STIGMA, STRENGTHS, AND MENTAL HEALTH AMONG CHINESE TRANSGENDER AND GENDER NON-CONFORMING INDIVIDUALS

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Stigma, Strengths, and Mental Health among Chinese Transgender and Gender Non-conforming Individuals

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CERTIFICATE OF ORIGINALITY

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ABSTRACT

Introduction: Transgender and gender non-conforming (TGNC) people refer to individuals who consider that their gender does not conform to their sex assigned at birth or the binary gender classification imposed by culturally defined norms. TGNC people are often confronted with widespread stigma, which is a reportedly critical factor contributing to their adverse mental health outcomes such as psychological distress and depression. The stigma manifests itself in multiple forms, which remain understudied. In addition, few studies consider the positive resources of TGNC individuals in an unfavorable environment. Thus, this study focused on enacted, anticipated, and internalized stigma simultaneously and their associations with mental health status among TGNC people in the context of mainland China, and also explored the roles of their strengths in affecting the mental health status in the adversity.

Methodology: This research adopted explanatory sequential mixed methods, aiming to assess the relationships among stigma, strengths, and mental health status among Chinese TGNC people in the quantitative research, and understand more details about how the stigma and strengths of Chinese TGNC individuals affected their mental health status in the complemented qualitative research. In study 1 of the quantitative research, I used a questionnaire survey to measure the enacted stigma, anticipated stigma, internalized stigma, community consciousness, social support, identity pride, self-esteem, resilience, and mental health status in Chinese TGNC people. Hierarchical multiple regression was used to examine the relationships among stigma, strengths, and

mental health status, and moderation analysis was further performed to see the moderating effects of strengths. Study 2 of qualitative research conducted follow-up semi-structured interviews with TGNC individuals to gain more understanding of the impacts of stigma and strengths on their mental health status, aiming to elaborate and validate the results in study 1.

Results: There were a total of 399 Chinese TGNC people in study 1. High rates of stigma were reported by the participants, and poor mental health outcomes were also showed in TGNC people that almost a half of the TGNC individuals showed symptoms of negative mental health outcomes and low level of well-being status. As I hypothesized, the enacted stigma, anticipated stigma, and internalized stigma were significantly associated with the variance of mental health outcomes among TGNC people. The TGNC individuals with a higher level of stigma were at higher risks of negative mental health outcomes. Among their psychological strengths, social support, identity pride, and resilience were found to play buffering effects in negative mental health status, but their community consciousness and self-esteem were likely to aggravate the detrimental relationships between stigma and mental health status.

In study 2, ten themes were identified in the follow-up interviews, including experiences of pervasive adversity, negative feelings of adversity, concealment and negative expectations of anticipated stigma, internalized stigma – “I had a transphobia of myself”, support from family and partner, support from people around and community members, identity pride for being special, self-esteem – both a weakness and a protection, and resilience for bouncing back. Study 2 validated the detrimental

influence of stigma on mental health status and that some strengths helped them recover from the adversity. It also elaborated more details about the mixed effects of community consciousness and self-esteem of TGNC individuals in affecting their mental health status.

Conclusions: Overall, the findings of this study advanced our understanding of the stigma, strengths, and mental health status of Chinese TGNC people and shed light on their psychological needs, which also provided some clinical and policy implications for improving their psychological status and living conditions.

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CONTENT

CHAPTER ONE INTERODUCTION

Transgender and gender non-conforming (TGNC) people have gained an increase in public visibility during the recent decades. TGNC people refer to the people who feel incongruence between their sex assigned at birth and their gender identity. It is an umbrella term for the individuals whose gender identity or expression differs from the culturally-bound gender associated with one‘s assigned birth sex (White Hughto, Reisner, & Pachankis, 2015). Many people know about TGNC people according to some films and celebrities. For instance, the famous American movie Boy Don't Cry described the life of a trans man (who was female assigned at birth and gender identity was male) named Brandon. He dressed as a boy and did everything that he thought a boy should do, such as smoking, driving, and dating a girl. However, others kept telling him that he was a girl, and he was eventually killed in a hate crime by two males because of his gender identity. The film was controversial, but it brought the life of TGNC people to the public. There are also some TGNC celebrities, such as the minister of Taiwan Executive Yuan named Tang Feng and the Chinese dancer named Jin Xing. They have come out as TGNC people, which increases the exposure to this group.

For me, I completed my master's degree in Shanghai, and I majored in psychology. During that period, I had an internship as a psychotherapist in the Shanghai Mental Health Center. It gave me a preliminary understanding of TGNC people. Some TGNC people came to the psychological clinic for consultation, and when I assisted my teacher in psychological assessments, I heard about some stories of them. Some TGNC people

expressed worries about the feeling of incongruence between their sex assigned-at-birth, for they thought the incongruence might be "abnormal." Some TGNC people talked about their experiences of being misunderstood and being rejected by others, including parents, peers, and colleagues, because of their gender identities. I remember I heard a trans woman came to the psychological clinic and talked about her experiences that her parents denied her gender identity. She felt disappointed that her parents thought she might have a psychological disorder, and they also discouraged her from dressing as a female. However, when she talked about another man who was her boyfriend, her eyes lit up. She said that this man knew her and accepted her as she was, and also made her braver to face an unfriendly social environment. She said that she might consider doing the sex reassignment surgery when the technology of this surgery was more mature, which might be helpful for her to have a "normal" marriage and life.

As I know, TGNC people have been pathologized for a long time because the transsexualism of TGNC people was treated as a curable disease in psychiatry during the past decades by being listed in the handbooks for treatment of mental disorders (American Psychiatric Association, 1980). It used to be defined as Gender Identity Disorder (GID) in psychiatry (American Psychiatric Association, 1994). Until the DSM-5 in 2013, GID was changed into Gender Dysphoria to refer to the distress of incongruence between one's sex assigned at birth and gender identity (American Psychiatric Association, 2013, p.451). The update has included the issues of TGNC people in the field of sexual health rather than mental disorders and reduced the pathologization of TGNC people to protect them from experiencing potential injustice

treatments and discrimination as transsexualism is no longer considered as a type of mental disorder (Drescher, Cohen-Kettenis, & Winter, 2012).

Unfortunately, many TGNC people have been suffering in the midst of their experiences of unfair treatments due to their gender identities, leading to their psychological distress. Based on the stories of TGNC people whom I have met, I can see their struggles through their interpersonal conflicts and negative perceptions of judgments from others. On the other hand, I can feel they are striving to adapt to society as well. I further read an autobiography written by Jun (2010), who was a transgender man (who was female assigned-at-birth and gender identity was male) and struggles related to his gender identity were also reported. He described the experience of discrimination and harassment during his growth and employment, and his family also discouraged him from behaving like a male during his early years. Based on the enacted experiences, he said he felt isolated and behaved resistance against others.

Before this study, I interviewed one of my transgender friends about his lived experiences related to his gender identity. He is a transgender man working as an orthopedist. He told me when he was in school, he experienced verbal harassment from his classmates, and some of them even tried to figure out his gender by forcing his clothes off. Currently, he also chose not to disclosure about his gender identity in his working place. His mother chose to ignore his gender identity instead of giving him support, probably due to her worries that he may get hurt in society because of his vulnerable status as a transgender person, but the ignorance and rejection also made him feel depressed. When talking about his romantic relationship, he felt happy about

finding a girl that accepted his gender identity and treated him as a man, but he also expressed anxiety and disappointment that the family of his girlfriend would not accept their relationship. He said he always felt hopeless when thinking about his experiences, and he could not imagine what a satisfying life would be like for him.

The experiences of TGNC people impressed me, and I started to study the negative impacts of adversity on them. I learned the term of stigma in the process. Stigma is "an attribute that was deeply discrediting," and it leads to the socially devalued or deviant of a person (Goffman, 1963, p. 3). It is a "mark" that the individual is "devalued," and it is also the reflection of the "discreditable characters" from social interactions (Link & Phelan, 2006). Due to the restriction of the gender binary in society and a long-time pathologization of TGNC people, a widespread stigma of them might exist. For instance, gender-related discrimination, rejection, and harassment from others can be manifestations of stigma. From internal perspectives, some TGNC people choose to conceal their gender identity to avoid potential rejection from others, and they may endorse views of others to devalue themselves because of their gender identity, which is also manifestations of stigma.

When leading to socially devalued or deviant, stigma might have adverse impacts on the psychological status of a person, so based on my research interests, I conducted a systematic review of 30 studies about the relationships between stigma and psychological status among TGNC people. But it should be noted that the studies I reviewed are mainly conducted in certain countries such as the United States and certain European countries like the United Kingdom and Netherlands (Sweileh, 2018). As

stated in the review of Valentine and Shipherd (2018), 80.5% of the American TGNC mental health studies were published in recent five years. In China, I have only found two studies to investigate the relationships between stigma and psychological status among TGNC people, and they just included a few manifestations of the enacted stigma, such as discrimination and bullying. Researchers seem to have little knowledge about the stigma and psychological needs of TGNC people in the Chinese context.

In addition, although TGNC people seem to experience stigma and an unfavorable environment, many TGNC people whom I have met are still very friendly and motivated. Through the stories I heard from TGNC people and also the interview with my TGNC friend, I realize that the support from others, including their romantic partners and friends, can be very important. More importantly, their inner resources and personal qualities make them more positive to adapt to society when they face adversity. For instance, the TGNC people who came to the psychological clinic to do the psychological assessments, they also showed hopeful for their future life. When I interviewed my friend, he said he considered himself as a good person to be kind, considerate, and hardworking. Self-esteem and self-efficacy can be helpful for them to adapt to the relatively unfavorable environment positively.

Above all, my interests focused on the relationships between stigma and their mental health status among Chinese TGNC people. Meanwhile, I started to pay attention to their positive qualities and would like to investigate how their inner resources and personal strengths contribute to their mental well-being in the face of stigma. In this thesis, I first conducted the literature review of the stigma, strengths, and

mental health of TGNC people to identify the research gaps and my research area. Then I introduced my theoretical framework in this study to help me develop my research. After that, I wrote my research methodology about the participants, procedure, measures, and analysis, and I also reported the results of the characteristics information, the relations of different kinds of stigma with their mental health outcomes, and the roles of their psychological strengths in the relations. On the basis of results, some discussions were conducted. At last, I highlighted the significance and limitations of this study.

CHAPTER TWO LITERATURE REVIEW

This chapter reviews the concepts of transgender and gender non-conforming (TGNC) individuals, and I further synthesize the studies of stigma, strengths, and mental health status among TGNC people from contemporary perspectives. At the end of the chapter, I outline the research gaps in the field of TGNC studies for the research direction of this study.

2.1 Concepts and medical definitions

Transgender and gender non-conforming (TGNC) people refer to the individuals whose gender identity or expression differs from the culturally-bound gender associated with one‘s assigned birth sex (White Hughto, Reisner, & Pachankis, 2015). Transgender individuals may identify themselves as trans men (female sex at birth and gender identities as transgender men or men) or trans women (male sex at birth and gender identities as transgender women or women), and not all TGNC people will identify themselves strictly into binary gender defined by cultural norms. Among TGNC people, some identify themselves as genderqueer, agender, and so forth and manifest the gender diversity among these people (Sutter, 2017).

TGNC people have some definitions in psychiatry and public health. Transsexualism was treated as a curable disease during the past decades by being listed in the handbooks for treatment of mental disorders (American Psychiatric Association, 1980), and it was first officially involved in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, American Psychiatric Association,

1980). In DSM-IV, transsexualism was revised to the definition of Gender Identity Disorder (GID), which referred to the people with cross-gender identification and felt discomfort with their own assigned sex at birth (American Psychiatric Association, 1994). In 2013, in the DSM-5, the most recent edition of DSM, GID was changed into Gender Dysphoria with the definition that "the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender" (American Psychiatric Association, 2013, p.451).

The International Classification of Diseases (ICD) prepared by the World Health Organization (WHO) provides another definition related to TGNC people (International Advisory Group for the Revision of Mental and Behavioural Disorders, 2011). ICD is an international standard for plenty of public or private institutes to define the range of eligible services. The version of ICD-10 included gender identity disorders in the chapter on Mental and Behavioral Disorders (World Health Organization, 2009). By contrast, the most recent version of ICD-11 revised the definition as Gender Incongruence in the chapter of Conditions Related to Sexual Health (Khoury et al., 2019). It defines Gender Incongruence as "a marked and persistent incongruence between an individual's experienced gender and the assigned sex, which often leads to a desire to 'transition,' in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual's body align, as much as desired and to the extent possible, with the experienced gender" (World Health Organization, 2018). Both updates in DSM and ICD have reduced the pathologization of TGNC people and protect them from

experiencing potential injustice treatments and discrimination as they no longer consider transgender as a type of mental disorder (Drescher, Cohen-Kettenis, & Winter, 2012).

Overall, the issues of TGNC people have become topics in sexual health instead of a mental disorder in recent years (Drescher, Cohen-Kettenis, & Winter, 2012). In this study, I adopt such more recent views of TGNC people and investigate the distress arising from the incongruence between their experienced gender and their sex assigned at birth.

2.2 Mental health issues among TGNC people

2.2.1 Global literature related to mental health issues among TGNC people

Currently, numerous studies focus more on mental health issues or mental disorders by categorizing TGNC people into sexual minority populations with lesbian, gay, and bisexual (LGB) people in the field of psychological, social work, nursing, and so forth, which involves extensive problems with various symptoms. A large sample (n=7403) of study targeting the non-heterosexual population in the UK examined their mental health status, especially the mental disorders of them (Chakraborty, Mcmanus, Brugha, Bebbington, & King, 2011). The study concluded their gender identities were associated with their higher prevalence of depressive episodes (adjusted odds ratio [OR]=1.80), anxiety disorders (adjusted OR=1.49), obsessive-compulsive disorder (adjusted OR=2.24), and even suicide attempts (adjusted OR=2.21) compared with heterosexual population. A review of 27 studies of lesbian, gay, bisexual, and

transgender (LGBT) people showed the increased risk of the prevalence of severe mental illness among them (Kidd, Howison, Pilling, Ross, & McKenzie, 2016). It synthesized the large sample data collected by survey-based methods and found the consistent results of studies that compared with the heterosexual population, non-heterosexual people were more likely to report psychosis experiences (OR=3.75, OR=2.56, and OR=2.30) (Chakraborty, McManus, Brugha, Bebbington, & King, 2011; Gevonden et al., 2014).

Poor mental health outcomes have also been highlighted when researchers specifically focus on TGNC people. In a review of 77 studies from 1997 to 2017 in the United States (Valentine & Shipherd, 2018), 64.49% of the studies chose to investigate the depressive symptoms among TGNC people, 42.86% of the studies investigated their suicidality, 25.97% of the studies assessed symptoms of anxiety, and 19.48% of the studies examined their posttraumatic stress symptoms. Numerous studies focused on the mental health status of TGNC people based on their incongruence feeling of sex assigned at birth and gender identity, and also their minority and marginalized status. Another review of 15 studies targeted transgender youths who were 5-29 years old, which suggested their higher prevalence of depressive symptoms compared with peers (Connolly, Zervos, Barone, Johnson, & Joseph, 2016). The review listed a study of 180 transgender people who were 12-29 years old, which showed 50.6% of them reported depressive symptoms (Reisner et al., 2016). Another study of 96 transgender people aged 12-24 years old showed that 35% of participants experienced depression, but the proportion of having suicide attempts was as high as 35% (Olson, Schrager, Belzer,

Simons, & Clark, 2015). Research in Europe also reported a high prevalence of mental health problems among TGNC people. Scandurra et al. (2018) investigated 149 TGNC adults in Italy, and they demonstrated that over 60% of the participants met the clinical cut-off of high depressive symptoms, and over 40% of them met the clinical cut-off of high anxiety symptoms.

2.2.2 Studies on TGNC people conducted in the context of Mainland China

There is little research on mental health status among TGNC people in the context of Mainland China compared to the studies in other countries, such as North American and European countries (Chen et al., 2019), but researchers also highlighted the poor mental health outcomes among this group. Yang et al. (2015; 2016) examined 209 transgender women in north China about their depression and anxiety status, and they found that 45.4% of them suffered from depressive symptoms and 34.5% of them suffered from anxiety symptoms. Transgender women with disadvantaged financial status experienced higher levels of anxiety compared with other transgender women. In line with the results of Yang and colleagues, studies (Li, Zhang, & Song, 2016; Zhao, Li, Song, & Zhang, 2018) conducted in Shanghai, the largest city in China, also found that levels of depression and anxiety among transsexuals were significantly higher than the general population. Researchers pointed out the transsexuals also got higher scores of other mental health issues such as interpersonal sensitivity, obsessive-compulsive, and psychoticism compared with the general population. A national survey of LGBT students in China (Wei & Liu, 2019) suggested that about 40% of them had suicidal

ideation, which was significantly higher than that of the general public (12%). However, compared with this result, another national survey of suicidal ideation among Chinese transgender people (Chen et al., 2019) showed that 56% of them had suicidal ideation, especially for transgender women, the prevalence of suicidal ideation could be up to 60.7%, which were much higher than the counterparts of LGB population.

When I am preparing for the current study, I conducted a study of 70 TGNC people and 73 cisgender counterparts with a team of psychometricians in Shanghai Mental Health Center in order to investigate the mental health status of Chinese TGNC people (Zhang, Wang, Zhang, & Lo, 2020). Compared with the comparison group, TGNC people reported poorer mental health ($p<0.05$), especially for interpersonal sensitivity (1.66±1.23, $t=4.561$), depression (1.74±1.19, $t=5.345$), anxiety (1.71±1.16, $t=2.445$), and obsessive-compulsive (1.78±1.31, $t=4.940$), the mean scores of TGNC people nearly reached moderate levels of symptoms (score reached 2 points) among these mental health issues. The results were consistent with earlier studies about the poor mental health of TGNC people (Li, Zhang, & Song, 2016; Zhao, Li, Song, & Zhang, 2018). Researchers in these studies also reported poor mental health outcomes such as high levels of depression, anxiety and obsessive-compulsive of Chinese TGNC people compared with the scores of the national norm.

2.2.3 Factors influencing mental health status of TGNC people

For poor mental health outcomes stated in numerous studies, TGNC people have some unique risk factors compared with their counterparts of the LGB population.

Because of the incongruence between their sex assigned at birth and gender identity among TGNC people, their gender expression may lead them to experience discrimination, violence, and harassment from various perspectives (Valentine & Shipherd, 2018). For example, they may experience institutional discrimination in employment and healthcare (Valentine & Shipherd, 2018). Interpersonal violence such as verbal, physical, or psychological violence from family and peers were also reported in TGNC studies (White Hughto, Reisner, & Pachankis, 2015; Valentine & Shipherd, 2018). These injustice treatments can result in their adverse mental health outcomes and let them postpone seeking assistance from healthcare services based on anticipation of future discrimination, which creates a vicious cycle in the process of their mental health recovery. Besides, compared with the infection rates of HIV/AIDS in other risk groups, including partners of people living with HIV (4.8%) or men who have sex with men (4.2%), due to more needle injection of drug and substance use related to their sex alternation, working as a sex worker, and high-risk sex behaviors (De Santis, 2009), HIV/AIDS infection rate among TGNC people was up to 27.7% in a systematic review of transgender people in the United States (Herbst et al., 2008). The high rate of infection was also considered as a risk factor for adverse mental health outcomes among TGNC people.

Overall, it can be seen that TGNC people may experience adverse mental health status and their mental health needs are obvious and critical, but their mental health status still needs to be understood from diverse perspectives. Various mental health issues and symptoms were pointed out among TGNC people in extensive studies, and

the research of TGNC mental health issues has been a rapidly growing area with increasing public visibility. As stated in the review of Valentine and Shipherd (2018), 80.5% of the American TGNC mental health studies were published in recent five years and focused on major cities such as Chicago and Boston. The results of a bibliometric analysis of transgender health (Sweileh, 2018) also pointed out the related articles were mainly retrieved from the United States and certain European countries such as the United Kingdom and the Netherlands. So the findings of these studies should not be generalized to other cultures and societies, and more studies should be conducted based on different samples around the world. Besides, previous studies focused more on mental health symptoms or disorders of TGNC people, but these may be part of the normal reactions due to pervasive unfair treatments such as discrimination and exclusion (Valentine & Shipherd, 2018).

2.3 Stigma among TGNC people

In the studies of vulnerable populations, stigma is a critical issue since it is related to stereotyping and status loss of vulnerable and marginalized groups (Link & Phelan, 2006). According to Goffman, stigma refers to "an attribute that is deeply discrediting, but it should be seen as a language of relationships, not attributes, is really needed" (Goffman, 1963, p. 3). He further explains that "an attribute that stigmatizes one type of possessor can confirm the usualness of another, and therefore is neither creditable nor discreditable as a thing in itself" (Goffman, 1963, p.3). Holding this view, Goffman emphasizes the stigma as a social construction instead of personal traits, and the stigma

can lead to the socially devalued or deviant of a person. So in this study, I adopt stigma as a "mark" that the individual is "devalued," and it is also the reflection of the "discreditable characters" from social interactions (Goffman, 1963; Link & Phelan, 2006).

Stigma has been stated as a critical public health problem among stigmatized populations as it is widespread and prevents their recovery process of such as HIV/AIDS and mental health issues. A review of the stigma among HIV/AIDS infected people (Earnshaw & Chaudoir, 2009) suggested a growing number of studies have concentrated on the stigma of people with HIV/AIDS. For example, they may experience enacted stigma such as rejection and discrimination from employment, which results in their disadvantaged status. Researchers emphasized that stigma may lead to adverse physical and mental health outcomes among infected HIV people, and also act as the barriers for them to take HIV prevention efforts such as testing the infection since they would like to avoid anticipated discrimination and rejection from healthcare providers (Earnshaw & Chaudoir, 2009). These are also the cases of people with mental health disorders. Corrigan (2006) described the stigma of mental disorders as a social attribution and summarized that people with mental health issues might be less likely to be hired and leased apartments since they were often stereotyped as dangerous and uncontrollable individuals by others. Even professionals in the field of mental health also admit to stereotyping people with mental disorders (Corrigan, 2006).

Due to the restrict of the gender binary in the society, high prevalence of poor mental health outcomes and HIV/AIDS infection among TGNC people (Baral et al.,

2013; Valentine & Shipherd, 2018), TGNC people have been pathologized for a long time, which results in the widespread stigma of them as reported by increasing studies. White Hughto, Reisner, and Pachankis (2015) conducted a systematic review by synthesizing different types of stigma among this group of people. They categorized the types of stigma as structural, interpersonal, and individual levels according to the means that TGNC people experienced. The structural stigma included norms and institutions that restricted the access of TGNC people to social resources. For instance, due to the social preference of gender binary, the high prevalence of unemployment was reported by TGNC people. Interpersonal stigma refers to discrimination, violence, harassment, and victimization in the daily lives of transgender people. The individual stigma refers to the internal consciousness such as negative beliefs of themselves and anticipations and avoidance of future negative responses from the society (White Hughto, Reisner, & Pachankis, 2015). Individual stigma may lead transgender people to feel shame about their own gender identity and reduce their self-efficacy of coping with the distress (Hendricks & Testa, 2012). For example, they are less likely to seek help from healthcare providers with a low level of self-care thoughts.

Stemming from Goffman's definition of stigma, Earnshaw and Chaudoir (2009) conceptualized three types of stigma as enacted stigma, anticipated stigma, and internalized stigma according to manifestations of stigma, which were adopted in several studies among TGNC people (Whitehead, Shaver, & Stephenson, 2016; Veale, Peter, Travers, & Saewyc, 2017; Brooks, Landrian, Nieto, & Fehrenbacher, 2019). The enacted stigma refers to the discrimination, rejection, and violence that the stigmatized

people have perceived in their lived experience. Anticipated stigma is the expectation and consequential concealment related to the future prejudice and discrimination of stigmatized people. For internalized stigma, it is the endorsement of the negative beliefs about themselves among the stigmatized people, and it is also called internalized transphobia in the TGNC studies (Earnshaw & Chaudoir, 2009; Whitehead, Shaver, & Stephenson, 2016).

In this study, I will also adopt definitions of three types of stigma-enacted stigma, anticipated stigma, and internalized stigma to investigate the stigma among TGNC individuals. When people are in a minority or marginalized status, they know they are socially devalued. So from the personal perspectives, these three types of stigma summarize the manifestations of both their internal personal perceptions and their external lived experiences (Earnshaw & Chaudoir, 2009). I can understand the perceptions and experiences of TGNC people by using definitions of the three types of stigma. Compared with cisgender people, a study of 169 rural TGNC people in the United States reported higher levels of three types of stigma ($p<0.001$, Whitehead, Shaver, & Stephenson, 2016). Thematic analysis based on enacted and anticipated stigma revealed the experiences of "disapproving judgment, negative labeling, rejection, and devaluing" among men who have sex with men (MSM), including TGNC people (Brooks, Landrian, Nieto, & Fehrenbacher, 2019). Studies showed the existence of three types of stigma among TGNC people, and they may manifest in complex ways in their daily lives.

2.4 Relationships between stigma and mental health among TGNC people

When reviewing the literature related to the stigma of TGNC people, stigma has been found as a critical cause of their adverse mental health outcomes, for it not only produces psychological stress but also restricts their access to healthcare services (Link & Phelan, 1995; Hatzenbuehler, Phelan, & Link, 2013). The existence of additional and unique stress among stigmatized people requires them to make more efforts to adapt to society than the people who are not stigmatized (Meyer, 2003). Socially stigmatized individuals commonly experienced stress caused by discrimination, rejection, and victimization in their daily life, and sexual minority individuals experienced more stress such as the concealment of their gender identity and the internalized homophobia or transphobia than the general stigmatized people (Meyer, 2003; Pitoňák, 2017)

I conducted a systematic review to understand various types of stigma that might impact mental health outcomes among TGNC people. A total of 807 studies were retrieved by searching seven databases, including Education Resources Information Center (ERIC), PsycINFO, Pubmed, Sociological Abstracts, Social Sciences Citation Index (SSCI), Social Service Abstracts, and the China National Knowledge Infrastructure (CNKI) databases. Both English and Chinese articles before March 2020 were identified through titles, abstracts, and keywords. I searched the articles by combining terms "transgender", " gender non-conform", " transsexual", " gender dysphoria", "transphobia", "genderqueer", "mental health", "mental illness", "mental disorders", and "stigma". The studies should meet the criteria that they contained the relationship between stigma and mental health outcomes among TGNC people,

including quantitative studies, qualitative studies, and mixed-method studies, and they should publish in English or Chinese before March 2020. A total of 807 studies were retrieved, and 111 of them were duplicated studies. Twenty-seven studies were left after removing the duplicated studies and studies that did not meet the criteria. By tracking the references and contents of related articles, three more studies were identified, and a total of 30 studies were included in this review (see details in Appendix 1).

Among them, 29 studies were conducted in recent ten years, and 21 of them were conducted in the United States. The remaining nine studies were conducted in Europe, Asia, Africa, and Canada. Except for one qualitative study and one mixed-method study, the remaining studies were all quantitative studies. There was only one longitudinal study, and the others were cross-sectional studies. The sample size of the studies ranged from 18 to 1375, and there were 10824 TGNC participants in total. Most of the studies recruited TGNC adults and only three studies targeted TGNC youths, and another three studies recruited old TGNC people. Nine studies included both transgender and gender non-conforming people, and the other studies targeted transgender people. In recent years, for considering gender diversity, studies are gradual including gender non-conforming people in the studies in addition to transgender people. As individuals are increasingly coming out as gender non-conforming people, still very few TGNC studies investigated stigma and mental health. For research methods, a questionnaire survey was adopted in 28 studies, including 27 quantitative studies and one mixed-method study, which was the most commonly used method to investigate the status of stigma and mental health. For one qualitative research and one mixed-method research, both

of them chose to use semi-structured interviews as a qualitative method to understand the lived experience among TGNC individuals.

Nineteen studies focused on the experience of enacted stigma among TGNC people such as discrimination, victimization, gender abuse, bullying, and violence because of their gender identity or gender presentation (Earnshaw & Chaudoir, 2009), and the relationships between enacted stigma and mental health outcomes among TGNC participants (Veale, Peter, Travers, & Saewyc, 2017; Carter et al., 2019; Peng et al., 2019). A cross-sectional study with a large sample of 1375 adult transgender women was conducted in Cambodia by using respondent-driven sampling (Yi et al., 2018). This is the study with the largest sample size in this review, and it focused on enacted stigma among transgender women. The study showed the high prevalence of gender-based violence among them, such as having difficulty in finding a job (41.9%) and being sexually assaulted or abused (39.3%). Their prevalence of depressive symptoms was as high as 45%, and 21.8% of them got severe depressive symptoms. In this study, the finding suggested that transgender women with depressive symptoms were significantly more likely to report the experiences of gender-related violence, such as having difficulties in finding a job (adjusted odds ratio [AOR]=1.67, 95% confidence interval [CI]=1.29-2.16) or getting health services (AOR=2.40, 95%CI=1.50-3.82). In response to the risk in mental health issues, healthcare services and macro-level collaborations, including the support of their rights from government, organizations, and civil society, can be beneficial. It should be noted that researchers pointed out their selection bias of districts that the sample may not be representative in this study.

Besides, some studies conducted in the United States indicated that the enacted stigma such as discrimination and victimization were associated with symptoms of depression and anxiety, suicidal ideation, and PTSD among TGNC people (Carter et al., 2019; Fiani, 2018; Reisner et al., 2016; White Hughto, Pachankis, Willie, & Reisner, 2017). Bockting and colleagues (2013) investigated 1093 transgender adults in the United States about the relationships between their enacted stigma and psychological distress. The study used online recruitment and secondary data analysis to recruit large samples from both rural and urban areas in the United States, which showed the associations between their psychological distress and the experiences of enacted stigma ($B=0.137$; $p<0.001$). Researchers pointed out that the online questionnaire survey enabled the researchers to reach a large sample of this marginalized population. However, researchers were also concerned about the validity of data collected from the Internet.

Among 30 studies of the review, two studies were conducted in China (Peng et al., 2019; Yang et al., 2016). Yang and colleagues (2016) examined the association between discrimination from friends and anxiety symptoms among 209 Chinese transgender women, which suggested a positive correlation between them ($t=-0.178$, $p<0.05$). Peng et al. (2019) suggested the school bullying may be related to suicidal ideation among 385 TGNC adolescents (OR=1.68, 95%CI=1.04-2.70, $p=0.03$). They collected the sample through the Internet, so they pointed out that it may be a concern of them about the validity of data since they could not control the status of participants when they filled in the questionnaires and whether they told the truth. Researchers further

emphasized that complicated factors of stigma such as discrimination and rejection rather than school bullying should be investigated for understanding associations between stigma and mental health outcomes (Peng et al., 2019). Through the review, it can be seen that the studies in China only focused on the relationships between enacted stigma and mental health outcomes among TGNC people. Few studies concentrated on the perspectives of anticipated stigma and internalized stigma in a Chinese context.

