

Social Support, Stigma, and Mental Health Outcomes among Transgender and Gender
Non-Conforming Adults in the United States

Ilyssa M. Kaplan, M.S. Ed.

Pace University

A Doctoral Project Submitted in Partial Fulfillment of
the Requirements of the Degree of Doctor of Psychology in the
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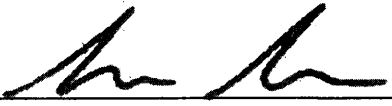
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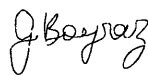
PROJECT ADVISOR: Dr. Lisa Rosenthal
Name
Associate Professor, Pace University
Title Affiliation

PROJECT CONSULTANT: Dr. Guler Boyraz
Name
Associate Professor, Pace University
Title Affiliation

FINAL APPROVAL OF COMPLETED PROJECT:

I have read the final version of the doctoral project and certify that it meets the relevant requirements for the Psy.D. degree in School-Clinical Child Psychology.

 1/3/20
Project Advisor's Signature Date

 1/3/2020
Project Consultant's Signature Date

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PREVIEW

ABSTRACT

Stigma experienced by transgender and gender non-conforming (TGNC) individuals has been associated with adverse mental health outcomes, like depression, anxiety, and suicidality. Some research documents that social support buffers associations of stigma with adverse mental health outcomes among TGNC individuals, while other research does not find buffering effects. Research has found direct associations of social support from families and friends with more positive mental health outcomes among TGNC individuals. More research is needed to understand the unique and combined consequences of different forms of stigma (i.e., enacted, anticipated, internalized) for mental health, as well as the specific functions and sources of social support that may both directly benefit mental health and moderate associations between stigma and mental health. This study recruited adult TGNC participants living in the U.S. through social media to complete an online survey about their experiences of stigma, social support, and mental health. Specifically, I tested direct associations of enacted, anticipated, and internalized stigma, as well as different sources of social support (i.e., TGNC people online, TGNC people in person, non-TGNC people online, non-TGNC people in person), with anxiety and depressive symptoms. Further, I tested potential moderation by social support of associations between stigma and mental health. I also examined the extent to which different types of support (instrumental and emotional) were more or less commonly received from particular sources of support. Analyses were conducted with data from 136 participants in the final analytic sample. Total, enacted, internalized, and anticipated stigma were each positively correlated with anxiety and depressive symptoms. In regression analyses with the three forms of stigma and control variables

included as simultaneous predictors, only enacted stigma remained positively associated with anxiety and depressive symptoms. Social support from non-TGNC people in person was negatively associated with anxiety and depressive symptoms in both correlation and regression analyses. Social support from TGNC people in person and from non-TGNC people online were not associated with anxiety or depressive symptoms in correlation or regression analyses. Social support from TGNC people online was significantly positively associated with anxiety and depressive symptoms in correlation and regression analyses. Social support and individual sources of support did not moderate associations of stigma with mental health outcomes. Individuals received more emotional support than instrumental support from all sources. Study findings contribute to our understanding of experiences of TGNC individuals to inform gender-affirming therapeutic interventions and techniques.

Keywords: anxiety, depression, gender-nonconforming, mental health, microaggressions, social network, social support, stigma, transgender

CHAPTER I

INTRODUCTION

Transgender and gender non-conforming (TGNC) individuals face disproportionately high rates of mental and physical health concerns, including depression, anxiety, suicidality, self-injurious behaviors and obesity (Budge, Adelson, & Howard, 2013; Fredriksen-Goldsen, Kim, Shiu, Goldsen, & Emlet, 2014; Graham et al. 2011; Nuttbrock, Rosenblum, & Blumenstein, 2002). A small but growing body of literature suggests that TGNC individuals face specific challenges as compared to their cisgender counterparts that contribute to adverse mental and physical health outcomes, including higher rates of victimization, gender discrimination, and internalized stigma, as well as fewer financial options and TGNC-specific barriers to obtaining healthcare (Fredriksen-Goldsen et al., 2014; Jen, 2018; Nuttbrock et al., 2010; Roberts & Fantz, 2014; Witten, 2016). TGNC individuals face multiple forms of stigma based on their gender expressions and identities, which play an important role in explaining disproportionate rates of adverse mental health outcomes, such as depression and suicide (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Hughto, Reisner, & Pachankis, 2015; Poteat, German, & Kerrigan, 2013).

