Trans Rican Guys Self Support Group: Unifying trans men with empowerment and knowledge

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"I have been waiting 10 years for this group." (Participant)
"This is the first time I am in front of a fellow trans man, before I just talked thru the internet." (Participant)

Abstract
Disparities in medical care are aggravated by the lack of data regarding transgender people within health providing services all over the country. Feeling identified with a different gender from the one assigned at birth is a complex situation they cannot manifest easily because of social oppression. To move forward to their transition and to accept who they are, mental health is a key factor. This study aims to explore the effectiveness of a self-support group for the transgender male population. A 13-day semi-structured self-support group was designed for transgender male population. Participants are 12 transgender males between 18 and 37 years of age (*M*= 27, SD= 7), from the San Juan metropolitan area in Puerto Rico. During the course of group meetings, a battery of instruments (Beck Scale for Suicide Ideations, Beck Hopelessness Scale, Depression, Anxiety, and Stress Scale) was administered in the engagement meeting (i.e. intake), 6 month meeting, and last meeting (12 month since the first meeting). The model that was used is the Participatory Action Research Model (PARM). A significant statistical decrease in scores was found on the BSSI at the 6-month evaluation period. As well, a statistically significant reduction in scores was also observed in stress, anxiety, and depression on the DASS at the 6-month and 12-month assessment points. This reduction in scores indicates that the program was effective for this group in reducing suicidal ideation, stress, anxiety, and depression. Hopelessness symptoms represent a lineal effect between the first intake and the 6 months follow up, however, although not statistically significant, there was a decrease of these symptoms at the 1-year follow up. Clinical implications are discussed.

Keyboards: Transgender - Self-support group

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Resumen

Las disparidades en la atención médica se ven agravadas por la falta de datos sobre las personas transgénero en los servicios de salud que se brindan en todo el país. Sentirse identificado con un género diferente al asignado al nacer es una situación compleja que no se puede manifestar fácilmente debido a la opresión social. Para avanzar en su transición y aceptar quiénes son, la salud mental es un factor clave. Este estudio tiene como objetivo explorar la efectividad de un grupo de auto ayuda para la población masculina transgénero. Se diseñó un grupo de autoayuda semiestructurado de 13 días para la población masculina transgénero. Los participantes fueron 12 hombres transgénero entre 18 y 37 años (M = 27, DT = 7), del área metropolitana de San Juan en Puerto Rico. Durante el transcurso de las reuniones de grupo, se administró una batería de instrumentos (Escala de Beck para ideas suicidas, Escala de desesperanza de Beck, Escala de depresión, ansiedad y estrés) en la reunión de participación (es decir, la admisión), la reunión de los 6 meses y la última reunión (12 mes desde la primera reunión). El modelo que se utilizó es el Modelo de Investigación Acción Participativa (PARM, en inglés). Se encontró una disminución estadística significativa en los puntajes en el BSSI en el período de evaluación de 6 meses. Además, también se observó una reducción estadísticamente significativa en las puntuaciones en el estrés, la ansiedad y la depresión en el DASS en los puntos de evaluación de 6 y 12 meses. Esta reducción en las puntuaciones indica que el programa fue eficaz para este grupo en la reducción de la ideación suicida, el estrés, la ansiedad y la depresión. Los síntomas de desesperanza representan un efecto lineal entre la primera ingesta y el seguimiento de 6 meses, sin embargo, aunque no es estadísticamente significativo, hubo una disminución de estos síntomas en el seguimiento de 1 año. Se discuten las implicaciones clínicas.

Palabras clave: Transgénero - Grupos de autoayuda.

Introduction

Puerto Rico's cultural influences embedded in *machismo*, impact the lens through which as a society we view gender identity, gender expression, gender roles and sexuality. More specifically, authors have been vocal about how cisnormative societal views have influenced miseducated assumptions about trans lives that, in occasions, result in prejudice and violence (Malavé & González, 2009; Rivera-Quiñones et al., 2013; Charriez, & Seda, 2015; Rodríguez-Madera, Ramos-Pibernus,

Padilla, & Varas, 2016, Brown, 2018). This is also true for sexual diverse communities, who sometimes also happen to be trans. We can easily bring up examples from the last four-decades to paint a picture. During the 80's, Ángel Colón Maldonado targeted and killed gay men and was later apprehended (Figueroa Rosa, 2013). People called him the "Ángel de los Solteros" (Figueroa Rosa, 2013), which means the angel of single men. Language is very important, why use terms like "single men" and not gay men? During 2009-2010, 11 bodies of members of the LGBT+ community were found decapitated, slain, shot in the head, or burned in the island (Noticel, 2010). This time, since 2002 there had been a law in place against hate crimes; nonetheless, not one attack had been officially treated as a hate crime and activists were appalled (Noticel, 2010). Fast forward to 2020, 6 transgender people had been killed by September just during that year. For the first time, one of those cases that involved two transgender women was treated as a hate crime (Rivera, 2020). Even though we are moving forward in policies and initiatives that aim to breach the gap among gender and sexual minorities, it is evident that there is a long way to go.

