PERCEIVED DISCRIMINATION AND DEPRESSION AMONG TRANS+ INDIVIDUALS: THE MEDIATING ROLES OF COGNITIVE EMOTION REGULATION AND PERCEIVED SOCIAL SUPPORT

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ETHICAL DECLARATION

I hereby declare that I am the sole author of this thesis and that I have conducted my work in accordance with academic rules and ethical behaviour at every stage from the planning of the thesis to its defence. I confirm that I have cited all ideas, information and findings that are not specific to my study, as required by the code of ethical behaviour, and that all statements not cited are my own.

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ABSTRACT

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This study aims to examine the effects of perceived discrimination on depression among transgender individuals and explore the mediating roles of cognitive emotion regulation strategies and perceived social support. A total of 112 participants, aged 18 and above, who identified with gender identities under the trans+ spectrum (including trans woman, trans man, non-binary, genderqueer, genderfluid, bigender, and agender), were reached. Data were collected using Demographic Information Form, Perceived Discrimination Scale, Multidimensional Perceived Social Support Scale, Cognitive Emotion Regulation Scale, and Beck Depression Inventory. The results of this study revealed that perceived social support and maladaptive cognitive emotion regulation strategies both significantly mediated the relationship between perceived discrimination and depression. Specifically, it was found that only the "acceptance" strategy significantly mediated this relationship among cognitive emotion regulation

strategies. Furthermore, a positive relationship was found between perceived discrimination and depression, indicating that as the level of perceived discrimination increased, the level of depression also increased. In addition, a negative relationship was demonstrated between perceived social support and depression, indicating that higher levels of perceived social support were associated with lower levels of depression. Finally, the findings of this study revealed that transgender individuals tend to perceive discrimination more strongly towards their own group, rather than perceiving it directed towards themselves as individuals. The findings are discussed within the framework of the Minority Stress Model. These findings are expected to raise awareness regarding the challenges experienced by transgender individuals and provide valuable clinical implications for treatment planning in working with transgender individuals.

Keywords: Perceived Discrimination, Perceived Social Support, Cognitive Emotion Regulation, Trans+, LGBTQ+, Depression

ÖZET

TRANS+ BİREYLERDE ALGILANAN AYRIMCILIK İLE DEPRESYON ARASINDAKİ İLİŞKİNİN İNCELENMESİ: BİLİŞSEL DUYGU DÜZENLEME STRATEJİLERİ VE ALGILANAN SOSYAL DESTEĞİN ARACI ROLLERİ

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Bu çalışma trans bireylerde algılanan ayrımcılığın depresyon üzerindeki etkisini ve bilişsel duygu düzenleme stratejilerinin ve sosyal desteğin bu ilişkideki aracı rollerini araştırmayı amaçlamaktadır. Bu amaçla cinsiyet kimliğini trans+ (trans kadın, trans erkek, non-binary, genderqueer, genderfluid, bigender, agender) şemsiyesi altındaki cinsiyet kimliklerinden biriyle tanımlayan 18 yaşından büyük 112 katılımcıya ulaşılmıştır. Veriler Demografik Bilgi Formu, Algılanan Ayrımcılık Ölçeği, Çok Boyutlu Algılanan Sosyal Destek Ölçeği, Bilişsel Duygu Düzenleme Ölçeği ve Beck Depresyon Envanteri ölçekleri kullanılarak toplanmıştır. Sonuçlar algılanan sosyal desteğin ve uyumsuz bilişsel duygu düzenleme stratejilerinin algılanan ayrımcılık ile depresyon arasındaki ilişkide anlamlı bir aracı rol oynadığını göstermiştir. Dahası, hangi bilişsel duygu düzenleme stratejilerinin bu ilişkide aracı rol oynadığı araştırıldığında sadece "kabul etme" stratejisinin bu ilişkiyi anlamlı bir şekilde aracı ettiği bulunmuştur. Ayrıca, algılanan ayrımcılık ile depresyon arasında pozitif yönde

bir ilişki olduğu, algılanan ayrımcılık seviyesi arttıkça depresyon seviyesinin de arttığı görülmüştür. Bunun yanında, algılanan sosyal destek ile depresyon arasında ters bir ilişki olduğu, algılanan sosyal destek seviyesi arttıkça depresyon seviyesinin düştüğü gözlenmiştir. Son olarak, bulgular trans bireylerin ayrımcılığı bireysel olarak kendilerine yönelik algılamaktan daha çok kendi gruplarına yönelik algıladığını göstermiştir. Bulgular, başta Azınlık Stresi Modeli olmak üzere ilgili literatür bağlamında tartışılmıştır. Çalışmanın bulgularının, trans bireylerin yaşadığı zorlukları dikkat çekeceği ve trans bireylerle terapötik çalışma yürütürken tedavi planlama noktasında faydaları olacağı düşünülmektedir.

Anahtar Kelimeler: Algılanan Ayrımcılık, Algılanan Sosyal Destek, Bilişsel Duygu Düzenleme, Trans+, LGBTQ+, Depresyon.

Dedicated to my mother and my grandmother…

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CHAPTER 1: INTRODUCTION

Transgender individuals often face pervasive and systematic discrimination based on their gender identities due to stigmatization (Bockting, 2005; Grant et al., 2011). LGBT+ (lesbian, gay, bisexual, and transgender) individuals, particularly transgender individuals, are subjected to discrimination in various aspects of their daily lives, such as employment, housing, and healthcare accessibility (Lombardi, 2002). Furthermore, discrimination rates for transgender people are alarmingly high (Grant et al., 2011; Herek, 2009; Takács, 2006). This discriminatory environment adversely affects their mental health.

Research has demonstrated the adverse effects of discrimination on mental health (Schmitt et al., 2014). Similarly, studies have shown the association between discrimination and negative mental health outcomes among transgender individuals, such as depression (Bockting et al., 2013; Testa et al., 2012). Moreover, high rates of depression have been reported among transgender individuals (Bocking et al., 2005; Nuttbrock et al., 2010). In addition, given the relationship between depression and suicide (Riberio et al., 2018) and the high rates of suicide among transgender people (Grant et al., 2011), these studies indicate that depression is an important issue for transgender individuals.

The Minority Stress Model (Meyer, 2003) describes the specific stressors experienced by individuals belonging to gender and sexual orientation minority groups. According to this model, discrimination and stigmatization have negative consequences on the mental health of individuals belonging to minority groups, such as depression. Furthermore, this model has shown that healthy coping methods and support mechanisms reduce the negative effects of discrimination. In line with this theory, research has shown that social support reduces the devastating effects of discrimination and that social support has an important role in the well-being of transgender individuals (Cohen and Wills, 1985; Nemoto et al., 2011). Similarly, research has shown that emotion regulation has an important role in well-being and coping with the adverse effects of discrimination (Thompson, 1991; Meyer, 2003). However, there is limited research regarding the role of the cognitive aspect of emotion regulation in transgender people's coping with discrimination. Cognitive emotion regulation strategies help people to regulate their emotions after impactful circumstances (Garnefski et al., 2001). In this context, these strategies are thought to

have an important role in transgender people's coping with discrimination and its effects on their mental health.

Considering all these, this study aims to investigate the effect of perceived discrimination on depression and the influences of social support and cognitive emotion regulation strategies in this relationship. In addition, it aims to be more inclusive by not only addressing gender from a binary (male-female) perspective, but also by including the experiences of transgender individuals who do not define their gender on the binary system (i.e., non-binary, genderqueer, genderfluid, etc.).

1.1. Definition of the Terms

In this chapter, the terms used in this study will be described in detail to prevent ambiguity and provide readers a clear description of what thwith e chosen terms refer to.

Gender, Assigned Gender at Birth, and Sex

Sex and gender are often used to refer to the same thing. However, sex refers to one's biological status, and is mostly thought of as being female or male in Western cultures, assigned at birth. While gender is a socially constructed term that relates to assumptions that individuals make about a person's sex, related to a given society (APA, 2011; Singh and Dickey, 2017). Therefore, the term 'assigned gender at birth' refers to sex.

Gender Identity and Expression

Gender identity refers to how an individual feels about themselves in terms of their gender. It is a fluid experience, which can change over time. Whereas gender expression refers to one's outward expression of their gender identity, such as how they present themselves, which pronouns they use to describe themselves, etc. (Singh and Dickey, 2017). It must be noted that gender identity is a separate concept from sexual orientation (APA, 2015). The term "sexual orientation" describes how someone feels attracted to another person, which can be physical, emotional, and romantical (APA, 2011). Therefore, one's gender identity does not give any information about their sexual orientation.

Transgender

The term "transgender" is used to describe people whose gender identity does not entirely correspond to the gender that was assigned to them at birth (APA, 2015). According to APA (2015), the concept of gender is non-binary, encompassing a broad spectrum of gender identities and expressions. Therefore, transgender individuals may

identify their gender identities as falling within or outside of the gender binary. The term “trans+” is often used as an umbrella term that includes both binary and non-binary gender identities, such as non-binary, genderfluid, genderqueer, agender, bigender, etc. The term "transgender" may occasionally be abbreviated and used as "trans" (APA, 2011). Accordingly, the words "trans" and "transgender" will be used interchangeably in the present study.

Non-binary

Non-binary refers to transgender individuals who experience and define their gender identity as existing beyond the confines of the traditional gender binary (Reisner and Hughto, 2019). Also, the term non-binary is used as an umbrella term that defines various gender identities and experiences, such as gender identities that fall between or outside of the female-male gender binary, a gender identity that fluctuates between being a woman or a man, or it could include individuals who do not align with a specific gender identity and actively reject the notion of adhering to any particular gender category (Matsuno and Budge, 2017).

Cisgender

The term cisgender is usually defined as “non-transgender”, referring to people whose gender identity aligns with their assigned gender at birth (Cava, 2016). Other “cis” concepts include cisgenderism (an ideology that privileges cisgender individuals), cisnormativity (dominance of cis norms), and cis privilege (opportunities that are mostly gained by one’s cis identity) (Cava, 2016).

Transphobia

The term transphobia refers to discrimination against transgender individuals on an institutional, societal, and individual level (Nemoto, Bödeker and Iwamoto, 2011).

1.2. Perceived Discrimination

Discrimination refers to the unjust mistreatment of individuals stemming from their association with specific groups (Matsumoto and Juang, 2013). Individuals who belong to minority groups tend to experience discrimination and relatively bad outcomes. The acts of mistreatment and negative life events stemming from discrimination represent significant challenges to psychological well-being in various contexts, such as finding a job or an apartment, getting deprived of adequate healthcare, etc. (Schmitt et al., 2014). Understanding the difference between objective encounters with discrimination and subjective interpretations of discrimination is crucial because it can have different effects on an individual's well-being depending

on whether they perceive themselves as the target of discrimination or not (Paradies, 2006; Schmitt et al., 2014). Perceived discrimination refers to the latter, the subjective perception of an individual facing discrimination (Schmitt et al., 2014). Perceiving oneself as an object of possible victimization implies something about one's social positioning within a given society, which can have various consequences for well-being (Pascoe and Richman, 2009; Schmitt and Branscombe, 2002; Schmitt et al., 2014).

According to numerous theoretical frameworks, perceiving discrimination has detrimental effects on an individual's mental health (Schmitt et al., 2014). For example, according to the symbolic interaction framework the self-concept emerges from social interactions, and often individuals internalize others' opinions about oneself. Therefore, the symbolic interactionist framework suggests that perceiving oneself to be the object of a possible discriminative event would jeopardize one's sense of self because the discriminative discourse says that the members of stigmatized groups are unworthy, which can be internalized (Goffman, 1963; Schmitt et al., 2014). Perceived discrimination suggests a form of rejection or exclusion directed toward a specific stigmatized group (Baumeister and Leary, 1995), while individuals have a need for their group identities to be recognized and valued within a given society (Tajfel and Turner, 1979). Therefore, perceiving discrimination against an ingroup membership through devaluation and exclusion is expected to have adverse and unique consequences on the members of that stigmatized group (Schmitt et al., 2014).

The extent to which discriminative experience is perceived as a singular incident or a persistent issue is associated with the severity of the effects resulting from perceptions of discrimination (Schmitt and Branscombe, 2002; Schmitt et al., 2014). When discrimination is perceived as less avoidable and more pervasive, the feelings of control may be weakened (Schmitt et al., 2014). Discrimination that is perceived as being pervasive is more likely to be experienced as a form of rejection and societal exclusion, as opposed to discrimination that is regarded as an isolated incident. Discrimination is more pervasive and systemic for groups who hold a relatively disadvantaged social status compared to groups who are relatively advantaged (Schmitt et al., 2014). Because perceptions of discrimination are perceived as more pervasive for disadvantaged groups, it can be concluded that members of disadvantaged groups, such as sexual, gender, and racial minorities, are more likely to be at risk for harm from the consequences of discrimination. It is also important to be

conscious of the intersectionality of identities in this context.

The literature on discrimination has highlighted a significant differentiation between discrimination targeted toward an individual due to their group membership, versus discrimination aimed at the entire group to which the individual belongs (Schmitt et al., 2014). Crosby (1984) argued that because discrimination against individuals is more distressing, individuals who are members of disadvantaged groups may be more inclined to deny personal discrimination, as opposed to discrimination targeting their entire group. A study demonstrated an inverse link between perceived individual discrimination and self-worth (Bourguignon et al., 2006). Furthermore, the authors discussed how the perceiving discrimination at the group level may mitigate the adverse effects of individual discrimination, since attributing discriminatory events to the group implies that one is not isolated in experiencing rejection and exclusion.

