Journal of LGBT Youth, 11:347–363, 2014

ISSN: 1936-1653 print / 1936-1661 online
DOI: 10.1080/19361653.2014.910483

Routledge
Taylor & Francis Group

Family Rejection, Social Isolation, and Loneliness as Predictors of Negative Health Outcomes (Depression, Suicidal Ideation, and Sexual Risk Behavior) Among Thai Male-to-Female Transgender Adolescents

MOHAMMADRASOOL YADEGARFARD,
MALLIKA E. MEINHOLD-BERGMANN,
and ROBERT HO

Graduate School of Counseling Psychology, Assumption University, Bangkok, Thailand

This study examined the influence of family rejection, social isolation, and loneliness on negative health outcomes among Thai male-to-female transgender adolescents. The sample consisted of 260 male respondents, of whom 129 (49.6%) were self-identified as transgender and 131 (50.4%) were self-identified as cisgender (nontransgender). Initial multivariate analysis of variance indicated that the transgender respondents, when compared to the cisgender respondents, reported significantly higher family rejection, lower social support, higher loneliness, higher depression, lower protective factors (PANSI-positive) and higher negative risk factors (PANSI-negative) related to suicidal behavior, and were less certain in avoiding sexual risk behaviors. Multiple regression analysis indicated that the exogenous variables of family rejection, social isolation, and loneliness were significant predictors of both transgender and cisgender adolescents' reported levels of depression, suicidal thinking, and sexual risk behaviors. The implications of these findings are discussed.

KEYWORDS Adolescents, depression, family rejection, loneliness, sexual risk behavior, social isolation, suicidal ideation, transgender

Received 6 July 2013; revised 29 November 2013; accepted 12 December 2013.

Address correspondence to Mohammadrasool Yadegarfard, Graduate School of Counseling Psychology, Assumption University, Bangkok, Thailand. E-mails: mohammadrasool.yadegarfard@study.beds.ac.uk or mohammadrasool.yadegarfard@gmail.com

INTRODUCTION

Past research has shown that a large percentage of transgender individuals experience family rejection, social isolation, and loneliness because of discrimination as well as the lack of a fulfilling relationship. Previous studies have also shown that the rejection, isolation, and loneliness experienced by transgender individuals can result in a number of negative issues, including depression, suicidal tendencies, sexual risk behavior, substance abuse, and academic failure (Ryan, Huebner, Diaz, & Sanchez, 2009).

The term *transgender* refers to a diverse group of individuals whose gender does not match their assigned sex at birth. It is an umbrella term that describes a wide range of gender-variant groups and individuals, from those who engage in transgender behavior on occasion, such as cross-dressers, to those who do so at all times (Namaste, 2000). Winter (2002) defines transpeople as individuals assigned male or female in any age group who are not happy or comfortable living the role of their assigned sex.

Generally, the biggest problem in families with transgender children starts during the transition from childhood to adolescence (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011). Adolescence is a very important time, when individuals begin to develop their identities as they become more aware of themselves. Confusion in puberty and the physical changes they undergo add up to make children vulnerable and, specifically for transgender children during this confusing time, any negative behavior they experience from their family with regard to their gender identity can have a severely detrimental influence on their mental well-being.

Thai Context

Thailand has a large male-to-female (MTF) transgender population, with as many as six out of every 1,000 male-assigned individuals identifying transgender (*phu-ying kham phet*) (Winter, 2002). Traditionally, Thailand has an image of social tolerance toward its homosexual and transgender population. However, such attitudes toward sexual and gender diversity are something of a paradox; while the behavior is for the most part tolerated, it remains stigmatized. Past studies present the impression that the transgender population is accepted in Thai culture, yet it is equally clear that family acceptance is far from complete, as many parents respond negatively to gender nonconformity. One possible explanation for this is the importance placed upon the preservation of family lineage, which comes from heterosexual marriage and procreation (Jackson, 1999). In his book chapter "The Myth of a 'Thai Gay Paradise,"' Jackson (1999) dispels the myth of homosexual acceptance by describing the situation as "tolerant but accepting." The same is true for the transgender population. This myth of tolerance is rooted in Cameron's

(2006) observation that those who break Thailand's social mores will be subtly alienated rather than directly confronted. Thus, it appears that while transgender people are visible in Thai society, this does not equate with acceptance, and both homosexual men and transgender individuals are, in fact, stigmatized by Thai society.