Theory and research suggest that there are three forms of stigma or stigma mechanisms that contribute to health disparities: enacted (experienced discrimination, harassment, and violence based on one's identity), anticipated (expected social rejection because of one's identity), and internalized (shame and/or guilt about one's identity) stigma (Chaudoir, Earnshaw, & Andel, 2013; Stotzer, 2009). Each of these three forms of

stigma has been associated with poorer mental and physical health outcomes among diverse groups, including people of color (e.g., Corrigan, Markowitz, & Watson, 2004), people with physical disabilities (e.g., Chaudoir et al., 2013; Earnshaw & Chaudoir, 2009), gay and lesbian individuals (e.g., Hatzenbuehler, McLaughlin, & Nolen-Hoeksema, 2008; Meyer, 2003; Platt & Lenzen, 2013), and people with health conditions (e.g., Meyer, 2003), but these forms of stigma have been less well studied among TGNC populations (Barnes & Meyer, 2012; Chaudoir et al., 2013; Hatzenbuehler et al., 2008; Quinn & Chaudoir, 2009). To date, more research has documented the experiences of both enacted and internalized stigma (e.g., Hunger, Major, Blodorn, & Miller, 2015; Puckett, Maroney, Levitt, & Horne, 2016; Reyes, Alcantara, Reyes, Yulo, & Santos, 2016), but less is known about the consequences of anticipated stigma for well-being among TGNC individuals. Additionally, little research has examined the unique and combined consequences of all three forms of stigma together for mental health and well-being in this population.

Multiple studies suggest familial support has associations with positive physical and mental health outcomes for TGNC youth and adults (Mustanski & Liu, 2013; Pflum, Testa, Balsam, Goldblum, & Bongar, 2015; Pflum, Testa, Balsam, Spitalewitz, & Ziegelbaum, 2016). However, some TGNC individuals lack family support owing to stigma and rejection, while others do receive familial support. Studies suggest that TGNC adults may have limited social supports as compared to their LGB counterparts, including even not feeling supported by the rest of the LGB community (Fredriksen-Goldsen et al., 2013; Fredriksen-Goldsen et al., 2011, Witten, 2003).

Additionally, some research suggests that support received from online platforms may have direct positive associations with mental health outcomes among TGNC adults (Craig et al., 2017; Craig, McInroy, McCreedy, & Alaggia, 2015; McInroy & Craig, 2015; Pascoe, 2011). However, less is known about whether social support buffers TGNC individuals from adverse effects of stigma on well-being, as well as about the roles of different types and sources of social support for well-being among these populations. These dynamics have been studied more among lesbian, gay, bisexual, and transgender (LGBT) individuals more broadly, but TGNC individuals have been underrepresented in research focused on LGBT populations (Grossman, D'Augellie, & Hershberger, 2000; Whitehead, Shaver, & Stephenson, 2016). Therefore, this study aimed to explore associations of multiple forms of stigma (i.e., enacted, anticipated, internalized) from multiple sources (i.e., TGNC people online, TGNC people in person, non-TGNC people online, non-TGNC people in person) with internalizing mental health outcomes (i.e., anxiety and depressive symptoms), and tested the potential buffering role of social support on the associations between stigma and mental health outcomes. The study also investigated different types of support (instrumental and emotional) and if they were more or less commonly received from different sources of support. The study findings can contribute to our understanding of the specific needs of TGNC communities and individuals in order to inform interventions and help to train healthcare providers.

CHAPTER II

LITERATURE REVIEW

History of TGNC Identities

The term “transgender” is often used as an umbrella term to refer to diverse groups of people who identify and/or express their gender beyond the male-female binary and/or in a way that is inconsistent with their assigned sex at birth (Austin, 2016; Nadal, Davidoff, Davis, & Wong, 2014). As gender is increasingly recognized and understood as multidimensional and on a spectrum, terms like gender non-conforming (GNC) are increasingly common and have become more inclusive of multiple identities, such as agender, genderfluid, genderqueer, nonbinary, transmasculine, and transfeminine (Austin, 2016). The Institute of Medicine (2011) has identified transgender adults as an understudied population in need of health research (Fredriksen-Goldsen, 2013). Recent estimates suggest that between .39% and .60% of the U.S. adult population (i.e., between 1 million and 1.4 million people) identifies as transgender (Crissman, Berger, Graham, & Dalton, 2017; Flores, Brown, & Herman, 2016; Meerwijk & Servelius, 2017).