1.2.1. Minority Stress Model

The minority stress model conceptualizes how the social stress sources that are specific to LGBT individuals affect lesbian, gay, and bisexual individuals' mental health (Meyer, 2003). According to minority stress theory, LGBT (lesbian, gay, bisexual, and transgender) individuals experience unique stressors due to prejudice and stigma, and these stressors result in negative health consequences (Meyer and Frost, 2013). Moreover, Meyer (2015) argues that environmental factors, particularly those associated with stigma and prejudice, can generate stressors that persist throughout the lifetimes of individuals who identify as LGBT.

The minority stress model posits that LGB individuals could experience minority stress in various ways. According to Meyer (2003), minority stress mechanisms are categorized along a spectrum from distal to proximal. From the distal to proximal, LGB individuals experience minority stress through three sources: external stressful events, the anticipation of such events, and the internalization of negative cultural perceptions. Distal or external stressors refer to stressors that are objective and independent of a person's perception. In contrast, proximal stressor are influenced by one's perception of discrimination, thus, in nature, they are more subjective. One source of minority stress is distal or external stressors, which include direct experiences or events of discrimination, rejection, or violence related to one's gender identity. These external and objective stressful events are the most distal sources of minority stressors. The expectation that these external stressful events will happen, along with the alertness that accompanies that expectation, constitutes the second

source of minority stress. Because of this alertness, individuals who identify as LGBT could anticipate rejection or discrimination based on their sexual minority status, therefore they may try to conceal their identities to protect themselves from rejection or discrimination. The third source of minority stress includes the process of internalizing prejudice and others' negative opinions about oneself. For LGB people this can be internalized homophobia or biphobia and for transgender people this can internalized transphobia. The internalized stigma is much more subjective, it cannot be observed like distal stressors. Also, internalized stigma can be the most harmful to the psychological well-being of LGBT individuals, as it can directly interrupt their ability to cope with external stressful events (Hendricks and Testa, 2012). The minority stress processes are conceptualized in Figure 1.

Even though the minority stress model initially emerged in the context of sexual orientation, the implications of the model in the context of gender identity are similar (Meyer, 2015). The model was also adapted to gender identity to reflect transgender and gender nonconforming people's experiences (Hendricks and Testa, 2012). Parallel with the initial minority stress model, transgender individuals encounter general stressors related to daily life similar to the general population, however, additionally, they face discrimination, rejection, and violence in various forms due to their gender identities or gender expressions at alarmingly high rates (Hendricks and Testa, 2012). Studies show that transgender people are subjected to high rates of minority stressors, including discrimination, physical and sexual violence, and stigmatization based on their gender identity (Clements-Nolle, Marx and Katz, 2006; Grant et al., 2010; Hendricks and Testa, 2012; Testa et al., 2012). Even though some minority stressors identified by Meyer (2003)'s minority stress model for sexual minorities are parallel for gender minorities, there are some unique minority stressors experienced by transgender individuals. For example, in addition to the violence, rejection, and discrimination encountered by both cisgender LGB and transgender individuals, transgender individuals may also encounter an additional distal stressor called non-affirmation, which refers to when one's gender identity is not affirmed by other people. This could include experiences such as getting misgendered or being referred to by their assigned name at birth even though they do not go by that name anymore. Non-binary individuals may also experience non-affirmation in their daily life, as people in their life may not be able to use gender-neutral terms to refer to them (Testa et al., 2015). Transgender individuals also experience proximal stressors, such as

internalized transphobia, similar to LGB individuals (eg., internalized homophobia). Anticipation and fear of the occurrence of discrimination, victimization, or rejection are also shared by both LGB and transgender individuals (Hendricks and Testa, 2012). However, there are some differences in terms of concealment. Because gender identity is often conveyed by physical cues, it may not be possible for transgender individuals to conceal their gender identity if or when they want to; and, for transgender individuals who go through a social and physical transition, the issue of the disclosure may become even more complex (Testa et al., 2015). However, these do not imply that gender is only conveyed by physical cues; gender expression may vary in many ways. Consistent with the minority stress model conceptualization, minority stresses have adverse consequences on mental health among transgender individuals. The studies conducted with transgender individuals showed that gender-related discrimination and victimization are associated with greater degrees of depression and increased rates of suicide attempts (Bockting et al., 2013; Testa et al., 2012).

Although minority stressors have adverse impacts on the mental health of individuals who belong to disadvantaged groups, Meyer (2003) posits that the impact of minority stressors is not always harmful. For example, individuals belonging to minority groups tend to develop resilience and acquire necessary coping strategies in response to discrimination. Meyer's conceptualization also describes the protective factors that reduce the adverse impacts of minority stress on mental health. The minority stress model shows that coping and social support can buffer minority stressors' impact, thereby reducing or preventing negative mental health outcomes. For example, minority coping, which refers to the ability of the group to construct self-affirming systems in response to stigmatization, can reduce the adverse consequences of minority stressors. According to the study conducted by Pflum et al. (2015), social support and being connected to one's community were found protective regarding the mental health of transgender individuals, supporting the minority stress model's conceptualization. The minority stress model also describes how sexual and gender minority individuals who participate in their community can gain access to factors that foster resilience, including social support from others who share similar identities and experiences, identity pride, and community membership (Meyer, 2003; Testa et al., 2015). Meyer (2015) argues that an individual's exposure to minority stress, their coping skills, and their opportunities to access resilience factors depend on whether or not and how much they identify with a sexual or gender minority identity. Therefore,

even though being out is related to more exposure to minority stress, it also enhances the possibility of getting access to factors that foster resilience.

The present study is going to use perceived discrimination as a distal stressor, cognitive emotion regulation strategies as both proximal stress processes and protective factors, social support as a protective factor, and depression as a negative mental health outcome in the context of the minority stress model. All of the terms referred to above will be presented in detail in the following chapters.

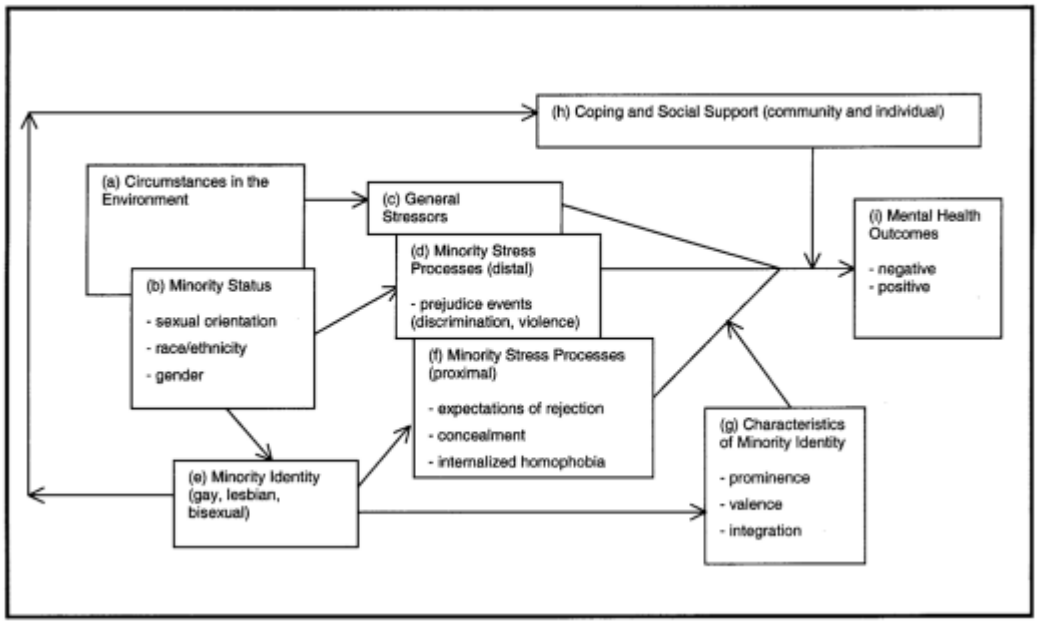

Figure 1. The concept of the minority stress model.

1.2.2. Personal/Group Discrimination Discrepancy Theory

For individuals belonging to minority groups, having to deal with discriminatory experiences on a daily basis is almost unavoidable (Ruggiero and Taylor, 1997). Two theoretical domains have emerged concerning the discriminatory experiences faced by members belonging to minority groups. These two domains focus on how individuals belonging to minority groups perceive discrimination and how they cope with it (Ruggiero and Taylor, 1997).

The initial theory is the attributional ambiguity theory (Crocker and Major, 1989). According to the attributional ambiguity theory, individuals belonging to stigmatized or disadvantaged groups frequently experience attributional uncertainties, in contrast to individuals belonging to advantaged groups. The uncertainty emerges when an individual belonging to a minority group receives feedback from a member of an advantaged group which includes the process of making attributional judgments about that feedback. The feedback may accurately reflect one's capacity and skills or it might

be the consequence of prejudice due to one's minority status. According to Crocker and Major (1989), members of disadvantaged groups have a tendency to associate adverse feedback with discrimination, which fosters self-esteem in facing failure. By doing so, individuals discard the personal implications of negative feedback regarding one's abilities, therefore it is self-protective. In sum, because the feedback individuals belonging to disadvantaged groups receive is ambiguous, individuals may associate the negative results they experience with discrimination to preserve their personal sense of esteem; this leads to the theory that individuals belonging to minority groups are more prone to associate unfavorable criticism they get with discrimination (Crocker and Major, 1989; Ruggiero and Taylor, 1995).

The second domain involves the personal/group discrimination discrepancy theory (Taylor et al., 1990). According to the personal/group discrimination theory, individuals who belong to minority groups often perceive more discrimination against their group compared to themselves as members of that group. In other words, individuals often perceive group discrimination to a greater degree than personal discrimination. A study regarding the perceived discrimination among transgender individuals in Turkey supported this (Başar, Öz and Karakaya, 2016). Ruggiero and Taylor (1995) argued that the hypothesis emerging from this theory is that individuals belonging to minority groups are less likely to attribute unfavorable criticism to prejudice. This theory and the attributional ambiguity theory propose two different things. The results of Ruggiero and Taylor's (1995) study provided evidence in favor of the personal/group discrimination discrepancy theory. Accordingly, they demonstrated that when the possibility of prejudice is ambiguous, individuals are less likely to attribute unfavorable criticism to discrimination. When the possibility of discrimination is certain or relatively unambiguous, individuals tend to attribute unfavorable criticism to discrimination. This finding is consistent with the attributional ambiguity theory but only when the discrimination is certain or less ambiguous. In sum, individuals belonging to minority group members are less likely to attribute unfavorable criticism to discrimination and rather they blame themselves for failing when the possibility of discrimination is uncertain; on the contrary, when discrimination is certain they are more likely to attribute unfavorable criticism to the discrimination they perceive. Furthermore, Ruggiero and Taylor (1997) argued that by minimizing discrimination, individuals protected their self-worth and maintained the belief that they are in control.

1.2.3. Discrimination Towards LGBTQ+ Individuals and Gender Identity-Based Discrimination

Lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals are subjected to institutionalized discrimination, social stress, social exclusion, and violence; and these have detrimental effects on their mental health. LGBT individuals appear to be at greater risk for negative mental health outcomes compared to their heterosexual and non-transgender counterparts (Landers and Gilsanz, 2009). A study demonstrated that individuals who identify as lesbian, gay, and bisexual are at almost twice the risk of experiencing anxiety and depression disorders compared to heterosexual individuals (King et al., 2008). According to a study, around 20% of individuals who identified as gay, lesbian, or bisexual (LGB) reported experiencing an offense due to their sexual minority status; half of the participants reported experiencing verbal harassment, and more than one in ten participants reported having experienced discrimination regarding employment or housing (Herek, 2009). In another study regarding the social exclusion of LGBTQ+ youth in 37 European countries, it was reported that a significant proportion of participants experienced discrimination across different areas of their lives; specifically, 67% of the participants reported discrimination in education, 51% within their family, 38% in their community, and 30% with their friends (Takács, 2006). Similar findings were reported in a study demonstrated by Göregenli et al. (2011) in Turkey. Accordingly, around 20% of the LGBT participants reported having experienced at least one type of discrimination because of their gender identity and sexual orientation. The participants reported having experienced discrimination the most in public settings, then in the close environment, and the least in their households. Furthermore, the study reported the fear of being subjected to discrimination among half of the participants; in parallel with the Minority Stress Model's (Meyer, 2003) conceptualization of the anticipation and expectation of discrimination as a proximal stressor. Another study demonstrated in Turkey reported that LGBT individuals face prejudice in employment, housing, and accessing healthcare, due to their minority identities (Yılmaz and Göçmen, 2016).

Transgender individuals experience high rates of systematic prejudice due to the societal stigmatization of their gender non-conformity at every turn: in their childhood homes, in the education environment, in their workplace, accessing healthcare and other service providers (Bockting, 2005; Grant et al., 2011; Lombardi, 2002). In a study, it was found that 66% of the transgender participants reported facing

discrimination based on their gender identity or expression. (Bockting, 2005). According to a study conducted by Grant et al. (2011), which included a substantial number of transgender participants, discrimination was prevalent throughout the entire sample. The study showed that 41% of the participants reported attempting suicide, which is significantly greater than the reported rate of 1.6% in the general population. 64% of the participants reported experiencing sexual assault, 61% reported being subjected to physical assault, 55% reported losing their job due to discrimination, and 51% experienced harassment in school. Furthermore, participants lived in extreme poverty. Lombardi et al. (2002) reported that transgender individuals were at a greater than threefold increased risk of experiencing economic discrimination in comparison to their non-transgender counterparts. In this study, 56% of transgender participants reported being subjected to verbal harassment, 37% reported experiencing discrimination in employment, and 19% reported experiencing physical violence. Accordingly, other studies reported high rates of experiencing physical and sexual violence, and gender-related verbal and physical victimization among trans people (Clements-Nolle et al., 2006; Testa, 2012). A qualitative study conducted by Aypar and Tanyaş (2017) reported that transgender individuals living in Turkey frequently face surveillance, social exclusion, and violence. Furthermore, the study showed that discrimination was experienced by participants in various settings such as medical and psychological services, work environments, educational institutions, housing, employment, and within their family relationships.