In collective societies such as Thailand, families—as the first microculture in which children grow up—have an all-important role in developmental transitions from childhood through adolescence to adulthood. Although people's knowledge about gender diversity is increasing, many Thai families still experience problems with their transgender children. The role of families in providing mental support for transgender people cannot be overstated. However, various studies have revealed that even when transgender people can count on the support of their families in the face of social stigma and discrimination, the amount of support they receive from society is usually minimal (Bockting, Coleman, & Benner, 2007). Social intolerance, discrimination, or rejection by partners and loved ones creates a lack of social support and result in social isolation for many transgender individuals. The resultant negative effects of isolation cannot be underestimated, increasing the likelihood of depression, anxiety, substance abuse, self-harm, sexual risk behavior, and suicidal tendencies among the gay and transgender youth population.

Transgender Mental Health

A psychological condition is considered a mental disorder only if it causes distress or disability. There are transgender individuals who find their transgender feelings distressing or disabling—in particular when they experience their gender identity as incongruent with their assigned sex at birth or with the gender role related to that sex. However, many transgender individuals do not experience their transgender feelings and traits as distressing or disabling, which suggests that being transgender does not represent a mental health risk per se. Indeed, the mental health problems faced by transgender people are no different from those faced by cisgender (nontransgender) people. However, being transgender often creates another set of mental health risk problems resulting from rejection by family, peers, and society, as well as any internal conflict they may experience, which are layered upon existing problems. Such problems include feelings of isolation and loneliness experienced by many transgender individuals. In Thai society many cisgender men end their relationships with transgender females and go on to marry biologically born women with whom they can have children and fulfill their expectations of being a parent and having a family. While the goal of many transgender females is to find a husband and live as a wife, this seldom happens and most transgender females are cynical about the

possibility of achieving their goal of getting married and enjoying a loving relationship (Jenkins, Pramoj na Ayutthaya, & Hunter, 2005). The suggestion is that, with the right support and the freedom to express their transgender identity without fear of rejection and discrimination, such individuals generally experience good psychological health. Despite the prevalence of diverse gender expressions and identities in Thailand, there have been few studies conducted on the impact of family acceptance or rejection, social isolation, and loneliness on transgender youth. The present study has been designed to investigate what impact rejection by or expulsion from the family, as well as negative responses such as social isolation and loneliness, may have on the MTF transgender adolescent's psychological health (depression, suicial behavior, and sexual behavior risks). The research questions investigated in the present study include the following:

RQ1: Are there significant differences in the reported levels of family rejection, social isolation, loneliness, depression, suicidal thinking, and sexual risk behaviors between transgender and cisgender adolescents?

RQ2: How may transgender and cisgender adolescents differ in the predictive relationship between their reported levels of family rejection, social isolation, and loneliness with their reported levels of depression, suicidal thinking, and sexual risk behaviors?

RQ3: Will transgender adolescents report stronger relationships between their reported levels of family rejection, social isolation, and loneliness with their reported levels of depression, suicidal thinking, and sexual risk behaviors than cisgender adolescents?

METHOD

Sample

Access to the transgender group of participants was via an association based in Bangkok: the Rainbow Sky Association. The director of the association was informed of the purpose of this study, and permission was sought to hand out the study's survey questionnaire to their transgender members. A total of 130 transwomen voluntarily filled in the study's questionnaire.

For the cisgender participants, 130 cisgender male students from the Assumption University of Thailand were invited to complete the study's questionnaire. For both the transgender and cisgender respondents, prior to their filling in the study's questionnaire, they were provided with an information sheet informing them that (1) they could withdraw from filling in the questionnaire at any time, (2) no names would be recorded to guarantee their anonymity, and (3) the data collected would be used only for the purposes of this study and only by the researcher.

Materials

For the purposes of the study, a seven-part questionnaire in the Thai language was employed to gather data. A cover letter was provided to explain the nature and purpose of the questionnaire. The questionnaire consisted of the following seven sections.

Part 1: Personal information. A researcher-constructed set of questions was written to tap the demographic variables of age, gender, ethnicity, education, current relationship status, and marital status.