Some acts of violence against minority groups are not as obvious as killings, but still affect their quality of life and health. The discrimination trans people face in their day-to-day life include access to care, which is the focus of our article. A qualitative study explored how physicians view stigmatization towards transgender women in Puerto Rico (Rodriguez-Madera et al., 2016). Results from interviews reflected that physicians demonstrated most negative feelings towards treating patients who are trans. For example, a doctor, an internist, said, "I don't support that. I think that, well, that each person must accept himself, okay? If they want to do that kind… of thing. Well, no. Because hormones have side effects… And we have to consider that. So, to repeat: That is individual. I don't recommend it to any patient." (p. 15-16) [translated].

Additionally, this study pointed out that some physicians use the phrase "I treat all patients equally" (p. 17) [translated] when explaining their practices. However, meaning that they will treat cisgender (an individual who identifies with the gender assigned at birth) patients and their specific needs, the same way they would a transgender patient, even though their needs are different than those of a cisperson. In the same way, results showed that "… regarding knowledge, competencies, and willingness to provide services to TW…" (p. 18) [translated] 39% of

participants supposed they had the capabilities to provide health care services, while 82% of the physicians did not have any training on providing health care to a trans person. “Most participants (71%) were unaware that Gender Dysphoria is classified as a mental health disorder, and 40% of them lacked information about standards of care for treating transgender individuals.” (p. 18) [translated].

During 2015, the first clinic addressing trans health was inaugurated (Guzmán, 2014). Soon, a few other followed suits. However, all of them are located at metropolitan areas; so, there are disparities between central areas and rural or distant areas from the capitol. As for transgender mental health, it has been a deep-rooted issue within the medical community, including the mental health area. Not only is there prejudice and discrimination against people who do not identify with binary gender norms withing mental health services, but there are limited policies that protect them in Puerto Rico (Díaz Rolón, 2019. During 2018, the first certification for LGBT interventions was created by Psicoalternativas, Inc. During 2020, the Psychologist Examination Board in the island prohibited conversion therapies for minors (Díaz Rolón, 2020).

Mental health is a big influence in quality life because of its connection to environment, finances, intellect, occupation, physical health, social systems, and spiritual beliefs. Feeling identified with a different gender from the one assigned at birth is a complex situation they cannot manifest easily because of social oppression. To move forward to their transition and to accept who they are, mental health is a key factor. Suggested practices for clinical treatment include: a client-centered approach, an inclusive, nonbinary view of gender, a global and multicultural framework, a sex-positive approach, social justice, feminism, and intersectionality driven, trauma-informed and resilience-based, cognitive derived clinical models, and mindful of developmental stages (Chang, Singh & Dickey, 2018). In the same way, practicing a type of therapy that makes clients comfortable enough for them to express how they feel and to provide a safe environment is an important step in building a strong therapeutic alliance. Studies show that therapeutic alliances are an influential factor in treatment effectiveness (Leonard, Campbell, & Gonzalez, 2018; MacDonald, 2014; Green, 2003). It is no different with clients who are trans.

In a recent study, Francia-Martínez, Esteban, and Lespier (2017) aimed to examine the "attitude, knowledge and social distance of a sample of psychologists and psychology graduate students in Puerto Rico". It is important to point out that Francia-Martínez et al. had to open their study to graduate students, because it was so hard to find volunteers for this study to start with. They found that even though their sample showed a more open and accepting attitude towards trans people, a considerable number lacked the knowledge to work with them in psychotherapy.

We know less information when it comes to trans men. Thus, exploring more about this group and addressing their concerns became the focus of our project. Ramos-Piberus et al. (2016) studied the stigmatization of trans men and "butch lesbians" in Puerto Rico. They found that participants faced stigma at a structural (e.g. receiving health care services or equal labor treatment), interpersonal (e.g. recognition of identity), and individual level (e.g. internalized transphobia). One participant even reported how they went to a mental health provider and their service "…became a biblical cult…" (p. 9) [translated]. Consonant with broad reviewed literature, stories of unfair treatment, transphobia and misinformation were apparent as well. The social stigma transgender people endure at multiple levels makes them an at-risk population, especially in relation to health; thus, their access to proper health providers sparked our interest.