As proposed by the Minority Stress Model (Hendricks and Testa, 2012; Meyer, 2003), distal stressors have adverse effects on the mental health of transgender individuals. For example, Bocking et al. (2013) reported that being subjected to discrimination was linked with greater degrees of emotional distress. Another study revealed that experiences of gender identity based prejudice and suicidal behaviors were associated (Clements-Nolle et al., 2006). These findings suggest that discrimination poses a significant risk to the mental health of transgender individuals.

1.3. Depression

Depression or major depressive disorder is a highly prevalent mental disorder that is characterized by “loss of interest or pleasure”, “feelings of guilt or low self-worth”, “disturbed sleep or appetite”, “fatigue”, and “poor concentration” (WHO, 2017). Moreover, depression can last for a long time or recur frequently, making it difficult to function or deal with daily life. It is one of the most frequently diagnosed

psychological disorders (Kesler et al, 2012). More than 320 million people are reported currently living with depression (WHO, 2017). Additionally, depression is a substantial risk factor for suicidality (Riberio et al., 2018). In the following chapters, symptoms of depression, epidemiology of depression, and risk factors for depression will be presented in detail.

1.3.1. Symptoms of Depression

The prominent symptoms of depression, known as major depressive disorder in DSM-V, include the following: depressed mood (e.g., sadness, emptiness, hopelessness) and markedly loss of pleasure or interest in nearly every activity. The somatic symptoms of depression are characterized by significant weight loss or weight gain, decrease or increase in appetite, disturbance in sleep/insomnia or hypersomnia, psychomotor agitation or retardation, and fatigue or loss of energy. The cognitive symptoms are characterized by a decreased capacity to concentrate and difficulty in decision-making. "Feelings of worthlessness" and "excessive or inappropriate guilt" are common characteristic symptoms of depression related to negative self-evaluation. People with depression may have frequent thoughts of death, and ideas of suicide and may attempt or commit suicide (APA, 2013). Some other physical symptoms such as gastrointestinal complaints, amenorrhea, and headaches are also often noted (Kendler, 2016).

1.3.2. Epidemiology of Depression

Estimates suggest that 300 million people worldwide struggle with depression (WHO, 2017). Similarly, the global point prevalence of depression was 4.4% in 1990, and 4.4% in 2005 and 2010 (Ferrari et al., 2013). Age has been found to be associated with depression (Stordal, Mykletun and Dahl, 2003). The prevalence of depression fluctuates by age and peaks in older adulthood; among women aged 55 to 74, it is above 7.5%, and among males, it is above 5.5% (WHO, 2017). Depression was found significantly less prevalent among individuals ages 65 and above compared to younger individuals (Kessler et al., 2010).

In a review study, the one-year and lifetime prevalence of depression was reported as 7.2% and 10.8%, respectively. Additionally, it was found that the prevalence of depression was noticeably greater among females (14.4%) (Lim et al., 2018). Ferrari et al. (2013), also reported higher rates of depression in women (5.5%) compared to men (3.2%); and, higher rates of depression from low to medium-income regions compared to higher-income regions. Compared to the prevalence from Western

Europe, the prevalence from South America, South Asia, Africa, and the Middle East was significantly greater, indicating regional and/or cultural differences (Ferrari et al., 2013).

In 2015, suicide accounted for approximately 1.5% of all deaths globally (WHO, 2017). Considering depression is an important risk factor for suicidality (Riberio et al., 2018), the prevalence of suicidality will be discussed as well, along with depression.

Prevalence of Depression Among Transgender Individuals

There have been numerous reports indicating a high prevalence of depression among trans individuals. For example, the lifetime prevalence of major depression was reported as 54.3% among transgender individuals, which was almost three times greater than the general population (19.6%); and lifetime suicide ideation was 53.5%, which was also three times greater than the general population (13.5%) (Nuttbrock et al., 2010). Similarly to this, in a study, 48.3% of transgender men and 51.4% of transgender women reported having depression (Budge, Adelson and Howard, 2013). Hoffman's (2014) literature review reported that the prevalence of depression among trans women is higher than in the overall population. A study reported that transgender participants had a high rate (44.1%) of clinical depression (Bockting et al., 2013). A study demonstrated that half of the genderqueer individuals reported clinical levels of depression (Budge, Rossman and Howard, 2014). In another study, 62% of the trans woman and 55% of the trans man participants were reported as depressed; each population's suicide attempt rate was 32% (Clements-Nolle et al., 2001). A more recent large-scale study reported 41% of transgender individuals attempted suicide (Grant et al., 2011). Another study reported 61% and 52% rates of depression and suicidal ideation among transgender participants (Bocking et al., 2005). Similarly, a more recent study found that 56.1% of the respondents reported experiencing some level of suicidal thoughts within the past year (Testa et al., 2017).

In a study demonstrated in Turkey, the prevalence of suicide attempts, current suicide ideation, and lifetime suicide ideation were 29.8%, 9.2%, and 55.3%, respectively, among transgender individuals (Yüksel et al., 2017). Also, Başar and Öz (2016) reported that 23% of the transgender participants had a history of suicide attempts.

1.3.3. Risk Factors of Depression

Depression is a multifaceted phenomenon with temperamental, environmental, genetic, and physiological risk factors (APA, 2013; Rotondi, 2012). Adverse childhood experiences are environmental risk factors for depression, while negative

affectivity is a temperamental risk factor. First-degree family members of people with major depressive disorder have a risk for depression two to fourfold greater than the general population, indicating a genetic risk factor (APA, 2013). A study showed that estimates of the heritability of depression ranged between 48% and 75% (McGuffin et al., 1996). In a study reviewing risk factors for chronic depression, researchers identified three factors: an earlier age at onset, extended duration of depressive episodes, and familial background of mood disorders (Hölzel et al., 2011). In another study, neuroticism, genetic risk, disturbed family environment, and low parental warmth were reported as strong predictors of depressive vulnerability (Kendler and Gardner, 2016). A study revealed that the traits of neuroticism and openness were positively associated with depression levels, while extraversion was negatively associated with depression levels (Chioqueta and Stile, 2005). Numerous studies showed that depression had significant associations with the frequency and intensity of adverse life experiences (Kendler, Karkowski and Prescott, 1998; Risch et al., 2009). Sexual abuse, especially childhood sexual abuse, is also associated with greater degrees of depression in clinical and non-clinical populations (Cooperman, Simoni and Lockhart, 2003).

Cognitive emotion regulation is a significant issue regarding mental health, such as depression. Accordingly, studies demonstrated that depression had a negative association with adaptive strategies, while it had a positive association with maladaptive strategies (Garnefski et al., 2004; Garnefski and Kraaij, 2006). These factors will be presented in detail in the following chapters.

Certain groups, such as those with low socioeconomic status, immigrants, ethnic minority groups, and sexual and gender minority groups, face a higher risk of developing depression. The next chapter will focus in detail on the risk factors for depression among transgender individuals.

Risk Factors for Depression Among Transgender Individuals

Depression among transgender individuals is a complex phenomenon that does not stem from a singular mechanism (Rotondi, 2012). Some risk factors that affect depression among transgender individuals are described. Stigma and discrimination are prevalent risk factors for mental health problems among transgender individuals, such as depression (Clements-Nolle et al., 2006). In a study, transphobia was found significantly correlated with depression (Nemoto et al., 2011). Additionally, high levels of transphobia were observed in a study (Clements-Nolle et al., 2006).

Furthermore, in the same study, it was found that prejudice based on gender identity and verbal and physical gender abuse were independently correlated with suicide attempts. In another study, a positive association was found between encountering a greater number of various forms of discrimination and depression levels (Couch et al., 2007). Trans individuals were found to be prone to encountering prejudice in the workplace, which was related to increased depression (Irwin, 2002). As studies suggest that sexual abuse is related to depressive symptomatology (Cooperman et al., 2003); a study reported that 23% of trans participants had experienced childhood sexual abuse, while 38% had experienced childhood physical abuse. (Bockting et al., 2005). In another study, 38% of the participants reported being sexually abused and half of them reported experiencing physical assault before the age of 18 (Nemoto et al., 2011).

Lack of social support is another risk factor for depression among transgender individuals (Hoffman, 2014; Rotondi, 2012). For example, a study found that participants were more likely to report depression symptoms when they had less social support (Nemoto et al., 2011). Studies have demonstrated an inverse association between depressive symptoms and social support among transgender and genderqueer individuals (Budge et al., 2014; Pflum et al., 2015).

Age is another important demographic factor for the mental health of transgender individuals (Rotondi, 2012). A study showed that transgender older individuals had a notably greater risk for depressive symptomatology than cisgender older individuals (Frekdriksen-Goldsen et al., 2014). A study exploring the prevalence of depression among a significant number of transgender participants showed that inadequate social support, older age, and weaker relational function predicted depression (Witcomb et al., 2018). This study also found that there was an almost four-fold increased risk of depression among transgender individuals who were not on hormone replacement therapy (HRT) (Witcomb et al., 2018). Başar and Öz (2016) found an association between poor resilience and vulnerability to mental health problems, such as depression, in transgender individuals with gender dysphoria. A literature review of depression among trans women demonstrated by Hoffman (2014) reported that being subjected to discrimination, having social support, and engaging in sex work are some of the important factors influencing depression.

As mentioned earlier, cognitive emotion regulation is a significant issue and a risk factor for depression. The next chapter will present the cognitive emotion regulation processes in detail.

1.4. Cognitive Emotion Regulation

1.4.1. Emotion Regulation

Before discussing what emotion regulation is, it is important to define what emotion is. The definition of emotion has been an ongoing discourse topic in literature. Despite the fact that there isn't a universally accepted definition for "emotion," there is a consensus that emotions only consist of a limited number of elements and attributes (Izard, 2006). Researchers acknowledge that emotions possess neural structures specifically designed to process them, influence cognition and behavior, and activate response mechanisms (Izard, 2009). Furthermore, emotions have core features, such as the fact that they manifest when someone pays attention to a circumstance that is important to their objectives.; they are multifaceted and encompass a range of bodily experiences that impact subjective feelings, behavior, and physiological processes throughout the central and peripheral nervous systems (Gross and Thompson, 2007; Mauss et al., 2005). As mentioned earlier, there is no agreement on what “emotion” refers to specifically; however, one of the most widely accepted definitions of emotion is that it refers to a specific feeling accompanied by particular thoughts, psychological and biological states, and a range of behavioral tendencies (Goleman, 1996). Contemporary functionalist perspectives emphasize the crucial roles that emotions play in preparing essential responses to circumstances, making decisions, enhancing memory for significant events, and facilitating interpersonal relationships (Gross and Thompson, 2007).

The term emotion regulation is used to describe the extrinsic and intrinsic mechanisms that monitor, assess, and adjust emotional responses, particularly with regard to their intensity and duration, in order to achieve one's objectives (Thompson, 1994). Gross (1998) defines emotion regulation as the process of modifying the emotions one experiences, when they are experienced, and how they are experienced or conveyed. The term “emotion regulation" by itself appears to be ambiguous and it can be understood as how emotions regulate something else or how emotions themselves are regulated. However, this definition makes it clear that it refers to the latter, the regulation of emotions, rather than the regulation by emotions (Gross and Thompson, 2007). Furthermore, this definition suggests that emotion regulation may refer to a broad variety of relational, biological, behavioral, and cognitive mechanisms (Garnefski, Kraaij and Spinhoven, 2001). Additionally, emotion regulation includes establishing a new emotional reaction as well as modifying an existing one (Ochsner

and Gross, 2005). Studies show that emotion regulation plays a significant role in determining well-being (Cicchetti, Ackerman and Izard, 1995; Thompson, 1991).

Gross and Thompson (2007) categorized emotion regulation processes into five categories. One strategy for emotion regulation is situation selection, which involves deliberate actions aimed at increasing the probability of encountering situations that are expected to evoke desirable emotions. The second category is situation modification, which entails making an effort to alter the circumstance in order to reduce its psychological effect on the person. Situation modification refers to modifying the external and physical environment, rather than modifying internal or cognitive processes. The third category is attentional deployment, which describes how people direct their focus on a particular scenario to alter their emotional experience. While situation selection and situation modification involve shaping one's situation by changing the environment, attentional deployment involves regulating emotions without changing the external environment. The fourth category is cognitive change, which refers to altering the cognitive appraisal of a situation to modify its emotional importance by changing how the situation is perceived or by strengthening one's capacity to manage the demands of the situation. The fifth category, response modulation is the act of directly affecting physiological, observational, or behavioral reactions. Examples of modifying the response may include engaging in physical exercise or using drugs and alcohol.

According to Garnefski et al. (2001), the entire process of emotion regulation is too broad and complex to examine all its aspects and processes simultaneously through empirical means. Therefore, they prefer focusing on the self-regulatory and cognitive aspects of emotion regulation. Similarly, the present study will focus on and examine only these aspects of emotion regulation.

1.4.2. Cognitive Emotion Regulation

Cognitive emotion regulation refers to the management of emotionally provoking material through cognitive processes (Garnefski et al., 2001; Thompson, 1991). Furthermore, it enables people to manage their emotions when faced with threatening situations or afterward, thereby preventing them from becoming overwhelmed. Cognitive emotion regulation can be conceptualized as an aspect, the cognitive aspect, of the expansive description of emotion regulation that was provided earlier (Ataman, 2011; Garnefski et al., 2001).