Williams Institute has also estimated that .7% of youth ages 13-17 identify as transgender (Herman, Flores, Brown, Wilson, & Conron, 2017). Some studies have found higher prevalence of youth who identify as TGNC. As examples, 1.3% of youth identified as transgender in a study of teenagers in San Francisco (Eisenberg et al., 2017; Shields et al., 2013); 1.6% of high school students identified as transgender in a study in Boston (Almeida et al., 2009; Eisenberg et al., 2017); and one study found that 1.2% of a group of New Zealand high school students identified as transgender, with an additional 2.5% of youth not being sure about their gender identity (Clark et al., 2014; Eisenberg et

al., 2017). Overall, prevalence rates of TGNC identified individuals remains unclear and inconclusive owing to difficulties with reporting biases and different instruments used to measure gender identity expression, coupled with a general lack of data on TGNC populations in the U.S. (Meerwijk & Sevelius, 2017).

In the mid to late 19th century, medical professionals began to recognize an increasing number of GNC individuals in individual case studies, and doctors often aimed to treat their nonconformity as a form of pathology (Beemyn, 2013). In 1950, the first female-to-male (FTM) surgery was performed successfully (Beemyn, 2013). The publication of Harry Benjamin's work published in 1966 titled "The Transsexual Phenomenon" became a source of validation and comfort for not only many closeted individuals who questioned their gender identities, but also for many clinicians and physicians. In the late 1960s, the first gender identity clinic opened at Johns Hopkins University (Beemyn, 2013). During this time, various activist groups such as Transsexuals and Transvestites (TAT) emerged. Across the U.S., many individuals who were part of these groups began to protest in an effort to change their gender-birth designations and insist on getting altered documentation (Stryker, 2004). In 1969, the Stonewall riots occurred, which played an important role in cultivating community action and bringing transgender individuals' experiences of harassment and police brutality to the forefront (Beemyn, 2013; Stryker, 2004). In the 1970's, the World Professional Association for Transgender Health established standards of care in order to address those diagnosed with Gender Identity Disorder (GID), and society began to recognize specific "standards of care" for individuals diagnosed with GID, including but not limited

to cross-sex hormonal therapy treatments, and later the consideration of gender reassignment surgery (Spack et al., 2012).

In the 1980's, a growing number of transgender groups and openly transgender individuals provided greater opportunities and gave greater voice to gender-nonconforming people (Spack et al., 2012). In the 1990's, medical professionals began to notice the growing population of individuals who would later become known as "cross-dressers" or "transgender." Predominately noted by U.S. and European physicians, these individuals started to be more recognized and became known as "individuals who identified as a gender different from their assigned gender," but were often still classified as "mentally disturbed" (Beemyn, 2013, p. 114). It was hypothesized that individuals who engaged in stereotypically "a-typical" gender behaviors were suffering from psychotic episodes and needed to be heavily medicated (Beemyn, 2013).

Since the recognition of GID in the Diagnostic Statistical Manual III in the 1980's (American Psychiatric Association, 1980), there has been controversy in the fields of psychiatry and psychology with regards to assessing, diagnosing, and providing therapeutic interventions to children, adolescents, and adults who present with a range of gender identity issues (Zucker & Spitzer, 2005). In a revision to the DSM III, the DSM IV placed gender identity disorder under "Sexual and Gender Identity Disorders," which were divided into three distinct categories: gender identity disorders, sexual dysfunctions, and paraphilias (American Psychiatric Association, 2000). In contrast to the diagnoses previously provided by the DSM-III and -IV focusing on the identity as a disorder, and in response to sustained activism and advocacy around these issues, the DSM-V revision introduced the term gender dysphoria, referring to the "distress that may accompany the

incongruence between one's experienced or expressed gender and one's assigned gender," with the goal of not pathologizing the identity itself (American Psychiatric Association, 2013, pp. 451). This term focuses on the clinical state of dysphoria as the treatable problem rather than the identity being the problem (American Psychiatric Association, 2013), although there are continued critiques of and controversy surrounding the inclusion of any clinical diagnosis for TGNC individuals' identities (Shulman et al., 2017).