Understanding the mental health of a transgender person requires a specific knowledge to aid in the related concerns of their gender identity and any co-occurring diagnosis. However, literature on trans men's health has abundantly requested to improve the scope, depth, and availability of said research to understand disparities and needs (Fredriksen Goldsen, Romanelli, Hoy-Ellis & Jung, 2022; Stephenson, Riley, Rogers, Suarez, Metheny, Senda, Saylor & Bauermeister, 2017), which can result in an obstacle for professionals. We do know that the social factors that affect trans's health are lack of social support, sexual and gender minority-based victimization and violence that can lead to symptoms of depression and suicide behavior in trans men (Newcomb, Hill, Buehler, Ryan, Whitton & Mustanski, 2020). We ought to remember that disparities magnify when these factors intersect. All these factors are key ingredients to assess and address in therapy services for the transmen population. Doing so can impact positively their quality of life, which in turn helps with

the efficiency of the individual or group therapy.

Using transgender affirmative cognitive behavioral therapy (TA-CBT) is the basis to provide a space for transgender people (Austin & Craig, 2015). Furthermore, it gives health providers the tools to have an effective therapy, communication and guidance process. The first step is to recognize transgender identities and the comprehensive outlook of gender and gender expressions, and also the diverse sexual orientations that a transgender person might identify with. Chang, Singh & Dickey (2018) stipulate the importance of using gender neutral language when it comes to having a direct communication with the client or knowing the essentials pronouns the person identifies with. The most common pronouns are he/she/they/them. Other people use pronouns such as zie/zim/zir, etc. to identify themselves because they might feel restricted by the language.

Another step in working with TA-CBT is the importance to clarify the role of the clinician to the client in stipulating the objective of the therapeutic session. That means telling the client about the work that they will make through the session. Also, it establishes the informal and formal communication between the two of them. One should have in mind that, although clients come for a specific purpose, when exploring client's history other situations might surface (i.e. family abuse, having difficulties socializing, additional goals, presenting a co-occurring disorder). Finally, the TA-CBT model offers an eight-session curriculum that helps clinicians guide the therapy in a way that the client comes to understands the cognitive and behavioral process.

Besides, using this model can be linked to psychoeducational guidelines that provide an introspection of discrimination, harassment, microaggressions and violence" (Austin & Craig, 2015) that can be used with transgender people. Also, it helps to view transphobic perspectives within their own community and internalized transphobia within themselves. This model promotes the "… idea of empowering oneself to adaptively challenge transphobic barriers in oneself … and society…" (Austin & Craig, 2015, p.24) helping the client manage negative feelings by looking into why they feel like that, identifying qualities and positive views they possess, and learning how to examine other people's views. All, while preserving a healthy cognitive approach when doing that.

The American Psychological Association (APA) published a "Guidelines

for Psychological Practice with Transgender and Gender Nonconforming People" (2015) that helps the clinician work with TGNC people and making the therapy session a unique space for their interaction. APA made a cluster of guidelines that assist mental health providers "… in the provision of culturally competent, developmentally appropriate, and trans-affirmative psychological practice…" (p.2). The 16 guidelines are prepared in 5 clusters that describe a rationale and application description on how the provider should interact with a TGNC person and how the provider should offer a therapy session using models that would help the client with their specific issues. The clusters are: (a) foundational knowledge and awareness; (b) stigma, discrimination and barriers to care; (c) lifespan development; (d) assessment, therapy and intervention; and (e) research, education and training (p.4).

Research Study Purpose

This study aims to explore the effectiveness of a self-support group for the transgender male population. Our group focuses in the needs of transgender people, and helps to empower and shine light to an otherwise invisible population. Additionally, it helps spread information to different fields of psychology, that there is a need for appropriate data and knowledgeable providers of the reality that this community is living. Engraving policies that contribute to the rights of this community is imperative to maintain physical and mental wellbeing

Method

A 13-day semi-structured self-support group was designed for transgender male population. At first, the motivation to develop this group was to unite transgender males that knew each other through a social platform but not in person.

Participants

Participants are 12 transgender males between 18 and 37 years of age (*M*= 27, SD= 7), from the San Juan metropolitan area. They were contacted by a snowball effect strategy. Most participants had already socially transitioned, but just a few had started hormone therapy (testosterone) and none had undergone gender affirming surgeries. None of the participants had changed their gender maker on official documents or identifications, nor had completed legal name changes at the beginning of the study. The 13 meetings took place in a 12-month period.