The regulation of emotions through cognitive processes is an essential part of everyday

life that helps individuals in managing their emotions following stressful circumstances (Garnefski et al., 2001). Even though everyone has the ability to cognitively regulate their emotions, there are individual variances in how people regulate their emotions following distressing circumstances (Garnefski and Kraaij, 2006). Therefore, it can be assumed that cognitive emotion regulation plays a significant role in relation to mental health.

Garnefski et al. (2001) distinguished nine different cognitive emotion regulation strategies: "Self-blame", "Other-blame", "Acceptance", "Refocus on Planning", "Positive Refocusing", "Rumination", "Positive Reappraisal", "Putting into Perspective", and "Catastrophizing". These nine distinct dimensions of cognitive emotion regulation are defined below:

1. Self-blame: It refers to thoughts of holding oneself responsible for a negative event or experience. It has been reported that self-blaming is associated with depression (Anderson et al., 1994).

2. Other-blame: It refers to thoughts of attributing responsibility for one's experiences to others. It was reported that in the face of various types of threatening situations, blaming others was related to negative mental health outcomes (Tennen and Affleck, 1990).

3. Acceptance: It refers to accepting and coming to terms with one's experiences and resigning yourself to what has happened. It has been reported that acceptance has a positive correlation with self-esteem, while it has a negative correlation with anxiety (Carver, Scheier and Weintraub, 1989). Although acceptance is generally described as an adaptive strategy, some studies suggest that it should be considered as maladaptive (Martin and Dahlen, 2005). Furthermore, some studies found that the use of acceptance had a positive association with depression (Huh et al., 2017; Kraaij, Pruymboom and Garnefski, 2002; Martin and Dahlen, 2005).

4. Refocus on Planning: It refers to the cognitive process of planning what steps to take and how to manage negative experiences. It has been reported that the use of refocus on planning has a positive relationship with self-esteem (Carver et al., 1989).

5. Positive Refocusing: It refers to thinking about more positive subjects rather than thinking about the experience itself. In other words, it can be described as shifting attention away from the actual incident and toward more uplifting subjects. In the short term, it may seem adaptive, but its adaptability, in the long run, may be compromised (Garnefski et al., 2001).

6. ***Rumination:*** It refers to focusing on the emotions and ideas that are connected with the unpleasant experience. It was reported that rumination was associated with greater depression levels (Nolen-Hoeksema, Parker and Larson, 1994).

7. ***Positive Reappraisal:*** It refers to the ideas of attributing a positive significance to a negative experience with regard to personal development. Positive reappraisal demonstrated a negative correlation with anxiety and a positive correlation with self-esteem (Carver et al., 1989).

8. ***Putting into Perspective:*** It refers to thoughts of devaluating or minimizing an event's significance or highlighting the relative significance of the event in comparison to other events.

9. ***Catastrophizing:*** It refers to ideas of intensely highlighting the terror associated with a particular experience. Catastrophizing was found to be significantly correlated with depression and emotional distress (Sullivan, Bishop and, Pivik 1995).

In general, the findings suggest that "Rumination", "Catastrophizing", "Other-blame", and "Self-blame" are assumed to be maladaptive strategies, and individuals who engage in these strategies more often may be prone to negative mental health outcomes; on the contrary, "Acceptance," "Putting into Perspective," "Positive Reappraisal," "Refocus on Planning," and "Positive Refocusing" are assumed to be more adaptive strategies, therefore individuals who use these strategies may be less prone to negative mental health outcomes (Garnefski and Kraaij, 2006).

1.4.3. Cognitive Emotion Regulation and Depression

According to the literature, challenges in emotion regulation are associated with various psychopathologies (Aldao, Nolen-Hoeksema and Schweizer, 2010). Studies show that the association between adverse life experiences and depression is significantly influenced by cognitive coping strategies (Garnefski et al., 2001). These negative life experiences could involve proximal stressors defined by Meyer (2003), such as discrimination. Even though cognitive emotional regulation processes are important issues regarding the mental health of all individuals, individuals belonging to minority groups may be subjected to negative life events more often than individuals belonging to more advantaged groups, for that reason, it may be important to pay attention to the relationship between cognitive emotion regulation strategies and mental health issues, such as depression. Therefore, it could be argued that cognitive emotion regulation is a significant issue regarding the mental health of individuals belonging to minority groups, such as transgender individuals. However, the

relationship between cognitive emotion regulation and depression among a transgender sample was not investigated in prior studies.

Numerous research has investigated the relationship between cognitive emotion regulation strategies and depression (Martin and Dahlen, 2005). For example, Garnefski et al. (2001) found that cognitive emotion regulation strategies played a significant role in the relationship between adverse life experiences and depression. They described that cognitive emotion regulation strategies could be specified as two categories: adaptive strategies including "positive refocusing", "acceptance", "putting into perspective", "refocus on planning", and "positive reappraisal"; and maladaptive strategies including "self-blame", "other blame", "catastrophizing", and "rumination". Accordingly, they found that adaptive strategies, especially positive reappraisal and positive refocusing had significant negative associations with depression. The more often the participants engaged in adaptive strategies, the less they reported depressive symptoms. On the contrary, catastrophizing, self-blame, and rumination had significant positive associations with depression. The more often the participants engaged in maladaptive strategies, the more depressive symptoms they reported. Maladaptive emotion regulation strategies have been linked to an increased risk of depression recurrence (Rude and McCharty, 2003). Moreover, according to research, the level of clinical severity may influence how strongly maladaptive strategies are related to psychopathology (Aldao et al., 2010). Another study that examined how gender differed among the association between cognitive emotion regulation strategies and depression reported similar findings (Garnefski et al., 2004). In both genders, greater extensions of engaging in catastrophizing, rumination, and self-blame were significantly correlated with greater levels of depression, meanwhile, greater frequencies of engaging in positive reappraisal was correlated with low levels of depression. Similarly, a study demonstrated in Turkey reported that greater frequencies of reporting the use of catastrophizing were correlated with depression in both male and female groups (Öngen, 2010). Cognitive emotion regulation strategies and their relationship to depression were evaluated among five populations, ranging from the adolescents to the elderly (Garnefski and Kraaij, 2006). Accordingly, these relationships remained consistent across all age groups. Rumination and catastrophizing had a positive correlation with depression among all samples; whereas positive reappraisal had a negative correlation. Additionally, self-blame was positively related to depression among almost all groups except the elderly. These findings

indicate that associations between cognitive emotion regulation strategies and depression are consistent across different age groups, from youth to the elderly. Furthermore, it was shown that catastrophizing, rumination, self-blame, and lack of positive reappraisal played the most significant roles in reporting psychopathology. Martin and Dahlen's (2005) findings supported this, as they showed that positive reappraisal, self-blame, catastrophizing, and rumination significantly predicted adverse emotional states. Similarly, Omran (2011) reported that catastrophizing, self-blame, and rumination were positively related to depression, whereas positive reappraisal and refocus on planning were negatively related. In a study demonstrated with a clinical sample, it was shown that refocus on planning, positive reappraisal, and less use of rumination contributed to resilience in patients with depression. These findings are in parallel with the literature as the significant relationships between psychopathology and rumination (Nolen-Hoeksema et al., 1994), catastrophizing (Sullivan et al., 1995), and self-blame (Anderson et al., 1994) were reported in earlier studies. Similarly, studies repeatedly reported that the strategies of self-blame, catastrophizing, rumination, and (negatively) positive reappraisal and positive refocusing show strong and significant relationships with depressive symptoms among adolescents (Garnefski et al., 2001, 2002, 2003; Garnefski and Kraaij, 2006; Kraaij and Garnefski, 2012, 2015). In addition, Epkins, Gardner and Scanlon (2013) found that rumination was related to depressive symptoms among preadolescents.

Emotion regulation is considered a possible mediator in the association between depression and stressful experiences (Moriya and Takahashi, 2013). A study investigating the association between stressful experiences and depression found that maladaptive strategies played a mediator role in this association (Stikkelbroek et al., 2016). In addition, maladaptive strategies were associated with higher depression levels, whereas adaptive strategies were associated with lower depression levels. Another study examining the association between the intensity of depression and childhood trauma found that this association was mediated by maladaptive strategies (Huh et al., 2017). They argue that one possible explanation for this is that depressive symptoms may disrupt cognitive functions such as executive function, leading to difficulties in utilizing adaptive cognitive emotion regulation strategies (Huh et al., 2017; Santorelli and Ready, 2015). These studies highlight the importance of the involvement of cognitive emotion regulation strategies as mediators in the association among negative life experiences and depression. Therefore, in the present study, the

investigation of adaptive and maladaptive strategies as mediators in the association between perceived discrimination and depression will be conducted.

1.5. Perceived Social Support

1.5.1. Definition of Perceived Social Support

The term "social support" includes a variety of concepts (Haber et al., 2007). Accordingly, social support refers to the act of a social network offering psychological and material support with the purpose of improving an individual's capability to deal with stress (Cohen, 2004). In the literature, the conceptions of perceived and received social support have been distinguished. Perceived social support refers to one's perceptions of the availability and cognitive sense about the sufficiency of various kinds of support from their network associates; whereas received social support refers to actual reports about the types of support an individual receives and its mobilization and expression (Gottlieb and Bergen, 2010; Park, 2007). Perceived social support scales assess participants' perceptions of the general accessibility of support, while received social support measures assess particular behaviors of support that are provided to participants (Sarason, Sarason and Pierce, 1990). Perceived social support is influenced not only by an individual's inherent traits such as personality but also by varying factors such as attitudes and moods (Deveci, 2011). The extent of a person's social support system and their satisfaction with the received support from that system may be distinct dimensions of social support, and both have crucial roles in dealing with stress independently (Sarason et al., 1983). However, the literature emphasizes that the most important component of social support functioning as a stress buffer is the belief that others will provide adequate assistance (Cohen, 1988; Cohen and Wills, 1985; Uchino et al., 1996). Regarding mental health, perceived support has greater and more positive impacts than actual support, which has less of an impact overall (Bolger and Amarel, 2007; Chan and Rance, 2005; Faber and Wasserman, 2002; Uchino, 2004; Uchino, 2009). Therefore, it can be assumed that the perception of the available support has rather more significant implications than the actual supportive behaviors one received for particular events. For these reasons, the present study will primarily focus on perceived support.

The types of resources provided by social support and the type of source of such support can vary. Social support is often categorized into three types of resources: "instrumental", "informational", and "emotional" (House and Kahn, 1985). Instrumental support includes providing material assistance, such as financial help.

Informational support includes providing the necessary knowledge to cope with ongoing difficulties, such as advice or guidance. Emotional support involves expressing empathy, concern, and reassurance, as well as providing opportunities for venting and expression.

Zimet et al. (1988) classified social support into three distinct sources: family, significant others, and friends. The first source, family support, involves the support from one's mother, father, and siblings. Family support is considered one of the most important support sources. The second source, significant other support, involves one's romantic relationships, relatives, neighbors, doctors, teachers, etc. The third source, friend support is important for the process of socialization, as peer relations strengthen one's sense of belonging.

In the following chapter, the two processes of social support which beneficially influence the well-being of individuals will be presented.

1.5.2. The Two Models of Social Support

According to Cohen and Wills (1985), the positive impacts of social support on mental health could occur in two distinct processes. One model proposes that the association between social support and better mental health is limited to, or primarily present in, individuals experiencing stress. This model is referred to as the *buffering model* because it suggests that social support functions as a buffer, protecting individuals from the adverse effects of stressful experiences. This model proposes that social connections contribute to better mental health by providing individuals with the material and psychological resources necessary to manage stress. According to this model, people facing significant challenges are expected to benefit most from social support, however social does not significantly impact the mental health of those who do not face highly demanding stressors. The presence of social support can function as an intervention between a stressful event and an individual's stress response in two ways. First, by perceiving that others are able and willing to provide necessary resources, the individual can change their perception of the situation, leading to a decrease in the perceived level of stress. Second, having adequate support can intervene between experiencing stress and developing pathological outcomes by reducing or eliminating the stress reaction. According to this perspective, the belief that necessary resources will be provided by others can enhance an individual's ability to cope with demands (Cohen and Wills, 1985; Thoits, 1986). Psychologists, particularly those involved in interventions, tend to focus on this primary model

(Cohen, 2004).

The second model, known as *the main effect model*, argues that social support systems have a beneficial impact irrespective of whether individuals are under stress (Cohen, 2004; Cohen and Wills, 1985). Accordingly, social networks offer individuals positive experiences and stable, socially recognized roles within the community, leading to a generalized beneficial effect of social support (Cohen and Wills, 1985). Therefore, social support could benefit individuals' well-being as it offers them positive feelings and security. In sum, this model implies that social integration could prevent individuals from having negative experiences and involvement in large social networks provides individuals with potential positive experiences, irrespective of whether one is under stress.

The present study will investigate the influence of social support within the framework of the buffering effect model.

1.5.3. Perceived Social Support and Psychopathology

It has been established that social support significantly impacts one's mental health and well-being and that social support may protect mental health during stressful times (Cohen and Thomas, 1985; Thoits, 2011). Various forms of social support have distinct impacts on well-being (Nurullah, 2012). Studies also have shown that social support's impact and effectiveness on well-being can vary depending on the source of the support (e.g., family, friends, or significant other) (Li et al., 2014; Walen and Lachman, 2000).