Given that psychological stress may be affected by perceptions of TGNC people, some studies studied the effects of anticipated and internalized stigma on mental health outcomes (Hoy-Ellis & Fredriksen-Goldsen, 2017; Chodzen, Hidalgo, Chen, & Garofalo, 2019; Gamarel et al., 2019). Gamarel and colleagues (2014) studied 191 couples of transgender women and their cisgender partners in the United States about the gender-based stigma and psychological status. They emphasized the anticipation of rejection among transgender women in their romantic relationships, which may be related to their symptoms of depression and anxiety (Gamarel, Reisner, Laurenceau, Nemoto, & Operario, 2014; Gamarel et al., 2019). A series of studies conducted in Italy also examined depression and anxiety among TGNC people (Scandurra, Amodeo, Valerio, Bochicchio, & Frost, 2017; Scandurra et al., 2018). Researchers found that their internalized stigma was associated with depression and anxiety symptoms among TGNC people. In addition, Scandurra and colleagues (2018) reported the mediating role of their feeling of alienation between gender-related discrimination and depression (B=0.91, 95%CI=0.17-2.28) and anxiety (B=0.65, 95%CI=0.08-1.56), and their feeling of shame was also found to mediate the relationships between gender-related

discrimination and depression (B=0.55, 95%CI=0.08-1.55), which showed the internalized stigma mediated the associations between gender-related discrimination and depression and anxiety among TGNC people.

2.5 Strengths of TGNC people in facing stigma

The psychological strength has been studied, and diverse classifications of it were developed by researchers. Erik Erikson (1982) studied strengths by focusing on personal characteristics. He came up with the idea that people developed their character strengths in different stages during their life span. For instance, individuals developed the strength of trust from their birth to age 1. When they entered puberty, their identity became coherent with the improvement of their social intelligence and spirituality, which was the strength they got in this period. But the stage approach was challenged since some strengths may not only appear in one period. Ellen Greenberger and colleagues (1975) classified strengths in personal and collective perspectives. They thought the reliance on oneself and identity could be the individual strengths. Besides that, collective strengths such as social commitment could also be crucial in the growth and development of individuals. Shalom Schwartz and colleagues (1995) also explored the strengths from individual and collective perspectives, and they pointed out that some strengths might be culturally emphasized in different contexts. Peterson and Seligman (2004) conceptualized strength as survival requirements of individuals, including their "satisfaction of biological needs, coordination of social interaction, and facilitation of societal functioning." Above all, the strengths are a mixed lot that some

of them might be psychological processes, and some can be psychological contents, which facilitate individuals to grow up healthily, take up the challenges in different life periods, and make oneself better adapt to the society.

Strengths were also explored among TGNC people since they were usually considered to be in a relatively unfavorable environment, and some of them may use their invulnerability and resilience to interact with adversity. In my systematic review, thirteen studies were found to examine the psychological strengths among TGNC people in order to explore whether their strengths play some roles in facing stigma. Among them, eight studies were conducted in the United States, three in Europe, one in Canada, and one in Asia. Researchers adopted the strength-based factors as mediators or moderators in the relations of stigma with mental health status among TGNC people, and the studies commonly examined one or two strength-based factors.

Nine studies in this systematic review focused on the roles of strength-based factors from a collective perspective. The support from others was the most commonly assessed factor by researchers, including social support (Carter et al., 2019; Chakrapani et al., 2017; Veale, Peter, Travers, & Saewyc, 2017), peer support (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013), partner support (Gamarel et al., 2019), and family support (Scandurra, Amodeo, Valerio, Bochicchio, & Frost, 2017; Veale, Peter, Travers, & Saewyc, 2017). Veale and colleagues (2017) conducted research with a large sample of 923 participants in Canada. They mainly focused on social support and the connectedness with family among TGNC youths aged 14 to 25 years old. Researchers found that social support (OR=0.10, $p<0.01$) and family

connectedness (OR=0.11, $p<0.01$) could buffer the negative effects of stigma on suicidal ideation. Besides, a higher level of social support was likely to decrease the levels of depression (OR=0.11, $p<0.01$) and self-injury (OR=0.15, $p<0.01$). In another large sample study of 1093 transgender individuals in the United States (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013), a high level of peer support given by other transgender individuals showed a significant moderating role (B=-0.156, $p<0.05$) in the relationship between enacted stigma and psychological distress, while a low or moderate level of peer support did not show that. Results indicated that the influences of lived experiences of stigma could be pervasive, and the transgender people were likely to ameliorate the impacts by keeping in regular contact with other community members.

When in a stressful environment, community connectedness could be the strength of TGNC people since they are likely to understand the circumstances and support each other in the face of adversity (Meyer, 2015). Hobfall and colleagues (2002) emphasized the community's belief that "being part of a closely-knit social fabric in itself generates successful confrontation with life problems (i.e., ‘I succeed because I am part of a social group that values me’). "In the selected studies of this systematic review, the role of community was also highlighted (Breslow et al., 2015; Jäggi et al., 2018). Breslow and colleagues (2015) adopted the collective strength of community action posited by Meyer (2015) to see its potential buffering effect among 552 TGNC adults in the United States. However, a higher level of community connectedness was found to strengthen the relation of internalized stigma with psychological stress (B=0.03, t=2.28). They

explained that a higher level of community interaction with other TGNC people might also mean a higher risk of being exposed to a context of transphobia, which was likely to increase the impacts of internalized transphobia on their psychological distress.

In addition to the collective strengths, seven studies were found to explore the roles of personal strength-based factors, including resilience (Breslow et al., 2015; Chakrapani et al., 2017; Jäggi et al., 2018; Scandurra, Amodeo, Valerio, Bochicchio, & Frost, 2017; Scandurra et al., 2018) and coping strategies, such as avoidant coping, internalization coping, and detachment coping (White Hughto, Pachankis, Willie, & Reisner, 2017; Puckett, Maroney, Wadsworth, Mustanski, & Newcomb, 2020). Coping strategies may vary with diverse life circumstances or even within an individual, so that studies focused on various coping strategies. When synthesizing the studies in my systematic review, resilience was the most commonly examined factor among the studies. In recent years, there have been numerous discussions about the definition and connotation of resilience. Block and Kremen (1996) used to consider resilience as a personal trait that enabled people to maintain emotional stability after trauma or stress. Resilience was also regarded as a vertical adversity recovery ability in some studies (Li, Chi, Sherr, Cluver, & Stanton, 2015; Luthar, Cicchetti, & Becker, 2000), and Bonano (2004) defined resilience as a process of oneself to successfully adapt to adversity. Several studies adopted resilience as resilient qualities of individuals, and in this way, researchers focused on positive perspectives of an individual such as strengths and gifts to see their problems diminish built upon the strengths rather than only focus on the problems of individuals (Connor & Davidson, 2003; Richardson, 2011; Meyer, 2015).

Richardson and Waite (2002) considered resilience as the personal qualities to make oneself flexibly adapt to adversity, which was popular and Connor and Davidson (2003) further developed the 25-item Connor-Davidson resilience scale (CD-RISC) based on this definition to briefly measure the resilience by generally taking the personal qualities such as tenacity and optimism into account (Connor & Davidson, 2003; Yu & Zhang, 2007).

In my systematic review, five studies were found to investigate the resilience of TGNC people to see whether it played some roles when they faced gender identity stigma (Breslow et al., 2015; Chakrapani et al., 2017; Scandurra, Amodeo, Valerio, Bochicchio, & Frost, 2017; Jäggi et al., 2018; Scandurra et al., 2018). In these studies, two of them were conducted in Europe, two studies were in the United States, and one was in Asia. Chakrapani and colleagues (2017) investigated 300 transgender women and 300 men who had sex with men in India in order to see the relationships between their gender-related stigma and depressive symptoms. They found resilience as a mediator in the pathways. They defined resilience as a belief in one's own personal competence and acceptance of themselves and their lives, which enhanced their adaptation in society. They used a five-item of the Brief Resilient Coping Scale (BRCS) for assessing both dispositional (e.g., self-confidence, optimism) and situational (e.g., active problem solving) dimensions of resilient coping in TGNC people.

Some debates can be seen in the studies about the buffering effects of resilience in the relationships between stigma and mental health status among TGNC people. Jäggi and colleagues (2018) conducted a study in Swiss in 143 transgender adults. They tested

the pride in gender identity as personal resilience factors using the Gender Minority Stress and Resilience Measure (GMSRM). It did not find a resilience factor to moderate the relationships between stigma and depression among transgender people that the resilience only accounted for 1% of the variance of depressive symptoms. The results of the study in the United States (Breslow et al., 2015) also reported that resilience was not moderating the relationships between stigma and psychological distress among TGNC people. This study defined resilience as an individual variable to protect the person from harmful influences of stressors in society, and a six-item Brief Resilience Scale (BRS) was adopted to measure it. For resilience not playing the moderating role, researchers pointed out the resilience of TGNC people might not be effective enough to counter the adverse effects of gender identity stigma on mental health outcomes.

However, resilience was also found to be psychological stress-buffering in studies (Scandurra, Amodeo, Valerio, Bochicchio, & Frost, 2017; Scandurra et al., 2018). Scandurra and colleagues (2017; 2018) found that resilience moderated the relationships between stigma and depression and anxiety by investigating 149 transgender adults in Italy. They thought resilience was the adaptation of the risk factors and also the personal ability to "bounce back" in society. The Resilience Scale (RS) was used in this study to measure resilience. Researchers found resilience significantly moderated the association between everyday discrimination and depression among transgender people, and it was not surprised since the resilience could promote their social adjustments and draw upon the inner resources to buffer the adverse effects of unfair treatments on their mental health outcomes. When discussing resilience, it is not

like other strength-based factors since it can not be isolated from the social contexts. In relation to the conflicts and the adversity that TGNC people are faced with, resilience is commonly seen as an individual variable to promote one's adaptation to society, which is a significant strength that researchers discussed in the TGNC studies.

Overall, some strength-based factors have been studied, and researchers commonly categorized them from personal and collective perspectives. However, most of the TGNC studies explored the strengths in relation to the conflicts and adversity experienced by TGNC people. More strength-based factors such as their character strengths and general psychological strengths need to be identified. It should also be noted that the previous studies assessed only one or two factors of their strengths, and few studies examine their strength-based factors in a systematic way.

2.6 Identified research areas for this study

It can be seen that the number of TGNC studies has been growing rapidly in the last decade, and limitations in the literature have been found in previous reviews.

First, the studies are mainly conducted in certain countries, such as the United States and certain European countries like the United Kingdom and the Netherlands (Sweileh, 2018). As stated in the review of Valentine and Shipherd (2018), 80.5% of the American TGNC mental health studies were published in recent five years and focused on major cities such as Chicago and Boston. Existing studies may not be able to generalize to TGNC people in other cultures. Second, several studies have focused on problems and adversity environments, and they have explored the stigma and mental

health outcomes of TGNC people, but few studies consider the roles of their strengths when they face adversity. Even when I found studies focusing on the strength-based factors, researchers only explored the roles of one or two positive factors instead of examining their strengths in a systematic way. It is important for researchers to focus on the positive perspectives of individuals and build upon the strengths to see their problems diminish rather than only focus on the problems of individuals (Richardson, 2011). Strengths are a mixed lot that some of them might be psychological processes, and some can be psychological contents, which facilitate individuals to grow up healthily, take up the challenges in different life periods, and make oneself better adapt to the society. According to the literature review, some of the strength-based factors such as social support and resilience have been considered, but more factors need to be understood and identified.

2.7 Theoretical framework

2.7.1 Minority stress theory

Minority stress theory describes the effects of stress on mental health outcomes among stigmatized individuals or groups, which is adopted in many lesbian, gay, bisexual (LGB), and transgender and gender non-conforming (TGNC) studies (Meyer, 2003; Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Meyer, 2015; White Hughto, Reisner, & Pachankis, 2015). Minority stress is defined as "the excess stress to which individuals from stigmatized social categories are exposed as a result of their social, often a minority, position" (Meyer, 2003, p. 3). Among stigmatized people,

they are required to make more efforts to adapt to society due to discrimination, rejection, and prejudice in their daily life. Sexual minority individuals may experience more stress, such as the concealment of their gender identity and the internalized homophobia or transphobia, than the general stigmatized people (Meyer, 2003; Pitoňák, 2017).

To express the process of minority stress among TGNC people, minority stress theory proposes the distal and proximal stressors in the process. Meyer and colleagues (2008) defined the distal stressors as objective conditions and events related to discrimination and prejudice. Researchers considered the stressors experienced by the sexual minority population as the stressors related to their gender identity stigma, and the distal stressors were mainly categorized by them into manifestations of enacted stigma (Earnshaw, & Chaudoir, 2009). Currently, numerous studies have reported the countless discrimination and prejudice among TGNC individuals along with stigma and stereotypical views (Pitoňák, 2017). For example, several researchers stated the employment discrimination was the most common reason for them to turn to substance use and prostitution (Xavier, Bobbin, Singer, & Budd, 2005; Wright, 2003), and in California, around 70% of transgender communities reported unemployed or underemployed (Letellier, 2003). Besides, TGNC people often face subtle expressions of prejudice and discrimination, including the discomfort expressions by others, harassment, etc. (Nadal, Skolnik, & Wong, 2012).

Minority stress among TGNC people also includes proximal stressors. The proximal stressors in the minority stress theory refer to "subjective because they rely

on individual perceptions and appraisals" (Meyer, 2003, p. 5). Internalized stigma, which is often called internalized transphobia among TGNC people, is their turning of negative social responses related to the gender non-conforming identity against themselves (Hatzenbuehler, 2009; Sapareto, 2018), which is the self-stigmatization of negative concepts of "self." The expectations of negative responses from others and the concealment of sexual identity (Pitoňák, 2017) are also proximal stressors, which are identified as manifestations of anticipation stigma among TGNC people (Earnshaw, & Chaudoir, 2009; Whitehead, Shaver, & Stephenson, 2016). Overall, proximal stressors are categorized into manifestations of internalized stigma and anticipated stigma (Earnshaw, & Chaudoir, 2009), and they are found to be psychological processes resulting in higher risks of adverse mental health outcomes such as depression, anxiety, suicide ideation, guilty, distress, hypervigilance, etc. (Abelson, Lambevski, Crawford, Bartos, & Kippax, 2006; Pitoňák, 2017; Sapareto, 2018).

However, some researchers thought the minority stress theory ignore the general or unspecific factors related to both stigmatized groups and groups that are not stigmatized, and these factors also play important roles when discussing relationships between the stigma or stressors and the psychological outcomes among minority groups (Hatzenbuehler, Corbin, & Fromme, 2008; Hatzenbuehler, 2009). Synthesized the views of researchers that the general psychological factors should also be focused on, Hatzenbuehler (2009) came up with psychological mediation framework, which concentrates on the mediators of the individual and interpersonal psychological process by using stigma-related stressors as the starting point and mental health status as the

outcome. He explained that although individuals might experience some mediators before they experience the stressors, the mediators in the psychological mediation framework would significantly be altered after being activated by stigma-related stressors.

Several researchers further considered some mediators in the psychological mediation framework as moderators. For example, resilience was seen as a potential moderator between minority stress and psychological status, and its buffering effect was tested in studies among TGNC people (Breslow et al., 2015; Scandurra, Amodeo, Valerio, Bochicchio, & Frost, 2017; Jäggi et al., 2018). Although there are some debates about mediators and moderators of the general psychological factors adopted in the minority stress theory, the psychological mediation framework provides the idea that the general psychological factors can be considered into the pathway about the associations between stigma-related stressors and psychological outcomes.

2.7.2 Minority strengths model

With recognizing minority stress theory as leading explanations of health disparities of TGNC people, the minority strengths model highlights several notable personal and collective strengths found to be prominent in diverse minority populations (Perrin, Sutter, Trujillo, Henry, & Pugh Jr, 2020). This model considers that the minority stress theory fails to explain why some TGNC people remain healthy in the face of adversity. In previous studies, researchers only involve one or two strength-based factors to see their moderating roles. So the minority strengths model combines both personal and

collective strengths together into a comprehensive theoretical model that might allow TGNC people to maintain or attain wellness as they face adversity and marginalization (Fredriksen-Goldsen, Kim, Bryan, Shiu, & Emlet, 2017).

In the minority strengths model, collective strength-based factors that enable TGNC people to positively adapt to society include social support and community consciousness (Hill & Gunderson, 2015; Pflum, Testa, Balsam, Goldblum, & Bongar, 2015). Social support is largely thought to be a protective factor because of its nature, strength, and availability, and it can help provide for an individual's basic social and psycho-emotional needs (Kaplan, Cassel, & Gore, 1977). When faced with stressful events, social support may exert buffering effects against the negative health outcomes of individuals, and it is often seen as a moderator between the adversity such as stigma and the mental health outcomes among TGNC people (Bockting, Miner, Swinburne Romine, Hamilton, Coleman, 2013; Carter et al., 2019; Scandurra, Amodeo, Valerio, Bochicchio, & Frost, 2017; Veale, Peter, Travers, & Saewyc, 2017). Besides, community consciousness, including the connection, affiliation, and identification with a community, can also be a strength-based factor for TGNC people. A community can be organized related to diverse things such as beliefs, behaviors, and demographic characteristics (Herek & Glunt, 1995). For TGNC individuals, the community can provide them a sense of belonging and identification with some shared culture and common experience such as "coming out" and pride flags (Herek & Glunt, 1995), which can further help them buffer against stigma and stressors.

The personal strength-based factors in the minority strengths model involve

identity pride, self-esteem, and resilience (Perrin, Sutter, Trujillo, Henry, & Pugh Jr, 2020). Identity pride means that an individual can accept the identity, derive satisfaction from, and fully immerse themselves in that identity (Cass, 1979). According to the social identity theory, when TGNC individuals assign themselves to the TGNC community by forming a related identity, they might produce allegiance to the group, and further identity pride (Bussey, 2011, p. 606). The identity pride might help promote the feeling of self-worth and further predict positive mental health outcomes (Fredriksen-Goldsen, Kim, Bryan, Shiu, & Emlet, 2017). The identity pride is likely to manifest one's self-esteem, which refers to one's sense of self-worth (Du, King, & Chi, 2017), and it can contribute to the resilience of TGNC people when they are in the face of stigma or adversity. Resilience embodies the personal qualities of people that enable them to survive and thrive despite adversity in society (Connor, & Davidson, 2003). People might experience disruptions by changes, challenges, stressors, and adversity. To get through the process of disruptions, personal qualities contributing to resilience is considered as the driving force within individuals. It drives people to "fulfill their potentials, seek wisdom, strive for perfection, be altruistic, and to be in harmony with her/his source of spiritual strength" (Richardson 2002).

Overall, the minority strengths model highlights several collective and personal strength-based factors that may help minority or marginalized groups to improve their mental health outcomes when they are in the face of an unfavorable environment. It summarizes the notable strengths instead of only examining one or two protective factors. But it should be noted that this is a relatively new model that the strength-based

factors have hardly been tested at the same time about their roles in the face of the adversity, and these factors also vary with context, gender, culture origin, and so forth (Rutter, 1985; Connor, & Davidson, 2003). When focusing on Chinese TGNC people in this study, the status of their strengths-based factors still needed to be explored.

2.7.3 Conceptual model

In this study, I adopted minority stress theory and the minority strengths model to see the relationships between gender identity stigma and mental health status among TGNC people with considering their strength-based factors as protective factors in facing gender identity stigma (Meyer, 2003; Hatzenbuehler, 2009; Richardson, 2011; Perrin, Sutter, Trujillo, Henry, & Pugh Jr, 2020). When I conducted the systematic review of the relationships between stigma and mental health status, minority stress theory was the most commonly used theory for it contains multiple stigma-related stressors from diverse perspectives and also illustrated the potential causality in the relationships (Hatzenbuehler, 2009; Lam et al., 2010; Scandurra, Amodeo, Valerio, Bochicchio, & Frost, 2017; Aaron, & Rostosky, 2019; Chen et al., 2019). For understanding the relationships between stigma and mental health status among TGNC people, I combined the stigma-related stressors with the concepts of different types of stigma and used the experiences of stressors as manifestations of stigma in order to assess their stigma status. In the theoretical framework, I consider distal stressors of discrimination, violence, and victimization as manifestations of enacted stigma. For proximal stressors, I use internalized transphobia as the internalized stigma among TGNC people

(Earnshaw & Chaudoir, 2009; Scandurra et al., 2018) and categorize concealment of gender identity and anticipation of future negative responses like rejection as manifestations of anticipated stigma.

Except for focusing on the stressors specifically among TGNC people, I also consider the strength-based factors as the positive aspects among TGNC people in order to explore how they maintain or attain positive mental health outcomes in the face of minority stressors related to their gender identity stigma (Hatzenbuehler, 2009). The minority strengths model provides both collective and personal strength-based factors (Perrin, Sutter, Trujillo, Henry, & Pugh Jr, 2020), which will be examined about their moderating roles in this study when TGNC people face three types of stigma.

CHAPTER THREE METHODOLOGY

In this chapter, my ontology stance and the accordingly epistemological paradigm are briefly introduced. Based on them, I elaborate on my research design, research aims, and research framework. In addition, the details of the methods are also introduced, including the participants, procedure, measures, and data analysis of this study.

3.1 The ontology and epistemology stance

In this study, my ontology stance is prone to pluralism (Johnson & Onwuegbuzie, 2004). I prefer a more moderate view of philosophical stance to think about reality. Being needs-oriented and problems-oriented, I hold the idea that reality is supposed to be considered based on "how well they work in solving problems." I recognize both "the existence and importance of the natural or physical world" and "the emergent social and psychological world" (Johnson & Onwuegbuzie, 2004). So in my study, for understanding the experienced stigma and strengths among Chinese TGNC people, I used research methods to observe the reality of human behaviors, such as their experienced discrimination and the concealment of their gender identities. Besides, I also explored their "social and psychological world" to explain more in detail about the perceptions, strengths, and feelings in the face of adversity.

Based on the ontology stance, my epistemological paradigm is pragmatism. A pragmatist concerns about applications and solutions to problems, and a pragmatist discovers the knowledge by both finding out and identifying the factual statements and understanding how the knowledge is constructed (Johnson & Onwuegbuzie, 2004).

Researchers have given some explanations and elaborations about pragmatism in social sciences (Murphy, 1990; James, 1975; Johnson & Onwuegbuzie, 2004). From their point of view, pragmatism states that “the current meaning or instrumental or provisional truth value of an expression is to be determined by the experiences or practical consequences of belief in or use of the expression in the world” (Johnson & Onwuegbuzie, 2004). The pragmatic rule is needs-oriented. For taking pragmatism as the epistemological paradigm, I consider the knowledge as “being both constructed and based on the reality of the world we experience and live in” (Johnson & Onwuegbuzie, 2004), and it can be approximately found out by using mixed methods.

As a pragmatist, I shall use two studies to explore both factual statements and constructed knowledge. In one study, I understood the stigma status among Chinese TGNC people and the potential relations of their experienced stigma with their mental health outcomes with considering the roles of their psychological strengths in the relations. I shall assess the individual behaviors and their lived experiences in this population in order to discover their potential associations and "probabilistic causal laws," which might be general patterns of the social reality (Tuli, 2010). In this way, I considered that the factual statements in the existing world could be understood through objective ways. I did the research quantitatively to let the numbers speak for the social patterns and realities. I held the quantitative methodology, which I was going to emphasize on testing the hypotheses related to my research aims, and correspondingly, I measured variables on the basis of the hypotheses to find out the potential relations. I tried to consider myself to be detached, although the statistical choices and

interpretation of results could still be influenced based on my prior experiences and research perspective.

On the basis of exploring the objective and factual statements, as a pragmatist, I shall also explore how the knowledge was constructed. I turned to TGNC individuals to understand their "social and psychological world." In this way, I adopted qualitative methodology and immersed myself into the process of understanding TGNC individuals in order to explain more in details about their perceptions, strengths, and feelings in the face of adversity.

Overall, when taking the pragmatism paradigm, I consider myself to be both detached and involved when focusing on different needs, so I hold the mixed methods combining both quantitative and qualitative methodology. When aiming at discovering the social patterns and realities of the world, I emphasize on testing the hypotheses related to my research aims, and correspondingly, I measure variables on the basis of the hypotheses to find out the potential relations. When aiming to understand the constructed knowledge, I explore the answers to research questions related to how individuals work, solve problems, and what helps them survive. The evidence they provide is finally extracted tentatively (Johnson & Onwuegbuzie, 2004).

3.2 Research design

As for the study design, I considered myself as a pragmatist, so that this research used explanatory sequential mixed methods. So there were two studies in my research, I conducted quantitative research first, and then I explained more in detail by conducting

qualitative research on the basis of the quantitative results. (Johnson & Onwuegbuzie, 2004).

On the one hand, quantitative methods are commonly used when a study includes "factors that influence an outcome, the utility of an intervention or understanding the best predictors of outcomes" (Creswell, 2003). Adopting a deductive logic, the quantitative study begins with the theories to come up with the hypotheses, and then the study measures variables to prove or disprove them (Lorenzetti, 2007). In study 1, combining with the minority stress theory and the minority strengths model, I examined the relationships between stigma and mental health among Chinese TGNC people with considering their strengths in facing adversity.

Under the broad category of quantitative methods, I used a questionnaire survey to examine the individual behaviors among TGNC people, which is a kind of quantitative research design. Survey approach is a "questionnaire administered to a sample of a population in order to identify trends in attitudes, opinions, behaviors or characteristics" (Creswell, 2005). With regards to investigate the trends of the experienced stigma, strengths, and mental health status among Chinese TGNC individuals, the results of surveys can be helpful to describe their current conditions, status, thoughts, and so forth, and further help me synthesize the social patterns of their living conditions (Lorenzetti, 2007).

On the other hand, qualitative research is discovery and induction. The researchers involve themselves in the qualitative research as the primary research “instrument” to conduct data collection and analysis. So in study 2, I involved myself in conducting

follow-up interviews with TGNC individuals as a complemented study for study 1. I could gain more details about their stigma and strengths in order to elaborate and validate the roles of their stigma and strengths in affecting their mental health status.

As for the research methods of study 2, I used follow-up semi-structured interviews with open-ended questions to understand how the stigma and strengths of Chinese TGNC individuals affected their mental health status. Open-ended questions give TGNC participants the chance to express their opinions related to their experiences, rather than being restricted to the psychometric measures that might have some "pre-existing, culturally biased assumptions" (Wang, Koh, & Song, 2015).

In a pragmatic position, I mixed the methods in an explanatory sequential way to find better chances to answer the research questions from multi-level perspectives (Johnson & Onwuegbuzie, 2004). By combining two approaches, this study used scales for getting primary results and used follow-up semi-structured interviews to collect diverse types of data. By systematically integrating and triangulating two types of data, the study synthesized the strengths of both of them, and I'm able to have a more comprehensive understanding of the research problems (Fetters, Curry, & Creswell, 2013; NIH Office of Behavioral and Social Sciences, 2018). The mixed methods research was able to help me elaborate and validate the results by synthesizing the data from both quantitative and qualitative approaches (Greene, Caracelli, & Graham, 1989). This research was approved by the Human Subjects Ethics Sub-Committee of the Hong Kong Polytechnic University.

3.3 Study 1 of quantitative research

3.3.1 Research aims and hypotheses

Study 1 of the quantitative study aimed to assess the relationships among stigma, strengths, and mental health outcomes among TGNC people (see details in Figure 1). I examined enacted stigma, anticipated stigma, and internalized stigma in predicting mental health outcomes, including negative mental health outcomes of psychological distress and depression and positive mental health status of well-being status. Besides, according to the minority strengths model, I examined the moderating roles of strengths in the relationships between stigma and mental health outcomes, and the strengths-based factors included community consciousness, social support, identity pride, self-esteem, and resilience. Based on the research aim, there were six hypotheses:

1. Enacted stigma, anticipated stigma, and internalized stigma were significantly associated with the variance of psychological distress.
2. Enacted stigma, anticipated stigma, and internalized stigma were significantly associated with the variance of depression.
3. Enacted stigma, anticipated stigma, and internalized stigma were significantly associated with the variance of well-being.
4. Social support, community consciousness, identity pride, self-esteem, and resilience had moderating effects in the associations between three types of stigma and psychological distress.
5. Social support, community consciousness, identity pride, self-esteem, and resilience had moderating effects in the associations between three types of stigma

and depression.

6. Social support, community consciousness, identity pride, self-esteem, and resilience had moderating effects in the associations between three types of stigma and well-being.