Instruments

During the course of group meetings, a battery of instruments was administered in

the engagement meeting (i.e. intake), 6 month meeting, and last meeting (12 month since the first meeting).

Beck Scale for Suicide Ideations (BSSI) (Beck et al., 1979). Suicidal ideation was evaluated via the BSSI. This is a scale which measures the severity of suicidal ideation among adults consisting of 21 items to which the respondent is asked to choose from the following alternatives: "0" moderate to strong, "1" weak, or "2" none. The BSSI provides three subscales: active suicide ideation, passive suicide ideation, and suicide preparation. The first 19 items measure the severity of suicidal ideation, attitude, and planning. The last two items evaluate the number of previous suicide attempts and the level of intent to die associated with the latest attempt. These last two items are not included in tallying the total score. The total scale score can fluctuate between 0 and 38 points. The scale presents a strong internal consistency with a Cronbach's alpha of .89 (Beck et al., 1979).

It also demonstrates convergent validity with the *Beck Hopelessness Scale* as well as the questions related to self-harm from the *Beck Depression Inventory*; it also exhibits high inter-rater reliability between interviewers (Beck et al., 1979; Clum & Yang, 1995). This scale has been historically used in research involving the evaluation of suicidal behavior in adult psychiatric patients (Dervic et al., 2004; Healy et al., 2006; Marčinko et al., 2008; Pinninti et al., 2002; Steer et al., 1993; Steer et al., 1993). Even though a translation and adaptation of the BSSI into Spanish exists (Vázquez, 2006), the literature review was unsuccessful in locating any information as to the validation of the Spanish language version of this scale or to any other Spanish language scale that evaluated suicide behavior.

Beck Hopelessness Scale (BHS). The BHS (Beck et al., 1974) is a 29-item inventory consisting of dichotomous choice (true/false) statements designed to measure hope regarding the future. This instrument was initially developed for use in research that evaluated suicidal behavior and depression. The total scale score may fall between 0 and 20 points. The responses are classified as follows: 0-3 minimal, 4-8 light, 9-14 moderate, and 15 to 20 severe. The internal reliability of this instrument has been established as being between .87 and .93, which supports the overall reliability of this measure. Beck et al. (1974, 1985) found the instrument to have good concurrent and predictive validity. No information regarding the validation of the Spanish language version of the BHS was found in the fairly

exhaustive literature review performed in relation to this study. However, to remain close to the original version, the "BHS Spanish Translation" was used.

Depression, Anxiety, and Stress Scale (DASS-21). The depression, anxiety, and stress scale are a 21-item test that is reliable and easy to administer in measure and serves for clinical and research purposes (Norton, 2007). This instrument contains three self-report scales designed to measure the emotional state of depression, anxiety and stress. Each of the scales contain seven items the depression scale assesses: dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/involvement, anhedonia and inertia. The anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The stress scale is sensitive to levels of chronic nonspecific arousal. It assesses difficulty relaxing, nervous arousal, and being easily upset/agitated, irritable/over-reactive and impatient. Scores for depression, anxiety and stress are calculated by summing the scores for the relevant items.

Numerous studies have found favorable psychometric properties of the DASS in adults with anxiety and/or mood disorders (Antony et al., 1998; Brown et al., 1997, Clara, Cox, & Enns, 2001), Spanish-speaking patients (Daza et al., 2002), and community-dwelling adults (Crawford & Henry, 2003). All studies have demonstrated excellent internal consistency of the DASS scales in both the 42- and 21-item (DASS-21) versions: Depression (range=.91 to .97); Anxiety (range=.81 to .92); and Stress (range=.88 to .95). A three-factor solution reflecting the three scales has been found consistently across samples and factor-analytic techniques with only minor variations. Inter-scale correlations range as follows: Depression – Anxiety (.45 – .71; .50 or below in all English-speaking samples (Antony et al., 1998; Brown, et al., 1997; Clara et al., 2001), Anxiety – Stress (.65 – .73), and Depression – Stress (.57 – .79).

Procedures

Invitations for the transgender male support group were sent to clients of a private psychology office and clients' guests could come if they identified as transgender males. The model that was used is the Participatory Action Research Model (PARM) (Mertens, 1998), which promotes a horizontal relationship between internal (community) and external agents (researcher) within the project; thus, allowing the voices of those most oppressed to be heard. This model

focusses on people's cultural knowledge and enables them to take part in the development of goals and agendas. This empowers participants to talk about their experiences, to participate in data collection and analysis, and to participate in determining how results are used and if it represents them appropriately. The goal is to stay true to perceived needs and to promote community autonomy. See the Table 1 below for the PARM Criteria used to determine model fidelity.