Part 2: Family rejection. Because there is no specific scale available for measuring family rejection, a series of six items was written by the researchers to assess a rejecting parents' or caregivers' reactions and behaviors to the participants' gender identity and gender expression when they were teenagers. These items were written to reflect the behaviors that families and caregivers exhibited to express acceptance or rejection of their transgender children (such as excluding these children from family activities or events). A sample item reads: "Between the ages of 15–25, my parents/caregivers often blamed me for any anti-transgender mistreatment that I experienced." For each item, participants indicated whether their parents or caregivers reacted in the way specified by the item on a 4-point Likert scale: 1 = *Strongly agree*; 2 = *Agree*; 3 = *Disagree*; or 4 = *Strongly disagree*.

All six items were analyzed for their internal consistency. Reliability analysis yielded a Cronbach's alpha of .91 and corrected item total correlations ranging from .59 to .80 for the six items. Together these findings indicated that the six scale items are highly internally consistent, in other words, they all tap the same underlying construct. Although no formal test of validity was conducted, the high internal consistencies of the items coupled with their face validity suggest that this six-item scale is a valid measure of the construct of "family rejection."

Part 3: Social isolation. This section consisted of the 23-item Social Support Appraisals (SSA) scale (Vaux et al., 1986). The SSA is highly reliable with excellent internal consistency and alpha coefficients ranging from .81 to .90. The SSA also possesses good concurrent, predictive, known groups, and construct validity, and is closely correlated with numerous social support and psychological well-being measures, including network satisfaction, perceived support, family environment, depression, positive effect, negative effect, loneliness, life satisfaction, and happiness (Vaux et al., 1986).

Part 4: Loneliness. This section consisted of the UCLA Loneliness Scale, a 20-item scale developed to evaluate subjective feelings of loneliness (Russell, Peplau, & Ferguson, 1978). In the current study, the third version of the UCLA Loneliness scale, which is also the most recent, was employed. Higher scores indicate greater degree of loneliness (Russell, 1996). The UCLA has high reliability, with coefficient alphas ranging from .89 to .94. In a study conducted by Russell, Kao, and Cutrona (1987), it was

indicated that the validity for the third version of the UCLA Loneliness Scale was demonstrated via its correlation with other established scales, including the NYU Loneliness Scale, Differential Loneliness Scale, and Social Support Scale. Because of the large number of items and various constraints, such as time, the short version of the UCLA Loneliness Scale was utilized.

Part 5: Depression. Depression, designated as the first negative health outcome in the current study, was measured by the short version of the Depression Anxiety and Stress Scale (DASS-21). The DASS-21, a short-form version of the DASS-42, consists of 21 items. This self-report scale measures three negative emotional states often found in clinical practice: depression, anxiety, and stress (Lovibond & Lovibond, 1995). The DASS was developed through a series of rigorous procedures beginning in 1979 using a number of samples, including several clinical samples. The result is a clinically reliable, valid, and sensitive instrument that measures three common client experiences. From a clinical sample of 437, the DASS scales had excellent internal consistency: .96, .89, and .93, for depression, anxiety, and stress, respectively. Test-retest reliability coefficients over a two-week period were .71, .79, and 81. A number of studies report similar evidence of reliability. A number of studies also support the validity of the DASS, including concurrent validity, confirmatory factor analysis, and known-groups validity (Lovibond & Lovibond, 1995).

Part 6: Suicidal thoughts and attempt. Suicidal tendency (thoughts and attempts) was measured by means of the Positive and Negative Suicide Ideation Inventory (PANSI). The PANSI is a 14-item measure designed to assess suicidal ideation in adolescents and college-age students in terms of the frequency of negative risk and protective factors associated with suicide-related behaviors. The PANSI is a valid measure for such assessments, and was developed in 1998 by Osman and colleagues (Fischer & Corcoran, 2007). It is comprised of two major subscales: Negative Suicide Ideation and Positive Suicidal Ideation. Among the negative risk factors associated with increased suicidal behavior and tendencies are symptoms that include depression, feelings of hopelessness, and an inability to deal with stress. However, these suicidal tendencies can be balanced out by appropriate protective factors, such as meaningful friendship and close family support (King, 2000). The PANSI is easily scored by summing the items on the two subscales. Higher scores on each subscale reflect stronger negative or positive thoughts. Participants with a history of suicide attempts scored significantly higher on the Negative Suicide Ideation subscale and significantly lower on the Positive Suicide Ideation subscale (Osman et al., 2002). It has excellent internal consistency with alphas for this sample: .89 for the Positive Suicide Ideation subscale and .96 for the Negative Suicide Ideation subscale. The scale has excellent validity characteristics with significant correlations in expected directions between the two subscales and several other valid measures such as the Beck Hope Scale and the Positive and Negative Affect Scale (Osman et al., 2002).