Mental Health among TGNC Individuals

TGNC youth and adults are at greater risk for developing negative mental health outcomes than their cisgender counterparts (Bockting et al., 2013; Budge et al., 2013; Fiani, 2018; Scourfeld, Roen, McDermott, 2008; Shumer, 2018). Transgender individuals report higher rates of anxiety, depression, substance use, suicidality, and social anxiety than their cisgender counterparts (Butler et al., 2019; Kessler & Waehler, 2005). Lifetime rates of depression in the TGNC community may be as high as 50-67% (Clements-Nolle, Marx, Guzman, & Katz, 2001; Nemoto, Bodeker, & Iwamoto, 2011, Nuttbrock et al., 2010). Lifetime prevalence rates of suicidality are estimated to range from 25-76% among TGNC individuals (Clements-Nolle et al., 2001; Clements-Nolle, Marx, & Katz, 2006; Grant et al., 2011). Hepp, Kraemer, Schnyder, Miller, and Delsignore (2005) found the rate of anxiety disorders within the TGNC population to be 26%. In a cross-sectional online study, individuals who identified as transgender had higher rates of depression, anxiety, somatization, and psychological distress than their cisgender counterparts (Bockting et al., 2013). Overall, 44.1% of transgender participants reported clinical depression, 33.2% reported anxiety symptomology, and 27.5% reported somatization

symptoms (Bockting et al., 2013). Similarly, in an Australian sample of transgender men and women ages 18-77 years old, 46% of the sample reported high levels of psychological distress (Bariola et al., 2015). Although research aiming to understand these disparities is increasing, historically research including TGNC identities has been limited (Carmel & Erickson-Schroth, 2016).

Data from a retrospective cohort study revealed a two- to three-fold disproportionality in risk of adverse mental health outcomes for transgender individuals ages 12-29, including depression, suicidal ideation, and suicidal attempts, compared to a cisgender comparison group (Reisner et al., 2015). The National Transgender Discrimination Survey found that 41% of TGNC adults had attempted suicide at one point in their lives, compared to only ~1.6% of the general population (Grant et al., 2010). Lederer and Oswald (2017) examined the mental health of transgender individuals during emerging adulthood (18-26 years) and found the highest rates of depression, anxiety, and panic disorders in these individuals as compared to their cisgender male and female counterparts of the same age (Lederer & Oswald, 2017; Pflum et al., 2015). In one study, Male-to-Female (MTF) transgender youth of color ages 16-25 reported self-esteem and depression rates similar to those reported in the general population, although they also reported limited social support from parents and siblings (Factor & Rothblum, 2007).

Haas, Rogers, and Herman (2014) studied suicidal behaviors among TGNC adults who responded to the National Transgender Discrimination Survey and found that suicide attempts among trans men (46%) and trans women (42%) were higher than the full sample of TGNC participants assessed in the survey (41%). A study by Downing and Przedworski (2018) analyzing data from the 2014-2016 Behavioral Risk Factor

Surveillance System estimated that individuals who identified as GNC had higher rates of chronic health conditions, poorer quality of life, and more disabilities than their cisgender male and female counterparts (Downing & Przedworski, 2018). Although prevalence rates of depression, anxiety, and overall psychological distress are generally above average in these populations, only a handful of studies examine the specific TGNC experiences and reasons why these disparities exist (Budge et al., 2013).

In addition to mental health disparities, research suggests TGNC individuals also suffer from disproportionately high physical health complications (Fredrikson-Goldsen et al., 2013; Peitzmeier, Gardner, Weinand, Corbet, & Acevedo, 2017). For example, binding (compression of chest tissue for transmasculine identity expression) can lead to scarring and lactation suppression, fractured ribs, and bruising (Nelson, Whallett, & McGregor, 2009; Swift & Janke, 2003). Other research suggests that individuals who choose to use medical interventions, including hormonal treatments and gender reassignment surgeries, report higher qualities of life and fewer mental health issues such as anxiety, suicidality, and depression than those who do not (Coleman et al., 2012; Newfield, Hart, Dibble, & Kohler, 2006; Rotondi et al., 2012). However, due to lack of opportunity and access to care for this population, many TGNC individuals engage in unhealthy risk behaviors (Garofalo, Deleoin, Osmer, Doll, & Harper, 2006).