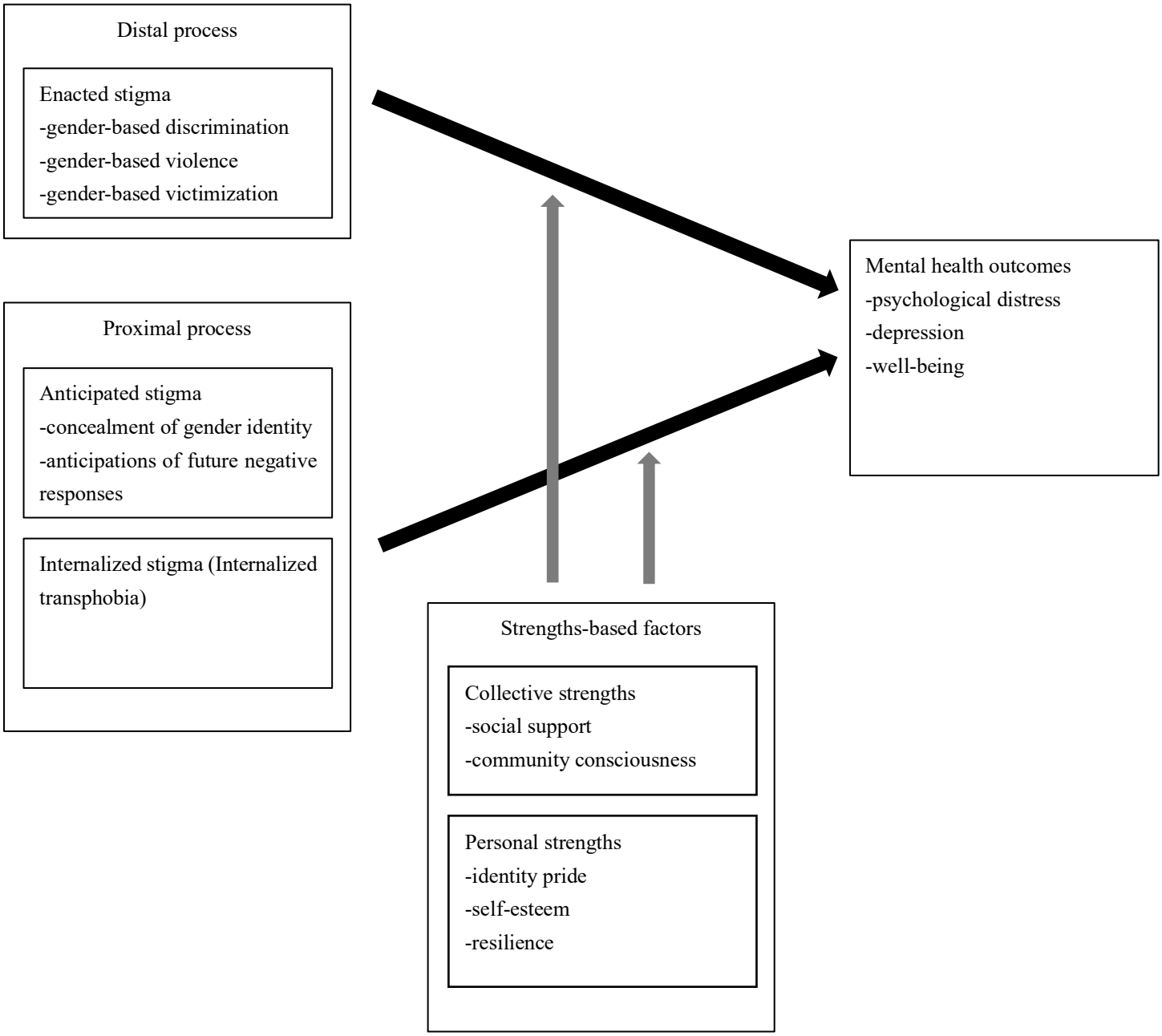

Figure 1 The research framework of the study 1

3.3.2 Participants and procedure

The study recruited TGNC people both at the Shanghai Mental Health Centre and online platform. Shanghai is the largest city in China. All TGNC people in Shanghai who intend to endorse themselves into sex reassignment treatment, or get a diagnosis of gender dysphoria, are required to take psychological assessments in this center. Shanghai Mental Health Centre is a psychiatric hospital of the "Three-A" level (the highest level hospital in China). In this hospital, gender dysphoria can be diagnosed by authoritative experts of the psychosexual field from the clinical psychiatry department, so that numerous TGNC individuals come to the psychological clinic or psychometric department of Shanghai Mental Health Center to conduct psychological assessments or psychological counseling. The effective minimum sample size was 98 for the TGNC individuals that this study intended to recruit. The sample size is calculated by using G*power 3.1 (Faul, Erdfelder, Lang, & Buchner, 2007) to identify the sample size with an alpha of 0.05, power of 0.80, and a 0.13 R^2 for medium effect size (Cohen, 1988, p.413).

From June 2020 to December 2020, I recruited every TGNC individual who came to do the psychological assessments in the psychological clinic and psychometric department of the Shanghai Mental Health Center. In the psychological clinic, every Monday and Thursday had the clinic for diagnosing gender dysphoria. I distributed the scales to them after getting their informed consent. They participated in the study on a

voluntary basis, and it would not cause any consequences for them if they refused to be participants in the study. In the psychometric department, TGNC individuals were asked by psychometricians whether they were willing to take the scales after they completed their psychometric tests, and they completed the scales distributed by psychometricians on a voluntary basis. Psychometricians could be more neutral since they were not endorsed in the process of sex-reassignment treatments of TGNC individuals. There would be no consequences for TGNC people if they refused to take the scales. A total of 58 TGNC individuals who came to the psychological clinic and psychometric department were asked whether they would like to participate in the study after they completed the psychological assessments or psychological counseling, and finally, 38 TGNC people agreed to complete the survey. The response rate was 65.5%, and all the questionnaires were qualified after being reviewed.

Besides, I recruited TGNC people through their online non-profit community, which was the Trans Well-being Team that aimed to improve the living environment and the mental health status of Chinese TGNC people. Trans Well-being Team was one of the biggest online TGNC communities in mainland China so its geographic spread could help me reach more TGNC individuals. Due to the influence of COVID-19, TGNC individuals could be more willing to participate in the research through the online way. This study was advertised as a survey of the stigma, strengths, and mental health status among Chinese TGNC people through this online community. When participants were voluntary to be involved in the study, they were directed to the online survey with the informed consent and inclusion criteria as the beginning page.

Participants who confirmed the informed consent and met the inclusion criteria would be showed the survey introduction, and then they were able to respond to the items. There were some inclusion criteria: participants should be Chinese who were 18 or above 18 years old without severe cognitive functioning impairments since they would be required to complete the scales and questionnaires by themselves. Besides, participants should identify themselves as TGNC individuals. Participants were required to complete the scales for measuring their enacted stigma, anticipated stigma, internalized stigma, social support, community consciousness, identity pride, self-esteem, resilience, mental health symptoms, and well-being. Before participating in the research, written informed consent should be obtained from them.

3.3.3 Measurements

Participant's demographic information. At the beginning of completing the scales, participants were required to provide their demographic information, including age, sex assigned at birth, gender identity, education, marital status, socioeconomic status, etc. In addition, I also asked about their status related to their gender identity, including the status of "coming out" and the status of the gender transition process. In this study, the transition process required medical transition such as hormone injection and sex reassignment surgery.

Enacted stigma. The enacted stigma refers to the lived experience of unfair treatment of individuals (Earnshaw & Chaudoir, 2009). This study used subscales of Gender-related Discrimination, Gender-related Rejection, and Gender-related

Victimization in the scale of The Gender Minority Stress and Resilience Measure (GMSRM; Testa, Habarth, Peta, Balsam, & Bockting, 2015). The subscales were self-reported with 17 items (e.g., *I have had difficulty finding employment or keeping employment, or have been denied promotion because of my gender identity or expression; I have had difficulty finding a partner or have had a relationship end because of my gender identity or expression; I have been threatened with being outed or blackmailed because of my gender identity or expression*), and each item had four options related to their lived experience of discrimination, rejection, and victimization, which were *Never; Yes, before age 18; Yes, after age 18; and/or Yes, in the past year*. One score would be added for choosing any option with *Yes*, and the total score of the subscales was the sum of all items. When targeting TGNC people, the subscales had shown good reliability and validity (Testa, Habarth, Peta, Balsam, & Bockting, 2015). For the Chinese version, this study has done the back-translation of the subscales. For back-translation, four experts were endorsed in this process (Baldacchino, Bowman, & Buhagiar, 2002). At first, I translated the English version of the subscales into the Chinese version since I had the background of stigma and mental health to determine the framework for the first draft. After that, a Chinese linguistic researcher, a psychometrician, and a researcher expertise in gender studies verified the draft compared with the English version for revising the words more appropriately, which should be the Chinese spoken language, and also compatible with the questions in the English version. An educator specialized in English then translated the verified version into English again, and cross-checking of both the Chinese version and English back-

translation version was conducted by comparing them with the original English version of subscales. The Chinese version would be verified again if there were some inconsistent content among different versions, and then the Chinese version was ready for this study. In this study, the Cronbach's alpha of the three subscales of gender-related discrimination, rejection, and victimization were 0.888, 0.903, and 0.929, which showed their good psychometric properties.

Anticipated stigma. For TGNC individuals, anticipated stigma contains the negative expectations of future unfair and unfriendly treatments and also the concealment of their gender identity (Earnshaw & Chaudoir, 2009). Subscales of Negative Expectations for the Future and Nondisclosure in the scale of GMSRM were adopted to measure the anticipated stigma among TGNC participants. The two subscales contained 14 items, and they are self-reported by TGNC individuals (e.g., *If I express my gender identity or history, people would think I am disgusting or sinful; I don't talk about past experiences/change details*). It was a 5-point Likert scale ranging from 0 (strongly disagree) to 4 (strongly agree). The subscales have been tested and have shown good internal consistency among TGNC people (Testa, Habarth, Peta, Balsam, & Bockting, 2015; Sutter, 2017). This study has conducted back-translation for using among Chinese TGNC people. The process of back-translation was the same as the process of back-translation of subscales for measuring enacted stigma that four experts were involved in the process, including a Chinese linguistic researcher, a psychometrician, a researcher expertise in gender studies, and an educator specialized in English (Baldacchino, Bowman, & Buhagiar, 2002). The Cronbach's alpha of the

scales of Negative Expectations for the Future and Nondisclosure were 0.950 and 0.827 in this study, which showed good internal consistencies.

Internalized stigma. The internalized stigma of TGNC people focuses on the internalized negative beliefs about their own gender identity (Earnshaw, & Chaudoir, 2009). They endorse the negative response from others about themselves. The internalized stigma can also be called internalized transphobia among TGNC individuals. This study adopted the subscale of Internalized Transphobia in the scale of GMSRM to measure the internalized stigma among TGNC people. The Internalized Transphobia subscale was a 5-point Likert scale and also a self-reported scale involving eight items to measure the internalized negative beliefs about their own gender identity among TGNC individuals (e.g., *I envy people who do not have a gender identity or expression like mine*). It has shown good reliability and validity in the sample of TGNC people (Testa, Habarth, Peta, Balsam, & Bockting, 2015; Sutter, 2017). This study used the back-translation version for measuring Chinese TGNC individuals. The process of back-translation was the same with the process of back-translation of subscales for measuring enacted stigma. After I translated the English version of the subscales into the Chinese version, four experts, including a Chinese linguistic researcher, a psychometrician, a researcher expertise in gender studies, and an educator specialized in English, engaged in the process of back-translation. Good internal consistency was tested in this study that the Cronbach's alpha was 0.955.

Social support. Social support was measured by using the Social Support Rating Scale (SSRS; Xiao, 1994). SSRS was a self-reported scale containing ten items to

measure their objective support, subjective support, and utilization of social support. Each item had a score, and the total score was the sum of them. A higher score in total indicated a higher level of their social support. SSRS was first established by Chinese researchers Xiao and Yang (1987) based on both the international scales of social support (Henderson, Duncan-Jones, Byrne, & Scott, 1980; Sarason, Levine, Basham, & Sarason, 1983) and Chinese environment and culture. Over the years, this scale has been tested in numerous studies, and the internal consistency was between 0.89-0.94 (Xiao, 1994), which showed good psychometric properties.

Community consciousness. The Community Consciousness scale was used in this study to measure the community consciousness of TGNC people, including their community connectedness and solidarity in the related social causes (Herek & Glunt, 1995). This was a self-reported scale with six items (e.g., *I feel that it is important to keep informed about transgender and gender non-conforming issues*). To be more appropriate for the participants in this study, I altered the term "gay and bisexual" in the original items to the term "transgender and gender non-conforming", and the term "homophobia" was altered into "transphobia". Each item ranged from "strongly disagree" to "strongly agree" and higher scores showed a higher level of sense of community consciousness. In previous studies, the internal consistency of this scales ranged from 0.76 to 0.79 (Herek & Glunt, 1995; Perrin, Sutter, Trujillo, Henry, & Pugh Jr, 2020). This study used the back-translation version for measuring Chinese TGNC individuals. The process of back-translation was the same as the process of back-translation of subscales for measuring enacted stigma. The Cronbach's alpha was 0.901

in this study, indicating a good psychometric property.

Identity pride. The identity pride was measured by using the subscale of Identity Pride in the scale of GMSRM (Testa, Habarth, Peta, Balsam, & Bockting, 2015), which was a self-reported scale with eight items (e.g. *Comfortable revealing gender identity and sex to others*). Each item ranged from "strongly disagree" to "strongly agree", and higher scores showed a higher level of sense of identity pride. This scale has been tested, and the internal consistency was 0.90. In this study, I used the back-translation version in Chinese in order to measure the identity pride of Chinese TGNC people. The process of back-translation was the same as the process of back-translation of subscales for measuring enacted stigma. A good internal consistency of this scale was also indicated in this study (the Cronbach's alpha was 0.896).

Self-esteem. The Self-esteem Scale (SES) was used in this study to measure the level of self-esteem among Chinese TGNC people. It was a self-reported scale containing ten items. Each item ranged from "strongly disagree" to "strongly agree", and higher scores showed a higher level of self-esteem. This scale was first established by Rosenberg (1965), and it has been wildly used worldwide over past years. Ji and Yu (1999) first revised it into a Chinese version, and it has been tested with good psychometric properties that its internal consistency ranged from 0.83 to 0.89 (Han, Jiang, Tang, & WANG, 2005; Chen, Bi, & Han, 2015).

Resilience. Resilience was measured by using the Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003). CD-RISC is a self-reported scale, and it was first established by Connor and Davidson (2003) for participants to brief self-rated

their levels of resilience. It contained 25 items with rating on a 5-point Likert scale, from 0 (strongly disagree) to 4 (strongly agree). Participants gave their responses (e.g., I'm able to adapt to change) based on the experience in the previous month. Higher scores in total indicated a higher level of resilience. The Chinese version of CD-RISC was revised by Yu and Zhang (2007), which showed good psychometric properties.

Mental health symptoms. This study used the Symptom Checklist 90 (SCL-90) to investigate the negative mental health status of TGNC participants. SCL-90 was a commonly used self-reported scale for assessing mental health status in the clinic. It was first built in the 1970s (Derogatis, Lipman, & Covi, 1973; Derogatis, Rickels, & Rock, 1976), and now it is widely used throughout the world in diverse versions of different languages with well-established reliability and validity. This scale has 90 items for measuring nine dimensions of psychological symptoms: somatization (S), obsessive-compulsive (O), interpersonal sensitivity (I), depression (D), anxiety (A), hostility (H), photic anxiety (PH), paranoid ideation (PA), and psychoticism (PS). Each item has four options range from 0 (not at all) to 4 (extremely). The Chinese version of SCL-90 has also been revised with good internal consistency (Feng & Zhang, 2001). Based on previous studies of mental health among TGNC people, the score of whole SCL-90 was used for assessing the general psychological distress, and its subscale of depression (D) was commonly adopted to see the state of mood among participants (Li, Zhang, & Song, 2016; Scandurra, Amodeo, Valerio, Bochicchio, & Frost, 2017; Sapareto, 2018; Zhao, Li, Song, & Zhang, 2018). In this study, I also selected the total score of SCL-90 and its subscale of depression (D) to understand the negative mental

health status among TGNC individuals.

Well-being. In addition to collecting the negative mental health status, this study used World Health Organization Well-Being Index (WHO-5) to measure the positive mental health outcomes among Chinese TGNC individuals (Jahoda, 1958; Bech, 1999; Bech, Gudex, Staehr Johansen, 1996). WHO-5 was a self-reported scale containing five items to measure the subjective well-being status of individuals (e.g., *My daily life has been filled with things that interest me*), and each item ranged from "all of the time" to "none of the time" with scoring 5 to 0. It had been widely used in research all over the world and its validity and sensitivity were valued (Topp, Stergaard, Sndergaard, & Bech, 2015). The revised Chinese version had also been tested in large samples of Chinese people to show its good psychometric property (the Cronbach's alpha was 0.82; Ou et al., 2009).

3.3.4 Data analysis

Multiple methods of data analysis were adopted in this study to analyze the data. Descriptive analysis was used to summarize the demographic information and the general levels of enacted stigma, anticipated stigma, internalized stigma, strengths-based factors, and mental health status of TGNC participants. I chose a one-way analysis of variance (ANOVA) to explore the group differences among TGNC participants based on their age, gender identity, socioeconomic status, education, etc. Besides, Pearson's correlation and hierarchical multiple regression were conducted to see the relationships between different types of stigma, strengths, and mental health

status in TGNC individuals. The potential moderating role of strength-based factors was examined in the pathways between different types of stigma and mental health outcomes. After controlling the demographic information as covariates, the moderation analysis was processed by using model 1 of the PROCESS SPSS macro in 95% confidence intervals (CIs) with a 5000-sample bias-corrected bootstrapping procedure (Hayes, 2012). When a significant moderating role was reported, I would conduct a follow-up simple slope analysis, which could be helpful to understand the nature of interactions between variables at different levels. The variables analyzed in the study were mean-centered in order to reduce multicollinearity. I conducted all the analysis in IBM SPSS 23.0 and its computational tool PROCESS.

3.4 Study 2 of qualitative research

3.4.1 Research questions

By using explanatory sequential mixed methods, the complemented qualitative research aimed to understand more details about how the stigma and strengths of Chinese TGNC individuals affected their mental health status. Based on the research aim, open-ended questions were adopted to conduct the follow-up semi-structured interviews in an induction, exploration, and discovery way on the basis of the results in quantitative research. I had the research questions to guide this study:

- *What are the relationships between stigma and mental health status?*
- *What are the roles of their strengths in affecting their mental health status?*

Guided by the research questions, I involved myself in gaining an in-depth

understanding of participants by capturing the nuances of their real-life experiences and perceptions from the interviews and identifying related themes accordingly (NIH Office of Behavioral and Social Sciences, 2018).

3.4.2 Participants and procedure

Among TGNC participants in the quantitative research, I further invited participants who reported experiences of stigma to do semi-structured interviews. I invited the participants in the Shanghai Mental Health Center after they completed the questionnaire survey. I also advertised the recruitment of follow-up interviews at the online platform so that the TGNC participants who were willing to engage in the interview could contact me after completing the online questionnaire survey. I recruited the TGNC participants based on their availability for understanding more details about how their stigma and strengths affected their mental health status. The TGNC individuals who participated in the quantitative part were asked to participate in a 45-90-minute follow-up semi-structured interview if they reported the experiences of stigma in the quantitative assessments.

I had invited twenty participants who participated in the quantitative study, and eight of them agreed to participate in semi-structured interviews (the acceptance rate was 40%). All the participants participated on a voluntary basis. They were willing to express their opinions related to their lived experiences, and they were informed that no consequences if they refused to do the interviews. When the chosen TGNC individuals agreed to do the interviews, I interviewed them in the way they preferred,

either in a private and quiet room of Shanghai Mental Health Center or through online video. All interviews have ensured the confidentiality of participants. The interviews were recorded after they agreed, and I transcribed the contents of the interviews for further analysis. Before participating in the research, written informed consent was obtained from them.

The open-ended questions encompassed the real-life experiences related to stigma and strengths of TGNC people, and also their mental health status such as psychological status, feelings, and so forth. I communicated with them about how they perceive, interact with, and survive when they were in the face of different types of stigma-related stressors. I conducted semi-structured interviews with TGNC people who reported adversity of stigma experiences before, and I had the assumption that they had tried to find ways to adapt to the adverse context (Alessi, 2016). The following is a protocol of the interview:

1. *Could you please talk about the experiences you encountered due to your gender identity, and what influences and feelings do they bring to you?*
2. *How do you think about your gender identity? What influence and feelings do you think it brings to you and your life?*
3. *How do you cope with the stressors related to your gender identity and bounce back from the negative thoughts and feelings?*
4. *How do other people support you or disapprove you in your daily life? What influence and feelings do you think they bring to you and your life?*
5. *How do you think about the connectedness between you and TGNC community?*

What influence and feelings do you think it brings to you and your life?

6. *How do you evaluate yourself? How do the comments from others influence you? What influence and feelings do you think the evaluations bring to you and your life?*
7. *When we are talking about your gender identity and its related topics, what else do you think that might have some influence on your life due to your gender identity?*

3.4.3 Data analysis

In this study, thematic analysis was utilized to analyze the qualitative data. Thematic analysis is a flexible qualitative approach to provide a nuanced and detailed understanding of data by identifying, synthesizing, and reporting the themes of data (Braun & Clarke, 2006). Themes are the recurrent topics according to the identification among different sets of data. This study extracted themes in a deductive way (Hayes, 1997), which was guided by the theoretical perspectives of the minority stress theory and the minority strengths model, and also based on the results of study 1 to elaborate and validate (Johnson & Onwuegbuzie, 2004; Meyer, 2013; Perrin, Sutter, Trujillo, Henry, & Pugh Jr, 2020). I analyzed the contents of the interviews by using existing theories and results of study 1 as the direction and framework to further understand the stigma and strengths status among TGNC participants. The theories and quantitative results provided me with coding directions to reflect themes. I focused on the stigma mainly from the aspects of enacted stigma, anticipated stigma, and internalized stigma, and the strengths were mainly analyzed from their collective and personal perspective, including their community consciousness, social support, identity pride, self-esteem,

and resilience.

Data was analyzed through the process of thematic analysis (Braun & Clarke, 2006). For the contents transcribed from the interviews, I read them and noted the items of interest based on the results of study 1 and the theoretical background of the minority stress theory and minority strengths model. The items were sorted into codes and themes for further generating definitions of the contents of interviews. The themes were re-examined to compose a thematic map, and each theme was reported with its supporting data (Braun & Clarke, 2006). According to the self-reports of the TGNC individuals, I immersed myself in the interviews to find their experience, meaning, and language (Braun & Clarke, 2006). By using this qualitative method, I had the chance to elaborate and validate how their stigma and strengths affected their mental health status from their individual perspective.

For rigor of the qualitative part of this research, I recruited the participants who have experienced gender identity stigma in their daily life and were willing to share the related lived experience, which made sure the accuracy and adequacy of the information they may provide. The analysis was in a consultant of my chief supervisor. Besides, the contextual information about myself as a researcher was also considered in the process of reflexivity.

CHAPTER FOUR RESULTS OF STUDY 1

In this chapter, I reported the results of study 1, which was a quantitative study using a questionnaire survey. I reported the participant characteristics and their group differences, findings of correlations among stigma, strength, and mental health status, and the moderating roles of strengths among TGNC participants.

4.1 Participant characteristics

4.1.1 The general information of participants

There were 513 individuals giving their responses in the online survey. After I reviewed the questionnaires, 152 of them were excluded because of some reasons: not meeting the inclusion criteria of age, n=8; not meeting the inclusion criteria of gender identity, n=17; not correctly answering the questions of ensuring the survey quality (e.g., for guaranteeing the quality of your answers, please select "C" in this question), n=123; not giving their informed consents, n=4. There were 361 qualified online questionnaires left. Through both face-to-face and online recruitment, a total of 399 TGNC people were included in the final.

A total of 399 TGNC participants were included in the final sample. The average age of the participants was 25.31±4.79 years old, ranging from 18 to 52 years old. Most of the participants were young adults aged 18 to 30 years old, and only 10.6% of them were above 30 years old. As for the sex assigned-at-birth, 288 (72.2%) of the TGNC participants were males, and 111 (27.8%) were females. However, they showed diverse

gender identities that 100 of the participants identified themselves as trans men (female to male, FtM), 283 participants identified themselves as trans women (male to female, MtF), and 16 participants considered themselves as gender non-conforming people, such as gender fluid, gender non-binary, and genderqueer individuals.

This study also collected the demographic information of their education, income, marital status, living area, and whether they were the only child in their family. Among the participants, a larger proportion of the education level was bachelor's degree or above, which was reported by 289 (72.4%) TGNC people. Most participants (83.0%) reported their income status to be less than RMB 10,000 per month. Twenty hundred and eighty-nine (72.4%) of the TGNC participants were unmarried, and 87.5% of the participants lived in urban areas. Besides, due to the one-child policy in China, 233 (58.4%) of the participants reported as the only child of their family, more than the 166 individuals (41.6%) who had siblings.

In spite of the demographic information, the TGNC participants reported other general information related to their gender identities. Among the participants, 286 (71.7%) of them said that they had already "coming out" of their gender identities to the people around them, while 113 (28.3%) of them still chose to conceal their gender identities. A larger proportion (58.1%) of the participants responded that they had undergone the gender transition treatments, such as hormone injection and sex reassignment surgery. See details in Table 1.

Table 1 The general information of the TGNC participants

Characteristics		N(%)
Age	18-30 years old	354(89.4%)
	Above 30 years old	42(10.6%)
Sex assigned-at- birth	Male	288(72.2%)
	Female	111(27.8%)
Gender identity	Trans men	100(25.1%)
	Trans women	283(70.9%)
	Gender non-conforming	16(4.0%)
Education	High school, technical school diploma, or below	110(27.6%)
	Bachelor's degree or above	289(72.4%)
Monthly income	Less than RMB10,000	331(83.0%)
	RMB10,000 or above	68(17.0%)
Marital status	Unmarried	289(72.4%)
	Married or living together	97(24.3%)
	Divorced, separated, or widowed	13(3.3%)
Living area	Urban	349(87.5%)
	Rural	49(12.3%)
The only child	Yes	233(58.4%)
	No	166(41.6%)

"Coming out"	Yes	286(71.7%)
	No	113(28.3%)
In the transition process	Yes	232(58.1%)
	No	167(41.9%)

4.1.2 The general levels of stigma among TGNC individuals

The general levels of stigma were reported in this study. The full score of the enacted stigma was 17 points, while the average score of the enacted stigma was 10.37±6.51. Among the participants, only 52 of 399 TGNC participants (13.0%) reported that they had never experienced enacted stigma. There were 347 (87.0%) participants reporting the experiences of different types of enacted stigma, including discrimination (81.2%), rejection (81.2%), and victimization (78.2%). See details in Table 2.

Table 2 The enacted stigma of the TGNC participants

Characteristics	M(SD)		N(%)
Discrimination	3.15(2.00)	Never	75(18.8%)
		Yes	324(81.2%)
Rejection	3.63(2.40)	Never	75(18.8%)
		Yes	324(81.2%)
Victimization	3.60(2.51)	Never	87(21.8%)

	Yes	312(78.2%)

For anticipated stigma, I collected the attitudes of negative expectations for the future and nondisclosure of their gender identities among the Chinese TGNC participants. The average score of their anticipated stigma was 28.75±12.30 (the full score was 56 points). However, after categorizing the options of “strongly disagree” and “disagree” into “disagree”, and categorizing “strongly agree” and “agree” into “agree”, a large proportion of the participants showed a trend of negative attitude towards their gender identities. Above 70% of the TGNC participants showed their negative expectations from others if they disclosed their gender identities. In detail, they agreed that they were more likely to be rejected from others(67.4%), be in unemployment (67.4%), and even be victims of crimes or violence (57.4%). Accordingly, it was not surprising to find out that 89.5% of the participants reported their nondisclosure related to their gender identities. Specifically, above 70% of the participants chose to change their ways of talking (76.9%) and behaviors such as sitting, standing, walking, and gesturing (74.4%). Especially for their personal image, 86.7% of the TGNC participants stated that they were extra careful in the aspect of their dressing, and 82.0% of them avoided exposing their bodies in front of others.

The TGNC participants also showed a high rate of experiencing internalized stigma in this study. The average level of internalized stigma was 13.97±8.87 (the full score was 32 points). After categorizing their options into “disagree,” “neutral,” and “agree,” I found that 53.9% of the participants expressed their disagreements of the thoughts of

internalized negative beliefs toward their gender identities. However, 40.4% of the participants still admitted their internalized stigma, such as feeling like an “outcast” because of their gender identities. See Table 3.

Table 3 The anticipated stigma and internalized stigma of the TGNC participants

Items		M(SD)	Disagree	Neutral	Agree
			N(%)	N(%)	N(%)
Anticipated stigma	Negative expectations for future	25.59(9.32)	86(21.6%)	17(4.3%)	296(74.2%)
	Nondisclosure	17.16(4.42)	30(7.5%)	12(3.0%)	357(89.5%)
Internalized stigma		13.97(8.87)	215(53.9%)	23(5.8%)	161(40.4%)

4.1.3 The general levels of strengths among TGNC individuals

Strengths were reported by participants from collective and personal perspectives. This study collected the community consciousness and social support as manifestations of their collective strengths among the Chinese TGNC individuals. The average level of community consciousness was 17.73±5.11 (the full score was 24 points), and they commonly showed a positive attitude toward the TGNC community. Specifically, 79.2% of them thought that it was of great importance for them to be informed about the issues of the TGNC community and 79.4% of them stated that they positively support the activities of their community. However, the average level of social support among TGNC participants was 34.31±10.11, which was significantly lower than that of the

Chinese national normative samples (Mean=44.34, standard deviation=8.38; t=-19.806, p<0.01), but still in the range of the normal level of social support (score≥20; Xiao, 1994).

Identity pride, resilience, and self-esteem were adopted in this study to measure personal strengths. The average level of identity pride was 20.06±6.78 (the full score was 32 points), which showed a positive trend of satisfying and immersing themselves in their gender identity. A large proportion of participants expressed that they were unique and different. For instance, 63.9% of the participants thought that they were "special and unique." However, only 40.9% of them thought it was comfortable when disclosing their gender identities to others, and only 45.6% of them showed their pride in the gender identities, which was relatively smaller compared with the proportion of individuals who thought they were unique and different. In addition, the average level of resilience among the participants was 56.92±18.94. It was significantly lower than the average score of the Chinese normative samples (Mean=65.40, standard deviation=13.90; t=-8.942, p<0.01; Jing & Cheng, 2018). Similarly, the average level of self-esteem (Mean=22.37, standard deviation=3.51) was also significantly lower compared with that of the Chinese normative samples (Mean=28.75, standard deviation=4.86; Liu, Cheng, Yao, & Zhang, 2010).

4.1.4 The general levels of mental health status among TGNC individuals

In regard to the mental health status, this study measured both the negative and positive aspects of TGNC participants. Based on previous studies of mental health among

TGNC people, this study selected variables of psychological distress, depression, and well-being. For the negative aspect of their mental health status, the average scores of psychological distress and depression were all reported to be in the range of mild to moderate levels (score≥2). Based on the general levels of mental health status, I further categorized the scores into different ranges, including the ranges of no symptoms to mild (score<2), mild to moderate (2≤score<3), and moderate or above levels (score≥3). According to the results, there were almost half of the participants experienced mild, moderate, and even major symptoms of psychological distress (42.9%) and depression (48.9%), which reflected the negative mental health outcomes among the TGNC individuals. See details in Table 4.

Table 4 The negative mental health status of the TGNC participants

Variables	M(SD)	No symptoms to mild	Mild to moderate	Moderate or above
		N(%)	N(%)	N(%)
Psychological distress	2.09(0.85)	228(57.1%)	104(26.1%)	67(16.8%)
Depression	2.20(0.89)	204(51.1%)	118(29.6%)	77(19.3%)

As for the positive aspect of the mental health status among the participants, the average raw score of their well-being status was 14.09±13.45. According to the validity of WHO-5, when I multiplied the raw score by 4, the score≤50 may correspond to a low well-being status and a higher mortality rate (Topp, Stergaard, Sndergaard, & Bech,

2015). So after categorizing the score of the well-being status, more than half of the participants showed that their well-being status remained in a normal range, 42.1% of the participants showed a relatively low well-being status. The details were listed in Table 5.

Table 5 The well-being status of the TGNC participants

Well-being range	N	%
Low level of well-being (the score≤50)	168	42.1
Normal range (the score>50)	231	57.9

Note: the score was multiplied the raw score by 4 for analysis.

Low level of well-being: the score≤50, normal range: the score>50.

4.2 Group differences of stigma, strengths, and mental health status

After reporting the TGNC participants' characteristics and their general levels of the studied variables, this study analyzed the group differences of their stigma, strengths, and mental health outcomes based on their demographic information and other information related to their gender identities.