Part 7: Sexual risk behavior. This section consisted of a series of questions written by the researchers to assess sexual behavior in the past six months These questions asked about the number, gender, and type of sexual partners, type of sexual activity, and whether condoms were used when any activity involved anal or vaginal penetration. Participants were also asked whether they had ever in their lives been diagnosed by a health care professional as having a sexually transmitted disease (STD).

Translation of the Questionnaire into Thai

As all the participants were Thai nationals, there was the probability that they were not able to read English. As such, the original English version of the questionnaire was translated into Thai (except for the DASS-21, for which a Thai version is available). The questionnaire was translated into Thai and back-translated into English to check for the consistency of meaning in the translated Thai version.

RESULTS

The sample consisted of 260 respondents, of whom 129 (49.6%) were self-identified as transgender and 131 (50.4%) were self-identified as cisgender. Their ages ranged from 15 to 25 years, with a mean age of 20 years. In terms of educational attainment, 57.9% ($n = 150$) of the respondents reported that they have had some university education, 15% ($n = 39$) reported that they completed high school, and 8% ($n = 21$) reported that they did not complete high school.

To investigate whether there are significant differences in the reported levels of family rejection, social support, loneliness, depression, PANSI–Positive Suicide Ideation, PANSI–Negative Suicide Ideation, and sexual risk behaviors between transgender and cisgender adolescents, a 2 (transgender versus cisgender adolescents) × 8 (dependent variables) generalized linear model (GLM) Multivariate Analysis of Variance (MANOVA) was conducted. Table 1 presents the means and standard deviations for the eight computed factors as a function of the respondents' transgender identity.

Results from the MANOVA showed that there is an overall group (transgender versus cisgender) effect for the eight variables combined, F (8, 246) = 41.47, $p < .001$. Follow-up tests of between-subjects effects showed that "group" has a significant effect for all eight dependent variables of family rejection, F (1, 253) = 152.70, $p < .001$; social support, F (1, 253) = 188.09, $p < .001$; loneliness, F (1, 253) = 19.04, $p < .001$; depression, F (1, 253) = 16.72, $p < .001$; PANSI–Positive, F (1, 253) = 20.82, $p < .001$; PANSI–Negative, F (1, 253) = 12.98, $p < .001$; and sexual risk behaviors, F

TABLE 1 Means and Standard Deviations for the Computed Factors of Family Rejection, Family Support, Friendship, Loneliness, Depression, PANSI-Positive, PANSI-Negative, and Engagement in Sexual Risk Behaviors as a Function of the Respondents' Transgender Identity

	Transgender		Nontransgender	
Factors	*M*	*SD*	*M*	*SD*
Family rejection	2.28	0.70	1.40	0.37*
Social support	2.47	0.46	1.72	0.42*
Loneliness	2.08	0.51	1.78	0.56*
Depression	0.83	0.71	0.52	0.48*
PANSI positive	2.51	0.72	2.87	0.49*
PANSI negative	1.99	0.60	1.74	0.51*
Sexual risk behaviors	5.04	1.82	5.98	1.30*

*$p < .001$.

$(1, 253) = 22.33$, $p < .001$. Examination of the marginal means showed that the transgender respondents, when compared to the cisgender respondents, reported significantly higher family rejection, lower social support, higher loneliness, higher depression, lower protective factors (PANSI–Positive) and higher negative risk factors (PANSI–Negative) related to suicidal behavior, and were less certain in avoiding sexual risk behaviors.

To test the predictive relationship between the exogenous variables of family rejection, social isolation, and loneliness with the transgender and cisgender adolescents' reported levels of depression, suicidal thinking, and sexual risk behaviors, multiple regression analysis was conducted. The analysis involved regressing the dependent variables of depression, suicidal thinking (PANSI–Positive; PANSI–Negative), and sexual risk behaviors on the predictor variables of family rejection, social support, and loneliness. The analysis was conducted separately for the two groups of transgender and cisgender respondents. The results are presented in Figure 1 and Figure 2, respectively.