Studies showed that greater social support was related to better well-being (Grav et al., 2012; Henderson et al., 1980). At a broad level, the lack of positive social relationships can result in negative psychological states (Cohen and Wills, 1985). Studies show that inadequate social support is related to clinical depression (Brown and Harris, 1979), and depressive and anxious symptomatology (Dour et al., 2014; Henry et al., 2018), emotional distress (Finch et al., 1999), and eating disorders (Stice, 2002). It is established that social support may protect mental health during stressful times (Cohen and Thomas, 1985; Thoits, 2011).

A significant body of evidence indicates that the perception of having social support available can reduce the impact of stress on mental health issues, such as depression (Cohen and Wills, 1985; Kawachi and Berkman, 2001). Accordingly, one study demonstrated that when participants were under stress, they reported more symptoms of depression, but this effect was reduced for individuals who believed that they had

access to necessary resources through their social connections (Cohen et al., 1985). A general population study with a large sample size found that individuals who receive inadequate social support have four times increased risk of developing depression (Grav et al., 2012). According to a study, low levels of contact with parents and friends were related to depression (Kleinberg, Aluoja and Vasar, 2013). Hallgren et al. (2017) found that individuals who had more availability of social resources experienced a more significant decrease in their depression levels than ones who had less access to such resources. A more recent study found that depressed patients who had sufficient social relationships were 60% less inclined to utilize mental health care (Andrea, Siegel and Teo, 2016). According to a study, both the onset and relapse of depression were associated with depression (Paykel, 1994). A study showed the mediating role of perceived social support in the association between perceived stress and depression (Choenarom et al., 2005). Numerous studies have demonstrated that individuals experiencing greater social strain or less social support showed poorer mental health outcomes; additionally, it has been demonstrated that perceived social support has a substantial impact on the overall outcome of depression and the recovery process (Escobar et al., 2020; Leskelä et al., 2006; Zhou, MacGeorge and Myrick, 2020). A meta-analysis study showed that people with depression and inadequate social support often have poorer results in relation to severity, the healing process, and functioning within social contexts (Wang, Huang and Kong, 2017). Various studies in Turkey also showed the association between depression and social support (Eldeleklioğlu, 2006; Yalçın, 2014). These findings emphasize the significance of perceived social support on mental health, especially depression.

1.5.4. The Significance of Social Support Among Transgender Individuals

The strongest predictor of depression was found to be social support, greater degrees of social support were associated with decreased depression levels (Wareham, Fowler and Pike, 2007; Wester, et al., 2007; Wright and Perry, 2006). The research findings from the studies on LGB individuals may not accurately capture the unique experiences of transgender individuals. There may be specific factors associated with the experiences of transgender individuals that contribute to higher rates of mental health issues, increased levels of suicidal thoughts and behaviors, and elevated instances of prejudice. Inadequate levels of social support, being rejected, and isolation are important elements regarding mental health, and these elements are frequently reported among the research regarding transgender individuals (Factor and Rothblum,

2007; Gapka and Raj, 2003; Maguen, Shipherd and Harris, 2005; Whittle, Turner and Al-Alam, 2007). Studies indicate that transgender individuals frequently report lower levels of social support compared to their non-transgender sisters and cisgender individuals overall (Bockting et al., 2005; Colton Meier et al., 2011; Factor and Rothblum, 2007). There was an association between social support and distress variables, and social support also had an indirect association with distress variables through avoidant coping (Budge et al., 2013). Social support for transgender individuals is particularly important to access information about healthcare, voice opinions on politics, and engage in social systems (Budge et al., 2012; Pinto, Melendez and, Spector, 2008). Furthermore, it was revealed that transgender people seem to receive less support from their families than their non-transgender siblings (Factor and Rothblum, 2007). The findings from studies conducted with transgender individuals experiencing gender dysphoria in Turkey suggest that social support is linked to resilience and increased satisfaction (Başar and Öz, 2016; Başar et al., 2016). These findings highlight the significance of perceived social support, specifically peer support, for transgender individuals.

1.6. Aim of the Study

Transgender individuals face pervasive and systematic discrimination due to societal stigmatization based on their gender identities (Bockting, 2005; Grant et al., 2011; Lombardi et al., 2002). Turkey is among the most disadvantageous and discriminative countries towards LGBTQ+ individuals in Europe in terms of justice, discrimination, hate crimes, discriminatory speech, and legally recognizing gender (ILGA-Europe, 2012). LGBTQ+ individuals, specifically transgender individuals, are at great risk of discrimination in various aspects of daily life such as in employment, housing, accessing healthcare and psychological services, educational settings, and their workplace; and they are subjected to verbal, physical, and sexual harassment, victimization, violence, and economic discrimination at concerning rates (Clements-Nolle et al., 2006; Grant et al., 2011; Lombardi et al., 2002; Testa, 2012). Even though it's limited, similar findings were reported in studies conducted in Turkey as well (Aypar and Tanyaş et al., 2017; Başar and Öz, 2016; Başar et al., 2016; Göçmen and Yılmaz, 2017). Consequently, such a discriminative environment and societal stigmatization have adverse effects on the mental health of LGBTQI+ individuals, especially transgender individuals. Thus, one aspect of this study's aim is to investigate the experiences of discrimination faced by transgender individuals residing in Turkey.

Such a discriminative environment and societal stigmatization have adverse effects on the mental health of LGBTQI+ individuals, especially among transgender individuals. Discrimination and stigmatization are risk factors for the well-being of trans people (Clements-Nolle et al., 2006). Studies show that depression is a prevalent mental health issue among LGBTQI+ individuals, specifically among transgender individuals (Clements-Nolle et al., 2006; Couch et al., 2007; Nemoto et al., 2011). Furthermore, transphobia was linked to greater depression levels (Couch et al., 2007). Moreover, depression is considered to be associated with suicidality (Riberio et al., 2018). Concerning rates of suicidality are also reported among transgender individuals (Bocking et al., 2005; Grant et al., 2011; Nuttbrock et al., 2010; Testa et al., 2017). Accordingly, it can be concluded that depression is a significant issue concerning the well-being of transgender individuals and it is crucial to focus on and draw attention to this domain of mental health of transgender individuals as it is closely linked to suicidality. Thus, another aspect of this study's aim is to explore the severity and symptoms of depression among transgender individuals residing in Turkey; and, to examine the association between perceived discrimination and depression.

The minority stress model conceptualizes how social stressors unique to LGBT individuals impact their mental health (Meyer, 2003; Hendricks and Testa, 2012). Accordingly, LGBT individuals experience unique stressors due to discrimination and stigmatization, and these stressors are related to adverse mental health conditions, such as depression (Meyer and Frost, 2013). Additionally, the model shows that coping and social support can mitigate the adverse impacts of minority stress. Accordingly, this study aims to examine the effects of protective factors such as perceived social support and cognitive-emotional coping in the relationship between perceived discrimination (as a distal stressor) and depression (as a negative mental health outcome).

As suggested by the minority stress model, coping can buffer the adverse effects of minority stressors on mental health (Meyer, 2003). Cognitive emotion regulation (CER), an aspect of emotion regulation, refers to the cognitive aspect of coping (Garnefski et al., 2001). Furthermore, CER is a crucial part of life, as it helps people to manage their emotions after stressful events. According to the literature, in line with the minority stress theory, cognitive coping plays a significant role in the relationship between adverse life experiences and various psychopathologies, including depression (Aldao et al., 2010; Garnefski et al., 2001; Martin and Dahlen, 2005). Specifically, maladaptive cognitive coping strategies are described as an important risk factor

regarding depression (Aldao et al., 2010; Rude and McCharty, 2003). Furthermore, emotion regulation is considered a possible mediator of depression (Moriya and Takahashi, 2013). For example, studies reported that maladaptive CER strategies have a mediating effect in the relationship between stressful events and depression (Huh et al., 2017; Stikkelbroek et al., 2016). Considering the information described earlier, this study aims to investigate how CER strategies mediate the association between perceived discrimination and depression among transgender individuals. Furthermore, it was noted by the author that this role of CER strategies among transgender individuals was not examined by prior studies.

In parallel with the minority stress model, Cohen and Wills (1985) propose that social support acts as a buffer, mitigating the adverse impacts of negative circumstances. This model, which is called the buffering effect model, argues that social support is specifically impactful for individuals experiencing adversity and stress. Additionally, the buffering effect model proposes that social support provides individuals with the necessary psychological and material resources to cope with stressors, contributing to better mental health. Considering transgender individuals are faced with pervasive distal stressors, such as systematic prejudice, and proximal stressors such as being vigilant to events of discrimination, it can be argued that social support is an important issue concerning the well-being of transgender individuals (Grant et al., 2011; Meyer, 2003). Thus, another aspect of this study's aim is to investigate the impact of perceived social support on the mental health of transgender individuals residing in Turkey.

To sum, the present study aims to investigate how perceived social support and cognitive emotion regulation strategies mediate the association between perceived discrimination and depression among individuals who identify their gender under the trans+ umbrella. Additionally, the relationships between perceived social support, cognitive emotion regulation strategies, and depression will be investigated. Another aspect of the present study's aim is to explore the experiences of transgender individuals who do not identify their gender on the binary spectrum (e.g., non-binary, genderqueer). It has to be noted by the author that many of the studies which examine the experiences of transgender individuals tend to approach the notion of gender as a binary construct. Therefore, this study aims to include the experiences of transgender individuals who do not belong on the binary spectrum as well as those who do. This study also aims to contribute to the existing body of literature by focusing on the experiences of non-clinical transgender individuals, as the majority of transgender

studies predominantly explore mental health concerns within clinical transgender populations of men and women (Harrison-Quintana, 2013; Lehavot, Simpson and Shipherd, 2016). Additionally, the aim of this study is to contribute to the clinical understanding by determining the unique needs of transgender individuals, drawing attention to these needs, and contributing to the clinical interventions tailored to address these needs. Moreover, previous studies have not collectively examined the relationships between social support, discrimination, depression, and cognitive emotion regulation strategies with a transgender sample. Lastly, it is believed that there is a lack of sufficient research on the experiences of transgender individuals in the existing literature, especially in Turkey, thus, one of the purposes of this study is to address this gap.

Based on the literature and aim of the study described above, the following hypotheses will be investigated.

1.7. Hypotheses

1. Participants will have higher scores on the perceived group discrimination scale compared to the perceived individual discrimination scale.
2. There is a significant positive relationship between perceived discrimination and depression.
3. There is a significant negative relationship between perceived social support and depression.
4. There are significant positive relationships between maladaptive cognitive emotion regulation strategies and depression, while there are significant negative relationships between adaptive cognitive emotion regulation strategies and depression.
5. Perceived social support will significantly mediate the relationship between perceived discrimination and depression.
6. Cognitive emotion regulation strategies will significantly mediate the relationship between perceived discrimination and depression. Specifically, maladaptive cognitive emotion regulation strategies will significantly mediate this relationship.

CHAPTER 2: METHOD

This chapter will present information about the participants, measurement instruments used in the study, study procedure, and statistical analysis, respectively.

2.1. Participants

A total number of 112 participants took part in the present study. Inclusion criteria for participation were: being 18 years old and above and identifying oneself under the trans+ umbrella (which includes trans women, trans men, non-binary, genderqueer, genderfluid, agender, bigender, and other transgender identities). The total number of participants was 113, but one participant was excluded because they were under the age of 18. The data were collected online using Google Forms. Participants were reached through social media platforms such as Twitter, Instagram, and WhatsApp groups.

Demographic information about the participants is given in Table 1. The average age of the participants is 24.2 (SD= 4.94), ranging from 18 to 42. The majority of the participants identified their gender under the non-binary umbrella (i.e., non-binary, genderqueer, genderfluid) (72.3), while the rest identified their gender under the binary (i.e., trans woman, trans man) (27.7).

For the level of education variable, the majority of the participants lastly graduated from high school (52.7%) and had bachelor's degrees (36.6%), while the others had master's degrees (9.8%) and doctoral degrees (0.9%).

For the area of settlement variable, the majority of the participants were living in a metropolis (81.3%), while the others were living in a city (12.5%) and in a town (6.3%).

For the employment status variable, the majority of the participants were students (50%), while the others worked in the private sector (22.3%), did not work (14.3%), worked as freelance (11.6%), and worked in the public sector (1.8%).

For the socioeconomic status variable, the majority of the participants identified as belonging to the middle-low income category (34.8%) and middle-income category (29.5%), while the others identified as belonging to the low-level income category (20.5%), middle-high income category (13.4%), and high-income category (1.8%).

More than half of the participants (58.9%) reported having a psychiatric disorder diagnosis while the rest did not (41.1%).

The majority of the participants were out about their gender identity to their close

friends (97.3%), and friends in school (57.1%). 41.1% of the participants were out to their families, 23.2% were out to their colleagues, and 2.7% were not out about their gender identity at all.

The majority of the participants reported that they were intensely vigilant against discrimination (72.3%), and had experienced verbal harassment due to their gender expression (67.9%). Almost half of the participants reported that they had experienced sexual harassment (48.2%), and had lost friends due to their gender identities (45.5%). The participants also reported that they had experienced discrimination in their educational settings due to being trans (31.3%), had lost family members due to their gender identities (27.7%), had experienced discrimination based on their trans identities in accessing healthcare services (22.3%), had been subjected to physical violence (21.4%), had experienced discrimination during a job application process (17.9%), and in their workplace (17%). 2.7% of the participants reported that they had not experienced discrimination due to their gender identities.