4.2.1 The group differences of stigma among TGNC individuals

Among the three types of stigma, there were numerous group differences. According to the results, participants assigned male at birth got a significantly higher score of enacted stigma than females (t=6.575, p<0.01), and compared with trans men and gender non-

conforming individuals, the score of trans women was also the highest (F=26.993, p<0.01). Participants who had a bachelor's degree or above got lower levels of enacted stigma (t=2.404, p=0.017) and internalized stigma (t=3.127, p<0.01) compared with the individuals with high school, technical school diploma, or below. Among the TGNC participants, the divorces, separated, or widowed individuals demonstrated a higher level of internalized stigma, while the individuals who were in the status of married or living together showed the lowest level of internalized stigma (F=3.152, p=0.044). As for the living area, the participants living in rural areas were more likely to experience enacted (t=-2.776, p<0.01), anticipated (t=-3.522, p<0.01), and internalized stigma (t=-2.188, p<0.01) compared with the individuals living in the urban areas. In addition, due to the one-child policy in China, there was a large population of the only child in a family. The only child in this study expressed a significantly higher level of internalized stigma compared to those who had siblings in their families (t=4.688, p<0.01). The details can be seen in Table 6.

The participants also provided information related to their gender identities, and differences were shown in the results related to their different identity statuses. It can be seen that the TGNC individuals who chose to "come out" experienced significantly higher levels of enacted stigma (t=11.465, p<0.01) and anticipated stigma (t=4.121, p<0.01) compared with those who did not "come out" their gender identities to the people around them. In addition, for the individuals who completed or were in the process of gender transition, they were more likely to report the experiences of enacted stigma (t=12.514, p<0.01), anticipated stigma (t=6.668, p<0.01), and internalized

stigma (t=3.839, p<0.01) than the people who did not start the transition process. The details were listed in Table 6.

Table 6 The group differences of stigma among TGNC individuals

Characteristics		Enacted stigma			Anticipated stigma			Internalized stigma		
		M(SD)	*t*/F	*p*	M(SD)	*t*/F	*p*	M(SD)	*t*/F	*p*
Age	18-30 years old	10.23(6.51)	-1.286	0.199	28.87(12.50)	0.992	0.322	13.79(9.11)	-1.005	0.319
	Above 30 years old	11.60(6.50)			26.88(10.08)			14.86(6.16)		
Sex assigned-at- birth	Male	11.64(6.05)	6.575	$p<0.001$	29.09(11.97)	0.907	0.365	13.88(8.57)	-0.344	0.731
	Female	7.09(6.54)			27.85(13.14)			14.23(9.62)		
Gender identity	Trans men	7.43(6.75)	26.993	$p<0.001$	27.89(13.61)	0.323	0.724	14.28(9.74)	0.080	0.923
	Trans women	11.76(6.03)			29.04(12.05)			13.88(8.57)		
	Gender non-conforming	4.19(2.34)			28.94(6.88)			13.75(8.96)		
Education	High school, technical	11.64(6.29)	2.404	0.017	29.19(14.93)	0.391	0.696	16.37(9.85)	3.127	0.002

	school diploma or below									
	Bachelor's degree or above	9.89(6.54)			28.58(11.17)			13.06(8.30)		
Monthly income	Less than RMB10,000	10.33(6.58)	-0.278	0.781	28.94(12.47)	0.690	0.491	13.92(8.92)	-0.296	0.768
	RMB10,000 or above	10.57 (6.19)			27.81(11.52)			14.26(8.67)		
Marital status	Unmarried	10.23(6.51)	2.376	0.094	29.53(12.52)	2.115	0.122	14.42(9.29)	3.152	0.044
	Married or living together	10.29(6.44)			26.72(11.53)			12.23(7.58)		
	Divorced, separated, or widowed	14.23（6.34）			26.54(11.84)			17.23(5.90)		
Living area	Urban	10.02(6.47)	-2.776	0.006	27.94(12.10)	-3.522	$p<0.001$	13.60(8.73)	-2.188	0.029
	Rural	12.76(6.38)			34.47(12.46)			16.55(9.53)		
The only child	Yes	10.80(6.41)	1.562	0.119	29.67(12.88)	1.771	0.077	15.62(9.45)	4.688	$p<0.001$

	No	9.77(6.63)			27.46(11.36)			11.66(7.40)		
"Coming out"	Yes	12.41(5.58)	11.465	$p<0.001$	30.41(11.51)	4.121	$p<0.001$	14.49(8.82)	1.837	0.067
	No	5.21(5.84)			24.55(13.26)			12.68(8.90)		
Complete or in the	Yes	13.35(5.21)	12.514	$p<0.001$	32.11(11.12)	6.668	$p<0.001$	15.40(8.98)	3.839	$p<0.001$
transition process	No	6.24(5.86)			24.08(12.38)			12.00(8.34)		

4.2.2 The group differences of strengths among TGNC individuals

For the status of psychological strengths among the TGNC participants, I analyzed the collective and personal strengths based on the different groups of the general characteristics among the TGNC participants. The community consciousness and social support were adopted in this study to measure the participants' collective strengths, and there were some significant differences in their different characteristics. In regard to the community consciousness, the participants who were 18-30 years old showed a significantly higher level of community consciousness compared with the individuals above 30 years old (t=3.847, p<0.01). The individuals who were in the status of unmarried had the highest sense of community consciousness (F=9.153, p<0.01) but the lowest level of social support (F=20.499, p<0.01). In addition, the participants who earned RMB 10,000 or above per month and who lived in urban areas showed a significantly higher level of social support compared with those who earned less than RMB10,000 per month (t=-3.701, p<0.01) and those who lived in rural areas (t=2.678, p<0.01). See details in Table 7.

Table 7 The group differences of collective strengths among TGNC individuals

Characteristics		Community consciousness			Social support		
		M(SD)	*t*/*F*	*p*	M(SD)	*t*/*F*	*p*
Age	18-30 years old	18.09(4.90)	3.614	0.001	34.07(10.12)	-1.353	0.177

	Above 30 years old	14.67(5.91)			36.31(10.30)		
Sex assigned-at-birth	Male	17.56(5.16)	-1.127	0.260	34.82(9.93)	1.614	0.107
	Female	18.20(4.94)			33.00(10.51)		
Gender identity	Trans men	18.05(5.14)	1.471	0.231	33.30(10.79)	2.021	0.134
	Trans women	17.52(5.18)			34.88(9.91)		
	Gender non-conforming	19.56(2.87)			30.63(8.47)		
Education	High school, technical school diploma, or below	17.35(5.83)	-0.916	0.360	33.51(11.02)	-0.980	0.328
	Bachelor's degree or above	17.88(4.80)			34.62(9.75)		
Monthly income	Less than RMB10,000	17.80(5.07)	0.571	0.568	33.48(9.79)	-3.701	$p<0.001$
	RMB10,000 or above	17.31(5.41)			38.38(10.73)		
Marital status	Unmarried	18.31(4.61)	9.153	$p<0.001$	32.42(9.74)	20.499	$p<0.001$
	Married or living together	16.57(6.08)			39.53(9.74)		
	Divorced, separated, or widowed	13.54(4.59)			37.62(6.29)		
Living area	Urban	17.79(5.13)	0.435	0.664	34.79(10.10)	2.678	0.008
	Rural	17.45(5.02)			30.69(9.59)		
The only child	Yes	17.68(5.24)	-0.240	0.810	33.93(10.91)	-0.935	0.350
	No	17.81(4.92)			34.86(8.88)		
"Coming out"	Yes	17.97(4.99)	1.438	0.151	33.79(9.80)	-1.647	0.100
	No	17.15(5.36)			35.64(10.79)		

Complete or in the	Yes	18.09(4.66)	1.615	0.107	33.49(10.19)	-1.920	0.056
transition process	No	17.23(5.64)			35.46(9.93)		

The identity pride, resilience, and self-esteem were measured for exploring the personal strengths among the Chinese TGNC participants. The participants ranging from 18 to 30 years old expressed a higher level of identity pride compared with those who were above 30 years old (t=4.030, p<0.01), but the self-esteem of the younger group was significantly lower than the older group (t=-2.142, p=0.033). The participants assigned male at birth showed a higher level of identity pride compared with the participants assigned female at birth (t=2.315, p=0.021). Besides, there was a significant difference of identity pride among the three gender identity groups, including trans men, trans women, and gender non-conforming individuals (F=3.212, p=0.041), and the identity pride of trans women was significantly higher than the trans men in the multiple comparisons (LSD; t=1.937, p=0.014). In regard to different education levels, the individuals with the education level of bachelor's degree or above had a higher level of resilience than the others (t=-2.247, p=0.026). For those who earned RMB10,000 or above per month, they showed a higher level of resilience (t=-4.051, p<0.01) but a lower level of self-esteem (t=2.909, p<0.01) in the results. For the marital status among the participants, those who were married or living together showed the highest level of resilience (F=4.823, p<0.01) but the lowest level of self-esteem (F=8.871, p<0.01). On the contrary, the individuals who were divorced, separated, or widowed got the opposite results that they expressed the highest level of

self-esteem and the lowest level of resilience compared with the other groups based on the marital status. Besides, the individuals living in urban areas had a significantly higher level of identity pride (t=2.122, p=0.034) and resilience (t=2.814, p<0.01) than those living in rural areas.

In addition to the demographic information, I also collected the information related to their gender identities of the TGNC participants. The results indicated that the TGNC individuals who chose to "come out" (t=2.138, p=0.033) and endorse themselves into the gender transition (t=2.380, p=0.018) might have a higher level of identity pride. Besides, the TGNC people who were in the process of transition or had completed the process were more likely to express a high level of self-esteem compared with those who did not start the transition process (t=2.285, p=0.023). For the level of resilience, no significant differences were found between the TGNC individuals in the different status of "coming out" or transition process. See details in Table 8.

Table 8 The group differences of personal strengths among TGNC individuals

Characteristics		Identity pride			Resilience			Self-esteem		
		M(SD)	*t*/*F*	*p*	M(SD)	*t*/*F*	*p*	M(SD)	*t*/*F*	*p*
Age	18-30 years old	20.56(6.69)	4.030	*p* < 0.001	57.29(19.09)	1.101	0.272	22.31(3.46)	-2.172	0.034
	Above 30 years old	16.19(6.22)			53.88(17.78)			23.43(3.12)		
Sex assigned-at-birth	Male	20.55(6.47)	2.315	0.021	57.93(18.34)	1.721	0.086	22.45(3.64)	0.729	0.466
	Female	18.80(7.40)			54.30(20.27)			22.16(3.15)		
Gender identity	Trans men	18.59(7.43)	3.212	0.041	54.86(21.08)	1.885	0.153	22.28(3.16)	0.596	0.552
	Trans women	20.53(6.46)			57.99(18.35)			22.45(3.66)		
	Gender non-conforming	21.00(7.13)			50.81(12.96)			21.50(2.78)		
Education	High school, technical	19.06(7.65)	-1.677	0.095	53.19(21.39)	-2.247	0.026	22.56(3.77)	0.686	0.493

	school diploma, or below									
	Bachelor's degree or above	20.44(6.39)			58.34(17.76)			22.29(3.40)		
Monthly income	Less than RMB10,000	19.84(6.84)	-1.434	0.152	53.21(18.56)	-4.051	$p<0.001$	22.63(3.33)	2.909	0.005
	RMB10,000 or above	21.13(6.43)			65.24(18.74)			21.10(4.52)		
Marital status	Unmarried	20.34(6.64)	1.337	0.264	55.46(18.63)	4.823	0.009	22.39(3.39)	8.871	$p<0.001$
	Married or living together	19.54(7.28)			61.95(19.48)			21.80(3.63)		
	Divorced, separated, or widowed	17.69(5.66)			51.92(16.01)			26.08(3.15)		
Living area	Urban	20.33(6.66)	2.122	0.034	57.93(19.16)	2.814	0.005	22.24(3.47)	-1.583	0.119
	Rural	18.14(7.41)			49.86(15.96)			23.10(3.57)		
The only child	Yes	19.87(7.17)	-0.675	0.500	57.08(21.33)	0.214	0.831	22.24(3.72)	-0.835	0.404

	No	20.33(6.20)			56.69(15.03)			22.54(3.18)		
"Coming out"	Yes	20.51(6.74)	2.138	0.033	57.17(18.86)	0.416	0.678	22.55(3.68)	1.608	0.109
	No	18.91(6.76)			56.29(19.22)			21.92(3.01)		
Complete or in the	Yes	20.74(6.57)	2.380*	0.018	56.13(18.70)	-0.988	0.324	22.71(3.46)	2.285*	0.023
transition process	No	19.11(6.96)			58.02(19.28)			21.90(3.52)		

4.2.3 The group differences of mental health status among TGNC individuals

There were some differences in their mental health status among the TGNC participants related to their different characteristics. Among the participants, the levels of psychological distress (t=-1.972, p=0.049) and depression (t=-1.982, p=0.048) were significantly higher in the groups of people above 30 years old compared with the young adults aged 18-30 years old. For the individuals in different groups of sex assigned-at-birth and gender identities, there was no difference indicated in the results. The participants who got a high school, technical school diploma, or below showed significantly higher levels of psychological distress (F=4.572, p<0.01) and depression (F=4.223, p<0.01) compared with the individuals with bachelor's degree or above. Besides, the individuals in the status of married or living together were more likely to report lower levels of negative mental health problems and a higher level of well-being status according to the results. As for the living area and status of siblings, the participants living in rural areas and as the only child in the family were at higher risks of mental health problems. Especially, the participants who were living in rural areas got an average score below 50 points (Mean=49.71, standard deviation=21.09), which indicated a higher risk of low level of well-being and high rate of mortality (Topp, Stergaard, Sndergaard, & Bech, 2015). At last, apart from the demographic information, the TGNC participants who were in the status of "coming out" or endorsing themselves into the gender transition process reported higher scores of the mental health outcomes

than those who chose to conceal their gender identities or did not start the transition process. The TGNC participants who completed or were in the transition process also showed a significantly lower level of well-being compared with those who did not start the process (t=-3.518, p<0.01). Details were listed in Table 9.

Table 9 The group differences of mental health status among TGNC individuals

Characteristics		Psychological distress			Depression			Well-being		
		M(SD)	*t*/*F*	*p*	M(SD)	*t*/*F*	*p*	M(SD)	*t*/*F*	*p*
Age	18-30 years old	2.05(0.86)	-1.972	0.049	2.16(0.90)	-1.982	0.048	55.59(23.93)	-2.260	0.027
	Above 30 years old	2.32(0.73)			2.45(0.76)			62.48(17.93)		
Sex assigned-at-	Male	2.05(0.77)	-1.081	0.281	2.15(0.81)	-1.586	0.115	55.56(23.01)	-1.109	0.268
birth	Female	2.17(1.03)			2.33(1.07)			58.45(24.28)		
Gender identity	Trans men	2.19(1.07)	1.087	0.338	2.34(1.12)	1.927	0.147	60.16(23.94)	3.459	0.032
	Trans women	2.05(0.77)			2.14(0.81)			55.67(23.07)		
	Gender non-conforming	2.03(0.47)			2.32(0.58)			44.75(21.43)		
Education	High school, technical school diploma, or below	2.44(1.04)	4.572	$p<0.001$	2.54(1.07)	4.223	$p<0.001$	55.67(25.01)	-0.347	0.729

	Bachelor's degree or above	1.95(0.72)			2.07(0.78)			56.62(22.76)		
Monthly income	Less than RMB10,000	2.07(0.84)	-1.028	0.305	2.17(0.88)	-1.131	0.259	55.34(23.99)	-2.223	0.028
	RMB10,000 or above	2.18(0.90)			2.31(0.94)			61.35(19.49)		
Marital status	Unmarried	2.13(0.87)	7.833	$p<0.001$	2.26(0.93)	8.797	$p<0.001$	52.87(24.53)	13.553	$p<0.001$
	Married or living together	1.87(0.72)			1.92(0.74)			66.72(16.84)		
	Divorced, separated, or widowed	2.76(0.82)			2.79(0.73)			56.62(15.82)		
Living area	Urban	1.99(0.77)	-4.982	$p<0.001$	2.10(0.81)	-4.676	$p<0.001$	55.27(23.59)	2.126	0.034
	Rural	2.78(1.04)			2.87 (1.11)			49.71(21.09)		
The only child	Yes	2.18(0.94)	2.871	0.004	2.28(0.98)	2.419	0.016	58.75(24.05)	2.467	0.014
	No	1.95(0.69)			2.08(0.74)			53.01(22.02)		

"Coming out"	Yes	2.17(0.88)	3.315	0.001	2.27(0.92)	2.930	0.004	55.15(23.07)	-1.654	0.099
	No	1.88(0.72)			2.00(0.79)			59.43(23.96)		
Complete or in the	Yes	2.25(0.90)	4.872	$p<0.001$	2.36(0.94)	4.537	$p<0.001$	52.93(23.30)	-3.518	$p<0.001$
transition process	No	1.86(0.72)			1.97(0.77)			61.13(22.69)		

4.3 The associations among the stigma, strengths, and mental health status

In this part, I shall use Pearson's regression analysis to examine the bivariate correlations among the studied variables, and then, a further multiple regression analysis was adopted to see how the stigma and strengths contributed to the variance of the mental health status.

4.3.1 The associations among the stigma, strengths, and psychological distress

The bivariate correlations among stigma, strengths, and psychological distress were examined. I adopted the Cohen's benchmarks to see the levels of different bivariate correlations. In the Pearson's correlation analysis, the *Pearson's r* was 0.10 or above indicating a small level of correlation, the *Pearson's r* was 0.30 or above showing a medium correlation, and the *Pearson's r* was 0.50 or above indicating a large correlation (Breslow et al., 2015). So in this study, the results showed that the internalized stigma (r=0.536, p<0.001) was highly and positively correlated with depression. The enacted stigma (r=0.407, p<0.001), anticipated stigma (r=0.490, p<0.001), social support (r=-0.421, p<0.001), and resilience (r=-0.472, p<0.001) were found to be correlated with depression status in medium levels. The strengths-based factors, including community consciousness (r=-0.130, p=0.005), identity pride (r=-0.258, p<0.001) and self-esteem (r=0.193, p<0.001) were reported to be small correlated with the participants' depression level. The details were listed in Table 10.

Table10 The bivariate correlations among stigma, strengths, and psychological distress

	1	2	3	4	5	6	7	8
1. Enacted stigma								
2. Anticipated stigma	0.489***							
3. Internalized stigma	0.324***	0.630***						
4. community consciousness	-0.024	0.331***	0.114*					
5. Social support	-0.218***	-0.495***	-0.420***	-0.012				
6. Identity pride	0.028	0.077	-0.196***	0.617***	0.260***			
7. Self-esteem	0.204***	0.218***	0.186***	0.111*	-0.166***	-0.016		
8. Resilience	-0.225***	-0.419***	-0.418***	0.160**	0.622***	0.360	-0.319***	
9. Psychological distress	0.407***	0.490***	0.536***	-0.130**	-0.349***	-0.242***	0.234***	-0.472***

Note: *$p<0.05$, **$p<0.01$, ***$p<0.001$

In addition to the bivariate correlation analysis, I conducted the hierarchical multiple linear regression to see the relations of stigma and strengths with the psychological distress among the TGNC participants. Their demographic information of age, sex assigned-at-birth, gender identity, education, monthly income, marital status, whether the only child, Living area, and their information related to the gender identities including “coming out” and transition process were controlled as covariates to be put in the model 1. The enacted stigma, anticipated stigma, and internalized stigma were put in model 2, and the strengths-based factors were put in model 3. According to Table 11, the stigma and strengths were significant predictors in predicting the variance

of psychological distress among TGNC people. In the hierarchical multiple regression model, after controlling the demographic information of the TGNC individuals, three types of stigma contributed to an additional 24.3% of the variance of psychological distress (△F=55.979, p<0.01). In model 3, the strengths of TGNC individuals further explained another 7.7% of the variance of psychological distress (△F=12.279, p<0.01).

According to the results of the models, the stigma and strengths totally accounted for 52.5% of the variance of their psychological distress among TGNC individuals (R^2=0.525, F=23.137, p<0.01). Specifically, three types of stigma, including enacted stigma (t=2.618, p=0.009), anticipated stigma (t=3.960, p<0.01) and internalized stigma (t=4.644, p<0.01), were reported as significant predictors. For the psychological strengths, the community consciousness (t=-3.840, p<0.01), self-esteem (t=2.076, p=0.039) and resilience (t=-3.365, p=0.01) were reported to significantly contribute to the variance of depression.

Table11 Hierarchical multiple regression of stigma and strength in predicting psychological distress

Variables	*Model 1*		*Model 2*		Model 3	
	B(SE)	*β*	B(SE)	*β*	B(SE)	*β*
Age	0.272(0.136)	0.099*	0.156(0.115)	0.057	0.044(0.109)	0.016
Sex assigned-at-birth	0.240(0.137)	0.127	0.285(0.118)	0.151*	0.270(0.112)	0.143*
Gender identity	0.114(0.121)	0.066	0.094(0.102)	0.055	0.094(0.096)	0.055

Education	-0.352(0.093)	-0.186***	-0.294(0.079)	-0.155***	-0.275(0.074)	-0.145***
Monthly income	0.174(0.110)	0.077	0.184(0.092)	0.081*	0.280(0.089)	0.123**
Marital status	-0.029(0.081)	-0.018	0.003(0.068)	0.002	-0.058(0.067)	-0.036
The only child	-0.125(0.085)	-0.073	-0.020(0.072)	-0.012	-0.023(0.068)	-0.014
Living area	0.646(0.119)	0.262***	0.448(0.101)	0.181***	0.391(0.095)	0.158***
"Coming out"	0.006(0.109)	0.003	0.081(0.095)	0.043	0.007(0.089)	0.004
Transition process	-0.368(0.102)	-0.215***	-0.056(0.091)	-0.033	-0.069 (0.085)	-0.040
Enacted stigma			0.028(0.007)	0.218***	0.018(0.007)	0.138**
Anticipated stigma			0.011(0.004)	0.166**	0.016(0.004)	0.239***
Internalized stigma			0.029(0.005)	0.305***	0.023(0.005)	0.237***
Community consciousness					-0.034(0.009)	-0.205***
Social support					0.004(0.004)	0.050
Identity pride					-0.002(0.007)	-0.013
Self-esteem					0.020(0.010)	0.082*
Resilience					-0.008(0.002)	-0.177**
R^2	0.205		0.447		0.525	
F	9.904***		23.800***		23.137***	
$\triangle R^2$	0.205		0.243		0.077	
$\triangle F$	9.904***		55.979***		12.279***	

Note: *$p<0.05$, **$p<0.01$, ***$p<0.001$

4.3.2 The associations among the stigma, strengths, and depression

According to Pearson's analysis, the bivariate associations were all significant in between symptoms of depression and the other studied variables except for the community consciousness. Among the three stigma types, anticipated stigma (r=0.506, p<0.001) and internalized stigma (r=0.571, p<0.001) were reported to be positively correlated with depressive symptoms in high levels, while the resilience was negatively correlated with depression in a high level among the TGNC participants (r=-0.503, p<0.001). The enacted stigma (r=0.340, p<0.001) and social support (r=-0.421, p<0.001) showed medium correlations with depression according to the responses from the TGNC participants. For the bivariate associations between personal strengths and depression, identity pride (r=-0.258, p<0.001) and self-esteem (r=0.193, p<0.001) were reported to be small correlated with depressive symptoms. See Table details in Table 12.

Table12 The bivariate correlations among stigma, strengths, and depression

	1	2	3	4	5	6	7	8
1. Enacted stigma								
2. Anticipated stigma	0.489***							
3. Internalized stigma	0.324***	0.630***						
4. community consciousness	-0.024	0.331***	0.114*					
5. Social support	-0.218***	-0.495***	-0.420***	-0.012				

6. Identity pride	0.028	0.077	-0.196***	0.617***	0.260***			
7. Self-esteem	0.204***	0.218***	0.186***	0.111*	-0.166***	-0.016		
8. Resilience	-0.225***	-0.419***	-0.418***	0.160**	0.622***	0.360	-0.319***	
9. Depression	0.340***	0.506***	0.571***	-0.080	-0.421***	-0.258***	0.193***	-0.503***

Note: *$p<0.05$, **$p<0.01$, ***$p<0.001$

By adopting the hierarchical multiple regression analysis, the studied variables were put into three hierarchical models to see their relations with depression among the TGNC participants. The demographic information was adopted as co-variates in model 1, and the studied variables of stigma and strengths totally accounted for 52.9% of the variance of depression status among the TGNC individuals (R^2=0.529, F=23.507, p<0.01). According to Table 13, after controlling the demographic information of the TGNC individuals, three types of stigma contributed to an additional 26.1% of the variance of depression (△F=60.989, p<0.01). In model 3, the strengths of TGNC individuals further explained an additional 7.5% of the variance of psychological distress (△F=11.963, p<0.01). The results in Table 13 further showed that the anticipated stigma (t=3.471, p<0.01) and internalized stigma (t=5.460, p<0.01) were significant predictors in the model, while the enacted stigma did not show significant association with depression status among the participants. In regard to the strengths, community consciousness (t=-0.124, p=0.020) and resilience (t=-3.806, p<0.01) of the TGNC individuals significantly contributed to the variance of depressive symptoms.

Table13 Hierarchical multiple regression of stigma and strength in predicting depression

Variables	*Model 1*		*Model 2*		Model 3	
	B(SE)	*β*	B(SE)	*β*	B(SE)	*β*
Age	0.344(0.144)	0.119*	0.246(0.120)	0.085*	0.147(0.114)	0.051
Sex assigned-at-birth	0.357(0.145)	0.180*	0.333(0.123)	0.168**	0.276(0.117)	0.139*
Gender identity	0.183(0.129)	0.102	0.142(0.107)	0.079	0.125(0.101)	0.070
Education	-0.345(0.098)	-0.173***	-0.288(0.083)	-0.145**	-0.267(0.078)	-0.134**
Monthly income	0.227(0.117)	0.095	0.244(0.097)	0.102*	0.359(0.093)	0.150***
Marital status	-0.123(0.086)	-0.073	-0.081(0.071)	-0.048	-0.096(0.070)	-0.057
The only child	-0.079(0.090)	-0.044	0.058(0.076)	0.032	0.047(0.071)	0.026
Living area	0.616(0.126)	0.237***	0.419(0.106)	0.161***	0.376(0.100)	0.145***
"Coming out"	0.013(0.115)	0.007	0.028(0.099)	0.014	-0.033(0.094)	-0.017
Transition process	-0.403(0.108)	-0.223***	-0.111(0.095)	-0.061	-0.140(0.089)	-0.078
Enacted stigma			0.014(0.007)	0.101	0.005(0.007)	0.037
Anticipated stigma			0.014(0.004)	0.191**	0.015(0.004)	0.208**
Internalized stigma			0.037(0.005)	0.365***	0.028(0.005)	0.277***
Community consciousness					-0.022(0.009)	-0.124*
Social support					-0.003(0.005)	-0.030
Identity pride					-0.006(0.007)	-0.047
Self-esteem					0.006(0.010)	0.025

Resilience			-0.009(0.002)	-0.200***
R^2	0.193	0.454	0.529	
F	9.183***	24.440***	23.507***	
$\triangle R^2$	0.193	0.261	0.075	
$\triangle F$	9.183***	60.989***	11.963***	

Note: *$p<0.05$, **$p<0.01$, ***$p<0.001$

4.3.3 The associations among the stigma, strengths, and well-being status

When studying the bivariate correlations between stigma, strengths, and well-being status, except for the identity pride among the strength-based factors, all the other studied variables were found to be correlated with well-being status among the TGNC participants (see details in Table 14). Among the three types of stigma, enacted stigma (r=-0.379, p<0.001) and internalized stigma (r=-0.384, p<0.001) were negatively correlated with well-being status in medium levels, and anticipated stigma (r=-0.550, p<0.001) was highly correlated with well-being status (Breslow et al., 2015). Besides, for the strength-based factors, the community consciousness (r=-0.106, p=0.017) and self-esteem (r=-0.228, p<0.001) were negatively correlated with well-being status in small levels, while the social support (r=0.609, p<0.001) and resilience (r=0.553, p<0.001) were found to be positively correlated with well-being in high levels (Breslow et al., 2015).

Table 14 The bivariate correlations among stigma, strengths, and well-being status

	1	2	3	4	5	6	7	8
1. Enacted stigma								
2. Anticipated stigma	0.489***							
3. Internalized stigma	0.324***	0.630***						
4. community consciousness	-0.024	0.331***	0.114*					
5. Social support	-0.218***	-0.495***	-0.420***	-0.012				
6. Identity pride	0.028	0.077	-0.196***	0.617***	0.260***			
7. Self-esteem	0.204***	0.218***	0.186***	0.111*	-0.166***	-0.016		
8. Resilience	-0.225***	-0.419***	-0.418***	0.160**	0.622***	0.360	-0.319***	
9. Well-being	-0.379***	-0.550***	-0.384***	-0.106*	0.609***	0.037	-0.228***	0.533***

Note: *$p<0.05$, **$p<0.01$, ***$p<0.001$

Based on the bivariate correlation analysis, I adopted the stigma and strengths as independent variables in the hierarchical multiple regression model to see their relations with well-being among the TGNC participants. After adopting the demographic information as co-variates, the studied variables totally explained 56.4% of the variance of well-being status (R^2=0.564, F=27.093, p<0.01). The enacted stigma (t=-4.099, p<0.01) and anticipated stigma (t=-3.326, p<0.01) significantly contribute to its variance, and the social support (t=6.23, p<0.01) and resilience (t=3.943, p<0.01) among the strength-based factors were found to play significant predicting roles in the final model. Specifically, when hierarchically putting the stigma and strengths in the

models, the three types of stigma additionally explained 29.1% of the variance of well-being status among TGNC individuals (△F=63.969, p<0.01) in model 2, and their psychological strengths contributed to another 14.3% of the variance of well-being status in the model 3 (△F=24.764, p<0.01). The details were listed in Table 15.