The results showed that for both transgender and cisgender respondents, their reported experience of loneliness was found to be the most common predictor of their levels of depression, suicidal thinking, and certainty in avoiding sexual risk behaviors. Thus, for the transgender respondents, the higher their reported level of loneliness (1) the higher their level of reported depression (Beta = .25) and (2) the higher the frequency of both negative risk factors (PANSI–Negative) (Beta = .45) and protective factors (PANSI–Positive) (Beta = .24) related to suicidal behavior. For these transgender respondents, family rejection was found to be a significant predictor of their level of depression, such that the higher their reported level of family rejection, the higher their reported level of depression (Beta = .19). Perception of social support was also found to be a significant predictor of their suicidal thinking such that the lower their reported level of social support, the higher their reported frequency of negative risk factors (PANSI–Negative) related to suicidal behavior (Beta = .17).

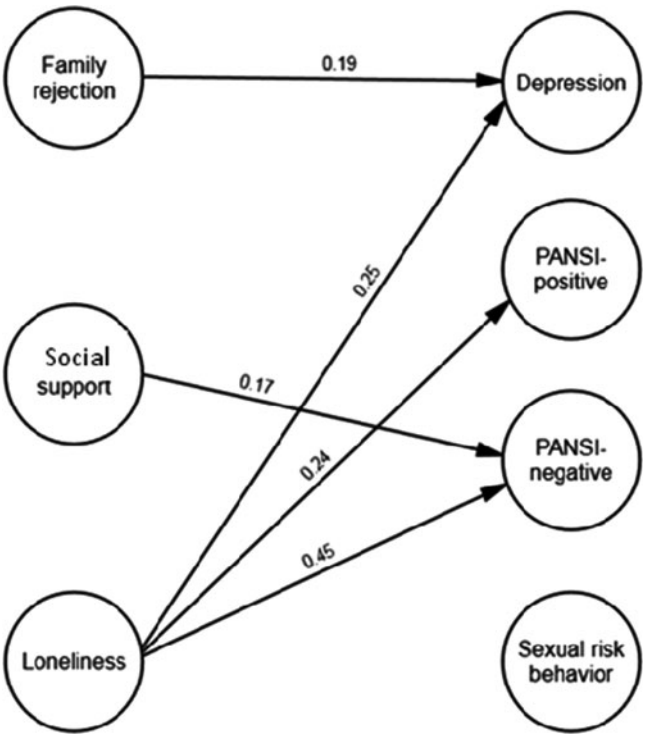

FIGURE 1 Regression model of the relationship between family rejection, social isolation, and loneliness with *transgendered* respondents' reported levels of depression, suicidal thinking, and sexual risk behaviors. Only coefficients that are significant ($p < .05$) have been included in the model.

For the cisgender respondents, the higher their reported level of loneliness (1) the higher their level of reported depression (Beta = .30), (2) the higher the frequency of negative risk factors (PANSI–Negative) related to suicidal behavior (Beta = .25), (3) the lower the frequency of protective factors related to suicidal behavior (Beta = −.34), and the less certain they are in using protective factors related to sexual risk behavior (Beta = −.24). For these cisgender respondents, family rejection was found to be a significant predictor of their suicidal thinking, such that the higher their reported level of family rejection, the higher the frequency of negative risk factors (PANSI–Negative) related to suicidal behavior (Beta = .27). Perception of social support was also found to be a significant predictor of their level of depression such that the lower their reported level of social support, the higher their reported level of depression (Beta = .28).