Garofalo et al. (2006) found that 29% of a sample of young TGNC adults ages 16-25 reported lifetime use of injection silicone and feminizing hormones. Feminizing hormones are designed to foster gender congruency, and can lead to positive outcomes for many TGNC individuals (Dahl, Feldman, Goldberg, & Jaber, 2006; Sanchez, Sanchez, & Danoff, 2009). However, owing to difficulties obtaining hormones from non-

medical providers, TGNC individuals often turn to online forums to acquire treatments at dangerous and lethal levels, leading to a number of health consequences like “mood swings, hepatic disease, thromboembolic disease, in addition to the transmission of HIV from shared needles” (Israel & Tarver, 1997 as cited by Garofalo et al., 2006, pp. 235). Due to the high desirability of using endocrine therapies and hormonal injections to facilitate a gender presentation more consistent with one’s gender identity and reduce distress, unsupervised hormone therapy has ranged from 29% to 63% within groups of transgender persons (Sanchez et al., 2009).

Additionally, many transgender individuals are without medical insurance to cover treatment they seek (e.g., hormones, surgeries) and thus are forced to pay out of pocket, which leads many to choose potentially risky treatments that can adversely affect physical and mental health (Coleman et al., 2012; Hughto et al., 2015; Nemoto, Luke, Mamo, Ching, & Patria, 1999; Williamson, 2010). TGNC youth also reported fearing anger and rejection from sexual partners and therefore, were likely to use condoms inconsistently (Garofalo et al., 2006). The majority of participants in this study reported engaging in unprotected sex in addition to experiencing sexual assault, which can lead to increased risks of contracting HIV and/or other sexually transmitted infections (Garofalo et al., 2006; Grossman & D'Augelli, 2006). These physical health concerns are often comorbid with mental health issues in the TGNC population, which should be taken into consideration when examining the socio-cultural contexts that may increase health risks in this population (Fredrikson-Goldsen et al., 2013).

Stigma and TGNC Individuals

Hatzenbuehler, Phelan, and Link (2013) conceptualize stigma as the “occurrence of labeling, stereotyping, separation, status loss, and discrimination in a context in which power is exercised” (p. 813). This conceptual framework includes experiences with multiple different stigmatized statuses and addresses how stigma operates at multiple levels (e.g., intrapersonal, interpersonal, structural), resulting in adverse consequences for mental and physical health outcomes and disparities (Crocker & Major, 1989; Hatzenbuehler et al., 2013; Major & O’Brien, 2005). Chaudoir et al. (2013) suggest a framework for understanding how stigma can lead to psychological and physical health disparities on multiple levels, including through three stigma mechanisms: enacted, anticipated, and internalized stigma (Earnshaw & Chaudoir, 2009). Enacted stigma refers to experiences of discrimination, victimization, exclusion, or marginalization because of one’s stigmatized group membership (Chaudoir et al., 2013). Anticipated stigma (also sometimes referred to as rejection-sensitivity) refers to someone expecting social rejection because of their stigmatized group membership (Chaudoir et al., 2013). Internalized stigma refers to shame or self-hatred someone feels because of their stigmatized group membership (Chaudoir et al., 2013). Each of these stigma mechanisms have been associated with adverse mental and physical health outcomes for many stigmatized groups (e.g., Hatzenbuehler et al., 2008; Mak, Poon, Pun, & Cheung, 2007; Pascoe & Richman, 2009; Quinn & Chaudoir, 2009; Wagner et al., 2016), but relatively less research has explored how these mechanisms affect TGNC populations specifically.

Research suggests experiences of stigma contribute to the disproportionately high rates of adverse mental and physical health outcomes found in LGBT populations