Table15 Hierarchical multiple regression of stigma and strength in predicting well-being status

Variables	*Model 1*		*Model 2*		Model 3	
	B(SE)	*β*	B(SE)	*β*	B(SE)	*β*
Age	-0.093(3.933)	-0.001	2.615(3.257)	0.034	3.445(2.887)	0.045
Sex assigned-at-birth	-7.838(3.955)	-0.150*	-9.677(3.341)	-0.185**	-5.499(2.960)	-0.105
Gender identity	-11.376(3.514)	-0.240**	-10.645(2.891)	-0.225***	-8.254(2.551)	-0.174**
Education	0.676(2.686)	0.013	0.562(2.243)	0.011	0.459(1.972)	0.009
Monthly income	1.023(3.196)	0.016	0.345(2.622)	0.005	-4.275(2.347)	-0.068
Marital status	9.186(2.353)	0.207***	7.826(1.936)	0.177***	4.378(1.776)	0.099*
The only child	-7.767(2.448)	-0.164**	-9.517(2.047)	-0.200***	-8.525(1.800)	-0.180***
Living area	-4.509(3.446)	-0.066	2.399(2.869)	0.035	2.102(2.523)	0.031
“Coming out"	-1.013(3.153)	-0.019	-4.466(2.687)	-0.086	-4.366(2.371)	-0.084
Transition process	10.403(2.961)	0.219***	-0.003(2.568)	*β*＜0.001	1.151(2.250)	0.024
Enacted stigma			-0.919(0.201)	-0.256***	-0.742(0.118)	-0.206***
Anticipated stigma			-0.720(0.108)	-0.377***	-0.367(0.110)	-0.192**
Internalized stigma			-0.298(0.140)	-0.113*	-0.059(0.129)	-0.022

Community consciousness			0.070(0.234)	0.015
Social support			0.792(0.114)	0.343***
Identity pride			-0.283(0.173)	-0.082
Self-esteem			-0.308(0.257)	-0.045
Resilience			0.246(0.062)	0.199***
R^2	0.130	0.421	0.564	
F	5.744***	21.349***	27.093***	
$\triangle R^2$	0.130	0.291	0.143	
$\triangle F$	5.744***	63.969***	24.764***	

Note: *p＜0.05, **p＜0.01, ***p＜0.001

4.4 The moderating roles of strengths in the relations of stigma with mental health status

In addition to the associations, I explored the moderating roles of psychological strengths in the relations between stigma and mental health status by using the IBM SPSS and PROCESS SPSS macro. Both collective and personal strengths were examined in the pathways between three types of stigma and mental health status.

4.4.1 The moderating roles of collective strengths in the relations between stigma and mental health status

Community consciousness was one of the manifestations of psychological strengths, and I examined its moderating role in the relations of three types of stigma with mental health status, including psychological distress, depression, and well-being. The demographic information was adopted as co-variates in the model, and when I examined one type of stigma, the other two types of stigma were also controlled as co-variables. According to the results in Table 16, the interactions of three types of stigma and community consciousness were not significant in the relations with psychological distress and depression. Only in the relations with well-being, the interaction of enacted stigma and community consciousness yielded a significant relation with well-being status (β=-0.549, $p < 0.01$), and the interaction involving anticipated stigma and community consciousness was also found to be significantly associated with well-being status among the TGNC participants (β=-0.344, p=0.026).

Table 16 The moderating roles of community consciousness in the relations between stigma and mental health status

Variables		*B*	*SE*	*β*	95%*CI*	*t*	R^2	*F*	*df*
Psychological	E×C	*B*<0.001	0.001	-0.061	(-0.002, 0.002)	-0.421	0.497	24.998***	(3, 380)
distress	A×C	*B*<0.001	*SE*<0.001	-0.111	(-0.001, 0.001)	-0.759	0.497	25.051***	(3, 380)
	I×C	-0.001	0.001	-0.257	(-0.003, 0.000)	-1.642	0.500	25.331***	(3, 380)
Depression	E×C	-0.001	0.001	-0.148	(-0.003, 0.001)	-1.013	0.494	24.781***	(3, 380)

	A×C	$B<0.001$	$SE<0.001$	0.008	(-0.001, 0.001)	0.055	0.493	24.647***	(3, 380)
	I×C	$B<0.001$	0.001	-0.024	(-0.002, 0.001)	-0.153	0.493	24.649***	(3, 380)
Well-being	E×C	-0.102	0.028	-0.549	(-0.158, -0.046)	-3.610***	0.447	20.493***	(3, 380)
	A×C	-0.030	0.013	-0.344	(-0.056, -0.004)	-2.231*	0.436	19.562***	(3, 380)
	I×C	-0.024	0.022	-0.181	(-0.068, 0.020)	-1.083	0.430	19.118***	(3, 380)

Note: E×C refers to the interaction of enacted stigma and community consciousness;

A×C refers to the interaction of anticipated stigma and community consciousness;

I×C refers to the interaction of internalized stigma and community consciousness;

*$p<0.05$, **$p<0.01$, ***$p<0.001$.

Based on the significant results that I had found in Table 16, the simple slope analysis was conducted to further explore the moderating roles of community consciousness in different levels. As for the enacted stigma, the low level (mean minus one standard deviation) of community consciousness was nonsignificant in the interaction (β=-0.354, p=0.134). On the contrary, the enacted stigma was found to be significantly negatively associated with well-being status in mean (β=-0.894, $p<0.01$) and high (mean plus one standard deviation; β=-1.434, $p<0.01$), which indicated an increase of the slope magnitudes with the level of community consciousness increasing. Besides, the results related to anticipated stigma indicated that the relations of anticipated stigma with well-being status were found to be negatively significant at low $p<0.01$, mean (β=-0.794, $p<0.01$), and high (β=-0.955, $p<0.01$) levels of community consciousness. It can be seen that as the level of community consciousness increased,

the magnitudes of slopes showed an increase, and a negative strengthen role of community consciousness was found among the TGNC individuals. The visualizing interactions were depicted in Figure 2.

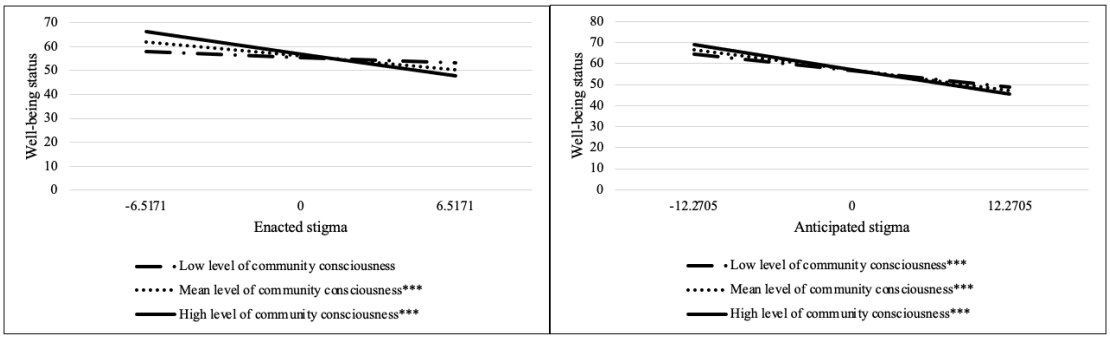

Figure 2 The association between stigma and well-being at low, mean, and high levels of community consciousness. ***$p<0.001$.

In addition to community consciousness, social support was also examined its moderating role as another collective strength factor in the relations of stigma with mental health status. In the moderation analysis, the demographic information of the TGNC participants was controlled, and when I examined one type of stigma, the other two types of stigma were also controlled as co-variables. According to the results in Table 17, the interaction of enacted stigma and social support was significantly associated with psychological distress (β=-0.337, p=0.023) and well-being status (β=0.275, p=0.044). Besides, the interactions involving social support with anticipated stigma were found to be significantly associated with all the mental health outcomes, including psychological distress (β=-0.324, $p<0.01$), depression (β=-0.347, $p<0.01$), and well-being (β=0.282, p=0.012). The internalized stigma×social support was

significantly associated with psychological distress (β=-0.406, p=0.001) and depression (β=-0.437, $p < 0.01$). The follow-up simple slope analysis was conducted, and the nature of interactions involving low, mean, and high levels of social support were examined. See details in the visualizing interactions were shown in Figure 3, which depicted the interactions of social support and enacted stigma, anticipated stigma, and internalized stigma, respectively. According to Figure 3, the results showed that social support was likely to be a buffer in the detrimental relations of stigma with mental health status.

Table 17 The moderating roles of social support in the relations between stigma and mental health status

Variables		*B*	*SE*	*β*	95%*CI*	*t*	R^2	*F*	*df*
Psychological	E×S	-0.001	0.001	-0.337	(-0.002, 0.000)	-2.285*	0.463	21.805***	(3, 380)
distress	A×S	-0.001	*SE*<0.001	-0.324	(-0.001, 0.000)	-2.673**	0.465	22.040***	(3, 380)
	I×S	-0.001	*SE*<0.001	-0.406	(-0.002, -0.000)	-3.237**	0.470	22.448***	(3, 380)
Depression	E×S	-0.001	0.001	-0.188	(-0.002, 0.000)	-1.294	0.479	23.308***	(3, 380)
	A×S	-0.001	*SE*<0.001	-0.347	(-0.001, 0.000)	-2.924**	0.488	24.184***	(3, 380)
	I×S	-0.001	*SE*<0.001	-0.437	(-0.002, -0.001)	-3.570***	0.494	24.719***	(3, 380)
Well-being	E×S	0.026	0.013	0.275	(0.001, 0.052)	2.022*	0.543	30.107***	(3, 380)
	A×S	0.016	0.007	0.282	(0.004, 0.029)	2.521*	0.546	30.434***	(3, 380)
	I×S	0.018	0.009	0.220	(-0.001, 0.036)	1.887	0.542	30.031***	(3, 380)

Note: E×S refers to the interaction of enacted stigma and social support;

A×S refers to the interaction of anticipated stigma and social support;

I×S refers to the interaction of internalized stigma and social support;

*p<0.05, **p<0.01, ***p<0.001.

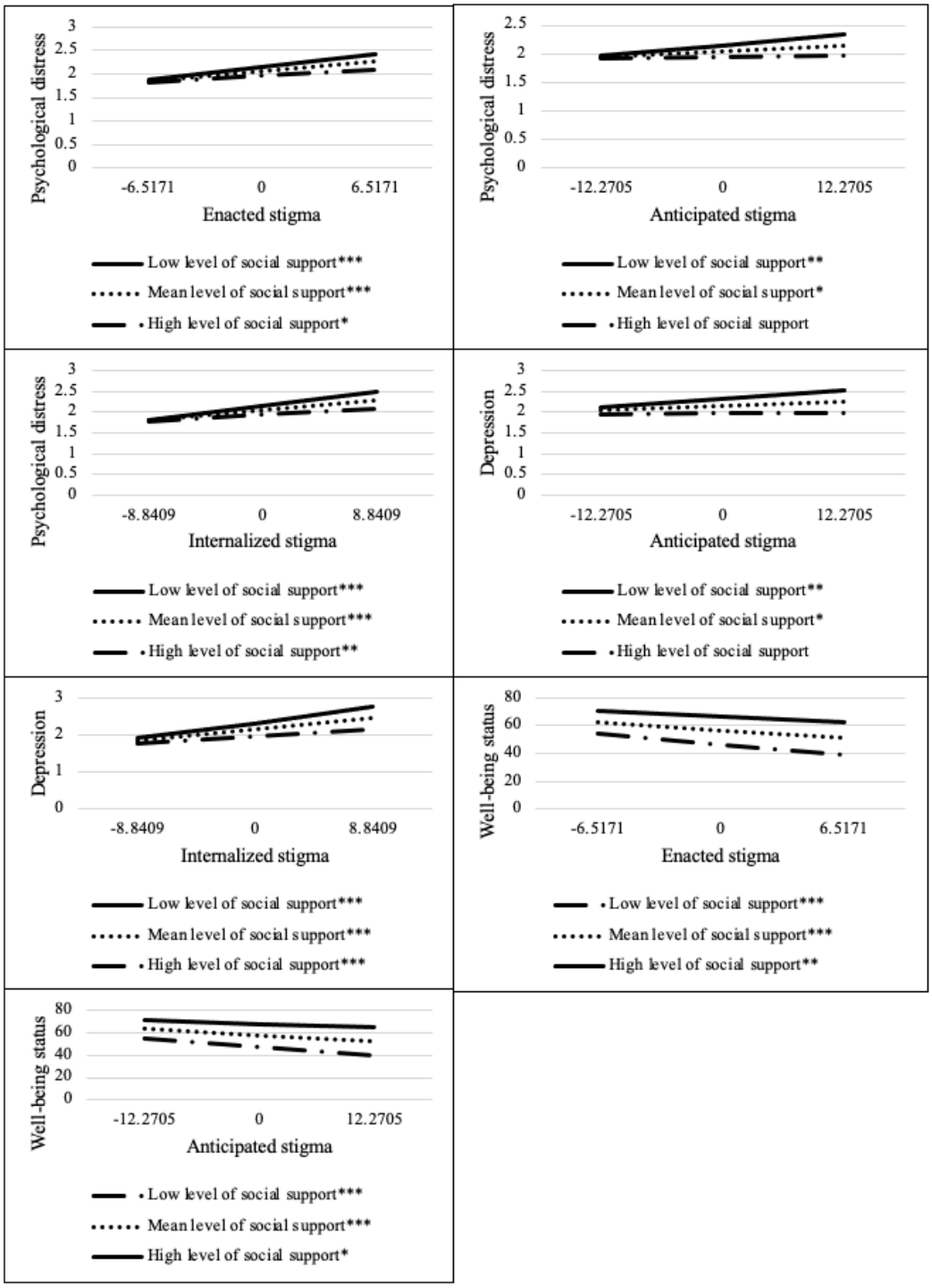

Figure 3 The association between stigma and mental health status at low, mean, and high levels of

social support. *p＜0.05, **p＜0.01, ***p＜0.001.

4.4.2 The moderating roles of personal strengths in the relations between stigma and mental health status

This study adopted identity pride, self-esteem, and resilience as the personal strength-based factors according to the minority strengths model, and I also examined their moderating roles in the relations of stigma with mental health status.

The enacted stigma×identity pride and anticipated stigma×identity pride were found to be associated with the status of psychological distress and depression (p＜0.05). The identity pride was only reported to play a moderating role between internalized stigma and depression (β=-0.231, p=0.024). It should be noted that the interactions involving identity pride were nonsignificant in the relations of stigma with well-being. The details were listed in Table 18.

Table 18 The moderating roles of identity pride in the relations between stigma and mental health status

Variables		*B*	*SE*	*β*	95%*CI*	*t*	R^2	*F*	*df*
Psychological	E×Id	-0.002	0.001	-0.383	(-0.004, -0.001)	-2.787**	0.486	23.923***	(3, 380)
distress	A×Id	-0.001	*SE*＜0.001	-0.270	(-0.001, 0.000)	-2.420*	0.483	23.681***	(3, 380)
	I×Id	-0.001	*SE*＜0.001	-0.172	(-0.002, -0.000)	-1.667	0.479	23.290***	(3, 380)
Depression	E×Id	-0.002	0.001	-0.419	(-0.004, -0.001)	-3.092**	0.500	25.337***	(3, 380)

	A×Id	-0.001	*SE*＜0.001	-0.332	(-0.002, 0.000)	-3.017**	0.499	25.277***	(3, 380)
	I×Id	-0.001	*SE*＜0.001	-0.231	(-0.002, -0.000)	-2.267*	0.494	24.762***	(3, 380)
Well-being	E×Id	0.039	0.021	-0.260	(-0.081, 0.003)	-1.805	0.434	19.415***	(3, 380)
	A×Id	0.007	0.009	0.088	(-0.011, 0.024)	0.747	0.430	19.100***	(3, 380)
	I×Id	0.014	0.014	0.113	(-0.012, 0.041)	1.050	0.431	19.164***	(3, 380)

Note: E×Id refers to the interaction of enacted stigma and identity pride;

A×Id refers to the interaction of anticipated stigma and identity pride;

I×Id refers to the interaction of internalized stigma and identity pride;

*p＜0.05, **p＜0.01, ***p＜0.001.

In addition, the simple slope analysis was conducted based on the results in Table 18 in order to explore the nature of the interactions between stigma and different levels of identity pride. The results showed that the enacted stigma was associated with psychological distress and depression in different levels of identity pride. As individuals reporting a higher level of identity pride, the magnitudes of slopes decreased, and the buffering role was found (p＜0.05). The visualizing interaction of enacted stigma and identity pride was depicted in Figure 4. According to Figure 4, the anticipated stigma was associated with psychological distress and depression in low, mean, and high levels of identity pride (p ＜ 0.05). Besides, all levels of identity pride were found to significantly buffer the relation of internalized stigma with depression (p＜0.05).

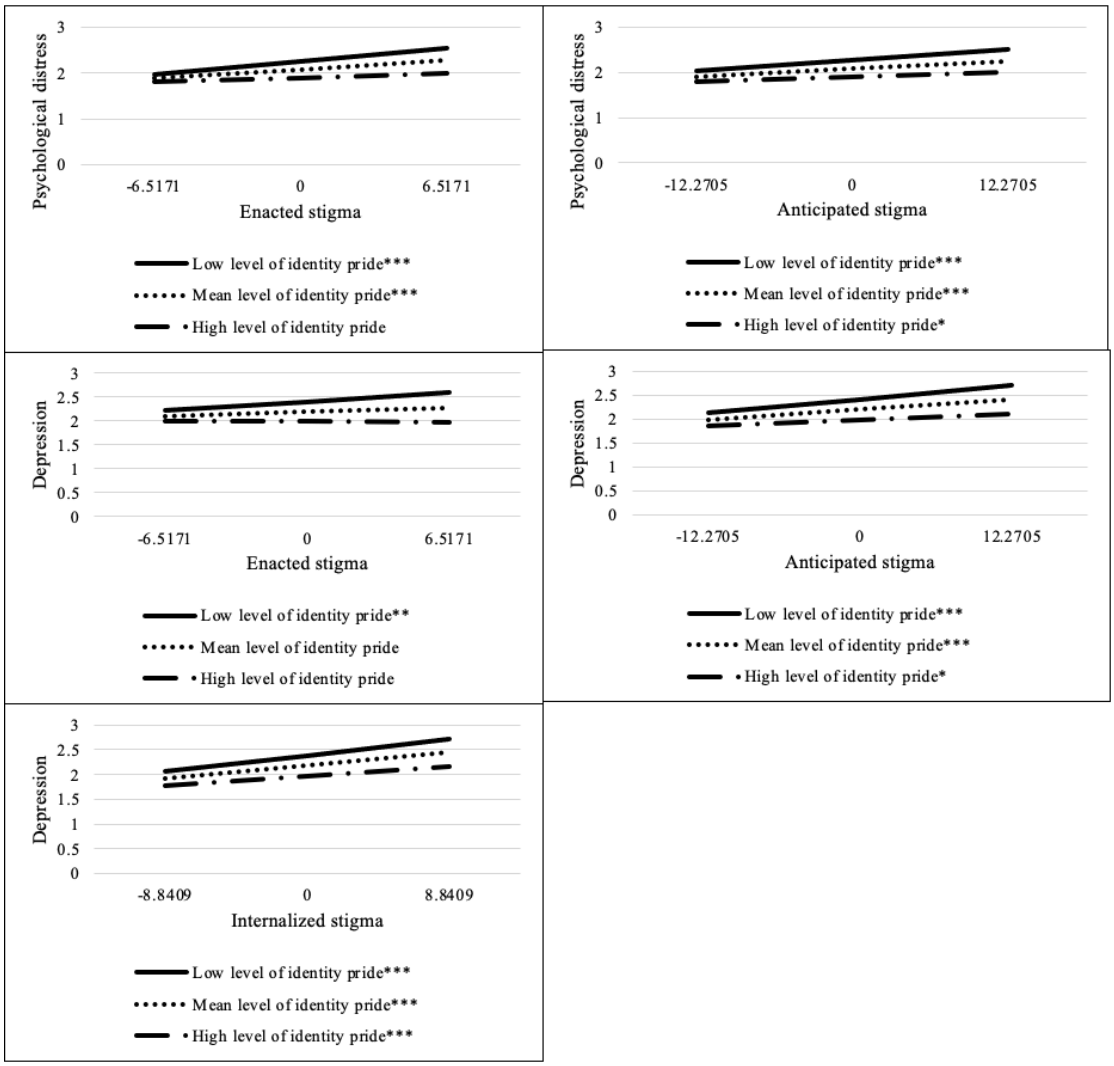

Figure 4 The association between stigma and mental health status at low, mean, and high levels of identity pride. *p＜0.05, **p＜0.01, ***p＜0.001.

The interactions of stigma and self-esteem were examined to see whether the self-esteem buffered the negative mental health outcomes as a strength-based factor. According to the results in Table 19, enacted stigma×self-esteem was found to be significantly associated with well-being status (β=-0.692, t=-2.460, p=0.014). The interactions involving self-esteem with anticipated stigma were nonsignificant in the analysis. As for the negative mental health outcomes, internalized stigma involved in

the interactions with self-esteem was significantly associated with the variance of psychological distress (β=0.627, t=2.475, p=0.014) and depression (β=0.523, t=2.061, p=0.040).

Table 19 The moderating roles of self-esteem in the relations between stigma and mental health status

Variables		*B*	*SE*	*β*	95%*CI*	*t*	R^2	*F*	*df*
Psychological	E×Se	0.002	0.001	0.463	(0.000, 0.005)	1.676	0.459	21.527***	(3, 380)
distress	A×Se	*B*＜0.001	0.001	0.156	(-0.001, 0.002)	0.682	0.456	21.240***	(3, 380)
	I×Se	0.003	0.001	0.627	(0.001, 0.005)	2.475*	0.464	21.933***	(3, 380)
Depression	E×Se	0.003	0.002	0.518	(0.000, 0.006)	1.879	0.462	21.722***	(3, 380)
	A×Se	0.001	0.001	0.180	(-0.001, 0.002)	0.744	0.457	21.357***	(3, 380)
	I×Se	0.002	0.001	0.523	(-0.002, -0.000)	2.061*	0.463	21.810***	(3, 380)
Well-being	E×Se	-0.103	0.042	-0.691	(-0.184, -0.021)	-2.460*	0.440	19.887***	(3, 380)
	A×Se	-0.019	0.019	-0.244	(-0.057, 0.019)	-0.987	0.432	19.292***	(3, 380)
	I×Se	-0.024	0.029	-0.218	(-0.081, 0.033)	-0.834	0.432	19.260***	(3, 380)

Note: E×Se refers to the interaction of enacted stigma and self-esteem;

A×Se refers to the interaction of anticipated stigma and self-esteem;

I×Se refers to the interaction of internalized stigma and self-esteem;

*p＜0.05, **p＜0.01, ***p＜0.001.

The follow-up visualizing interactions of different levels of self-esteem were also depicted in Figure 5. The enacted stigma was reported to be significantly associated with well-being status in all levels of self-esteem, including low, mean, and high levels ($p<0.05$). Similarly, the internalized stigma also showed significant associations with psychological distress and depression in low, mean, and high levels of self-esteem ($p<0.05$). It should be noted that a higher level of self-esteem indicated an increase of slope magnitudes so that the self-esteem was likely to be an aggravator in relations between stigma and mental health outcomes. See details in Figure 5.

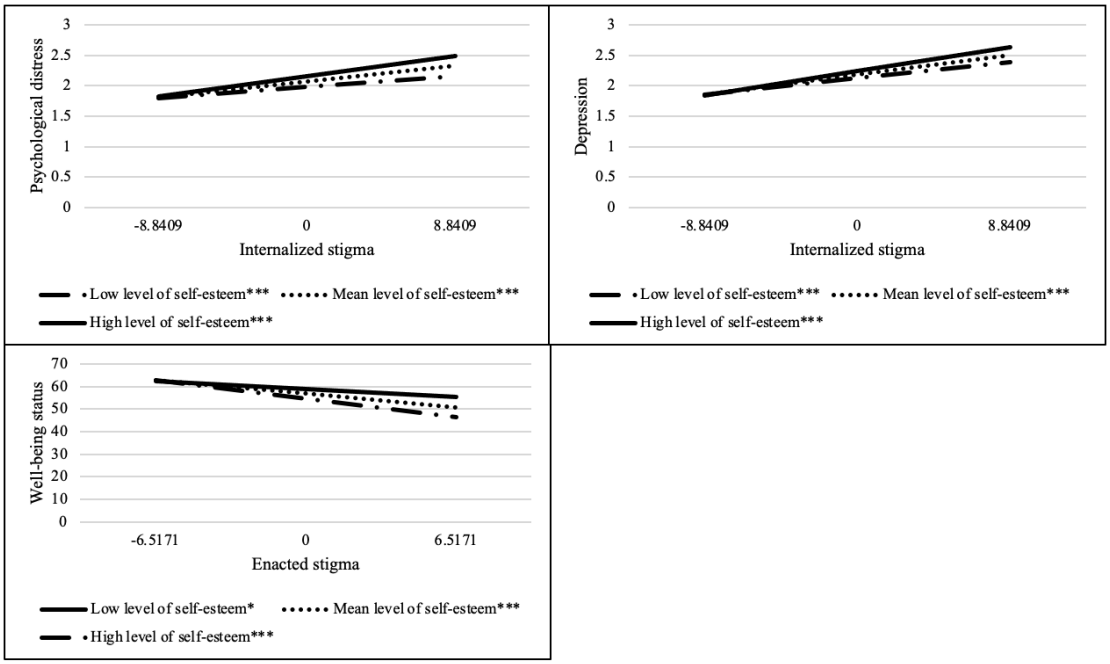

Figure 5 The association between stigma and mental health status at low, mean, and high levels of self-esteem. *$p<0.05$, **$p<0.01$, ***$p<0.001$.

In addition to identity pride and self-esteem, the personal strength-based factors included resilience according to the minority strengths model. When examining the

moderating role of resilience, I found that resilience played a moderating role in the relations of internalized stigma with negative mental health outcomes, including psychological distress (β=-0.349, t=-3.353, p=0.001) and depression (β=-0.324, t=-3.171, p=0.002). Besides, the variance of psychological distress was found to be associated with the interactions of resilience and enacted stigma (β=-0.288, t=-2.413, p=0.016). The interactions between resilience and stigma were nonsignificant in the relations with well-being. The details were listed in Table 20.

Table 20 The moderating roles of resilience in the relations between stigma and mental health status

Variables		*B*	*SE*	*β*	95%*CI*	*t*	R^2	*F*	*df*
Psychological	E×R	-0.001	*SE*＜0.001	-0.288	(-0.001, 0.000)	-2.413*	0.501	25.439***	(3, 380)
distress	A×R	*B*＜0.001	*SE*＜0.001	-0.215	(0.000, 0.000)	-1.969	0.499	25.183***	(3, 380)
	I×R	-0.001	*SE*＜0.001	-0.349	(-0.001, 0.000)	-3.353**	0.508	26.152***	(3, 380)
Depression	E×R	*B*＜0.001	*SE*＜0.001	-0.210	(-0.001, 0.000)	-1.785	0.516	26.978***	(3, 380)
	A×R	*B*＜0.001	*SE*＜0.001	-0.193	(0.000, 0.000)	-1.810	0.516	26.986***	(3, 380)
	I×R	-0.001	*SE*＜0.001	-0.324	(-0.001, 0.000)	-3.171**	0.524	27.915***	(3, 380)
Well-being	E×R	0.001	0.007	0.012	(-0.013, 0.014)	0.103	0.507	26.069***	(3, 380)
	A×R	0.002	0.003	0.073	(-0.004, 0.009)	0.675	0.508	26.129***	(3, 380)
	I×R	0.002	0.005	0.043	(-0.008, 0.012)	0.417	0.507	26.091***	(3, 380)

Note: E×R refers to the interaction of enacted stigma and resilience;

A×R refers to the interaction of anticipated stigma and resilience;

I×R refers to the interaction of internalized stigma and resilience;

*p＜0.05, **p＜0.01, ***p＜0.001.

Based on the significant associations found in Table 20, the follow-up simple slope analysis was conducted. According to Figure 6, the enacted stigma was significantly associated with psychological distress in the low (t=4.545, p<0.01) and mean (t=3.912, p=0.007) levels of resilience. As the magnitudes of slopes decrease, a higher level of resilience was reported. The low, mean, and high levels of resilience were found to play moderating roles in the relations of internalized stigma with all negative mental health outcomes, including psychological distress and depression (p<0.05). A higher level of resilience was more likely to buffer the positive association between stigma and negative mental health outcomes. The visualizing interactions were showed in Figure 6.

4.5 Chapter summary

This chapter reported the results of the data analysis. I reported the demographic information of the TGNC participants and their general experiences of stigma, levels of strengths, and mental health status. High rates of stigma were reported by the participants, and almost half of the TGNC individuals showed symptoms of negative mental health outcomes and low level of well-being status. The stigma was found to significantly contribute to the variance of mental health outcomes among TGNC people

as I hypothesized. As for their psychological strengths, social support, identity pride, and resilience were found to be buffers in the relationships between stigma and mental health status, which was consistent with my hypothesis. However, community consciousness and self-esteem were likely to be aggravators when examining their moderating roles. The summary of significant moderating roles among the strengths-based factors was listed in Table 21.

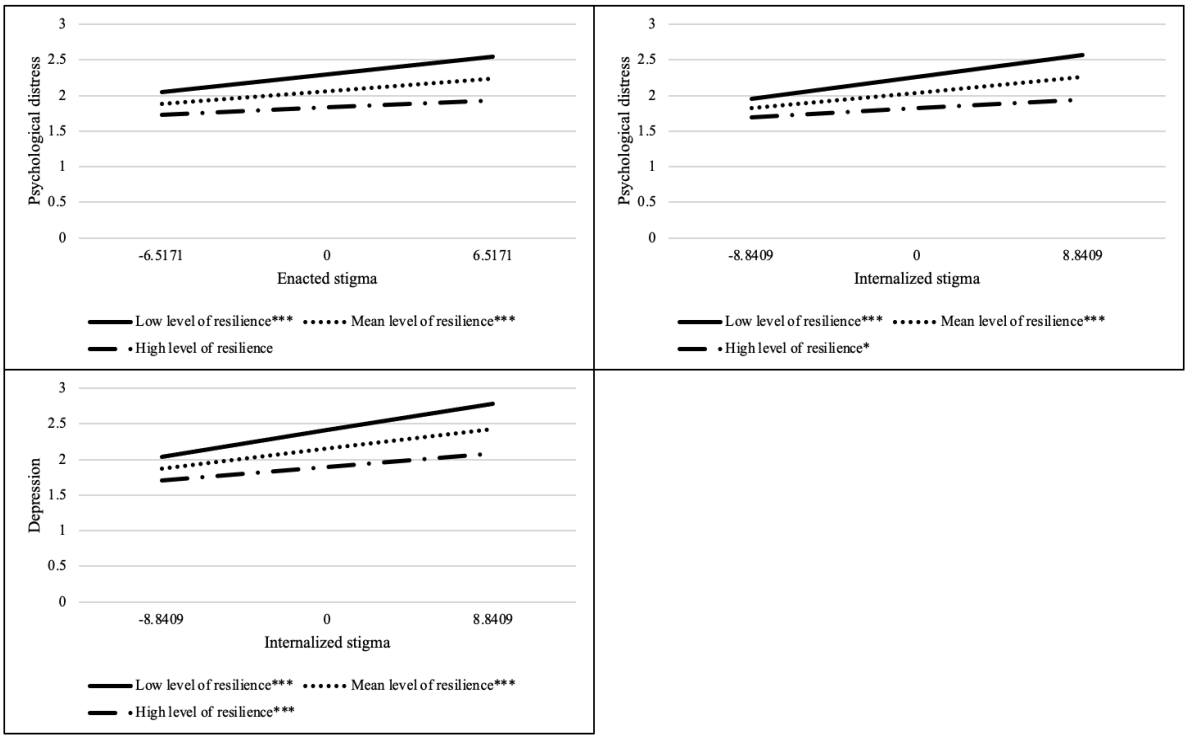

Figure 6 The relations of stigma with mental health status at low, mean, and high levels of resilience.