Table 1. *PARM Criteria used to Determine Model Fidelity*

PARM Criteria (Mertens, 1998)	Compliance
Was the problem addressed by the research originally identify by the community who experienced the problem?	Yes. Individually, the transgender male participants alluded to the fact that they did not know any other transgender male personally, only thru social media. Most of them expressed the fact that a group meeting had to take place.
Was the goal of the research to fundamentally change and improve the lives of people of marginalized groups?	Yes. As established by participants, the meetings were a way to connect with fellow transmen. Also, they developed a group chat to stay in touch outside of the meetings.
Did the research process give power to participants?	Yes. In the engagement meeting, the participants decided which topics to address, the name of the group, assessment instruments, and how to make sense of the results.
Did the research participants belong to the group who experience the problem being studied?	Yes. The participants were the ones that observed the need and were the ones who partook in the meetings.
Will the participants experience increased consciousness, skilled development and resources?	Yes. The meetings were nourished by the participants' experiences and the consciousness, skills and resources that they received were from the knowledge shared in the group meetings.
Do researchers and participants share a peer relationship?	Partially. The researcher is a cisgender male, and by that, does not qualify as a peer for transgender males. Nevertheless, the meetings were facilitated by the group, and the knowledge acquired arose by the group and not information handed to them by the facilitator.
Can the results be used by and benefit the participants?	Yes. Participants were presented with the results and in a group meeting the discussion was developed. They understood that the study would benefit their community by provoking other initiatives such as this one.

The engagement meeting found consensus within the group for the name, the rules, the objectives and the topics to discuss. The agreed rules consisted of: (a) to inform in advance (2 hours) the nonattendance, (b) take turns to talk, (c) keep cellphones in

silence mode, (d) respect the opinions of others, € no personal insults, (f) keep confidentiality, (g) use the correct names and pronouns, and (h) be punctual.

The time determined was 2.5 hours monthly and a telehealth chat support mobile platform. The format of the meetings included beginning with negative and positive situations that occurred during the month before and then to discuss the topics that were established by the group with a question guide. Table 2 shows what topics and subtopics were discussed during the meetings using the Participatory Action Research Model.

Table 2. *Topics and Subtopics during the Meetings*

Topics	Subtopics
Engagement meeting	Name of the group, topics and rules
Pre-coming out (2 meetings)	Life experiences
	Gender Dysphoria
	Stigma Management
Coming out (2 meetings)	Transitioning steps
	Coming out process
	Self-esteem
	Positive aspects of being Trans
Transition management (2 meetings)	Effects of hormone treatment
	Impulse control
	Emotional control
Trans life (4 meetings)	General well being
	Opportunity and safe spaces
	Trans rights and laws
	Sexuality issues
Group future (2 meetings)	Expansion efforts

Data Analysis

The measures assessed for this study were attendance and the scores of the administrated instruments. 12 different participants assisted to the 13 meetings. On average 6 participants attended per day. Each individual person attended a minimum of 2 meetings to a maximum of 13 (M = 6, SD = 4.23).

It was decided that the score from the instruments would be considered if these conditions were present: 1. The participant attended to more than half of the meetings and 2. The participant answered the instruments at each intake date (Engagement meeting, 6 months meeting and 1-year meeting). Therefore, although there were in total 12 participants throughout the different