Table 2 presents the regression coefficients between the predictor variables of family rejection, social support, and loneliness, with the criterion variables of depression, PANSI–Positive, PANSI–Negative, and sexual risk behaviors, as a function of the two groups of transgendered and cisgender

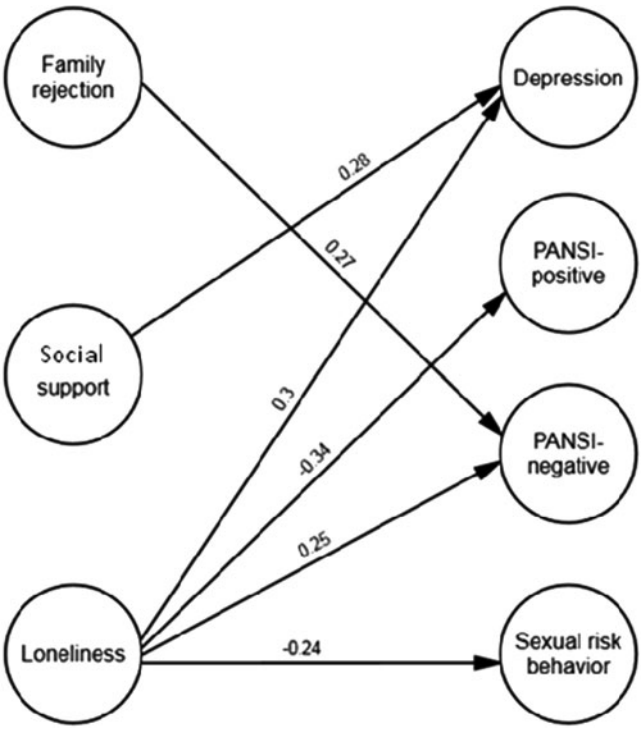

FIGURE 2 Regression model of the relationship between family rejection, social isolation, and loneliness with *nontransgendered* respondents' reported levels of depression, suicidal thinking, and sexual risk behaviors. Only coefficients that are significant ($p < .05$) have been included in the model.

TABLE 2 Regression Coefficients Between the Predictor Variables of Family Rejection, Social Support, and Loneliness, With the Criterion Variables of Depression, PANSI-Positive, PANSI-Negative, and Sexual Risk Behaviors, as a Function of the Two Groups of Transgendered and Nontransgendered Respondents. Fisher's z Test of Significance Between Coefficients

Variables			Transgendered respondents	Nontransgendered respondents	Fisher's z (one-tailed)	p
Family rejection	→	depress	0.20*	0.13	0.57	n.s.
Social support	→	depress	−0.01	0.23*	−1.45	< .05
Loneliness	→	depress	0.15	0.28*	−1.09	n.s.
Family rejection	→	Pansi_positive	0.02	0.02	0.00	n.s.
Social support	→	Pansi_positive	0.05	−0.13	−0.64	n.s.
Loneliness	→	Pansi_positive	0.21*	−0.30*	0.77	n.s.
Family rejection	→	Pansi_negative	0.00	0.20*	−1.61	n.s.
Social support	→	Pansi_negative	0.13	0.15	−0.16	n.s.
Loneliness	→	Pansi_negative	0.46*	0.18	2.51	< .01
Family rejection	→	Sexual_risk beh	−0.18	0.11	0.57	n.s.
Social support	→	Sexual_risk beh	0.11	−0.06	0.34	n.s.
Loneliness	→	Sexual_risk beh	0.07	−0.25*	−1.47	n.s.

Note. n.s. = not significant.

respondents. To test whether the obtained coefficients are statistically significant for the two groups of respondents, Fisher's z test was conducted. Fisher's z test involved calculating a value of z that can be applied to assess the significance of the difference between two coefficients obtained from two independent samples.

It can be seen from Table 2 that a total of 16 comparisons (between transgender and cisgender respondents) were made. Based on Fisher's z test, only two of these 16 comparisons were found to be statistically significant ($p < .05$). Thus, contrary to expectation, the relationship between social support and depression was found to be significantly higher for the cisgender respondents (Beta = .23) than for the transgender respondents (Beta = −0.01). It appeared that, for the cisgender respondents, not only does perception of lower social support increase their level of depression significantly, the relationship is also significantly stronger than that reported by the transgendered respondents. The results showed that the relationship between loneliness and PANSI–Negative is significantly higher for the transgendered respondents (Beta = .46) than for the cisgender respondents (Beta = .18). Thus, it appears that, for the transgendered respondents, not only does perception of loneliness increase their frequency of suicidal thinking significantly, the relationship is also significantly stronger than that evident by the cisgender respondents.