*p＜0.05, **p＜0.01, ***p＜0.001.

Table 21 The summary of moderation analysis among strengths-based factors

	Variables		β	t	R^2	F
Psychological distress	Enacted stigma	Social support	-0.337	-2.285*	0.463	21.805***

		Identity pride	-0.383	-2.787**	0.486	23.923***
		Resilience	-0.288	-2.413*	0.501	25.439***
	Anticipated stigma	Social support	-0.324	-2.673**	0.465	22.040***
		Identity pride	-0.270	-2.420*	0.483	23.681***
	Internalized stigma	Social support	-0.406	-3.237**	0.470	22.448***
		Self-esteem	0.627	2.475*	0.464	21.933***
		Resilience	-0.349	-3.353**	0.508	26.152***
Depression	Enacted stigma	Identity pride	-0.419	-3.092**	0.500	25.337***
	Anticipated stigma	Social support	-0.347	-2.924**	0.488	24.184***
		Identity pride	-0.332	-3.017**	0.499	25.277***
	Internalized stigma	Social support	-0.437	-3.570***	0.494	24.719***
		Identity pride	-0.231	-2.267*	0.494	24.762***
		Self-esteem	0.523	2.061*	0.463	21.810***
		Resilience	-0.324	-3.171**	0.524	27.915***
Well-being status	Enacted stigma	Community consciousness	-0.549	-3.610***	0.447	20.493***
		Social support	0.275	2.022*	0.543	30.107***
		Self-esteem	-0.691	-2.460*	0.440	19.887***
	Anticipated stigma	Community consciousness	-0.344	-2.231*	0.436	19.562***
		Social support	0.282	2.521*	0.546	30.434***

Note: *$p<0.05$, **$p<0.01$, ***$p<0.001$

CHAPTER FIVE RESULTS OF STUDY 2

In this chapter, I reported study 2 of qualitative results. By using thematic analysis, the themes were synthesized from the interviews with their supporting data.

5.1 Participants characteristics

A total of eight TGNC people participated in the interviews. I showed the demographic information of each participant in the Table 22. They were invited to do the interviews after they reported experiences in the quantitative research, and I listed the general levels of their stigma, strengths, and mental health status in the questionnaire survey as well.

Table 22 General levels of stigma, strengths, and mental health status of participants

Participant/age (years old)	Sex assigned at birth	Gender identity	Sexual orientation	Stigma	Strengths	Mental health status
01 Wes/27	Female	Male	Straight/heterosexual	ES:8 AS:34 IS:26	CC:19, SS:32 IP:11, SE:24, R:78	PSY:1.07 D:1.23 WB:36
02 Len/28	Female	Male	Straight/heterosexual	ES:4 AS:13 IS:16	CC:21, SS:42 IP:22, SE:22,R:82	PSY:1.50 D:1.31 WB:24

03 Wilson/30	Female	Male	Straight/heterosexual	ES:4	CC:14, SS:39	PSY:2.38
				AS:25	IP:10, SE:21, R:68	D:2.38
				IS:24		WB:40
04 Yellow/26	Male	Female	Lesbian	ES:4	CC:18, SS:29	PSY:1.70
				AS:37	IP:17, SE:24, R:63	D:1.85
				IS:22		WB:40
05 Helen/24	Male	Female	Bisexual or	ES:7	CC:19, SS:31	PSY:1.29
			pansexual	AS:32	IP:20, SE:24, R:57	D:1.15
				IS:8		WB:36
06 Alice/24	Female	Male	Straight/heterosexual	ES:10	CC:16, SS:30	PSY:1.80
				AS:32	IP:7, SE:23, R:63	D:1.62
				IS:14		WB:28
07 Chris/28	Female	Male	Straight/heterosexual	ES:2	CC:24, SS:41	PSY:1.56
				AS:15	IP:29, SE:22, R:34	D:2.31
				IS:19		WB:32
08 Thomas/34	Female	Male	Straight/heterosexual	ES:3	CC:19, SS:37	PSY:1.24
				AS:17	IP:16, SE:26, R:65	D:1.15
				IS:22		WB:36

Note: Es: enacted stigma, AS: anticipated stigma, IS: internalized stigma, CC: community consciousness, SS: social support, IP: identity pride, SE: self-esteem, R: resilience, PSY: psychological distress, D: depression, WB: well-being status

Among the eight TGNC participants, their mean age was 26.75 years old with a 4.03 standard deviation (SD), and their ages ranged from 21 to 34 years old. The samples included five trans men and three trans women, and most of them (n=6) were heterosexual individuals. Among the participants, six individuals reported a degree of bachelor or above bachelor. More than half of them (n=5) earned more than RMB 10,000 per month, and half of the samples (n=4) were in the status of employment. With regard to their behaviors related to their gender identities, most of the participants (n=7) had "come out" to the people around them, and half of the samples (n=4) were in the process of gender transition. See details in Table 23.

Table 23 Demographic information of participants in qualitative interviews (N=8)

Demographic characteristics		M(SD) or N(%)
Age		26.75(4.03)
Gender identity	Trans men	5(62.5%)
	Trans women	3(37.5%)
Education	High school or technical school diploma	2(25.0%)
	Bachelor's degree	3(37.5%)
	Above bachelor's degree	3(37.5%)
Monthly income	＜RMB10,000	3(37.5%)
	RMB10,000 or above	5(62.5%)
Sexual orientation	Straight/heterosexual	6(75.0%)

	Gay or lesbian	1(12.5%)
	Bisexual or pansexual	1(12.5%)
Employment status	Employed	4(50.0%)
	Self-employed	1(12.5%)
	Unemployed	1(12.5%)
	Student	2(25.0%)
"Coming out"	Yes	7(87.5%)
	No	1(12.5%)
In the transition process	Yes	4(50.0%)
	No	4(50.0%)

During the follow-up semi-structured interviews, I adopted thematic analysis in this research by extracting themes in a deductive way to further understand the stigma and strengths status among TGNC participants (Hayes, 1997). I used the minority stress theory (Meyer, 2003) and the minority strengths model (Perrin, Sutter, Trujillo, Henry, & Pugh Jr, 2020) as the theoretical foundation to focus on my research aims and questions. The results of study 1 also provided directions to conduct the follow-up semi-structured interviews for elaboration and validity (Johnson & Onwuegbuzie, 2004; Meyer, 2013; Perrin, Sutter, Trujillo, Henry, & Pugh Jr, 2020). I adopted a deductive way by using existing theories and results of study 1 as the direction and framework. The theories and quantitative results provided me with coding directions to reflect themes. Table 24 listed directions with the number of codes reported by TGNC

participants, and then the themes sorted from codes were reported in the following sections.

Table 24 Directions with the number of codes

Factors		Codes per directions
Stigma	Enacted stigma	20
	Anticipated stigma	19
	Internalized stigma	10
Strengths-based factors	Social support	45
	Community consciousness	21
	Identity pride	8
	Self-esteem	29
	Resilience	17

5.2 Enacted stigma

5.2.1 Experiences of pervasive adversity

Among eight Chinese TGNC participants, seven TGNC individuals reported the negative impacts on their emotions and feelings of their lived experiences of adversity, including unemployment, lack of respect, verbally and physically abuse, rejection, the barrier to healthcare services (Participant 01,02, 03, 04, 05, 06, and 08). In the word of

Participant 01 (Wes, a trans man aged 27, had not come out or in the transition process; he was a residency of orthopedist with a monthly salary of 6,000 RMB), “the adversity due to the gender identity is really pervasive.” The TGNC participants commonly talked about their enacted experiences that came from their parents since their parents may consider them to be abnormal, freak, and so forth. Parents may use their relationships with their children to engage in a series of behaviors in the hope that their children could change through their actions. For example, one participant was rejected by her parents because of her gender identity. Her parents thought it was abnormal, so that they sent the participant to a church for changing her gender expressions by being educated when she was in high school:

> “*My family members rejected to accept my gender identity, and they sent me to a church, forced me to confess my sins for acting like a girl. Besides, the whole family verbally abuse me, since I was the only man in my generation, and you know, a boy means a lot in a family. My stepfather would verbally abuse me as a eunuch in front of the whole family.* ” (Participant 06: Alice, a trans woman aged 21, had come out and in the transition process; she was a student and had an internship as an acupuncturist with a monthly salary of 2,000 RMB)

Some parents expressed rejection to their TGNC children when they realized that it might be hard to change the behaviors of their children. Another participant recalled his experience of being rejected by his parents. He stated that his parents refused to talk

to him for years when they found his gender identity as a trans man. Although things got better after a few years that his mother started to talk with him, but she still "refused to talk about my gender identity, once we talked about this topic, she would shed tears" (Participant 08: Thomas, a trans man aged 34, had come out and in the transition process; he was self-employed with a monthly salary of 10,000RMB). Besides, participant 03 (Wilson, a trans man aged 29, had not come out or in the transition process; he was employed with a monthly salary of 12,000RMB) told me about the tremendous negative impacts of the rejection and prejudice from his mother toward his gender identity:

> "*My mother has always had a big prejudice against my gender expression. When I was growing up, her persistent prejudice had a great negative impact on me. I was always in a state of confrontation with her, and I felt that if my mother treated me like this, it should be normal for others not to treat me with kindness. I look at things very pessimistically and feel that I am unlucky.*"

5.2.2 Negative feelings from the adversity

In the interviews, participants revealed the negative feelings they were actually feeling through the adversity from time to time. Wilson (participant 03) showed his pessimism, and in line with the negative expressions from Wilson, Wes (Participant 01) also explicitly expressed his negative feelings due to his gender identity. "I do not even know what an ideal life should look like," Wes told me with a wry smile, "No one has actually pointed to my nose to scold me, but with a series of pressures such as

employment, family, and so forth, I am so unhappy."

Participant 04 (Yellow, a trans woman aged 26, had come out but not in the transition process; she was an IT programmer with a monthly salary of 30,000 RMB) also expressed her pressure and disappointment from the experiences of adversity related to her gender identity. She shared with me about her experiences and consequentially negative feelings as well, "I explained my gender identity to those whom I trust, but they refused to accept me and also refused to call me by the title of my preferred gender identity title…I just feel sad and disappointed for not being understood and respected." She also remembered that some netizens had verbally harassed and assaulted her after learning that she was a TGNC person on the Internet. "I could explain and argue with them once or twice, but there are too many of such people, and arguing, again and again, leaves me so desperate, angry, and powerless. I cannot change anything." Speaking of this, I could also feel her voice sinking.

5.3 Concealment and negative expectations of anticipated Stigma

All the participants reported their experiences of concealment of gender identity or gender history at diverse points in their lives, and in the face of such anticipated stigma, they might show much pressure and even depressive symptom. Their nondisclosure could result from their previous experiences of rejection or hearing of adversity experiences of other TGNC individuals after they came out. Although some participants expressed their pressure of lying and the concealment could lead to depressive symptoms, in order to avoid more conflicts and adversity, they still chose to conceal

their gender identity or related history. As one participant said:

> "*Lying really brings me pressure, and I can't argue when being educated to find a partner…I feel depressed. My mom told me to change into a 'normal' person. Otherwise, she pretended not to know my gender identity, then I did not tell anyone else since it is not safe for me to disclose my gender identity. I do not want to get myself in trouble. Now I even can't imagine a dream life…I just feel so unhappy, even though there is no one treat me bad. I just feel so unhappy to live in such an environment that I need to conceal my gender identity.*"(Wes, Participant 01)

Besides, some participants even did not have adverse experiences before, but they still had negative expectations of others because they heard of the negative feedbacks of other TGNC individuals. Like one participant said, "I did not experience unfair treatments, but I heard of the experiences of other TGNC individuals after they came out. I felt sympathy. I am relatively lucky from this aspect, but I won't dress too girly to avoid attention from others. I don't want to induce such unnecessary trouble." (Participant 05: Helen, a trans woman aged 21, had come out and in the transition process; she was a graduate student). They were afraid to be judged, be overly paid attention, and even "lose the job" (Wes, participant 01). Most of them talked about their negative anticipations due to the unexpected reactions from others, so based on previous experiences of attitudes toward the TGNC population, they would expect negative feedbacks from others. Yellow (participant 04) dressed in the way of his sex

assigned-at-birth in her daily life, and she explained her reasons for not living in her gender identity:

> "*I'm afraid of an unexpected reaction, and I do not like to be pointed at in the street by strangers. I will suppose a negative stand if I don't know a person very much… Males sometimes make some unfriendly remarks related to women and the LGBT population, which makes me think that it is not safe to come out.* "

Wes (participant 01) further added, "due to my gender identity, sometimes I am afraid of meeting strangers. They bring me too much social pressure." It can be seen that based on their own previous experiences or the experiences from other TGNC individuals, the worries of being judged among TGNC individuals do bring them negative expectations and feelings, which may further increase the risk of social isolation and aggravate their negative mental health statuses such as psychological distress and depression.

5.4 Internalized stigma – "*I had a transphobia of myself*"

More than half of the TGNC participants reported their internalized transphobia that they endorsed the negative beliefs toward their gender identities resulting in devaluing themselves (participant 01, 02, 04, 06, and 08). Participants endorsed others' questioning and views into their own negative beliefs, and they would have self-doubts for not being able to bring normal life to the people around them. Wes (participant 01)

expressed his feeling that he thought he was not a nice person: "*When I heard so many questioning and negative comments about myself, I took it seriously.*" Besides, when talking about his girlfriend, He was plunged into great anxiety that he could not bring a "normal" life to his girlfriend, which made him fell into deep self-doubt as well: "I bring so much pressure and problems to her because of my gender identity, my gender identity really is a bad thing for both of us." Wes further expressed his confusion when talking about his gender identity and also the negative feelings he suffered due to the internalized beliefs toward his own gender identity:

> "*I am just confused about my gender identity. I live in a state of division…My brain must know what my body looks like, so why does it make me feel like I am a person of different sex? It is weird…Actually, I do not like my gender identity at all. I am unlucky that my gender identity is this way, and it brings me lots of trouble in my life. The prevalence is very low for being a TGNC individual, but it chooses me. This is miserable.*"

In line with Wes using "miserable" to describe his feelings when talking about his gender identity, Alice (participant 06) and Thomas (Participant 08) also pointed out their negative beliefs and feelings towards their gender identities when they were young. Thomas considered himself as a "freak and weirdo" as he gradually realized the incongruence between his sex assigned at birth and his gender identity. "*That was horrible, not to mention that I was so young at the time, and I did not know what happen*

to me," Thomas smiled and talked about that period of time. Now when I interviewed him, he was more accepting of it, and he also concentrated in making a website named Trans Man Helper so that he could popularize basic knowledge related to TGNC people to others. "*But at that time, I thought that the society would not accept me as such a freak. I felt ashamed and anxiety every day for I owning the thought of being a man*". Compared with Thomas, Alice has suffered a more serious negative impact that she had been experiencing severe anxiety for a long time. She thought her desire for being a woman was immoral and disgusting: "*I thought that was immoral and disgusting…I rarely looked in the mirror, and I did my best to suppress my gender expression. Thus…you know…I experienced symptoms of severe anxiety for a few years, and I needed to take medicine in my daily life. To be honest, I thought I had transphobia of myself.*"

5.5 Social support

All the TGNC participants talked about their social support, including support from their family members, partner, friends, colleagues, teachers and classmates, healthcare providers, and community members. Like Yellow (participant 04) said, the support from others could be the backup for an individual to face adversity in the world.

5.5.1 Support from family and partner

The most commonly reported social support was from family members and partners. Wes (participant 01) expressed a warm feeling when talking about his girlfriend. He thought that his girlfriend was a nice person that she could see the real him and admitted

his gender identity. However, the support from his partner also brought huge pressure to him since he thought that he could not give her a "normal life" in the predictable future.

Another participant, Thomas (participant 08), reported that after a few years of effort, his family members finally accepted him and gave him support. He was one of the few transgender people I interviewed who had the support of his entire family, and he expressed his appreciation for the support from his family members: "*After I came out to my family members, my close friends and relatives did not abandon me. Although they did not fully support me at the first time, they did not alienate me because of my gender identity, for which I was really grateful. My cousins took the initiative in letting their children call me by the male title, such as uncle. I have to say that I feel comfortable being treated like this."* Compared with the acceptance and support from the entire family reported by Thomas (participant 08), Wes (participant 01) and Yellow (participant 04) did not receive so much support from their families, but they also showed satisfaction and appreciation to their parents for their understanding and not opposing their gender identities.

5.5.2 Support from people around and community members

In addition to the support from family members and partners, participants talked about the people around them, such as their friends, classmates, colleagues, and community members. Usually, they talked more about the people with whom they often spent their time. Helen (participant 05, a trans woman aged 21, had come out and in the

transition process; she was a graduate student) said that she was supported by her friends and classmates, especially those girls around her, which made her delighted and relaxed. According to her words, the support from friends and classmates also promoted her self-acceptance:

> "*I gain support mainly from my friends and classmates, especially girls. Once they accept my gender identity…how to say…they will not consider me as a traditional boy. For example, they do not mind going out and having some intimate physical contact with me, which makes me feel very delighted and relaxed. I feel that I am not seen as a guy, and I am accepted. Such acceptance and support also make me feel more confident in social activities and more comfortable with my body.*"

Besides, some TGNC participants mentioned the support from the other TGNC community members (participant 06 and participant 07). When getting into trouble, they reported multiple ways to seek help, such as looking for the help of community members and hurt themselves for seeking care from peers. Alice (Participant 06, a trans woman aged 21, had come out and in the transition process; she was a student and had an internship as an acupuncturist with a monthly salary of 2,000 RMB) told me about her experiences of running away from home because of a fight related her gender identity with her family members. When she was desperate, she turned to the TGNC community for help, and other community members offered her a place to live instead of sleeping out on the streets. As Alice said, "at that time, they saved me, temporarily

calmed my anxiety and fear, and made me feel supported." Chris (participant 07, a trans man aged 20, had come out and in the transition process; he was unemployed) was the interviewee who was most involved in the TGNC communities. He cared a lot about the support from other community members, and he was very conscious of their attention as well. Chris recalled his behaviors and feelings when he thought he lacked support and attention. He felt abandoned and isolated so that he decided to adopt a negative way of hurting himself in order to attract the attention of peers. He said as follows:

> "*Sometimes I felt lonely…It was just like…I am abandoned and isolated…I wondered if they all disliked me, so I put photos of my self-injury on social media, and I just wanted to use self-injury to get the attention of my friends and let them care about me. You know…sometimes lack of support made me a little sensitive and paranoid, and I would do some crazy things to try to get people's attention without explicitly telling them that I wanted their care and support."*

5.6 Community consciousness and its two-sided influence

TGNC participants kept different views toward the TGNC community and their gender identity, but these views basically revolve around a sense of belonging. People talked about their community connectedness, which represented the level of their community consciousness. All the participants still showed their belonging sense, and

connectedness with the TGNC community. They considered themselves as a member of the TGNC community as long as they got the incongruence between their sex assigned at birth and gender identities.

According to the results of interviews, the impact of community consciousness among TGNC people on their mental health status is two-sided. Three TGNC participants expressed that “the only thing I had in common with members in TGNC community is the gender identity” (participant 01 and participant 03). Rarely interactions with the community made them not have much to talk about on this topic. Wilson (participant 03) considered himself to have an integration of multiple identities, and he did not particularly agree with the category of TGNC people. As he said, “the act of categorizing such incongruencies is weird in itself.” However, when I interviewed Wes (participant 01), he thought about this topic for a while and said to me: "Actually…if there is any influence, I think it is positive. The existence of the TGNC community lets me know that there is a group of people in this world who live like me… So if they can live, then I can also live well." Yellow (participant 04) further made a similar point that when she heard of the good life of other TGNC individuals, she felt encouraging since it turned out that the TGNC people could also live well.

Thomas (participant 08) explicitly expressed his sense of community consciousness in the interview. He kept informed of the TGNC news and issues, and the sense of bond to the TGNC community made him quit his job as an editor, and now he was in self-employment to create a TGNC website named Trans Man Helper, aiming to wrote some educating articles of TGNC people for popularizing the basic knowledge

of this population. In his words, he thought this was what he "*really wanted to do*", and this was his "*original intention to make contributions to this community*". From his point of view, the sense that TGNC individuals may need to join and work together against transphobia offered him strengths and motivation. But during the interview, Thomas also admitted that he rarely participated in community activities and had very little contact with other community members. "I do not know exactly what is going on inside the community…Usually, they find me on the website and come to me with their own confusions, looking for reassurance and solutions."

Both sides of the coin were also revealed in the participants' words that a high level of community consciousness reported by TGNC participants might also bring some negative influences on their psychological status. Yellow (participant 04) used to try to build a close connection with the TGNC community through WeChat groups, but as they got along, negative feelings gradually caught up with her:

> "*When I was closely connected with the community, I found that many community members talked about suicide or quarrels with others every day. You know… many TGNC individuals have not been getting along well with their families since they were young, and some of them may be crowded out by classmates and friends. So they are likely to be more sensitive, neurotic, and even difficult to communicate with. So deeply connectedness did not make me feel good, while sometimes I felt that maliciousness was everywhere in this world. It was like...for example, I was surrounded by depression and suicide...Some members in the WeChat groups*

thought that they did not look good and they could not become what they wanted to be. At that time, I would reflect on myself whether I was facing the same problem. If there were some similarities in certain aspects, then it would increase my self-doubts to a greater extent. Listening to others would also increase my own anxiety in some aspects."

It seems that a high level of community consciousness may have a negative impact on their mental health among TGNC individuals. Helen (participant 05) also expressed similar views to those of Yellow. From her point of view, there were a lot of negative energies in the TGNC community. Some of the community members just vented out their depression without considering whether others would be affected. Therefore, as she said: "*people who wanted to develop better, they should get rid of these negative things, and they may no longer need this kind of connection in the community*". Chris (participant 07) showed a high level of community consciousness that he considered himself as a member of the TGNC community, and he spent a lot of time in interacting with the other members in his daily life. He revealed that some TGNC members would despise those who had not undergone gender reassignment treatments since they believed that the individuals who did not involve themselves in such treatments were fake TGNC individuals. "T*hat is ridiculous,*" Chris said, "*such contempt may cause negative feelings among some TGNC members… Everyone is miserable enough…why bother to hurt each other like this?*"

5.7 Identity pride for being special

When talking about the sense of belonging to the TGNC community, two TGNC participants mentioned their identity pride that came with it (participant 02 and participant 07), while most participants were neutral or negative about their gender identities. Some participants said that they considered their gender identities as normal things, but they could not be delighted when thinking about the unfavorable living environment due to their gender identities. Some TGNC individuals expressed negative attitudes toward their gender identities by using negative words in their descriptions, such as “freak” or “weirdo” (participant 08), and they may further devalue themselves, which may result in their internalized transphobia.

As for identity pride, participants revealed that their gender identities gave them a feeling of being different and also brought them self-confidence and pride. One participant named Len (participant 02, a trans man aged 27, had come out but not in the transition process; he was a car designer with a monthly salary of 8,000RMB). He said that “*I am special because I am a TGNC individual. It is like a gift to bring me a special life.*” Another participant, Chris (participant 07), told me that he was willing to disclose his gender identity to others and popularize related concepts to those who were not familiar with the TGNC population. He talked about his identity pride by using the word “*bonus*” to describe the impact of gender identity on his life. From their description, they showed satisfaction from their gender identity, and also, they immerse themselves in their identity.

5.8 Self-esteem – both a weakness and a protection

In addition, when talking about experiencing adversity, most participants discussed their self-esteem, which referred to the sense of their self-worth, coming from their experiences of being evaluated by others and self-affirmation of their own values. From the results, self-esteem was affected by social comparison, evaluation by others, and self-affirmation of success or failure in doing things, resulting in their self-confidence and self-deprecation (Rosenberg, Schooler, Schoenbach, & Rosenberg, 1995).

More than half of the participants told me similar opinions that they were used to suffering the judgments from others (participant 01, 03, 04, 06, and 08), and the conflicts between their self-affirmation and others' judgments had negative impacts on their psychological status. Wes (Participant 01) explicitly expressed the conflicts between his expected ways of self-affirmation and the evaluations by others, which resulted in his self-deprecation:

> "I w*ish to do things well to get the affirmation of others, but others will judge me based on something assigned-at-birth...something that I cannot change by making efforts…I cannot say that I am a good person when everyone else tells you that you are not good. The only result is that I do not think I am good, neither. This is really discouraging.*"

Because of the gender incongruence, some participants showed low levels of self-esteem, such as the unsatisfaction with their body image, which seemed to be a possible

reason for their psychological distress. Yellow (Participant 04) preferred to dress as a female. But he was unconfident to do so since he thought he was not very good-looking and he was too masculine to wear a skirt. If he wore as a girl, he believed that he would be the focus on the street, which he was afraid of, “I do not have a girly appearance, which limits me to dress as what I like…I’m not a confident person, and I need to hide. If I am exposed in front of the public, I will feel much pressure.” Chris also pointed out similar opinions. “What I am most anxious is my appearance. I wish I could be taller. Sometimes I feel uncomfortable standing with other ‘real’ boys because most of them are taller than me.”

However, participants provided me with a view that they lowered their sense of self-esteem for protecting themselves from being hurt. As Thomas (Participant 08) said, “anyway, I cannot stop other people from making negative comments about myself…so I just accept it…again and again. Then it does not matter, and the evaluations from others cannot hurt me anymore. ” From the description of the TGNC participants, it can be seen that at the beginning, they were negatively affected by the judgments from others. They gradually learned to lower their expectations of others’ evaluations to avoid hurting themselves, and some of them further needed to lower their sense of self-worth to ease the discomfort of conflicts between their self-affirmation and evaluations from others. According to the results, it seems that a lower sense of self-worth is instead a layer of protection they add to themselves.

5.9 Resilience for bouncing back

All participants talked about how to use their resilience to interact with the adversity and bounce back from the bottom of their mental health status. The resilience in this study referred to their personal resilient yearnings, qualities, and drives, including their exploration of the meaning of life, understanding of social construction, self-improvement, and rationalization of their experiences. For example, Wes (Participant 01) discussed the preferred gender binary under social construction. As he said, "*male and female were just the social categories. People had more gender expressions and identities… I won't follow the social rules to find a man and get married anyway.* " Besides, Len (Participant 02) seemed to rationalize his experiences as something that everyone would encounter, so in this way, he recovered from not being understood by others when talking about his gender identity with others. Alice (Participant 06) also pointed out a similar view:

> "*Gender incongruence is very normal, do not exaggerate it, or consider it as a disorder. Just try to live better and improve your living environment."*

Above all, the TGNC participants experienced unfair treatments in their daily lives, but they use their inner resources to help themselves "fulfill their potentials, seek wisdom, strive for perfection, be altruistic, and to be in harmony with her/his source of spiritual strength" (Richardson, 2002). For instance, Helen (participant 05) showed me her evident resilience in fulfilling her sense of accomplishment. She went through the

stages of self-doubt and self-exploration, but the yearnings and drives for self-accomplishment made her do a lot of charity for the TGNC community and brought her own pleasant feelings. Besides, Helen spent a lot of time in doing charity work related to TGNC issues, which indicated that being altruistic may help her recover from the negative feelings in her daily life. Wes (participant 01) also confirmed this view: "I think I am just an ordinary person, but if I have something to make myself feel better, maybe I can say that I am a kind person." The resiliency model had some explanations about the buffering effects of such resilience (Richardson, 2002). It pointed out that being altruistic and kind should be one's character resilience to provide a person who lives "within a moral framework" with energies to bounce back from the negative feelings. When TGNC individuals are stigmatized, not only kindness, all the resilient qualities, yearnings, and drives contributing to their resilience might be able to save their negative perceptions of themselves, thereby improving their mental health status.

5.10 Chapter summary

This chapter reported the results of study 2. Eight Chinese TGNC individuals participated in the semi-structured interviews. I used the minority stress theory and minority strengths model as the framework and directions to conduct data analysis to elaborate and validate the results of study 1. According to the results, ten themes were identified based on the contents of their interviews when the TGNC participants were talking about their stigma and strengths and the influences on their mental health status. I reported the supporting data for each identified theme. The identified themes included

experiences of pervasive adversity, negative feelings of adversity, concealment and negative expectations of anticipated stigma, internalized stigma – “I had a transphobia of myself”, support from family and partner, support from people around and community members, identity pride for being special, self-esteem – both a weakness and a protection, and resilience for bouncing back.

Among the identified themes, the TGNC participants reported their stigma related experiences, including experiences of pervasive adversity, negative feelings of adversity, concealment and negative expectations of anticipated stigma, and internalized stigma – “I had a transphobia of myself”, which were detrimental to the mental health status among TGNC people. The participants used words of “sad”, “disappointed”, “anxiety”, “pressure”, and even “miserable” to describe their feelings brought by such experiences. Meanwhile, the participants reported their strengths of social support, identity pride, and resilience that gave them powers and helped them recover from the negative mental health status.

During the interviews, it should be noted that the community consciousness and self-esteem were hypothesized as strengths-based factors in the minority strengths model, but in this study, they were reported to have mixed influences on the psychological status among TGNC individuals. Some participants indicated that the existence of the TGNC community gave them hope and support to live in the world, while some individuals demonstrated that a high level of community consciousness might lead to a close connectedness with the TGNC community so that they may further be affected by the negative mental health status of other TGNC individuals. High

exposure to a TGNC environment seemed not to be a good thing for their mental health status. Besides, some participants expressed that self-esteem provided them with a sense of self-worth in the face of adversity. However, some of them talked about the conflicts between their self-affirmation and evaluations from others due to their gender identities, which could bring them negative feelings such as angry, disappointment, anxiety, depression, and so forth. Participants further posited that a lower level of self-esteem might be self-protection for them to get used to the judgments from others so that they would not be influenced so much by the negative comments from others and could remain peaceful and calm in their daily lives.

CHAPTER SIX DISCUSSION

In this chapter, I discussed whether the results of study 1 supported or rejected the hypotheses related to the relationships between stigma, strengths, and mental health status, and I also explained the results of data analysis by integrating the theories and previous studies. As for study 2, I further discussed how the results of the qualitative research elaborated and validated the results of study 1.