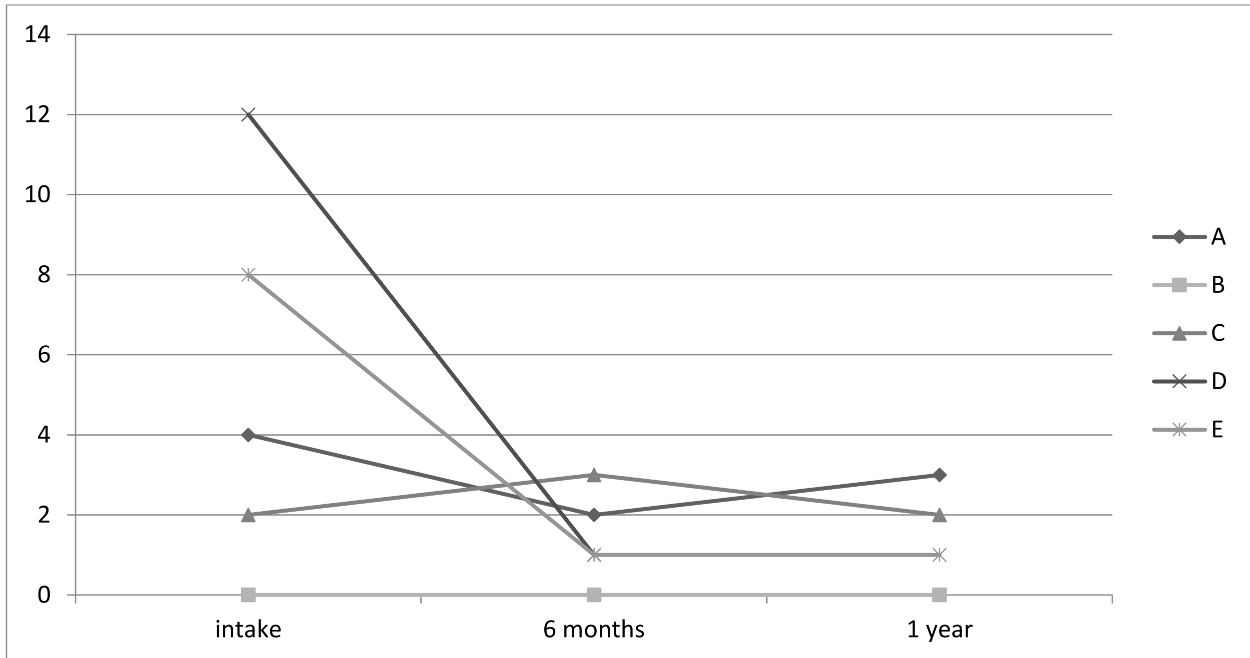
meetings, only 5 met the inclusion criteria; the overall participation rate at all 3 time points was 42%. Table 3 presents the mean scores at the Initial intake, 6-month follow-up, and 12 month follow-up for all measures administered.

In addition, individual scores for each participant are presented in Graph 1 (BSSI scale), Graph 2 (BHS scale), and Graph 3 (DASS).

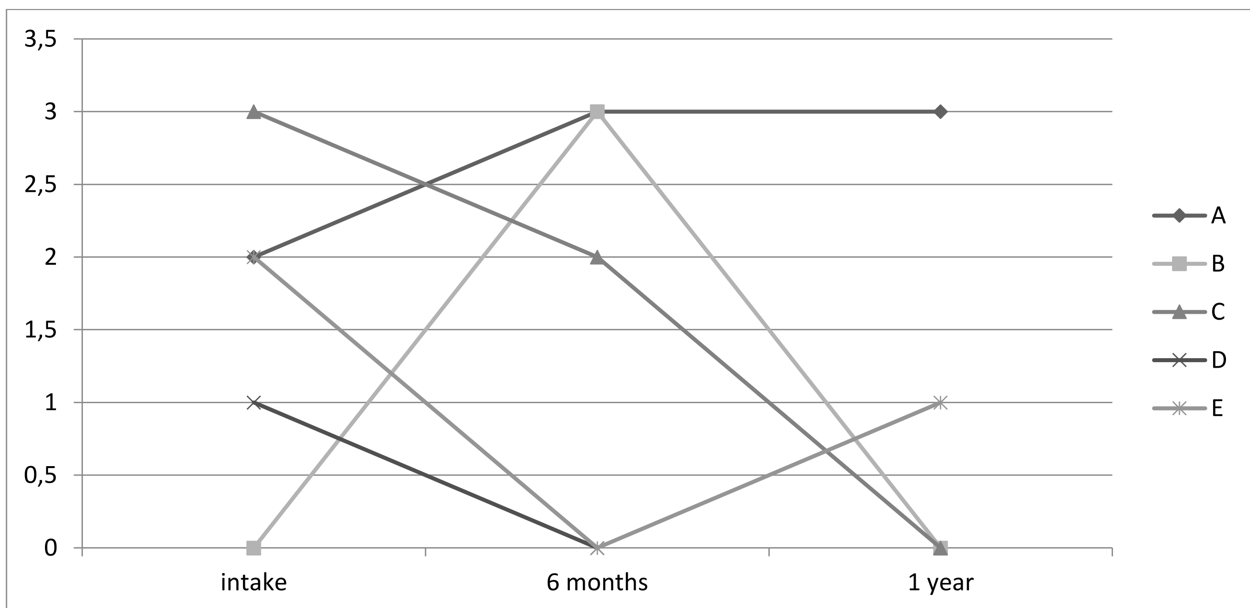
Table 3. *Mean scores of the BHS, BSSI, and DASS at Each Assessment Point*