Table 1. Demographic Characteristics of the Participants

Study Variables		N	%
Gender category	Binary	31	27.7
	Non-binary	81	72.3
Level of education	High school	59	52.7
	Bachelor's degree	41	36.6
	Master's degree	11	9.8
	Doctoral degree	1	0.9
Area of settlement	Town	7	6.3
	City	14	12.5
	Metropolis	91	81.3
Employment status	Not working	16	14.3
	Student	56	50
	Public Sector	2	1.8
	Freelance	13	11.6
Socioeconomic status	Low	23	20.5
	Middle-low	39	34.8
	Middle	33	29.5

Table 2. (Continued) Demographic Characteristics of the Participants

	Middle-high	15	13.4
	High	2	1.8
Psychological disorder	Yes	66	58.9
	No	46	41.1

2.2 Instruments

In the present study, the data was collected using the Demographic Information Form, Discrimination Event List, Perceived Discrimination Scale (PDS), Multidimensional Scale of Perceived Social Support (MSPSS), Cognitive Emotion Regulation Questionnaire (CERQ), and Beck Depression Inventory (BDI).

2.2.1. Demographic Information Form

The demographic information form was developed by the researcher and consists of questions regarding participants' age, gender identity, level of education, socioeconomic status, employment status, whether they have any psychiatric diagnosis, and to whom they shared their gender identity with (Appendix C).

2.2.2. Event List of Discrimination

An event list of discrimination was developed by the researcher to obtain information about the participants' experience of discrimination. This was developed because the Perceived Discrimination Scale measures only the perceived discrimination on a personal level, it does not include actual events of discrimination experienced by the participants. Therefore, it was thought that evaluating the actual events of discrimination would also be important. The items were developed in the light of literature regarding discrimination based on gender identity (Aypar and Tanyaş, 2017; Grant et al., 2011; Yılmaz and Göçmen, 2016). The items include statements about discrimination related to education, job application, healthcare access, housing, discrimination in the workplace, verbal, physical, and sexual harassment, relationship cutoff related to gender identity, and being intensely on alert to discrimination (Appendix D).

2.2.3. Perceived Discrimination Scale

The Perceived Discrimination Scale (PDS) is a self-assessment scale developed by Ruggiero and Taylor (1995) to evaluate the perceived level of individual and group discrimination. The Perceived Individual Discrimination Scale (PID) and Perceived Group Discrimination Scale (PDG) are components of the Perceived Discrimination Scale. The scale consists of 8 items with a 5-point Likert scale ("1= Never" to "5=

Always"). Each scale consists of four items. Elevated scores correspond to increased perceived discrimination levels (Appendix E).

The scale was adapted to Turkish by Baykuş (2007) and was used in studies with minority samples (Akbaş, 2010; Başar and Öz, 2016). In the Turkish adaptation study, the internal consistency alpha coefficients were .73 for group discrimination and .85 for individual discrimination, demonstrating reliability proofs (Baykuş, 2007). In another study, the items in the Turkish version of the scale were adjusted to evaluate the perceived level of gender identity discrimination experienced by transgender individuals; PID included four items related to the individual experience of discrimination (such as, 'I was made fun of' or 'I was insulted because I am transgender') and PGD included seven items related to discrimination against transgender individuals in Turkey (such as, 'How often do transgender individuals experience discrimination at school in Turkey?') (Başar and Öz, 2016). In the mentioned study, Cronbach's alpha coefficients were reported as .84 for PID and .89 for PDG (Başar and Öz, 2016). In the present study, the mentioned adjusted version of the scale was used to evaluate the frequency of perceived discrimination based on transgender identity. The 5-point Likert type ("1= Never" to "5= Always") scale consisted of two domains: PID and PGD. PID included four items related to experiences of feeling not accepted, feeling persecuted, feeling humiliated/harassed, and feeling ostracized; PGD included seven items related to discrimination experiences while applying for a job, looking for accommodation, in the street, while shopping, at school, at work, and in health facilities (Başar and Öz, 2016). The first domain's scores ranged between 4 to 20, while the latter ranged from 7 to 35. The distribution of responses and median score for each item was calculated. Higher scores correspond to greater levels of perceived individual and group discrimination. This scale was selected to be used in this study due to its compatibility with the present study's sample to measure discrimination perceived by transgender individuals. In the present study, Cronbach's alpha values were .82 for the total scale, .80 for the Perceived Individual Discrimination subscale, and .88 for the Perceived Group Discrimination subscale.

2.2.4. Multidimensional Scale of Perceived Social Support

The Multidimensional Scale of Perceived Social Support (MSPSS) is a self-report scale developed by Zimet et al. (1988) to evaluate the levels of perceived social support (Appendix E). The scale has twelve items with 7-point Likert typed ("1= Strongly

Disagree" to "7= Strongly Agree") responses. MPSS has three sub-scales, each related to a different source of support: family, friends, and significant other. The subscale scores are estimated by adding the scores of the items in each domain and the total score is estimated by adding each subscale score. Elevated scores correspond to greater perceived social support levels. The internal consistency coefficient of the total scale was reported as .88. For the "Family", "Friends", and "Significant Other" subscales, the internal consistency coefficients were reported as, .87, .85, and, .91, respectively; demonstrating good internal consistency, as a whole and for the subscales. Test-retest reliability values for the "Family", "Friends", and, "Significant Other" subscales were reported as .85, .75, and, .72, respectively; and .85 for the total scale (Zimet et al., 1988).

The Turkish validity and reliability study was demonstrated by Eker et al. (2001). The three-factor and twelve-item structure of the scale was preserved. However, the "Family" and "Significant Other" subscales were revised to make the scale more culturally appropriate. In the revised scale, the family was defined by parents, spouse, children, and siblings. Since the word "significant other" has a particularly specific connotation in Turkish culture, it has been removed and it was defined by exclusion: someone who is outside of friends and family (e.g., partners, relatives, neighbors, etc.). The internal consistency coefficient of the total scale was found as .89. For the "Family", "Friends", and "Significant Other" subscales, the internal consistency coefficients were found as .85, .88, and .92, respectively (Eker et al., 2001). In this study, Cronbach's alpha values were .85 for the total scale, .97 for the" Significant Other" subscale, .90 for the "Family subscale", and .95 for the "Friends" subscales.

2.2.5. Cognitive Emotion Regulation Questionnaire

The Cognitive Emotion Regulation Questionnaire (CERQ), developed by Garnefski et al. (2002), is a self-assessment scale designed to evaluate the cognitive emotion regulation strategies employed by individuals after experiencing situations that induce stress or pose a threat (Appendix F). The 36-item scale consists of nine subscales, each evaluating different cognitive emotion regulation strategies and each subscale consists of four items. The cognitive emotion regulation strategies are: (1) "other blame", (2) "putting into perspective", (3) "positive refocusing", (4) "positive reappraisal", (5) "acceptance", (6) "refocus on planning", (7) "self-blame", (8) "rumination", and (9) "catastrophizing". It is a 5-point Likert-typed scale, with answers ranging from 1 (almost never) to 5 (almost always). Each particular subscale score is estimated by

adding the scores from the selected subscale, which range from 4 to 20. Scores for maladaptive and adaptive strategies were summed from the corresponding subscales. The internal consistency coefficients of the subscales ranged between .75 and .86 at the initial measurement and between .75 and .87 at the follow-up, demonstrating good internal consistency. Test-retest reliability for the subscales ranged between .48 and .65, indicating adequate to good reliability (Garnefski et al., 2002).

CERQ was adapted to Turkish by Ataman (2011). The scale preserved its 9-factor structure. In the original study, subscales explained %68.1 of the total variance; and in the adaptation study, subscales explained %65.8 of the total variance. The internal consistency coefficients of the total scale were reported as .85. The internal consistency coefficients of the subscales were; .80 for “refocus on planning”; .83 for “other blame”; .78 for “putting into perspective”; .81 for “catastrophizing”; .80 for “positive refocusing"; .68 for "self-blame"; .65 for “acceptance”; .70 for “rumination”; .79 for “positive reappraisal” (Ataman, 2011). In this study, the Cronbach’s alpha values were .85 for the total scale, .84 for “refocus on planning”, .89 for “other blame”, .76 for “putting into perspective”, .78 for “catastrophizing”, .77 for “positive refocusing", .81 for "self-blame", .69 for “acceptance”, .72 for “rumination”, and .85 for “positive reappraisal” subscales.

2.2.6. Beck Depression Inventory

Beck Depression Inventory (BDI) is a self-report and transtheoretical scale developed to measure the severity of depressive symptoms (Beck, Ward and Mendelson, 1961) (Appendix G). The 21-item inventory evaluates cognitive, physical, emotional, and somatic symptoms of depression. Items are rated from 0 to 3 regarding the intensity of each symptom. The total score ranges between 0 and 63, greater scores indicate increased severity of depressive symptoms. Scores higher than 17 were considered as a cut-off point. The internal consistency coefficient in the original version was .88 and .86 in the revised version (Beck et al., 1961).

The Turkish validity and reliability study was demonstrated by Hisli (1989) and the reliability coefficient was found as .74. In this study, Cronbach's alpha value of the scale was .91.

2.3. Procedure

The ethical approval was granted by the Izmir University of Economics Ethics Committee before the data collection. Due to the study's inclusion criteria, a purposeful sampling procedure was preferred. The data were collected online using Google

Forms. It was decided that collecting the data online would be more convenient in order to reach more participants as the study's target population is a minority group. The online survey was shared on different social media platforms such as Twitter, Instagram, and WhatsApp. The participant's consent was taken with an informed consent form (Appendix B) and participants were informed about the length of the study, the study's purpose, the researcher's contact information, and their right to withdraw from the study.

After giving consent to volunteer in the study with the Informed Consent form, the participants were directed to the questionnaires. The questionnaires that were asked the participants to complete were: the Demographic Information Form, Discrimination Event List, Perceived Discrimination Scale, Multidimensional Scale of Perceived Social Support, Cognitive Emotion Regulation Questionnaire, and Beck Depression Inventory, respectively. The length of the study was approximately 10-15 minutes.

2.4. Statistical Analysis

In order to determine the necessary number of participants G*Power analyses were conducted. The results of G*Power analyses revealed that the minimum number of participants required to participate in the study was 55.

SPSS 20 (Statistical Package for Social Sciences) was used to analyze the data. First, the data was checked for missing data, and then the data set was organized. Before the main analyses, the preliminary analyses were conducted. Accordingly, Cronbach Alpha values were calculated to evaluate the reliability of the scales. After that, skewness and kurtosis values were calculated to check the normality of the variables used in the study. Then, mean values, standard deviations, and the minimum and maximum values of the variables were calculated to examine the descriptive statistics. For the main analyses, first, a paired samples t-test was performed to analyze the within-group differences between individual and group discrimination. Second, the interrelationships of the study variables (ie., perceived discrimination, depression, perceived social support, cognition emotion regulation) were examined by correlation analyses. Third, the mediation analyses were performed through PROCESS Macro for SPSS to investigate the mediating roles of cognitive emotion regulation strategies and perceived social support among the relationship between perceived discrimination and depression.

CHAPTER 3: RESULTS

In this chapter, preliminary analyses will be presented, including reliability tests, normality checks, and descriptive statistics. Then, the main analyses will be presented, consisting of within-group differences, correlations between study variables, and mediation analyses.

3.1. Preliminary Analyses

3.1.1. Reliability Tests

The reliability of the scales used in this study was measured by calculating Cronbach's Alpha values. All scales' Cronbach's Alpha values are presented in Table 2, indicating that the scales showed good to excellent internal consistency.

Table 3. Cronbach's Alpha Values of the Scales Used in the Study

Scales	*a*
Perceived Discrimination Scale	.82
Perceived Individual Discrimination	.80
Perceived Group Discrimination	.88
Multidimensional Scale of Perceived Social Support	.85
Significant Other	.97
Family	.90
Friends	.95
Cognitive Emotion Regulation Questionnaire	.85
Refocus on Planning	.84
Other Blame	.89
Putting Into Perspective	.76
Catastrophizing	.78
Positive Refocusing	.77
Self-Blame	.81
Acceptance	.69
Rumination	.72
Positive Reappraisal	.85
Beck Depression Inventory	.91

3.1.2. Normality

In order to check the normality of the variables used in the study, skewness and kurtosis values were calculated. Values were displayed in Table 3. All values fell between -2 and +2, which are the critical values for normality (George and Mallery, 2019).

Table 4. Skewness and Kurtosis Values of the Variables

Variables	Skewness	Kurtosis
Perceived Discrimination Total	-0.239	-0.394
Perceived Individual Discrimination	0.010	-0.589
Perceived Group Discrimination	-0.638	-0.200
Social Support	-0.298	-0.269
Significant Other Support	-0.169	-1.597
Family Support	0.209	-1.029
Friends Support	-1.321	1.093
Cognitive Emotion Regulation Strategies	-0.553	1.699
Depression	0.441	-0.287

3.1.3. Descriptive Statistics

Means (*M)*, standard deviations (*SD)*, minimum, and maximum values of the study's variables were calculated and displayed in Table 4.

Table 5. Descriptive Statistics of the Variables

Variables	*M*	*SD*	*Minimum*	*Maximum*
Perceived Discrimination Total	43.04	5.97	27	55
Perceived Individual Discrimination	11.72	3.95	4	20
Perceived Group Discrimination	31.32	3.32	21	35
Social Support Total	4.45	1.23	1.42	6.92
Significant Other	4.21	2.34	1	7
Family	3.48	1.67	1	7
Friends	5.67	1.51	1	7
Cognitive Emotion Regulation Strategies	111.70	16.39	55	160
Refocus on Planning	14.08	3.69	6	20
Other Blame	11.96	4.02	4	20

Table 4. (Continued) Descriptive Statistics of the Variables

Putting Into Perspective	10.76	3.42	4	20
Catastrophizing	10.96	3.80	4	20
Positive Refocusing	9.43	3.26	4	17
Self-Blame	12.57	3.66	4	20
Acceptance	13.63	3.21	4	20
Rumination	16.01	2.92	8	20
Positive Reappraisal	12.30	3.88	4	20
Depression	22.62	12.02	0	51

*Scales that are used to measure the variables are as follows: Perceived Discrimination Scale, Multidimensional Scale of Perceived Social Support, Cognitive Emotion Regulation Questionnaire, and Beck Depression Inventory.