This research focused on the relationships between stigma and mental health status among Chinese TGNC individuals and also the roles of their strengths in the relationships. In study 1, I combined the minority stress theory and the minority strengths model to explore the relations of enacted stigma, anticipated stigma, and internalized stigma with mental health outcomes with considering the buffering roles of their psychological strengths among Chinese TGNC individuals. An increasing number of studies have focused on the mental health and stigma issues of TGNC people, and they were mainly concerned with the negative mental health problems and outcomes. Compared with that, little is known in the context of mainland China. This study not only examined different types of stigma and their relationships with mental health status in the context of mainland China but also exploring the psychological strengths from both collective and personal perspectives to understand how the problems diminished from a positive perspective. The findings of this study demonstrated that the minority stress theory could possibly be useful for being applied to the Chinese TGNC individuals. The minority strengths model could be partly applied

since some strength-based factors were tested while the buffers of a few factors still needed to be discussed.

In study 2, I further elaborated and validated the results of study 1 by understanding more details about how the stigma and strengths of TGNC individuals affected their mental health status. I found the supporting data that the enacted stigma, anticipated stigma, and internalized stigma were detrimental to their mental health status, and some of their strengths gave them positive feelings. Especially, the mixed effects of community consciousness and self-esteem were reported by the TGNC participants.

By understanding the stigma, strengths, and mental health status among Chinese TGNC people, this research played a role in contributing to the knowledge of TGNC people. It explained how the minority stressors of different types of stigma were associated with the variance of mental health outcomes and how Chinese TGNC people exerted themselves by using their positive resources. Moreover, this research showed some theoretical contribution for it discovered the mixed effects of some strengths, which was inconsistent with the minority strengths model. The findings related to the mental health status of TGNC individuals may provide some practical implications as well.

6.1 The stigma, strengths, and mental health status among the TGNC people

6.1.1 The general levels of stigma, strengths, and mental health status among TGNC individuals

In general, the stigma was found to be widespread among the TGNC people. A high

rate of enacted stigma was reported by the TGNC participants. Experiences of discrimination, rejection, and victimization as the manifestations of enacted stigma were very common among Chinese TGNC people, and only less than 20% of the participants had never experienced such unfavorable treatments. As stated in the minority stress theory (Meyer, 2003), the TGNC people suffered excess stress such as unfair treatments due to their minority and stigmatized position, and under such circumstances, they needed to take more effort to live a "normal" life. The high rates of such experienced unfair treatments indicated a relatively hostile and unfavorable environment towards Chinese TGNC people, and the sociocultural prejudice has also existed against this population in the context of mainland China (Peng et al., 2019). The results of this study confirmed that the minority stress theory could be applied to the group of Chinese TGNC individuals. The qualitative results also found that most of the TGNC participants reported their lived experiences of adversity, including unemployment, lack of respect, verbal and physical abuse, rejection, the barrier to healthcare services, which were consistent with the high rates of enacted stigma reported in the questionnaire survey.

Besides, the TGNC participants also expressed their high levels of anticipated stigma and internalized stigma in study 1. For their anticipation, above 70% of the TGNC participants reported their negative expectations from others if they disclosed their gender identities, such as being rejected from others (67.4%), unemployment (67.4%), and even being victims of crimes or violence (57.4%). Accordingly, it was not surprising to find out that the participants showed a high rate (almost 90%) of

nondisclosure related to their gender identities. In line with the results of study 2, all the TGNC participants in study 2 recalled their experiences related to the negative expectations and the consequential concealment of their gender identities, and it could be seen that the anticipated stigma was widespread among TGNC people. According to their explanations, the negative expectations and consequential nondisclosure of gender identities could result from their previous experiences of rejection and hearing of adversity experiences of other TGNC individuals after they came out.

When talking about internalized stigma or internalized transphobia, around half of the participants further agreed that they had the thoughts or feelings of internalized negative beliefs toward their gender identities. The high rates of anticipated stigma and internalized stigma were also consistent with the proximal stressors in the minority stress theory, which referred to the stressors that were "subjective because they relied on individual perceptions and appraisals" (Meyer, 2003, p. 5). The TGNC people considered themselves devalued since the social stigmatized category influenced their perceptions, and they may also endorse the negative beliefs about themselves (Earnshaw, & Chaudoir, 2009). The TGNC participants further provided some elaborations and explanations toward their internalized stigma that their self-devaluation may result from their disability to live a “normal” life as a cisgender person, and they may also consider themselves as “freak” or “weirdo” due to the incongruence feelings of gender identities. Both study 1 and study 2 could be seen that the social preference of gender binary might put pressure on the TGNC individuals so that the stigmatized and minority position of their gender identities made them endorse the

negative beliefs and comments from others into their internalized transphobia.

It was unsurprising that the average level of some psychological strengths was lower than those of the Chinese normative samples, including their social support, self-esteem, and resilience. Social support is one of the collective strengths, and it helps provide for an individual's basic social and psycho-emotional needs (Kaplan, Cassel, & Gore, 1977). The nature of it makes researchers commonly consider it as a protective factor for individuals to live healthily. The finding was consistent with previous studies that the TGNC people had lower social support compared with other groups of people. Factor and Rothblum (2007) concluded that the TGNC people perceived less social support from their family members compared with their siblings. Bockting and colleagues (2005) also found that the TGNC individuals experienced a lower level of social support than of women who had sex with men and women and men who had sex with men. This study also showed that it might not be easy for some family members to accept the gender identities or expressions of Chinese TGNC individuals. In addition, the previous study pointed out that one possible reason might be the relatively conservative Chinese culture, which attached great importance to family reputation so that the acceptance of stigmatized categories might be at a low level (Jun, 2010). The TGNC people also showed low levels of self-esteem and resilience in this study. Self-esteem refers to one's sense of self-worth (Du, King, & Chi, 2017), and it is consistent with the stigmatized position to some extent. Their sense of self-esteem formed during their growth process with gradually being able to influence their thoughts and behaviors. However, the TGNC people may devalue themselves due to their minority and

stigmatized category. Similarly, resilience may also be affected when it embodies the personal qualities of TGNC people when they are in the face of stigma or adversity (Connor, & Davidson, 2003).

Besides, the community consciousness and identity pride were considered as the strength-based factors related to the gender identities of TGNC individuals. Above 70% of the participants expressed positive attitudes toward the TGNC communities, including largely keeping informed of the TGNC issues and positively supporting the TGNC causes. Researchers explained that the large proportion of TGNC people who expressed community consciousness might result from a sense of belonging and identification with some shared culture and common experience provided by the community, such as "coming out" and pride flags (Herek & Glunt, 1995). As for identity pride, the TGNC people with a high level of identity pride are more likely to accept their gender identity, derive satisfaction from, and fully immerse themselves in that identity (Cass, 1979). In this study, I found that a large proportion of TGNC individuals considered themselves as unique and different due to their own gender identities. However, more than half of the TGNC individuals were still unwilling to disclose their gender identities, and they said that they were not proud of their gender identities. Such finding was consistent with their high level of internalized stigma. The acceptance of the negative comments from others negatively affected them on satisfaction and immersing themselves in their gender identities.

In line with previous studies, the TGNC people were at higher risks of negative mental health outcomes, including psychological distress and depression (Valentine &

Shipherd, 2018; Reisner et al., 2016; Scandurra et al., 2018). According to the results, there were almost half of the participants experienced mild, moderate, and even major symptoms of psychological distress (42.9%) and depression (48.9%), which reflected the negative mental health outcomes among the TGNC individuals. Specifically, almost 20% of the TGNC individuals reported a moderate or severe level of mental health symptoms, including 16.8% of them in psychological distress and 19.3% of them showed moderate or severe depressive symptoms. As I early expected, under a relatively unfavorable environment, the poor acceptance of TGNC people could cause negative effects on their mental health status (Nuttbrock et al., 2010; Ou et al., 2009). Such as it is, there were still 57.9% of the TGNC individuals who remained in a normal level of well-being status (score>50). It should be noted that the well-being status could be affected by numerous factors, and the issues related to gender identities could be detrimental to their mental health status, but it did not hinder the TGNC people so profoundly in improving their well-being status in their daily lives.

6.1.2 Group differences of stigma, strengths, and mental health status among TGNC individuals

Prior to testing the hypotheses of this study, I conducted an analysis of group differences to explore whether TGNC people with different demographic information experienced different levels of stigma, strengths, and mental health status. The participants whose sex assigned-at-birth were males and gender identity were transwomen reported a significantly higher level of enacted stigma compared with other groups. This finding was consistent with the results in Europe (Bonierbale et al., 2016). The male TGNC

people might be poorer accepted by the general public compared with the female TGNC individuals. Even so, the individuals did not report any significant differences in mental health status based on their different groups of sex assigned-at-birth and gender identities. There were significant differences in mental health status among the groups of age and education, but almost all the average levels of groups remained in the mild to moderate symptoms.

It should be noted that the TGNC people who were living in the urban areas and in the status of married or living together reported significantly lower levels of psychological distress and depression, but a significantly higher level of well-being status compared with those who were living in rural areas and other marriage groups. Compared with rural areas, urban areas are more refined and intellectualized to be free out of prejudices. People living in the urban areas are more indifferent and open-minded so that the acceptance of TGNC people could be at a higher level (Simmel, 2002). In regard to the marital status, the results indicated that the partner and a romantic relationship might be a part of social support and provide strengths for improving the mental health status of TGNC people.

Besides, the *one-child policy* is a specific policy in mainland China, which was initiated in the late 1970s to limit Chinese families to only one child each (Cameron, Erkal, Gangadharan, & Meng, 2013). The TGNC people who were the only child of their families showed significantly higher levels of psychological distress and depression, but also a significantly higher level of well-being status compared with those who had siblings in their families. The reasons could be complicated. According

to the previous study, the only child could be more likely to be in neuroticism. They were less taught pro-social values by their parents, and in addition, the family's expectations for the next generation all fell on their shoulders (Cameron, Erkal, Gangadharan, & Meng, 2013). Based on such conditions, the TGNC people might be at higher risks to report negative mental health outcomes when dealing with the issues related to their gender identities. There was also a significant difference in well-being between the TGNC individuals who were the only child and those who had siblings, but both groups remained at a level above 50 points.

The information related to their gender identities I focused on was whether the TGNC individuals had “come out” to the people around them and whether they had completed or were in the process of gender transition. The results showed that the TGNC people who had “come out” and endorsed themselves in the process of gender transition reported higher levels of stigma and poorer mental health outcomes compared with those who did not “come out” and endorsed themselves into the transition process. Researchers in the previous study explained that when “coming out”, the TGNC individuals could be likely to meet disapproval from others such as their family members (Aguayo-Romero, Reisen, Zea, Bianchi, & Poppen, 2015). Especially when they drove for a gender transition process, the TGNC people also reported significantly higher levels of stigma, which meant they may experience various kinds of discrimination, rejection, and so forth due to the change in their appearance. The stigmatized situation could trigger their inner negative beliefs about themselves (Aguayo-Romero, Reisen, Zea, Bianchi, & Poppen, 2015) and then be detrimental to

their mental health status.

6.2 The associations between stigma and mental health status among TGNC individuals

In support of the first hypothesis in this research, enacted stigma, anticipated stigma, and internalized stigma significantly contributed to the variance of psychological distress. Three types of stigma explained an additional 24.3% of the variance of psychological distress. The result of study 1 in this research was consistent with the results in the previous study, which indicated that the stigma-related stressors were correlated with their psychological distress among the TGNC people (Breslow et al., 2015; White Hughto, Pachankis, Willie, & Reisner, 2017; Gamarel, Sevelius, Reisner, Coats, Nemoto, & Operario, 2019;). The results were in line with the minority stress theory (Meyer, 2003) that the excess stressors of diverse types of stigma could be detrimental to the mental health among Chinese TGNC individuals, and the psychological distress required them to take more efforts to remain in a healthy psychological status. In the follow-up interviews in study 2, TGNC participants talked about their perceptions and feelings to give me more details and also validate the results of the relationships between stigma and psychological distress. Words such as desperate, angry, powerless, and miserable were used by them to describe their psychological distress in the face of stigmas, such as the unfair treatment due to their gender identities and their internalized transphobia towards their own gender identities. Participants also expressed that they felt lots of pressure when they needed to conceal their gender identities and gender expressions from others. Unwillingly lying and concealment in an

unfavorable environment might be another reason for them to feel psychological distress.

With partially confirming the second hypothesis of this study, the anticipated stigma and internalized stigma significantly contributed to the variance of depression, while the enacted stigma of Chinese TGNC people was not found to be a significant predictor in the hierarchical multiple regression. Previous studies also found that the anticipated stigma and internalized stigma were associated with the variance of depressive symptoms among TGNC individuals (Puckett, Maroney, Wadsworth, Mustanski, & Newcomb, 2020; Hoy-Ellis & Fredriksen-Goldsen, 2017). According to the rejection sensitivity model, the experienced rejection from others towards TGNC people might learn to anticipate negative responses from others (Mendoza-Denton, Downey, Purdie, Davis, & Pietrzak, 2002). It could be the way for them to guard against some anticipated potential threat, which was likely to aggravate their social isolation and their depressive symptoms (Pachankis, Hatzenbuehler, & Starks, 2014). From this perspective, the previous experiences of enacted stigma may not be sufficient enough to cause their negative mental health outcomes, but TGNC people are able to be affected on their subjective perceptions and appraisals, resulting in the elevation of their anticipated stigma or internalized stigma, and also their levels of depression. However, few studies focused on enacted stigma by examining all the stressors, including discrimination, rejection, and victimization. Some studies examined specific stressors of enacted stigma, such as discrimination and victimization, and significant associations were reported (Zhang, Lo, & Au, 2021; White Hughto, Pachankis, Willie,

& Reisner, 2017; Peng et al., 2019). Enacted stigma was commonly experienced among Chinese TGNC people, and they may be negatively influenced by some adversity experiences, but the general level of enacted stigma may not be strong enough to cause their negative mental health outcomes, and they were also likely to deal with them better by using their invulnerability (Peterson & Seligman, 2004).

Accordingly, the third hypothesis was also confirmed that all three types of stigma significantly explained the variance of well-being status among Chinese TGNC individuals. Specifically, the anticipated stigma was found to be highly correlated with well-being status, and the enacted stigma and internalized stigma were correlated with well-being status in medium levels. When combined together, the three types of stigma were found to explain another 29.1% of the variance of well-being status. Well-being status represented the positive mental health status among the TGNC individuals, and it was not surprising that the adverse experiences and perceptions related to their gender identities had detrimental associations with their well-being status. However, it should be noted that there were almost half of the TGNC individuals reported a low level of well-being status, and all eight participants in the follow-up interviews reported low levels of well-being status as well (Topp, Stergaard, Sndergaard, & Bech, 2015). The excess stressors they needed to face in a disadvantaged position would bring negative effects on them. Apart from the results in study 1, the qualitative results in study 2 gave more details for their well-being status. When they talked about dealing with their stigma, for example, they talked about their final decision to no longer conceal their gender identity but came out, and the words they commonly used to describe their

feelings were “relaxed” and “released”.

6.3 The moderating roles of the psychological strengths among TGNC individuals

The fourth, fifth, and sixth hypotheses were partially supported in this research that some strengths-based factors played moderating roles in the relationships between three types of stigma and mental health status, including psychological distress, depression, and well-being status. It should be noted that in the face of multiple manifestations of stigma, the strengths-based factors that became the moderating variables were also different. Among the strengths, social support was the most commonly found to be a buffer of their mental health status among Chinese TGNC individuals in the face of all three types of stigma. It seemed to attenuate the negative influence of stigma on mental health status among TGNC people, and the results were in line with previous studies as well (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Carter et al., 2019; Scandurra, Amodeo, Valerio, Bochicchio, & Frost, 2017). With a high level of perceived social support, TGNC people could find more functional ways to cope with the experienced unfair treatments and their negative anticipations and beliefs related to themselves (Scandurra, Amodeo, Valerio, Bochicchio, & Frost, 2017). Thoits (1985) pointed out that when perceiving social support from their significant others such as partners and family members, the social support primarily lied in its “positive emotional functions”, which could be a powerful reason to explain the positive moderating role in the relations of stigma with mental health outcomes.

In the follow-up interviews, the qualitative results also highlighted the importance

of social support in affecting their mental health status among the TGNC individuals. All the TGNC participants talked about the roles of social support in their daily lives, indicating the great importance of social support. The most commonly reported social support was from their partners and family members. According to the views of participants, the support from their significant others could be the backup for them to face the adversity in the world. When they encountered some difficulties such as being rejected or victimized due to their gender identities, the support could decrease their anxiety, powerlessness, and even desperate feelings. Participants also provided me with more details that the acceptance from family members and friends could attenuate their psychological distress and depression towards their appearance. Above all, social support could decrease the psychological distress of TGNC individuals from multiple perspectives when they were in the face of both objective and subjective manifestations of stigma.

The personal strengths were also found to have moderating effects on their negative mental health. As expected, identity pride and resilience buffered the negative associations between stigma and mental health status, although they played moderating roles in front of different types of stigma. Few studies focused on identity pride among TGNC people. Bockting and colleagues (2013) demonstrated that identity pride was negatively associated with psychological distress, but they did not find a moderating role of identity pride in the relationships between stigma and mental health status among TGNC people, which was inconsistent with the results in this study. The difference may be related to geographical and cultural distinctions. According to the

identity theory, TGNC individuals could have multiple identities integrated into their self-identities (Stryker, 1987). The self-identity varied in salience on the basis of the commitment of oneself to the communities of their social relationships (Mossakowski, 2003). The gender identity of TGNC people could be a sense of commitment to the TGNC community, and their identity pride could be their coping resource to buffer against stigma. As for resilience, some studies also found resilience as a moderator in the face of stigma (Scandurra, Amodeo, Valerio, Bochicchio, & Frost, 2017; Scandurra et al., 2018; Zhang, Lo, & Au, 2021). Scandurra and colleagues (2018) also pointed out that the internalized stigma was moderated by the resilience of TGNC individuals in affecting their depression and psychological distress. It seemed that the resilient coping among TGNC people could be beneficial for them to struggle against their internalized beliefs about their gender identities. They may use their resilient qualities and abilities to interact with the internalized disruptions and then achieve harmonious integration of their inner resources (Richardson, 2011).

Rejecting the fourth, fifth, and sixth hypothesis, community consciousness was a negative moderator in the relations of stigma with mental health status, which was not as expected and inconsistent with the minority strengths model as well. I found the community consciousness was likely to aggravate the negative associations between stigma and positive psychological status. The results were opposite to the views of some researchers. Herek and Glunt (1995) reported community consciousness as a protective factor among gay and bisexual men. Perrin and colleagues (2020) further explained that community consciousness included their sense of belonging to the sexual minority

community and the identification with the community, which could be beneficial for the TGNC people to gain social affirmation and self-affirmation and to buffer against their negative perceptions and feelings. However, the results in this study were in line with research conducted by Breslow and colleagues (2015) to some extent. They concluded that a high level of community consciousness actually strengthened the influence of stigma on psychological stress. With the increase of community consciousness, TGNC people might endorse themselves into activism and suffer from consequential risks such as depression and fatigue (Vaccaro & Mena, 2011). With a high level of community consciousness, they were likely to take community action, which may lead them to be exposed to transphobic contexts as well (Breslow et al., 2015).

Since the community consciousness was not found to buffer the detrimental associations between stigma and well-being status, I paid more attention to discuss with the TGNC individuals in the follow-up interviews about the impacts of community consciousness on their mental health status. The qualitative results provided more information to validate and elaborate the negative moderating roles of community consciousness. The community consciousness had mixed influences on the psychological status among TGNC individuals. Partially consistent with the views of previous studies (Herek and Glunt, 1995; Perrin, Sutter, Trujillo, Henry, & Pugh Jr, 2020), the TGNC participants in this research expressed that the existence of the TGNC community had a positive influence on their feelings. It was knowing that there were others who shared similar gender identities provided them with social affirmation and

self-affirmation. However, a high level of community consciousness may lead to a close connectedness with the TGNC community, and some TGNC participants talked about their negative feelings when they were actually involved in the community. They might be negatively affected by the intensity of negative emotional output from other community members. Besides, a chain of contempt was also revealed by the TGNC participants that some individuals may look down on those who did not endorse themselves into the gender transition process and thus considered them as “fake TGNC people”. That is, the negative rumination and the split within the community due to a high level of community consciousness were likely to aggravate the influence of stigma on mental health status.

Similar to community consciousness, self-esteem was also found to be a negative moderator, rejecting the fourth, fifth, and sixth hypotheses. Its moderating roles were significant in front of enacted stigma and internalized stigma. The minority strengths model proposed self-esteem could buffer the stress against the stigma encountered by TGNC people. Previous studies also pointed out that a higher level of self-esteem was considered to improve the mental health status and promote oneself to accept their gender identities (Swann & Spivey, 2004; Pyszczynski, Greenberg, Solomon, Arndt, & Schimel, 2004). However, some researchers pointed out that self-esteem may contain both positive aspect of self-confidence and negative aspect of self-deprecation (Rosenberg, Schooler, Schoenbach, & Rosenberg, 1995). In the face of stigma-related stressors, TGNC people with a high level of self-esteem may experience conflicts between their self-conceptions of efficacy, ability, and competence and the evaluations

from others only based on the gender identities and expressions of gender non-conformity of TGNC individuals (Owens, 1993). Such conflicts flooded their growth process and might further be detrimental to their mental health status.

After the data analysis of study 1, I intentionally further discussed with the TGNC participants in the follow-up interviews about their experiences and feelings relating to their self-esteem. Consistent with the results in study 1, some participants in study 2 showed their low self-esteem by talking a lot about their self-deprecation. It is worth noting that at the beginning, the TGNC participant recalled that they could not understand the reason why they were negatively evaluated by others, but they felt uncomfortable in the face of the judgments from others. The conflicts between their expected ways of affirmation and the evaluations by others flooded their growth process, and they gradually learned to lower their expectations of others' evaluations to avoid hurting themselves. Consequentially, some of them gradually lowered their sense of self-worth to ease the discomfort of conflicts between their self-affirmation and evaluations from others, but accordingly, they may suffer from internalized stigma since they internalized the negative beliefs toward themselves. This finding was similar to the views of self-verification theory (Swann, Stein-Seroussi, & Giesler, 1992) that holding a low sense of self-conception was likely to help TGNC people "maintain a viable self-system and predictable orderly social relations". Above all, a lower sense of self-esteem seemed to be a layer of protection they add to themselves for protecting themselves from the harm of negative psychological status.

CHAPTER SEVEN CONCLUSIONS AND IMPLICATIONS

7.1 Key findings of the research

High rates of stigma were reported by the participants, and almost half of the TGNC individuals showed symptoms of negative mental health outcomes and a low level of well-being status. As I hypothesized, the stigma was found to significantly contribute to the variance of mental health outcomes among TGNC people. Among their psychological strengths, social support, identity pride, and resilience were found to play buffering roles in the relationships between stigma and mental health status, which was consistent with my hypotheses. However, rejecting the hypotheses, community consciousness and self-esteem were likely to be aggravators when examining their moderating roles.

For elaborating and validating the quantitative results, ten themes were identified in the follow-up interviews, including experiences of pervasive adversity, negative feelings of adversity, concealment and negative expectations of anticipated stigma, internalized stigma – "I had a transphobia of myself", support from family and partner, support from people around and community members, identity pride for being special, self-esteem – both a weakness and a protection, and resilience for bouncing back. The participants confirmed the detrimental influence of stigma on their mental health status, and some strengths-based factors help them recover from the adversity.

I paid attention to the strengths of community consciousness and self-esteem. They were reported to be an aggravator for the relations of stigma with mental health status

and were also showed mixed influences on the psychological status in the follow-up interviews with TGNC participants. The existence of the TGNC community could provide the TGNC individuals with hope and support, while the negative rumination and the split within the community due to a high level of community consciousness were likely to aggravate the influence of stigma on mental health status. Besides, self-esteem was likely to offer a sense of self-worth in the face of adversity. However, the conflicts between their self-affirmation and evaluations from others due to their gender identities could bring them negative feelings such as angry, disappointment, anxiety, depression, and so forth. TGNC participants further expressed that a low level of self-esteem might be self-protection for themselves to get used to negative comments from others and avoid being influenced so much, which was not a good way but could lead to peace and calm in their daily lives. As mentioned above, future studies may need to concentrate more on the strengths of TGNC people instead of only keeping an eye on their negative mental health status. Further studies should also be conducted to explore the complex roles of community consciousness and self-esteem, and their mixed effects might be helpful for developing possible strategies to improve the mental health status of TGNC people.

7.2 Limitations of the study

The results were considered based on the collected data, and some limitations should be noted. First, this study used self-report questionnaires to investigate their stigma, strengths, and mental health status, which were mostly objective experiences and relied

on themselves to recall to give their answers. The self-report way might induce the assumptions and bias of retrospection among the TGNC participants, and their impression arrangement may also be a limitation for the data collection (Zhang, Lo, & Au, 2021). Further studies may consider collecting data from multiple perspectives. For example, except for collecting the views of TGNC individuals, the studies can also recruit their family members, partners, healthcare providers, and so forth so that researchers are able to have a comprehensive understanding of their issues. Second, a skewed distribution might exist among the samples, and the generalization of the results was limited (Fiani, 2018). On a voluntary basis, the TGNC participants who were willing to participate in the research were more likely to be open to sharing their experiences. The TGNC people who were in severe psychological symptoms such as major depression might be reluctant to participate in this study, focusing on the experiences related to their gender identities. In the future, researchers can consider investigating TGNC individuals who were in different statuses to improve the generalization of the results. Third, the cross-sectional and retrospective research methods had a limitation in understanding the chronological process among the studied variables. I examined them based on the current theories and hypotheses so that the antecedents and causal relationships overtime needed to be further studied. Fourth, I only recruited a small sample of eight TGNC individuals for the follow-up interviews. I intended to interview more TGNC individuals when I was conducting the research. However, during this process, many WeChat official accounts related to sexual minority populations were shut down, and some people who had agreed to be interviewed

therefore had a negative attitude towards being involved in the research. Under such circumstances, I was hindered in recruiting more interviewees, and all the identified themes were based on the contents of interviews with these eight TGNC individuals. Therefore it is not sure whether findings in the study can be generalized to all TGNC individuals in China.

7.3 Implications of the study

7.3.1 Clinical implications

In spite of limitations, this study has some implications in multiple aspects. For the clinical implications, the findings in this study were in support of the clinical guidelines listed by the American Psychological Association (2015). The guidelines pointed out that there may exist bidirectional influences between the gender identity development of TGNC people and their mental health status. Therefore, it seems to be fundamental for healthcare providers to help improve the mental health status in tandem with facilitating the development of their gender identities among TGNC people. The findings of this study further demonstrated that the TGNC people who experienced stigma-related stressors were at higher risks of negative mental health outcomes. The healthcare providers may need to focus on screening the adverse early experiences and their internalized thoughts related to gender identities of those TGNC individuals who had mental health symptoms instead of only concentrating on their mental health concerns. The healthcare providers should also consider offering interventions for addressing their trauma-related experiences accordingly.

The intervention programs might be developed by understanding their strengths-based factors among TGNC people. On the basis of being aware of the stigma and its potentially corresponding detrimental influences, clinicians are able to provide support for helping the TGNC individuals facilitate their self-understanding and even their identity pride. It is also an effective way to develop family therapy to improve their social support among TGNC people since almost every TGNC individual attaches great importance to the support from their family members in dealing with issues related to their gender identities (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Besides, it might be helpful for clinicians to stimulate the TGNC clients to find out their resilient resources, such as their moral characteristics (Richardson, 2011), which can be used to promote their resilience and be beneficial for them to bounce back from the stigma-related stressors. It should be noted that higher levels of self-esteem and community consciousness were reported to aggravate the negative mental health outcomes, and the healthcare providers should be careful when considering these two strengths-based factors as means of attenuating the influences of adversity on mental health status. On the contrary, if a TGNC individual shows a high level of TGNC community consciousness, the healthcare provider may pay attention to the potential negative influence on the agents, such as the negative rumination in the community. Besides, a high level of self-esteem should also be concerned by the healthcare provider, and they are likely to think about how to protect the TGNC individuals from the potential harm due to the conflicts between their self-affirmation and judgments from others.

7.3.2 Policy implications

Based on the results, supportive policies are needed to be developed to ameliorate the relatively unfavorable living environment for TGNC people, especially to decrease their social invalidation, decrease the stigma-related stressors, and facilitate their gender identity development. Lack of support and acceptance are likely to hinder the gender identity development of TGNC individuals (Jackman, Edgar, Ling, Honig, & Bockting, 2018). Developing parent education programs is an essential direction to help TGNC people explore their gender identities and gender expressions. The programs are supposed to highlight the importance of educating ways since the enforcement of binary gender norms from parents may cause detrimental effects on the healthy development of their TGNC children.

The school education programs should also be developed for promoting the knowledge of TGNC identities among teachers, administrators, school counselors, and so forth. The support from school staff can reduce the discrimination, rejection, and victimization occurred in the school setting. Many TGNC people spend lots of time in school settings during important stages, such as puberty, of exploring and developing gender identities. They are likely to take a long time to psychologically adjust themselves to recover from the unfair treatments related to their gender identities and expressions caused by both school staff and classmates (Toomey, Ryan, Diaz, Card, & Russell, 2010).

The findings from this study indicated that the policy was needed to be developed for improving the healthcare services for TGNC individuals, such as the healthcare

services of gender-affirming process. For reducing current barriers to attaining the services, education programs and training are needed for healthcare providers so that they are able to provide professional treatments and also avoid unintended discrimination and rejection toward TGNC clients (Safer et al., 2016). Finally, the inequalities and discrimination in such areas are likely to be associated with mental health status among TGNC people. The legislation is also essential to be ameliorated for reducing the inequalities experienced by TGNC people in multiple areas, including employment, housing, insurance, and so forth.

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APPENDIX 1 CHARACTERISTICS Of THE INCLUDED STUDIES IN THE SYSTEMATIC REVIEW

The results of the systematic review are as below, which listed the studies focusing on the relationships between stigma and mental health status among TGNC people.

Author (Year)	District	Study design	Participants	Methods	Selected findings
Bockting et al. (2013)	US	CS	1093 transgender people; aged 18 or above	Online questionnaire survey	Stigma was positively associated with psychological distress.
Breslow et al. (2015)	US	CS	552 TGNC people; aged 18-71	Online questionnaire survey	Discrimination and internalized transphobia were positively correlated with psychological distress.
Carter et al. (2019)	US	CS	298 transgender veterans; aged 18 or above	Online questionnaire survey	Discrimination was positively associated with suicidal ideation.
Chakrapani et al. (2017)	India	CS	300 transgender women and 300 men who have sex with men (MSM); aged 18 or above	Face-to-face questionnaire survey	Stigma was a significant predictors of depression.
Chodzen et al. (2019)	US	CS	109 TGNC adolescence; aged 12-18	Face-to-face questionnaire survey	Internalized transphobia was significantly more at higher risks of both Major Depressive Disorder and Generalized Anxiety Disorder.
Clements-Nolle et al. (2006)	US	CS	392 male-to-female (MTF) and 123 female-to-male (FTM) individuals; aged 18 or above	Questionnaire survey	Gender-based discrimination was associated with suicidal ideation.