Scale	*n*	*M*	*S.D.*
BHS			
Intake	5	1.6	1.14
6 months	5	1.6	1.52
12 months	4	1.0	1.41
BSSI			
Intake	5	5.2	4.82
6 months	5	1.4	1.14
12 months	4	1.5	1.29
DASS - Stress			
Intake	5	13.2	5.58
6 months	5	7.8	6.38
12 months	4	6.75	2.63
DASS - Anxiety			
Intake	5	11.8	7.26
6 months	5	6.0	5.70
12 months	4	3.0	3.56
DASS - Depression			
Intake	5	11.4	5.68
6 months	5	3.8	4.32
12 months	4	3.0	2.83

Graph 1. BSSI Scales: Intake, 6 months, and 12 months.



Graph 2. BHS Scales: Intake, 6 months, and 12 months



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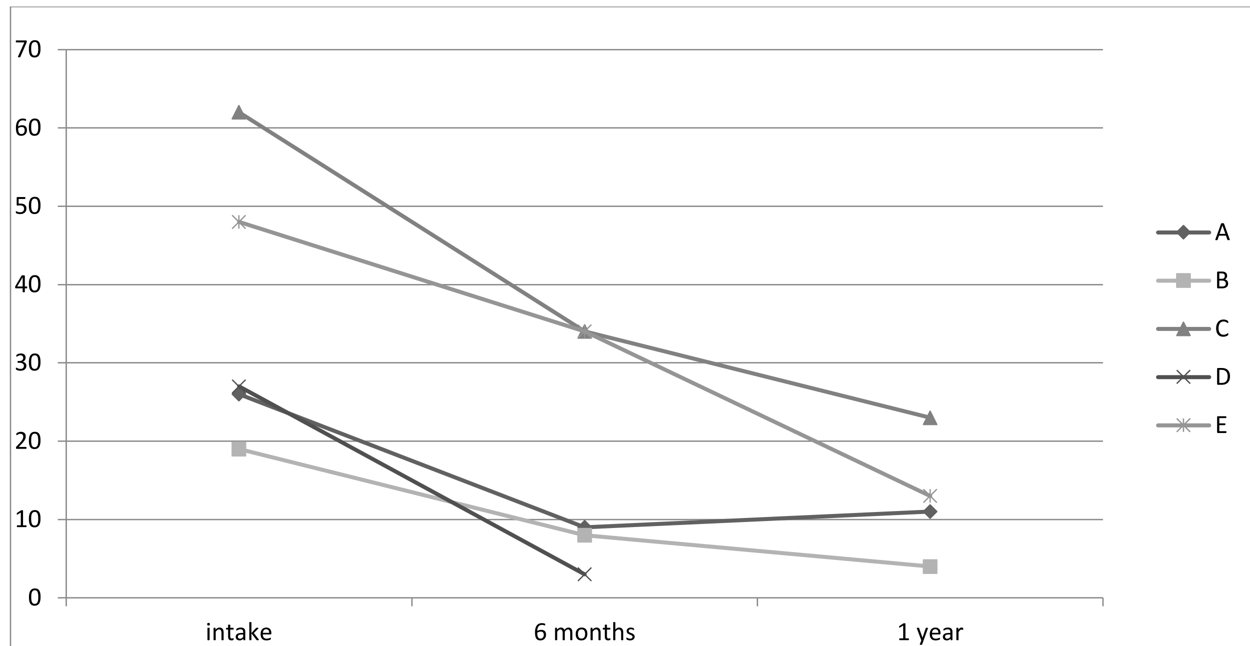
Graph 3. DASS-21: Intake, 6 months, and 12 months.



Although the sample size was 5 participants, a paired sample Student *t*-test was performed between each measure to determine if any significant statistical differenced existed in reducing test scores over time. Due to the small sample size, only two time points were compared at a time: Intake and 6-month assessment, Intake and 12-month assessment, and 6-month and 12-month assessment (Table 4 presents the results of this analysis). A *p*-value of .01 was used to determine statistical difference due to the small sample size. Overall, although a reduction of scores is observed at the 6-month and 12-month assessment period, no significant statistical differences are observed on the BHS over time. However, a significant statistical reduction is observed on the DASS (for all measurements) at the Intake vs. 6-month assessment as well as the Intake and 12-month assessment using a p-value of .05 and .01. Finally, a significant statistical reduction is scores is also observed on the DASS at the 6-month vs. 12-month assessment on anxiety (p = .05), depression (p = .09), and total scores (p = .09).

