coping, and political-empowerment coping) resembled research on resilience factors relating to self-esteem, activism, and emotion-focused coping among transgender individuals (Grossman et al., 2011; Singh et al., 2011). The finding on gender-normative coping also related to findings in

another study that attempts to conceal one's transgender identity through passing may be a strategy used to avoid transphobia, albeit a sometimes stress-inducing strategy given the need for hypervigilance (Bockting et al., 2013). The identification of the preventative-preparative coping strategy also reinforced previous literature that identified stigma prevention as important to coping with stigma (Kunreuther & Solovic, 1999). Disengagement coping was also reported by participants in the present study, reinforcing findings on psychological disengagement from prejudice as coping strategies used among other marginalized groups (Major & Schmader, 1998; Miller & Kaiser, 2001).

General Discussion

The use of a large number of coping strategies across individual, interpersonal, and systemic levels reflected several coping strategies found in other populations encountering marginalization, and several coping strategies somewhat unique to transgender groups, such as gender-normative coping, anticipatory stigma, and disclosure strategies. This research attests to the resilience among transgender individuals with mental health problems and the utility of supporting coping strategies for reducing the likelihood of external experiences of stigma becoming internalized, which pose added risks to mental health and functioning.

Limitations

This research would benefit from replication with a larger sample size and participants from a wider geographic area. Limitation to one region of the country and focus on transgender participants with mental health problems also limits generalizability. Moreover, MTF versus FTM populations have unique differences, and grouping them together in this study may fail to fully capture within-group variation in the transgender population. Another limitation of the study was the nonrandom selection process involved in data recruitment. This sample may have included individuals with different coping strategies given that they were willing to participate in a study related to transgender identity. The sample was predominantly White, limiting generalizability to other racial-ethnic cultural groups. While a number of validity strategies were used, member checking (participant review of researcher coding) would have enhanced meaning of the present analysis and might be considered in other qualitative studies on this topic.

While many subscales demonstrated strong to adequate reliability, a number of subscales in Study 1 were low in reliability scores, including the Stigma Resistance and Public Identification subscales, potentially affecting results. In addition, reliability for the Coping Skills Interview is typically gathered through interrater reliability, given that it is a flexible, open-ended interview. Given the use of only one interviewer, interrater reliability was not assessed in the present study, also posing a limitation. Furthermore, several of the measures were new adaptations of previous scales, potentially accounting for some of the low reliability scales. Problems with reliability of some of the subscales in addition to a small sample size may have accounted for some nonsignificant findings. Further revi-

sion, evaluation, and interrater reliability of these new scales can be conducted in future study.

Clinical Implications

The present dataset suggests that mental health stigma, transphobia, and internalized transphobia may be higher among employed transgender individuals, indicating that employed transgender individuals may benefit from clinical support to explore and ameliorate the effects of double stigma and internalized transphobia. Employed participants had higher levels of stigma associated with disclosure of mental health problem, suggesting the need for clinicians to support transgender clients in considering issues of disclosure of mental health problems in work settings.

The difference in coping effectiveness among individuals receiving psychiatric medication versus outpatient services suggests that medication may be associated with higher effectiveness of coping. Alternatively, individuals seeking mental health services may benefit from additional support to enhance coping with mental health stigma. These findings highlight the need for future study of coping skills transgender individuals utilize in the workplace as well as interventions for transgender individuals to enhance effective coping with transphobia (Mizock, 2014). Training programs for mental health and medical professionals are also needed to reduce transphobia among providers (Grossman & D'Augelli, 2007; Stieglitz, 2010). Given the benefits of peer support in reducing the effects of stigma on mental health, an intervention to reduce psychiatric distress from transphobia and boost peer support is also needed (Bockting et al., 2013).

In addition, clinicians can focus clinical efforts on investigating the type of coping strategies for transphobia. Clinicians can assist clients with building additional coping strategies based on this list in order to enhance effectiveness and number of strategies used to cope with transphobia. Some clients may be more focused in one area of coping, such as at the individual level, but might benefit from support in developing interpersonal or systemic levels of coping to maximize empowerment in the face of transphobia. It is also important for clinicians to investigate and reduce the use of maladaptive coping strategies for transphobia, such as substance abuse or self-harm.

Conclusion

Findings in the present study indicate that transgender individuals with mental health problems may internalize stigma, especially those who are employed. Further training and awareness within the general public, workplace, and mental health service settings are likely to enhance coping, reduce stigma, and promote acceptance. Coping with transphobia is not simply an individual endeavor but one that also involves the efforts of the larger community. Further interventions, education, activism, and policy changes can help reduce stigma in the broader public.

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Appendix

Semistructured Interview

(Interview description for participant): The reason for this interview is to have a conversation about issues of work, stigma, mental health, and gender. Please feel free at any time to let me know if there are any questions you have for me.

I) I'd like to talk with you about your experience with gender.

- a. How do you identify and describe your gender?
- b. What has it been like for you to develop an awareness of being transgender?
- c. Did you decide to transition? If so, what was it like for you to transition or affirm your gender?
- d. What have been own attitudes toward being transgender? Have you noticed any internalized transphobia—directing society's transphobic attitudes at yourself? How have these attitudes affected you? How have you dealt with this?
- e. Have you faced any experiences of prejudice, discrimination, and stereotypes related to being transgender? Have you encountered any stigma in your family? In your relationships?
- f. Can you describe the coping strategies you have used to cope with transphobia?
- g. Can you talk about if being transgender has or has not affected your experiences with work? Have you experienced stigma or transphobia at work? How have you dealt with this?

II) Next, I'd like to talk with you about your mental health experiences, which is one of the focuses of the study.

- a. Would you say you've had any mental health problems in your history?
- b. Can you tell me what this mental health problem has been like for you?
- c. Have you found yourself having any negative attitudes toward your mental health problems? If so, have they affected you in any way? How have you dealt with this?
- d. Have you faced any prejudice, discrimination, and stereotypes related to your mental health problem?
- e. Can you describe the coping strategies you have used to cope with stigma related to mental health?
- f. Can you talk about if your mental health problem has or has not affected your experiences with work? Have you faced any stigma related to your mental health at work?
- g. Can you describe coping strategies you have used to cope with stigma related to mental health at work?

III) a. Before moving to a final question is there anything that we didn't get to talk about today that you'd like to include?

b. Lastly, do you have any recommendations for mental health services and research related to the topics we've addressed today?

Received December 11, 2013

Revision received April 19, 2014

Accepted April 21, 2014 ■