Fiani (2018)	US	MS	357 TGNC people; aged 18 or above	Qualitative interviews and questionnaire survey	Victimization explained levels of depression, anxiety, and gender dysphoria.
Fredriksen-Goldsen et al. (2014)	US	CS	174 transgender older adults; aged 50 or above	Questionnaire survey	Victimization, concealment of gender identity, and internalized stigma were significantly associated with depressive symptomatology and perceived stress.
Gamarel et al. (2014)	US	CS	191 couples comprising transgender women and their cisgender primary male partners; aged 18 or above	Online questionnaire survey	Discrimination and relationship stigma were associated with depression
Gamarel et al. (2019)	US	CS	191 couples comprising transgender women and their cisgender primary male partners; aged 18 or above	Online questionnaire survey	Interpersonal stigma was associated with depression and anxiety.
Hoy-Ellis et al. (2017)	US	CS	174 transgender people; aged 50 or above	Questionnaire survey	Disclosure of gender identity was not significantly associated with perceived general stress and depression. Internalized heterosexism was a mediator between perceived general stress and depression.
Hoy-Ellis, Shiu et al. (2017)	US	CS	183 transgender older adults; aged 50 or above	Face-to-face and online questionnaire survey	Stigma was significantly associated with depressive symptomatology.
Jackman et al. (2018)	US	QS	18 transmasculine spectrum people; aged 16-39	Semi-structured interview	Enacted stigma and concealment and expectations of rejection contributed to non-suicidal self-injury.
Jäggi et al. (2018)	Swiss	CS	143 transgender people; aged 18-75	Face-to-face and online questionnaire survey	Unemployment, non-affirmation of gender identity, and internalized transphobia explained

					variance of depression.
Klemmer et al. (2018)	US	CS	233 transgender women; aged 18 or above	Face-to-face questionnaire survey	Victimization was associated with anxiety and depression.
Nuttbrock et al. (2010)	US	CS	571 transgender women; aged 19-59	Face-to-face Life Chart Interview (LCI)	Gender abuse was associated with major depression.
Nuttbrock et al. (2014)	US	LS	230 transgender women; aged 19-59	Face-to-face questionnaire survey and life review	Gender abuse was associated with depressive symptoms.
Peng et al. (2019)	China	CS	385 transgender and gender non-binary adolescents; aged 12-18	Online questionnaire survey	Bullying from school was significantly associated with suicidal ideation.
Puckett et al. (2020)	US	CS	695 transgender and gender diverse (TGD) individuals; aged 16 or above	Online questionnaire survey	Discrimination was associated with depression and anxiety.
Reisner et al. (2016)	US	CS	412 transgender adults	Online questionnaire survey	Discrimination was associated with posttraumatic stress disorder (PTSD) symptoms.
Sapareto (2018)	US	CS	29 transgender people; aged 18 or above	Online questionnaire survey	Perceived stigma and internalized transphobia were associated with suicidal ideation.
Scandurra et al. (2017)	Italy	CS	149 transgender people; aged 18 or above	Online questionnaire survey	Discrimination and internalized transphobia were associated with mental health problems.
Scandurra et al. (2018)	Italy	CS	149 TGNC people; aged 18-63	Online questionnaire survey	Internalized transphobia and discrimination were associated with depression and anxiety.
Scheim et al. (2019)	Cote d'Ivoire	CS	962 cisgender men and 339 transgender women; aged 18 or above	Questionnaire survey	Gender identity was mediated by stigma in the association with depression.

Schvey et al. (2019)	US	CS	174 TGNC active duty service members; aged 18 or above	Online questionnaire survey	Stigma was significantly associated with poorer mental health outcomes, including depression, anxiety, and stress.
Veale et al. (2017)	Canada	CS	923 transgender, genderqueer and gender non-conforming people; aged 14-25	Online questionnaire survey	Enacted stigma was positively related to mental health problems.
White White Hughto et al. (2017)	US	CS	452 transgender people; aged 18-75	Online questionnaire survey	Victimization was positively associated with depressive symptomology.
Yang et al. (2016)	China	CS	209 transgender women; aged 18 or above	Face-to-face questionnaire survey	Discrimination from friends was positively associated with anxiety.
Yang et al. (2015)	US	CS	191 adult transgender women	Online questionnaire survey	A higher level of stigma was associated with higher levels of depression and anxiety.
Yi et al. (2018)	Cambodia	CS	1375 transgender women; aged 18 or above	Face-to-face questionnaire survey	Gender-based violence was significantly associated with depressive symptoms.

APPENDIX 2 MEASUREMENT OF ENACTED STIGMA

与性别相关的歧视、拒绝和受害条目（前 17 条），请选中所有适用项（例如，在 18 岁之后和过去一年中的选项可能同时适用,则两者都是正确的）。

在这项调查中，性别表达是指基于多种因素，男性、女性或间性人如何表现，例如举止、着装、性格等等因素。

对于别的条目，请选出你同意它们的程度。

性别相关的歧视

回复选项：从不； 是的，在 18 岁之前； 是的，在 18 岁以后； 是的，过去一年中。

1. 由于我的性别认同或性别表达的原因，我在接受医学或心理健康治疗（与性别过渡有关或别的治疗）时遇到困难。

☐从不 ☐是，在 18 岁之前 ☐是，在 18 岁以后 ☐是，过去一年中

2. 由于我的性别身份或性别表达的原因，当我外出去公共场所时，我很难找到使用的卫生间。

☐从不 ☐是，在 18 岁之前 ☐是，在 18 岁以后 ☐是，过去一年中

3. 我在获得与我的性别身份匹配的身份证明文件时遇到了困难。

☐从不 ☐是，在 18 岁之前 ☐是，在 18 岁以后 ☐是，过去一年中

4. 由于我的性别身份或性别表达的原因，我很难找到住所或继续居住。

☐从不 ☐是，在 18 岁之前 ☐是，在 18 岁以后 ☐是，过去一年中

5. 我很难找到工作、保持工作，或者由于我的性别认同或表达而被拒绝晋升。

☐从不 ☐是，在 18 岁之前 ☐是，在 18 岁以后 ☐是，过去一年中

性别相关的拒绝

回复选项：从不； 是的，在 18 岁之前； 是的，在 18 岁以后； 是的，过去一年中。

6. 由于我的性别身份或性别表达的原因，我很难找到伴侣或曾经终止了关系。

☐从不 ☐是，在 18 岁之前 ☐是，在 18 岁以后 ☐是，过去一年中

7. 由于我的性别身份或性别表达的原因,我被宗教团体拒绝或在其中感到不受欢迎。

☐从不 ☐是，在 18 岁之前 ☐是，在 18 岁以后 ☐是，过去一年中

8. 由于我的性别身份或性别表达的原因，我在我的民族/种族社区被拒绝或在其中感到不受欢迎。

☐从不 ☐是，在 18 岁之前 ☐是，在 18 岁以后 ☐是，过去一年中

9. 由于我的性别身份或性别表达的原因，我被我的朋友拒绝或疏远。

☐从不 ☐是，在 18 岁之前 ☐是，在 18 岁以后 ☐是，过去一年中

10. 由于我的性别身份或性别表达的原因，我在学校或工作中遭到拒绝。

☐从不 ☐是，在 18 岁之前 ☐是，在 18 岁以后 ☐是，过去一年中

11. 由于我的性别身份或性别表达的原因，我被我的家人拒绝或疏远。

☐从不　　☐是，在 18 岁之前　　☐是，在 18 岁以后　　☐是，过去一年中

性别相关的受害

回复选项：从不； 是的，在 18 岁之前； 是的，在 18 岁以后； 是的，过去一年中。

12. 由于我的性别身份或性别表达的原因，我受到语言上的骚扰或嘲笑（例如，被称为“它”）。

☐从不　　☐是，在 18 岁之前　　☐是，在 18 岁以后　　☐是，过去一年中

13. 由于我的性别身份或性别表达的原因，有人威胁过要暴露我的身份或因此而勒索我。

☐从不　　☐是，在 18 岁之前　　☐是，在 18 岁以后　　☐是，过去一年中

14. 由于我的性别身份或性别表达的原因，我的个人财产遭到过破坏。

☐从不　　☐是，在 18 岁之前　　☐是，在 18 岁以后　　☐是，过去一年中

15. 由于我的性别身份或性别表达的原因，我受到身体伤害的威胁。☐从不　　☐是，在 18 岁之前　　☐是，在 18 岁以后　　☐是，过去一年中

16. 由于我的性别身份或性别表达的原因，我被别人推挤过、打过，或者别人用东西扔到过我的身上。☐从不　　☐是，在 18 岁之前　　☐是，在 18 岁以后　　☐是，过去一年中

17. 由于我的性别身份或性别表达的原因，在我不情愿的情况下与别人有了性接触。

☐从不　　☐是，在 18 岁之前　　☐是，在 18 岁以后　　☐是，过去一年中

APPENDIX 3 MEASUREMENT OF ANTICIPATED STIGMA

以下问题是要确定关于对未来的负面期望和对自己性别身份的不公开的项目的适当措辞：您目前是否一直或几乎一直以您自己肯定的性别生活？

（*您肯定的性别是指您认为对自己来说是准确的性别）

回应选项：是，我大部分或所有时间都生活在我肯定的性别中；否，我大部分或所有时间都没有以肯定的性别生活

如果是，请在以下项目中使用“历史”。如果否，在以下项目中使用“身份”。

对未来的负面期望

回应选项：5 分制，从非常不同意到非常同意

1. 如果我表达自己的性别身份/历史，别人不会接受我。

☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意

2. 如果我表达自己的性别身份/历史，公司将不会招聘我。

☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意

3. 如果我表达自己的性别身份/历史，人们会认为我有精神病或是“疯了”。

☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意

4. 如果我表达自己的性别身份/历史，人们会认为我令人作呕或是有罪的。

☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意

5. 如果我表达自己的性别身份/历史，大多数人会看不起我。

☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意
6.如果我表达自己的性别身份/历史，大多数人会看不起我。
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意
7.如果我表达自己的性别身份/历史，我可能会成为犯罪或者暴力的受害者。
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意
8.如果我表达自己的性别身份/历史，我可能会被警察逮捕或骚扰。
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意
9.如果我表达自己的性别身份/历史，我可能无法得到良好的医疗护理。
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意

性别身份的不公开
10.我不谈论过去的性别身份相关的经验、性别过渡的细节。
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意
11.我转变我说话的方式。
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意
12.我特别注重个人着装和修饰。
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意
13.我避免暴露我的身体。
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意
14.我改变我走路、做手势、坐和站的姿势。
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意

APPENDIX 4 MEASUREMENT OF INTERNALIZED STIGMA

内化的跨性别嫌恶
回复选项：5 分制，从非常不同意到非常同意
1.我怨恨我的性别身份或性别表达。
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意
2.我的性别身份或性别表达使我感觉自己像个怪胎。
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意
3.当我想到我的性别身份或性别表达，我会感到沮丧。
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意
4.当我想到我的性别身份或性别表达，我会感到不开心。
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意
5.因为我的性别身份或性别表达，我感觉自己像个被排斥的人。
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意
6.我经常问我自己：“为什么我的性别身份或性别表达不能正常一些呢？”
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意
7.我觉得我的性别身份或性别表达很令人尴尬。
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意
8.我嫉妒那些性别身份或性别表达不像我一样的人。

☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意

APPENDIX 5 MEASUREMENT OF COMMUNITY CONSCIOUSNESS

社群意识（community consciousness）

1. 如果我们共同努力，跨性别者者及非性别常规者可以解决我们面临的问题
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意
2. 我觉得持续关注与跨性别者及非性别常规者相关的问题很重要
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意
3. 我积极地支持全国性的跨性别者及非性别常规者的组织
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意
4. 我和其他跨性别者及非性别常规者有一种联系
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意
5. 我认为大多数跨性别者及非性别常规者都有一个共同的使命感，那就是为争取平等权利而努力
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意
6. 我认为所有的跨性别者及非性别常规者应该联合起来结束对跨性别的恐惧
☐非常不同意　　☐不同意　　☐中立　　☐同意　　☐非常同意

APPENDIX 6 MEASUREMENT OF SOCIAL SUPPORT

社会支持

指导语：下面的问题用于反映您在社会中所获得的支持，请按各个问题的具体要求，根据您的实际情况写。谢谢您的合作。

1.您有多少关系密切，可以得到支持和帮助的朋友？（只选一项）
A.一个也没有　　B.1—2 个　　C.3-5 个　　D.6 个或 6 个以上
2.近一年来您：（只选一项）
(1)远离家人，且独居一室。
(2)住处经常变动，多数时间和陌生人住在一起。
(3)和同学、同事或朋友住在一起。
(4)和家人住在一起。
3.您与邻居：（只选一项）
(1)相互之间从不关心，只是点头之交。
(2)遇到困难可能稍微关心。
(3)有些邻居都很关心您。
(4)大多数邻居都很关心您。

4.您与同事：（只选一项）
(1)相互之间从不关心，只是点头之交。
(2)遇到困难可能稍微关心。
(3)有些同事很关心您。
(4)大多数同事都很关心您。
5.从家庭成员得到的支持和照顾（在无、极少、一般、全力支持四个选项中，选择合适选项）
I．伴侣、恋人
A.无　　B.极少　　C.一般　　D.全力支持
II．父母
A.无　　B.极少　　C.一般　　D.全力支持
III．儿女
A.无　　B.极少　　C.一般　　D.全力支持
IV．兄弟姐妹
A.无　　B.极少　　C.一般　　D.全力支持
V．其他成员（如嫂子）
A.无　　B.极少　　C.一般　　D.全力支持
6.过去，在您遇到急难情况时，曾经得到的经济支持和解决实际问题的帮助的来源有：
(1)无任何来源。
(2)下列来源：（可选多项）
A.配偶；B.其他家人；C.亲戚；D.朋友 ；E.同事；F.工作单位；G.党团工会等官方或半官方组织；H.宗教、社会团体等非官方组织；I.其它（请列出）
7.过去，在您遇到急难情况时，曾经得到的安慰和关心的来源有：
(1)无任何来源。
(2)下列来源（可选多项）
A.配偶； B.其他家人；C.朋友 D.亲戚；E.同事；F.工作单位；G.党团工会等官方或半官方组织； H.宗教、社会团体等非官方组织；I.其它（请列出）
8.您遇到烦恼时的倾诉方式：（只选一项）
(1)从不向任何人诉述.
(2)只向关系极为密切的 1-2 个人诉述。
(3)如果朋友主动询问您会说出来。
(4)主动诉述自己的烦恼，以获得支持和理解。
9.您遇到烦恼时的求助方式：（只选一项）
(1)只靠自己，不接受别人帮助。
(2)很少请求别人帮助。
(3)有时请求别人帮助。
(4)有困难时经常向家人、亲友、组织求援。
10.对于团体（如党团组织、宗教组织、工会、学生会等）组织活动，您：（只选一项）
(1)从不参加
(2)偶尔参加
(3)经常参加
(4)主动参加并积极活动

APPENDIX 7 MEASUREMENT OF IDENTITY PRIDE

身份自豪（identity pride）

1. 感觉自己是独特的而且独一无二的

☐非常不同意 ☐不同意 ☐中立 ☐同意 ☐非常同意

2. 让人们知道我的出生分配性别/指派性别和性别认同不同是可以的

☐非常不同意 ☐不同意 ☐中立 ☐同意 ☐非常同意

3. 可以讨论自己的性别认同、性别历史

☐非常不同意 ☐不同意 ☐中立 ☐同意 ☐非常同意

4. 我的性别认同和出生分配性别/指派性别是不同的，这对我来说是一份礼物

☐非常不同意 ☐不同意 ☐中立 ☐同意 ☐非常同意

5. 因为我的性别认知，我与别人一样但是又有所不同

☐非常不同意 ☐不同意 ☐中立 ☐同意 ☐非常同意

6. 我的性别认同和出生分配性别/指派性别是不同的，对此我感到自豪

☐非常不同意 ☐不同意 ☐中立 ☐同意 ☐非常同意

7. 我可以舒服地向别人透露我的性别认同和出生分配性别/指派性别

☐非常不同意 ☐不同意 ☐中立 ☐同意 ☐非常同意

8. 倾向于让人们了解我的一切并接受我

☐非常不同意 ☐不同意 ☐中立 ☐同意 ☐非常同意

APPENDIX 8 MEASUREMENT OF SELF-ESTEEM

自尊

1.我感到我是一个有价值的人，至少与其他人在同一水平上。

☐非常符合 ☐符合 ☐不符合 ☐很不符合

2.我感到我有许多好的品质。

☐非常符合 ☐符合 ☐不符合 ☐很不符合

3.归根结底，我倾向于觉得自己是一个失败者。

☐非常符合 ☐符合 ☐不符合 ☐很不符合

4.我能像大多数人一样把事情做好。

☐非常符合 ☐符合 ☐不符合 ☐很不符合

5.我感到自己值得自豪的地方不多。

☐非常符合 ☐符合 ☐不符合 ☐很不符合

6.我对自己持肯定态度。

☐非常符合 ☐符合 ☐不符合 ☐很不符合

7.总的来说，我对自己是满意的。

☐非常符合 ☐符合 ☐不符合 ☐很不符合

8.我希望我能为自己赢得更多尊重。

☐非常符合 ☐符合 ☐不符合 ☐很不符合

9. 我确实时常感到自己毫无用处。
□非常符合　　□符合　　□不符合　　□很不符合
10. 我时常认为自己一无是处。
□非常符合　　□符合　　□不符合　　□很不符合

APPENDIX 9 MEASUREMENT OF RESILIENCE

心理韧性
1. 我能适应变化。
□从来不　　□很少　　□有时　　□经常　　□一直如此
2. 我有亲密、安全的关系。
□从来不　　□很少　　□有时　　□经常　　□一直如此
3. 我对自己的成绩感到骄傲。
□从来不　　□很少　　□有时　　□经常　　□一直如此
4. 我努力工作以达到目标。
□从来不　　□很少　　□有时　　□经常　　□一直如此
5. 我感觉能掌控自己的生活。
□从来不　　□很少　　□有时　　□经常　　□一直如此
6. 我有强烈的目的感。
□从来不　　□很少　　□有时　　□经常　　□一直如此
7. 我能看到事情幽默的一面。
□从来不　　□很少　　□有时　　□经常　　□一直如此
8. 事情发生总是有原因的。
□从来不　　□很少　　□有时　　□经常　　□一直如此
9. 我不得不按照预感行事。
□从来不　　□很少　　□有时　　□经常　　□一直如此
10. 我能处理不快乐的情绪。
□从来不　　□很少　　□有时　　□经常　　□一直如此
11. 有时，命运或上帝能帮忙。
□从来不　　□很少　　□有时　　□经常　　□一直如此
12. 无论发生什么我都能应付。
□从来不　　□很少　　□有时　　□经常　　□一直如此
13. 过去的成功让我有信心面对挑战。
□从来不　　□很少　　□有时　　□经常　　□一直如此
14. 应对压力使我感到有力量。
□从来不　　□很少　　□有时　　□经常　　□一直如此
15. 我喜欢挑战。
□从来不　　□很少　　□有时　　□经常　　□一直如此
16. 我能作出不寻常的或艰难的决定。
□从来不　　□很少　　□有时　　□经常　　□一直如此
17. 我认为自己是个强有力的人。

□从来不　□很少　□有时　□经常　□一直如此
18.当事情看起来没什么希望时，我不会轻易放弃。
□从来不　□很少　□有时　□经常　□一直如此
19.无论结果怎样，我都会尽自己最大努力。
□从来不　□很少　□有时　□经常　□一直如此
20.我能实现自己的目标。
□从来不　□很少　□有时　□经常　□一直如此
21.我不会因失败而气馁。
□从来不　□很少　□有时　□经常　□一直如此
22.经历艰难或疾病后，我往往会很快恢复。
□从来不　□很少　□有时　□经常　□一直如此
23.我知道去哪里寻求帮助。
□从来不　□很少　□有时　□经常　□一直如此
24.在压力下，我能够集中注意力并清晰思考。
□从来不　□很少　□有时　□经常　□一直如此
25.我喜欢在解决问题时起带头作用。
□从来不　□很少　□有时　□经常　□一直如此

APPENDIX 10 MEASUREMENT OF NEGATIVE MENTAL HEALTH

STATUS

症状自评量表 SCL-90
说明：下面有 90 条测验项目，列出了有些人可能会有的问题，请仔细地阅读每一条，然后根据最近一星期以内， 您的实际感觉，选择适合的答案点击，请注意不要漏题。
1. 头痛
□从无　□轻度　□中等　□偏重　□严重
2. 神经过敏，心中不踏实
□从无　□轻度　□中等　□偏重　□严重
3. 头脑中有不必要的想法或字句盘旋
□从无　□轻度　□中等　□偏重　□严重
4. 头昏或昏倒
□从无　□轻度　□中等　□偏重　□严重
5. 对原本令自己感到吸引的性别群体兴趣减退
□从无　□轻度　□中等　□偏重　□严重
6. 对旁人责备求全
□从无　□轻度　□中等　□偏重　□严重
7. 感到别人能控制你的思想
□从无　□轻度　□中等　□偏重　□严重
8. 责怪别人制造麻烦
□从无　□轻度　□中等　□偏重　□严重

9. 忘记性大
□从无 □轻度 □中等 □偏重 □严重
10. 担心自己的衣饰整齐及仪态的端正
□从无 □轻度 □中等 □偏重 □严重
11. 容易烦恼和激动
□从无 □轻度 □中等 □偏重 □严重
12. 胸痛
□从无 □轻度 □中等 □偏重 □严重
13. 害怕空旷的场所或街道
□从无 □轻度 □中等 □偏重 □严重
14. 感到自己的精力下降，活动减慢
□从无 □轻度 □中等 □偏重 □严重
15. 想结束自己的生命
□从无 □轻度 □中等 □偏重 □严重
16. 听到旁人听不到的声音
□从无 □轻度 □中等 □偏重 □严重
17. 发抖
□从无 □轻度 □中等 □偏重 □严重
18. 感到大多数人都不可信任
□从无 □轻度 □中等 □偏重 □严重
19. 胃口不好
□从无 □轻度 □中等 □偏重 □严重
20. 容易哭泣
□从无 □轻度 □中等 □偏重 □严重
21. 同令自己感到吸引的性别群体相处时感到害羞不自在
□从无 □轻度 □中等 □偏重 □严重
22. 感到受骗，中了圈套或有人想抓您
□从无 □轻度 □中等 □偏重 □严重
23. 无缘无故地突然感到害怕
□从无 □轻度 □中等 □偏重 □严重
24. 自己不能控制地大发脾气
□从无 □轻度 □中等 □偏重 □严重
25. 怕单独出门
□从无 □轻度 □中等 □偏重 □严重
26. 经常责怪自己
□从无 □轻度 □中等 □偏重 □严重
27. 腰痛
□从无 □轻度 □中等 □偏重 □严重
28. 感到难以完成任务
□从无 □轻度 □中等 □偏重 □严重
29. 感到孤独
□从无 □轻度 □中等 □偏重 □严重
30. 感到苦闷
□从无 □轻度 □中等 □偏重 □严重

31. 过分担忧
□从无 □轻度 □中等 □偏重 □严重
32. 对事物不感兴趣
□从无 □轻度 □中等 □偏重 □严重
33. 感到害怕
□从无 □轻度 □中等 □偏重 □严重
34. 我的感情容易受到伤害
□从无 □轻度 □中等 □偏重 □严重
35. 旁人能知道您的私下想法
□从无 □轻度 □中等 □偏重 □严重
36. 感到别人不理解您不同情你
□从无 □轻度 □中等 □偏重 □严重
37. 感到人们对你不友好，不喜欢您
□从无 □轻度 □中等 □偏重 □严重
38. 做事必须做得很慢以保证做得正确
□从无 □轻度 □中等 □偏重 □严重
39. 心跳得很厉害
□从无 □轻度 □中等 □偏重 □严重
40. 恶心或胃部不舒服
□从无 □轻度 □中等 □偏重 □严重
41. 感到比不上他人
□从无 □轻度 □中等 □偏重 □严重
42. 肌肉酸痛
□从无 □轻度 □中等 □偏重 □严重
43. 感到有人在监视您谈论您
□从无 □轻度 □中等 □偏重 □严重
44. 难以入睡
□从无 □轻度 □中等 □偏重 □严重
45. 做事必须反复检查
□从无 □轻度 □中等 □偏重 □严重
46. 难以作出决定
□从无 □轻度 □中等 □偏重 □严重
47. 怕乘电车、公共汽车、地铁或火车
□从无 □轻度 □中等 □偏重 □严重
48. 呼吸有困难
□从无 □轻度 □中等 □偏重 □严重
49. 一阵阵发冷或发热
□从无 □轻度 □中等 □偏重 □严重
50. 因为感到害怕而避开某些东西，场合或活动
□从无 □轻度 □中等 □偏重 □严重
51. 脑子变空了
□从无 □轻度 □中等 □偏重 □严重
52. 身体发麻或刺痛
□从无 □轻度 □中等 □偏重 □严重

53. 喉咙有梗塞感
□从无 □轻度 □中等 □偏重 □严重
54. 感到对前途没有希望
□从无 □轻度 □中等 □偏重 □严重
55. 不能集中注意力
□从无 □轻度 □中等 □偏重 □严重
56. 感到身体的某一部分较弱无力
□从无 □轻度 □中等 □偏重 □严重
57. 感到紧张或容易紧张
□从无 □轻度 □中等 □偏重 □严重
58. 感到手或脚发沉
□从无 □轻度 □中等 □偏重 □严重
59. 想到有关死亡的事
□从无 □轻度 □中等 □偏重 □严重
60. 吃得太多
□从无 □轻度 □中等 □偏重 □严重
61. 当别人看着您或谈论您时感到不自在
□从无 □轻度 □中等 □偏重 □严重
62. 有一些不属于您自己的想法
□从无 □轻度 □中等 □偏重 □严重
63. 有想打人或伤害他人的冲动
□从无 □轻度 □中等 □偏重 □严重
64. 醒得太早
□从无 □轻度 □中等 □偏重 □严重
65. 必须反复洗手、点数目或触摸某些东西
□从无 □轻度 □中等 □偏重 □严重
66. 睡得不稳不深
□从无 □轻度 □中等 □偏重 □严重
67. 有想摔坏或破坏东西的冲动
□从无 □轻度 □中等 □偏重 □严重
68. 有一些别人没有的想法或念头
□从无 □轻度 □中等 □偏重 □严重
69. 感到对别人神经过敏
□从无 □轻度 □中等 □偏重 □严重
70. 在商店或电影院等人多的地方感到不自在
□从无 □轻度 □中等 □偏重 □严重
71. 感到任何事情都很难做
□从无 □轻度 □中等 □偏重 □严重
72. 一阵阵恐惧或惊恐
□从无 □轻度 □中等 □偏重 □严重
73. 感到在公共场合吃东西很不舒服
□从无 □轻度 □中等 □偏重 □严重
74. 经常与人争论
□从无 □轻度 □中等 □偏重 □严重

75. 单独一人时神经很紧张
□从无 □轻度 □中等 □偏重 □严重
76. 别人对您的成绩没有作出恰当的评价
□从无 □轻度 □中等 □偏重 □严重
77. 即使和别人在一起也感到孤单
□从无 □轻度 □中等 □偏重 □严重
78. 感到坐立不安心神不宁
□从无 □轻度 □中等 □偏重 □严重
79. 感到自己没有什么价值
□从无 □轻度 □中等 □偏重 □严重
80. 感到熟悉的东西变成陌生或不象是真的
□从无 □轻度 □中等 □偏重 □严重
81. 大叫或摔东西
□从无 □轻度 □中等 □偏重 □严重
82. 害怕会在公共场合昏倒
□从无 □轻度 □中等 □偏重 □严重
83. 感到别人想占您的便宜
□从无 □轻度 □中等 □偏重 □严重
84. 为一些有关“性”的想法而很苦恼
□从无 □轻度 □中等 □偏重 □严重
85. 认为应该因为自己的过错而受到惩罚
□从无 □轻度 □中等 □偏重 □严重
86. 感到要赶快把事情做完
□从无 □轻度 □中等 □偏重 □严重
87. 感到自己的身体有严重问题
□从无 □轻度 □中等 □偏重 □严重
88. 从未感到和其他人很亲近
□从无 □轻度 □中等 □偏重 □严重
89. 感到自己有罪
□从无 □轻度 □中等 □偏重 □严重
90. 感到自己的脑子有毛病
□从无 □轻度 □中等 □偏重 □严重

APPENDIX 11 MEASUREMENT OF WELL-BEING STATUS

请针对以下五个句子，选出在过去两周中最接近您的感受。
1.我感到愉快并且精神状态好
□在全部时间内 □在大部分时间内 □超过一半的时间中 □少于一半的时间中 □有时候 □任何时候都不
2.我感到平静和轻松
□在全部时间内 □在大部分时间内 □超过一半的时间中 □少于一半的时间中 □有时候 □任何时候都不
3.我感到积极向上并且精力充沛

☐在全部时间内　　☐在大部分时间内　　☐超过一半的时间中　　☐少于一半的时间中　　☐有时候　　☐任何时候都不

4.我睡醒时感觉清新并睡得很足

☐在全部时间内　　☐在大部分时间内　　☐超过一半的时间中　　☐少于一半的时间中　　☐有时候　　☐任何时候都不

5.在日常生活中充满了令我感兴趣的东西

☐在全部时间内　　☐在大部分时间内　　☐超过一半的时间中　　☐少于一半的时间中　　☐有时候　　☐任何时候都不

APPENDIX 12 CHINESE VERSION OF FOLLOW-UP INTERVIEW

PROTOCOL

1. 请谈一下因为你的性别认知而产生的一些经历，以及这些经历如何影响你后续的行为和想法的？
2. 你如何看待你的性别认知？（例如：馈赠？累赘？中立？……）以及你认为你的性别认知给你带来的什么样的感觉或心理变化？
3. 在生活中，你如何应对与你的性别认知相关的压力？你又是如何从这些负面的影响和感觉中恢复的？
4. 请谈一下社会支持在你生活中所扮演的角色。在你的日常生活中，其他人是如何给予你支持或是不支持你的？你认为你的社会支持给你带来的什么样的感觉或心理变化？
5. 你认为你与跨性别及非性别常规者社群之间的联系是什么？你认为社群给你带来的什么样的感觉或心理变化？
6. 你如何评价你自己？其他人的评价又会对你产生什么样的影响呢？这些评价给你带来的什么样的感觉或心理变化？
7. 当我们谈论你的性别认知以及它对你的影响时，你认为还有什么其他的与性别认知相关的因素会对你的生活产生影响呢？