(Bariola et al., 2015; Hughto et al., 2015, Kosciw, Greytak, Giga, Villenas, & Danischewski, 2016a; Nadal, et al., 2014; Valdiserri, Holtgrave, Poteat, & Bevrer, 2018). Often, individuals who identify with LGBT communities report multiple experiences with harassment and discrimination related to their sexual orientations, gender identities, and gender expressions throughout their lives, even before they reach high school years (Kosciw et al., 2009; Kosciw, Greytak, Giga, Villenas, & Danischewski, 2016; Nadal, Whitman, Davis, Erazo, & Davidoff, 2016). Anticipated, enacted, and internalized stigma have each been found to be associated with adverse outcomes, such as depression, anxiety, and suicide among LGBT individuals broadly (e.g., Almeida et al., 2009; Bockting et al., 2013; Hughto et al., 2015; Poteat et al., 2013). However, most of the existing work on LGBT populations has actually focused on gay men and lesbian women, leaving TGNC individuals completely out of or underrepresented in their research, suggesting the need for more research on these stigma mechanisms and their consequences that focuses specifically on these populations. A small but growing body of literature has recently begun to explore specific gender-related stressors such as “discrimination, victimization, exposure to transphobia, and internalized stigma” that are associated with psychopathology among TGNC individuals, supporting the importance of these experiences to understanding well-being among these populations (Bariola et al., 2015, p. 2108; also see Bockting, et al., 2013; Gamarel, Reisner, Laurenceau, Nemoto & Operario, 2014; Kelleher, 2009; Valdiserri et al., 2018).

Enacted stigma among TGNC individuals. TGNC individuals experience disproportionately high rates of violence compared to their cisgender counterparts, such as physical and sexual assault, which are often perpetrated by known others like family,

friends, and significant others (Grant et al., 2010; Grossman & D'Augeli, 2006; McCauley, Cooulter, Bogen, & Rothman, 2018; Schilt & Westbrook, 2009; Stolzer, 2009). In some studies, estimates of discrimination, harassment, victimization, and violence against TGNC teen and adult communities range from 50-90% (Carmel & Erickson-Schroth, 2016; Clements-Nolle et al., 2006; Kattari & Hasche, 2016). As examples, the use of transphobic and/or incorrect terminology, assumption of universal transgender experiences, exoticism, discomfort/disapproval, endorsement of gender normative and binary culture of behaviors, denial of existence of transphobia, assumption of sexual pathology, physical threats/harassment, denial of personal body privacy, familial microaggressions, and systematic and environmental microaggressions are some of the different forms of enacted stigma that research finds TGNC individuals experience (Nadal et al., 2014).

In one study, Nadal, Skolnik, and Wong (2012) utilized focus groups to identify interpersonal types of microaggressions, or subtle forms of discrimination that transgender individuals experience. They found that their transgender participants reported experiencing interpersonal stigma with regards to language and incorrectly gendered terminology, questions about their bodies and the way they look, and questions about reasons for not wanting to self-identify (Nadal et al., 2012). Additionally, a longitudinal study examining LGBT adolescents and levels of psychological distress associated with self-reported rates of victimization found that transgender individuals reported significantly greater rates of victimization than their cisgender LGB counterparts who participated in the study (Birkett, Newcomb, & Mustanski, 2015).

Transgender individuals' experiences with these different forms of enacted stigma are also found to have adverse consequences for their well-being. For example, transphobia has been found to be a key contributor to elevated rates of suicidality among transgender individuals in multiple studies (Clements-Nolle et al., 2006; Hellman, Sudderth, & Avery, 2002; Kidd, Veltman, Gately, Chan, & Cohen, 2011; Liu & Mustanski, 2012; Mizock & Mueser, 2014). Reyes et al. (2016) found a strong association between transphobia and self-concept in transgender men and women from the Philippines (Reyes et al. 2016). Haas et al. (2014) found that perpetual stigmatizing experiences from others as a result of appearing gender variant was associated with higher rates of attempted suicide among transgender adults in the United States. Rood et al. (2017) suggest that negative social messages received by society (an aspect of enacted stigma) lead to internalized transphobia in TGNC individuals and represent a larger health concern. In another study, transgender participants ages 18 and older living in a metropolitan area expressed frustration with providers' uncertainty with how to use their pronouns appropriately as well as their lack of knowledge about transgender individuals' needs and medical procedures (Poteat et al., 2013). Specifically, transgender individuals who are unable to access gender affirmation treatments and procedures are at particular risk of experiencing enacted stigma owing to their gender nonconforming appearances being visible to others (Bockting et al., 2013; Grant et al., 2011; Radix, Lelutiu-Wienberger, & Gamarel, 2014; Reisner et al., 2015).

Enacted stigma can impact individuals at a structural level in addition to an interpersonal level. Structural-stigma refers to societal norms, conditions, or policies that limit means for stigmatized groups (Hatzenbuehler & Pachankis, 2016). At the core of