Table 4. *Paired Sample t-Test Results*

Scale	*t*	*d.f.*	*p*
BHS			
Intake vs. 6 months	0.00	4	.50
Intake vs. 12 months	0.88	3	.22
6 months vs. 12 months	1.10	3	.18
BSSI			
Intake vs. 6 months	1.68	4	.08
Intake vs. 12 months	1.19	3	.16
6 months vs. 12 months	0.58	3	.30
DASS - Stress			
Intake vs. 6 months	4.07	4	.008*
Intake vs. 12 months	3.57	3	.02
6 months vs. 12 months	1.08	3	.18
DASS - Anxiety			
Intake vs. 6 months	3.96	4	.008*
Intake vs. 12 months	3.96	3	.01*
6 months vs. 12 months	2.31	3	.05
DASS - Depression			
Intake vs. 6 months	8.20	4	.0006*
Intake vs. 12 months	4.24	3	.01*
6 months vs. 12 months	1.70	3	.09

Note. * $p \leq .01$

Discussion

A significant statistical decrease in scores was observed in stress, anxiety, and depression on the DASS at the Intake vs. 6-month and Intake vs. 12-month assessment points. This reduction in scores indicates that the program was effective for this particular group in reducing stress, anxiety, and depression in a short period of time (i.e. 6 months) as well as over a 12 month period. In general, per our results, it appears that a 6-month program is sufficient to assist in reducing stress, anxiety, and depression signs experienced by the participants who participated in the program.

On a more qualitative approach, participants from the study concluded that:

- "The telehealth support mobile platform helps because whenever you feel badly, you can write there, and someone will respond."

- "The group works because it is filled with people that are going through the same issues, and we usually think we were alone."
- "We feel at ease and united in the group, and the symptoms of dysphoria decrease when we are amongst us."
- "The exchange of experiences helps to debrief and we can talk freely about anything."
- "It's is a space of total and unconditional acceptance."

Participants said the following statements at the discussion of the results:

- "We have changed internally, but the outside keeps on being somewhat the same: toxic people and a paralyzed oppressive system."
- "We still have many obstacles to fulfill our needs."
- "We can compare it with water boiling, the group uncovers the lid, and that helps, but the water keeps on boiling."

Stress, depression, and anxiety symptoms had a major decrease throughout the 6 and 1-year follow up. Participants discussed the following reasons:

- "The group is a support group, and we feel comforted and encouraged."
- "We have a network that we can depend on: This is very difficult, but I have "my boys"."
- "I have the chat group, and when I feel anxious, they are there, even if it is virtually."

Limitations

Our study had a number of limitations starting with our recruitment method. Most of the participants were from the same psychotherapist and others were invited by those participants. This fact is important since most of the participants were active in individual psychotherapy.

Another important fact that was not assessed was their social and physical transition status. There was a big variation in the sample. Attendance was also an important factor that limited the number of participants that were included in the assessment. Finally, our study had a small sample size and this limited the type and number of statistical analysis performed.

Conclusion

Results from this initiative point out that the group has been effective in the reduction of psychological symptoms.

Nevertheless, a support group is not sufficient to relieve them of the emotional burden of being trans in a society where there is a need for education in this topic, there are rigid gender expectations, naturalization of gender, among other noxious dynamics in the Puerto Rican society. For this reason, some symptoms like hopelessness did not disappear initially, it is important to remember that the future keeps on being uncertain and cloudy. Psychosocial group initiatives seem to be necessary in work with the trans community. This strategy has helped to unify the efforts towards the search for treatment, universal suffering, and goal-oriented motivation. Empowerment methods are extremely important for the trans community so that they can face future difficulties and obstacles provoked by a cissexist and binary society. This group contributes to visibility of the trans male community, to alleviate emotional consequences of living in a transphobic society, and to make aware professionals of this population's necessities.

The preliminary results of this initiative point out that the group had an effective decrease of symptomatology that is harmful and prejudicial to the mental health. Furthermore, it can recognize that a support group is not sufficient to free them of an emotional ailment caused by social dynamics that is founded on poor education, rigid social expectations of gender, the naturalization of what gender is and other dynamics rooted in society. The initiative of psychosocial groups is necessary to work with the Trans community. These strategies help to unify the research for treatment, generalize the conditions they are going through as a Trans person and encourage them as a group to achieve their goals. It's important to use methods that give Trans people the tools to confront and manage any difficulty in the future induced by a cissexist and binary society. This group offers visibility to the community of transgender men, alleviates emotional consequences of living in a society that subjugates issues of gender and helps make awareness to professionals about the needs of this community.

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