DISCUSSION

Family Rejection

Results from the MANOVA indicated that Thai transgender adolescents experienced more rejection from their family than did their cisgender counterparts. More specifically, descriptive statistics relating to this scale's items indicated that they experienced more physical punishment, financial deprivation, exclusion from family activities, ejection from the house, and social deprivation with respect to friends. These findings are consistent with the position of Costa and Matzner (2007), who in their book *Male Bodies, Women's Souls*—a collection of personal narratives of Thailand's MTF transgender youth—showed that although some families seemed to accept their children regardless of their gender expression, many parents used physical punishment in an effort to force their children to change. In a study of a sample of 195 transgender youth in Thailand, Winter (2006) revealed that 5.8% of mothers and 21.0% of fathers rejected youth outright. The present study's findings on family rejection are in line with these past findings and suggest that, although a generally permissive attitude toward sexual diversity is tolerated in Thailand, many still do not accept this explicitly and this negative attitude may result in families manifesting inappropriate behavior against their transgender children. One possible explanation for this is the

importance placed upon the preservation of family lineage, which derives from heterosexual marriage and procreation. Other causes and antecedents of family rejection within the Thai context relate to factors such as a sense of personal failure, or feelings of loss of trust, anger, fear, guilt, embarrassment, or uncertainty. In addition, religious and cultural influences and ignorance are also likely reasons. It is not uncommon to see some parents reject completely their transgender child because they simply do not know what to do or say.

Results from the regression analysis showed that family rejection is a significant predictor of transgender adolescents' level of depression but is not significantly related to their suicidal thinking and sexual risk behavior. These findings are partially in line with the findings of Ryan (2003) and Sugano, Nemoto, and Operario (2006), who showed that a lack of parental support can increase the risk of depression experienced by transgender youth, leading to an increased likelihood of dropping out of school and running away from home, as well as increasing the risks of substance abuse and sexual exploitation. In contrast, family rejection was found to be a significant predictor of cisgender adolescents' suicidal thinking, such that the higher their reported level of family rejection, the higher their suicidal thinking. While there is a scarcity of research evidence relating to this finding, it can be surmised that feelings of family rejection arising from disagreement with one's parents' demands, wishes, and aspirations may lead to increased levels of suicidal ideation.

Social Isolation

Results from the present study showed that Thai transgender adolescents, compared to their cisgender counterparts, experienced more isolation and less social support, as exemplified by feelings of isolation from others, feeling they lacked someone to talk to, feeling alone and friendless, and experiencing difficulty relating to others. These findings suggest that, despite the image of transgender acceptance in Thai society, transgenderism is still stigmatized and unacceptable. This suggestion is consistent with Cameron (2006), who posited that those who break Thailand's social mores will be subtly alienated rather than directly confronted. According to Cameron (2006), although MTF transgender people are visible in Thai society, this does not equate with acceptance; both homosexual men and transgender individuals are, in fact, stigmatized by Thai society.

Results from the regression analysis showed that social isolation is a significant predictor of transgender adolescents' suicidal thinking but is not significantly related to their level of depression and sexual risk behaviors. These findings offer partial support for Patten and Juby's (2008) findings that isolation can lead to increased suicidal tendencies, as well as increased risk

of emotional and mental problems, such as depression, anxiety, substance abuse, sexual risk behavior, and self-harm. Clearly, feelings of isolation, of being totally alone, represent a direct threat to one's sense of worth and psychological well-being. In other words, feeling isolated with no family or peer support magnifies one's sense of worthlessness and impacts directly and negatively on one's psychological well-being. The result is a higher likelihood of suicidal tendencies. In contrast, for the cisgender adolescents, it was found that social isolation is a significant predictor of depression, such that the higher their reported level of social isolation, the higher their depression. This finding is not unexpected and is indeed consistent with Patten and Juby's (2008) findings that isolation can lead to increased risk of emotional and mental problems, such as depression and anxiety,

Loneliness

The findings from the present study demonstrated that feelings of loneliness are higher among transgender youths compared with their cisgender counterparts. These findings support those obtained by Brown and Rounsley (1996), who showed that transgender youth experienced both intense loneliness during adolescence and great difficulty finding acceptance or identification with mainstream as well as gay and lesbian youth. While rejection by the family and isolation from society are clearly the main causes for transgender loneliness, Costa and Matzner (2007) also pointed out that a common complaint of many Thai transgender adolescents is loneliness due to lack of love and satisfactory relationships. The problem arises not because the transgender females are not able to find a partner, but because they are not able to keep one. As previously mentioned, many men end their relationships with transgender females and go on to marry female-assigned individuals with whom they can have children and fulfill their expectations of being a parent and having a family. While the goal of many transgender females is to find a husband and live as a wife, this seldom happens and most transgender females are cynical about the possibility of achieving their goal of getting married and enjoying a loving relationship (Jenkins et al., 2005).