3.2. Main Analyses

3.2.1. Within-Group Differences

A paired samples t-test was conducted to compare the participants' perception of discrimination (i.e., perceived individual and perceived group discrimination) (Table 5). There was a significant difference in scores for perceived group discrimination (M = 31.32, SD = 3.27) and perceived individual discrimination (M =11.72, SD = 3.95); $t(111) = 50.39$, $p < .01$. Participants perceived discrimination as a group to greater degrees compared to perceiving discrimination individually.

Table 6. Paired Samples T-Test for Attribution of Perceived Discrimination

Perception of Discrimination	Perceived Group Discrimination		Perceived Individual Discrimination		
	M	*SD*	*M*	*SD*	*t*
	31.32	3.26	11.72	3.95	50.39**

**$p < .01$

3.2.2. Correlation Analyses

Pearson product-moment correlation coefficients were calculated to examine the relationships among perceived discrimination, perceived individual discrimination, perceived group discrimination, depressive symptoms, perceived social support, and cognitive emotion regulation strategies.

Depressive symptoms had significant positive correlations with (total) perceived

discrimination (r = .46, p < .01), perceived individual discrimination (r = .46, p < .01), and perceived group discrimination (r = .28, p < .01). As perceived discrimination levels increased (total, individual and group), depression levels also increased. The summary of the results were given in Table 6.

There was a significant negative correlation between perceived social support and depressive symptoms, r = -.37, p < .01, showing that increased perceived social support levels were associated with decreased depression levels. Depressive symptoms had significant correlations with perceived significant other support (r = -.36, p < .01) and friends support (r = -.21, p < .05). However, there was not a significant relationship between depressive symptoms and perceived family support, r = -.14, p > .05. As perceived support from significant others and friends increased, depression levels decreased.

There was a significant negative correlation between perceived social support and perceived group discrimination, r = .19, p < .05. However, there was not a significant correlation between perceived social support and perceived individual discrimination, r = .18, p > .05. Participants with greater perceived social support level had lower perceived group discrimination levels.

Furthermore, depression had significant positive correlations with self-blame (r = .48, p < .01), catastrophizing (r = .35, p < .01), acceptance (r = .36 p < .01), and putting into perspective (r = .24, p < .05). As the frequency of engaging in self-blame, catastrophizing, acceptance, and putting into perspective increased, depression levels also increased. Depression had a significant negative correlation with refocus on planning r = .21, p < .05. Participants who engaged greater frequencies in refocus on planning had lower depression levels. However, depression did not have significant relationships with rumination (r = .12, p > .05), positive refocusing (r = -.12, p > .05), positive reappraisal (r = -.16, p > .05), and other blame (r = .14, p > .05). The results of the correlation analysis were given in Table7.

There was a significant negative correlation between age and depression, r = -.32, p < .01. In this study, younger participants had higher depression levels.

Table 7. Correlations Among Variables

	1.	2.	3.	4.
1. Depression	-	.46**	.28**	-.37**
2. Perceived Individual Discrimination	-	-	.36**	-.18

Table 6. (Continued) Correlations Among Variables

3. Perceived Group Discrimination	-	-	-	-.19*
4. Perceived Social Support	-	-	-	-

*p <.05, **p <.01

Table 7. Correlations Among Cognitive Emotion Regulation Strategies and Depression

	1	2	3	4	5	6	7	8	9	10	11	12
1. Depression												
2. Self-blame	.475**											
3. Acceptance	.357**	.544**										
4. Rumination	.119	.251**	.268**									
5. Positive refocusing	-.116	-.030	.079	-.044								
6. Refocus on planning	-.206*	.015	.076	.362**	.513**							
7. Positive reappraisal	-.162	.017	.127	.323**	.475**	.616**						
8. Putting into perspective	.240*	.197*	.472**	.072	.334**	.190*	.373**					
9. Catastrophizing	.351**	.326**	.336**	.285**	-.176	-.194*	-.213*	.062				
10. Other blame	.140	-.055	.201*	.244**	-.011	.031	-.109	.002	.459**			
11. Maladaptive Strategies	.416**	.566*	.509**	.618**	-.099	.052	-.025	.124	.802**	.656**		
12. Adaptive Strategies	.039	.194*	.479**	.185	.835*	.675**	.600**	.666**	-.049	.060	.137	

*p <.05, **p <.01

3.2.3. Mediation Analyses

Based on the hypotheses and by examining the results of correlation analyses, mediation analyses were carried out in order to examine the mediating role of perceived social support and cognitive emotion regulation strategies in the relationship between perceived discrimination and depression.

First, the mediating role of perceived social support in the relation between perceived discrimination and depression was investigated.

Then, the mediating role of maladaptive and adaptive strategies in the relation between perceived discrimination and depression was investigated. Scores for maladaptive and adaptive strategies were summed from the corresponding subscales.

Lastly, which cognitive emotion regulation strategies played a role as a significant mediator between perceived discrimination and depression was investigated.

All of the subscales of the variables were examined in the models according to the hypotheses of the study; however, only the significant models were shown in the figures.

The Mediating Role of Perceived Social Support in Relation between Perceived Discrimination and Depression

The first mediation model was demonstrated to investigate the mediating role of perceived social support in the relation between perceived discrimination and depression. The mediation model was given in Figure 2.

The results indicated that perceived discrimination significantly predicted perceived social support, b = -.05, t = -2.37, p < .05. Perceived discrimination explained 5% of the variance in perceived social support. The negative b value indicated a negative relationship; as the perceived discrimination levels increased, the level of perceived social support decreased. Perceived discrimination significantly predicted depression, with the inclusion of perceived social support in the model, b = .79, t = 4.76, p < .01. Perceived social support also significantly predicted depression, b = -2.78, t = -3.45, p < .01. This model explained 29% of the variance in depression. The negative b value indicated a negative relationship; as the level of perceived social support increased, depression levels decreased. When perceived social support was excluded from the model, perceived discrimination significantly predicted depression, b = .92, t = 5.39, p < .01. When the mediator was not included perceived discrimination explained 21% of the variance in depression. The variance explained by the model when the mediator was included was more than the model in which the mediator was not included. The

indirect influence of perceived discrimination on depression through perceived social support was significant, b = .13, 95% BCa CI [.013, .286]. The bootstrapped confidence intervals did not include zero. Therefore, perceived social support significantly mediated the relationship between perceived discrimination and depression, indicating that the influence of perceived discrimination on depression was mediated by perceived social support.

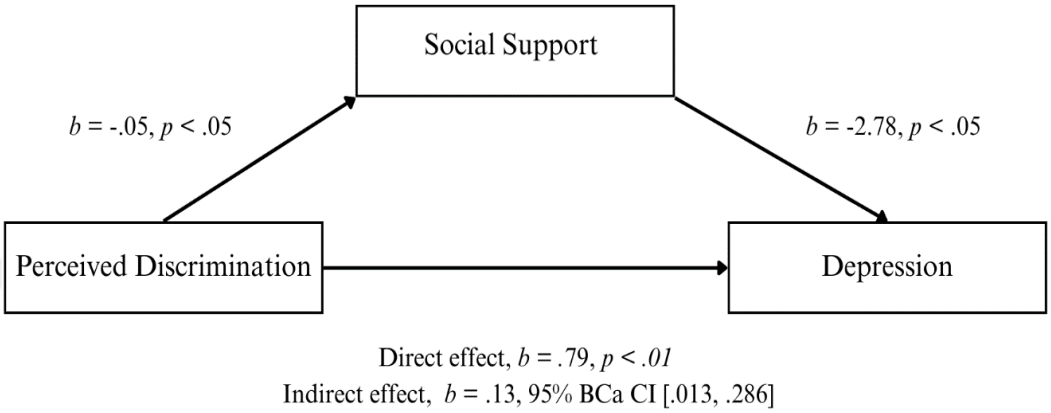

Figure 2. The mediation diagram for the relationship between perceived discrimination and depression, mediated by social support.

The Mediating Role of Perceived Social Support in Relation between Perceived Group Discrimination and Depression

The second mediation model was demonstrated to investigate the mediating role of perceived social support in the relation between group perceived discrimination and depression. This model was constructed to examine the perceived group discrimination as a predictor of depression, whereas the first model examined the total perceived discrimination as a predictor. The mediation model was given in Figure 3.

The results indicated that perceived group discrimination significantly predicted perceived social support, b = -.07, t = -2.00, p < .05. Perceived group discrimination explained 4% of the variance in perceived social support. The negative b value indicated a negative relationship; as the perceived group discrimination levels increased, the level of perceived social support decreased. Perceived group discrimination significantly predicted depression, with the inclusion of perceived social support in the model, b = .81, t = 2.50, p < .05. Perceived social support also significantly predicted depression, b = -3.22, t = -3.77, p < .01. This model explained 19% of the variance in depression. The negative b value indicated a negative relationship; as the level of perceived social support increased, depression levels

decreased. When perceived social support was not in the model, perceived group discrimination significantly predicted depression, $b = 1.04$, $t = 3.09$, $p < .01$. When the mediator was not included, perceived group discrimination explained 8% of the variance in depression. The variance explained by the model when the mediator was included was more than the model in which the mediator was not included. The indirect influence of perceived group discrimination on depression through perceived social support was significant, $b = .23$, 95% BCa CI [.006, .503]. The bootstrapped confidence intervals did not include zero. Therefore, perceived social support significantly mediated the relationship between perceived group discrimination and depression. The influence of perceived group discrimination on depression was mediated by perceived social support.

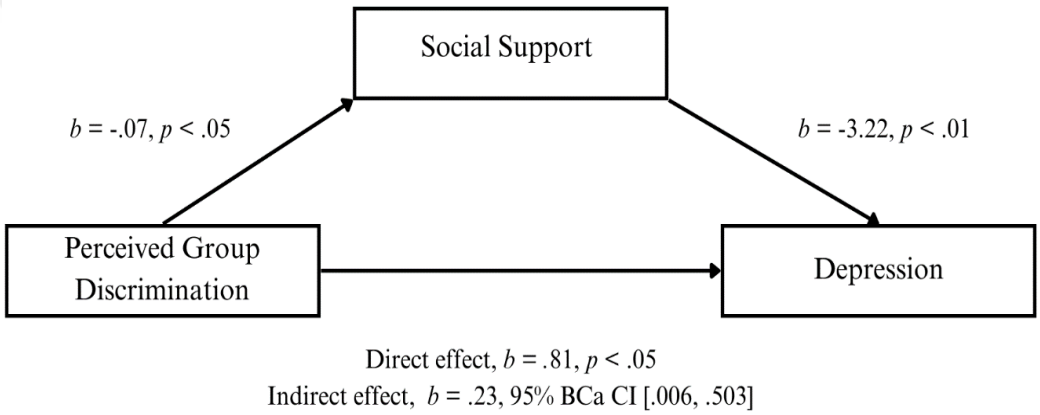

Figure 3. The mediation diagram for the relationship between perceived group discrimination and depression, mediated by social support.

The Mediating Role of Maladaptive Cognitive Emotion Regulation Strategies in Relation between Perceived Discrimination and Depression

The third mediation model was demonstrated to investigate the mediating role of maladaptive cognitive emotion regulation strategies in the relation between perceived discrimination and depression. The maladaptive strategies included catastrophizing, rumination, other blame, and self-blame. The mediation model was given in Figure 4. The results indicated that perceived discrimination significantly predicted maladaptive strategies, $b = .41$, $t = 2.80$, $p < .01$. Perceived discrimination explained 7% of the variance in maladaptive strategies. The positive b value indicated a positive relationship; as perceived discrimination levels increased, the use of maladaptive strategies also increased. Perceived discrimination significantly predicted depression, with the presence of maladaptive strategies in the model, $b = .75$, $t = 4.53$, $p < .01$.

Maladaptive strategies also significantly predicted depression, b = .40, t = 3.87, p < .01. This model explained 30% of the variance in depression. The positive b value indicated a positive relationship; as the usage of maladaptive strategies increased, depression levels also increased. When maladaptive strategies were not included in the model, perceived discrimination significantly predicted depression, b = .92, t = 5.39, p < .01. When the mediator was not included, perceived discrimination explained 21% of the variance in depression. The variance explained by the model when the mediator was included was more than the model in which the mediator was not included. There was a significant indirect effect of perceived discrimination on depression through maladaptive strategies, b = .17, 95% BCa CI [.017, .353]. The bootstrapped confidence intervals did not include zero. Therefore, maladaptive strategies played a significant role in mediating the relationship between perceived discrimination and depression. The influence of perceived discrimination on depression was mediated by the usage of maladaptive cognitive emotion regulation strategies.