In addition, it is said that developing a gender identity such as transgenderism is an individualistic process, which could separate individuals from their collective identity. Through this process transgender individuals may not place such a high value on the collective or be reliant on a collective for their mental well-being. In contrast, gender-conforming cisgender individuals would continue to place a high value on collective support for their identities, because they would not have had the same kind of individuating experience.[1]

Results from the regression analysis showed that loneliness is the most common predictor of negative health outcomes for both Thai transgender

and cisgender adolescents. More specifically, for these two groups of adolescents, the higher their reported level of loneliness, the higher their level of depression and the higher their frequency of negative risk factors (PANSI–Negative) related to suicidal behavior. These findings are consistent with those obtained by Perlman, Gerson, and Spinner (1978), who showed that empirical evidence linking loneliness with depression and suicide is strong. While loneliness was found to be a common predictor of negative health outcomes in both groups, it was not found to be a significant predictor for sexual risk behavior among transgender individuals. This finding contradicts those obtained by Bockting, Robinson, and Rosser (1998), who showed that loneliness is one of the potential human immunodeficiency virus (HIV) risk cofactors for trans individuals. In addition, Bockting and Coleman (2007) showed that many transgender females resort to alcohol and drugs to combat their loneliness and help them cope with subsequent problems. These substances have the effect of lowering inhibitions and increasing sexual risk behavior, suggesting that factors such as alcohol and drugs can impact loneliness and sexual risk behavior to some degree.

Interestingly, the present results also indicated that, among transgender people, there is a positive, significant relationship between loneliness and positive risk factors (PANSI–Negative) related to suicidal behavior, which is contrary to expectations and to the presented literature. A possible explanation for this contrary finding may lie with a study by Long and Averill (2003), which demonstrated that loneliness is not necessarily a negative concept. According to the authors, development of self is considered to be one of the benefits of loneliness. When a person spends time in solitude from others, he or she may experience changes to self-concept. This can also help a person to form or discover an individualized identity without any outside distractions. Loneliness also provides time for contemplation, growth in personal spirituality, and self-examination. In these situations, feelings of loneliness can be avoided as long as the person in solitude knows that he or she has meaningful relations with others (Long & Averill, 2003).

CONCLUSION

While the findings from the present study have highlighted significant differences between transgender and cisgender adolescents on a number of health risk variables, as well as the predictive relationship between these variables and the groups' reported levels of depression, suicidal thinking, and sexual risk behaviors, there is still room for further research. For example, while the present study employed a purely quantitative methodology to investigate the impact of the study's predictor variables on the negative health outcomes among Thai transgender and cisgender youth, future research could employ

a mixed-design approach that incorporates both in-depth interviews and the survey/questionnaire method that target both transgender and cisgender individuals. Information obtained from in-depth interviews can provide important information from both these groups' perspectives and inform the writing of survey questionnaire items that accurately reflect their feelings, attitudes, and opinions. The conduct of more in-depth research to determine the opinions, attitudes, and in particular the status of transgender individuals in every stratum of Thai society can contribute to a better understanding for and an acceptance of these individuals into mainstream Thai society.

NOTE

1. One of our reviewers contributed this idea.

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CONTRIBUTORS

Mohammadrasool Yadegarfard, MSCP, Graduate School of Counseling Psychology, Assumption University. His research interest area is health psychology, LGBT mental well-being, professional ethic codes and conduct, and mainly work on the influence of social factors on mental well-being.

Mallika E. Meinhold-Bergmann, PhD, Graduate School of Psychology, Assumption University. Her interest area is health psychology, and mainly worked

with cultural sensitive approaches, counselling students and clients suffering from HIV/Aids, psychosomatic ailments and Post Traumatic Stress Disorder (PTSD).

Robert Ho, PhD, is an Associate Professor, Graduate School of Psychology, Assumption University. His research interests include health psychology, attribution theory, intergroup relationships, and quantitative methods.