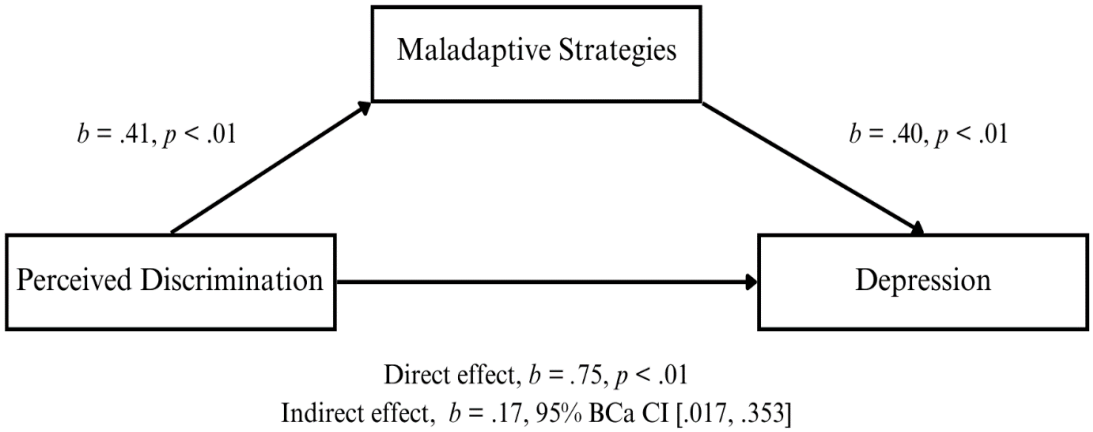

Figure 4. The mediation diagram for the relationship between perceived discrimination and depression, mediated by maladaptive strategies.

The Mediating Role of Maladaptive Cognitive Emotion Regulation Strategies in Relation between Perceived Group Discrimination and Depression

The fourth mediation model was demonstrated to investigate the mediating role of maladaptive cognitive emotion regulation strategies in the relation between perceived group discrimination and depression. This model differs from the previous model by using perceived group discrimination as the predictor rather than the total perceived discrimination. The mediation model was given in Figure 5.

The results indicated that perceived group discrimination significantly predicted maladaptive strategies, b = .77, t = 2.86, p < .01. Perceived group discrimination

explained 7% of the variance in maladaptive strategies. The positive *b* value indicated a positive relationship; as perceived group discrimination levels increased, the use of maladaptive strategies also increased. Perceived group discrimination significantly predicted depression, with the inclusion of maladaptive strategies in the model, $b = .68$, $t = 2.10$, $p < .05$. Maladaptive strategies also significantly predicted depression, $b = .46$, $t = 4.15$, $p < .01$. This model explained 21% of the variance in depression. The positive *b* value indicated a positive relationship; as the usage of maladaptive strategies increased, depression levels also increased. When maladaptive strategies were not included in the model, perceived group discrimination significantly predicted depression, $b = 1.04$, $t = 3.09$, $p < .01$. When the mediator was not included, perceived group discrimination explained 8% of the variance in depression. The variance explained by the model when the mediator was included was more than the model in which the mediator was not included. There was a significant indirect effect of perceived group discrimination on depression through maladaptive strategies, $b = .36$, 95% BCa CI [.053, .749]. The bootstrapped confidence intervals did not include zero. Therefore, maladaptive strategies played a significant role in mediating the relationship between perceived group discrimination and depression. The influence of perceived group discrimination on depression was mediated by the usage of maladaptive cognitive emotion regulation strategies.

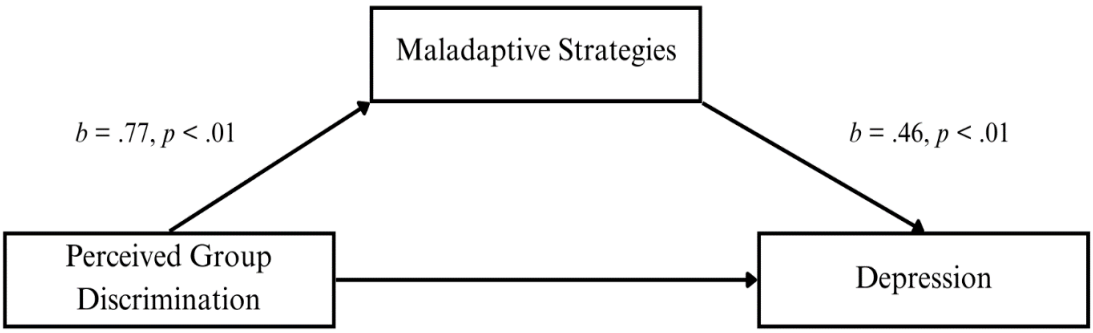

Figure 5. The mediation diagram for the relationship between perceived discrimination and depression, mediated by maladaptive strategies.

The Mediating Role of Acceptance in Relation between Perceived Individual Discrimination and Depression

Which cognitive emotion regulation strategies significantly mediated the association between discrimination and depression was examined. In this study, only acceptance

significantly played a role as a mediator in the relationship between perceived discrimination and depression; however, acceptance only mediated the relationship between perceived individual discrimination and depression. A significant mediation model was not found when perceived group and total discrimination was used as a predictor. Therefore, the fifth mediation model was performed to examine the mediating role of acceptance in the relationship between perceived individual discrimination and depression. The mediation model was given in Figure 6.

The results indicated that perceived individual discrimination significantly predicted acceptance, $b = .21$, $t = 2.78$, $p < .01$. Perceived individual discrimination explained 7% of the variance in acceptance. The positive *b* value indicated a positive relationship; as perceived individual discrimination levels increased, the use acceptance also increased. Perceived individual discrimination significantly predicted depression, with the inclusion of acceptance in the model, $b = 1.20$, $t = 4.63$, $p < .01$. Acceptance also significantly predicted depression, $b = .96$, $t = 3.04$, $p < .01$. This model explained 27% of the variance in depression. The positive *b* value indicated a positive relationship; as the usage of acceptance increased, depression levels also increased. When acceptance was not included in the model, perceived individual discrimination significantly predicted depression, $b = 1.40$, $t = 5.40$, $p < .01$. When the mediator was not included, perceived individual discrimination explained 21% of the variance in depression. The variance explained by the model when the mediator was included was more than the model in which the mediator was not included. There was a significant indirect effect of perceived individual discrimination on depression through acceptance, $b = .20$, 95% BCa CI [.017, .497]. The bootstrapped confidence intervals did not include zero. Therefore, acceptance played a significant role in mediating the relationship between perceived individual discrimination and depression. The influence of perceived individual discrimination on depression was mediated by the usage of acceptance as a cognitive emotion regulation strategy.

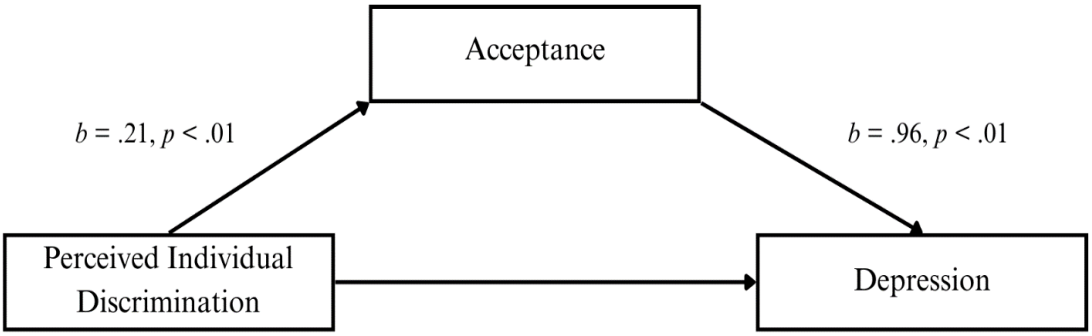

Figure 6. The mediation diagram for the relationship between perceived individual discrimination and depression, mediated by acceptance.

CHAPTER 4: DISCUSSION

The present study mainly aimed to examine the mediating roles of cognitive emotion regulation strategies and perceived social support in the association between perceived discrimination and depression in a transgender sample. To be more specific, in the present study, perceived discrimination refers to perceived discrimination that is based on gender identity. The majority of the participants reported being intensely vigilant against discrimination, and experiencing verbal harassment regarding their gender expression; almost half of the participants reported experiencing sexual harassment and losing their friendships due to their gender identities. The participants also reported experiencing discrimination in their educational settings, losing family members due to their gender identity, experiencing discrimination in accessing healthcare services, being subjected to physical violence, and experiencing discrimination in their work settings and job applications. Thus, it was thought that investigating the relationship between perceived discrimination and depression, and the mediating roles of perceived social support and cognitive emotion regulation strategies in this relationship, will have a valuable contribution to the literature.

In the following, firstly, differences within groups regarding the attribution of perceived discrimination (perceived individual discrimination vs. perceived group discrimination) will be discussed. Second, the relationships between perceived discrimination, depression, cognitive emotion regulation strategies, and perceived social support will be discussed. Lastly, the mediating effect of cognitive emotion regulation strategies and perceived social support in the relationship between perceived discrimination and depression will be discussed.

4.1. Within-Group Differences

The results from within-group differences showed that the transgender participants scored significantly higher on the perceived group discrimination scale than on the perceived individual discrimination scale. This finding indicates that the participants tended to perceive higher levels of discrimination targeting their group rather than perceiving it as an individual experience, which is consistent with the literature. According to the personal group discrimination discrepancy theory, individuals belonging to a minority group often perceive group discrimination to a higher degree compared to personal discrimination (Taylor et al., 1990). Ruggiero and Taylor (1995) argued that individuals belonging to a minority group tend to minimize attribution to

discrimination. By attributing discrimination to their group rather than to themselves, individuals can preserve their self-esteem and sense of control, enabling them to regulate their emotions following a potentially discriminatory event. In the context of the present study, it can be argued that transgender individuals tended to attribute discrimination to their gender minority group to higher degrees than to themselves as individuals. This may be because attributing prejudice to a group protects self-esteem as individuals feel less alone in their exclusion, therefore it serves as a buffer role on the negative effects of exclusion or discrimination (Bourguignon, 2006). However, self-esteem is beyond the scope of the current study, therefore, it may be enlightening for the following studies to examine this relationship. In addition, individuals who participate frequently in their social network may be exposed to more information regarding gender-related discrimination even though they do not experience it personally. Therefore, this may be another aspect/explanation of the discrepancy between the perceived group and individual discrimination. Furthermore, considering Turkey is among the most disadvantageous and discriminatory countries towards LGBTQI+ individuals in Europe when it comes to issues such as equality, discrimination, hate crimes, discriminatory speech, and recognizing gender legally, the high rates of reported perceived group discrimination may be a reflection of this (ILGA-Europe, 2012).

A study regarding the perceived discrimination among transgender individuals in Turkey reported similar findings, supporting the personal/group discrimination discrepancy theory (Başar et. al., 2016). Accordingly, they found that transgender individuals with gender dysphoria tended to perceive discrimination directed to their group at higher levels than themselves. Other studies also demonstrated findings that support the personal/group discrimination discrepancy theory concerning gay and lesbian customers in hospitality settings (Ro and Olson, 2020), anti-black racism (Slaughter-Acey et al., 2018), the association between trait group-identity and prejudice among lesbian women (Chopp, 2011), and ethnic discrimination (Verkuyten, 2002). The present study's results support the personal/group discrimination discrepancy theory in the context of gender-related discrimination among transgender individuals.

4.2. Correlations

Perceived Discrimination and Depression

The results demonstrated that depression and perceived discrimination are positively correlated, as hypothesized. This association was significant for every factor of perceived discrimination. Accordingly, perceived individual and group discrimination were positively associated with depression. As perceived discrimination levels increased, depression levels also increased. These findings are consistent with the literature. Studies and various frameworks suggest that perceived discrimination poses a threat to one's well-being and mental health (Meyer, 2003; Schmitt and Branscombe, 2002). Accordingly, the minority stress model proposes that distal stressors such as discrimination have adverse effects on the well-being of minorities including trans people (Hendricks and Testa, 2012; Meyer, 2003). A body of literature demonstrates the association between discrimination, specifically gender-related discrimination, and depression among transgender individuals (Başar and Öz, 2016; Bockting et al., 2013; Clements-Nolle et al., 2006; Couch et al., 2007; Nemoto et al., 2011; Testa et al., 2012). In addition, alarmingly high rates of various forms of discrimination were reported in the literature concerning the experiences of trans people (Clements-Nolle et al., 2006; Grant et al., 2010; Testa et al., 2012). High rates of discrimination were reported in the present study as well. Considering the association between perceived discrimination and depression, it can be argued that perceiving discrimination both individually and as a group has detrimental effects on transgender individuals' mental health. Therefore, it can be concluded that perceiving discrimination may increase the probability and severity of depression among transgender individuals, and as the rates of discrimination are high, it is crucial to be aware of this relationship. However, because this is a correlational relationship, having greater depression levels may be related to greater levels of perceived discrimination as well as perceiving greater levels of discrimination may be related to greater depression levels. Even though the literature suggests the latter, the causality of this relationship is out of the scope of the study. Overall, the study's results highlight the significance of the association between perceived discrimination and depression; and reflect the experiences of discrimination perceived by transgender individuals living in Turkey.

Perceived Social Support and Depression

The results indicated an inverse association between perceived social support and depression, indicating that increased perceived social support levels were associated

with decreased depression levels. Among the subscales of perceived social support, depression had significant correlations with perceived significant other support and friend support. These findings are consistent with the literature. However, contrary to the literature, the association between family support and depression was not significant. Research has demonstrated that social support's impact on mental health can vary regarding its source (Li et al., 2014; Walen and Lachman, 2000). According to the present study's findings, it can be inferred that the influence of support from family may be weaker than support from significant others and friends.

Research has established that social support has significant effects on one's mental health as it functions as a protective mechanism (Cohen and Thomas, 1985; Thoits, 2011). Consistent with the present results, studies demonstrated the positive impacts of social support on mental health (Grav et al., 2012; Henderson et al., 1980). Accordingly, a body of literature has demonstrated that inadequate social support is associated with adverse mental health outcomes (Brown and Harris, 1979; Cohen and Wills, 1985; Dour et al., 2014; Henry et al., 2018; Paykel, 1994). Similar results supporting this association were reported in Turkey as well (Eldeleklioğlu, 2006; Yalçın, 2014). Furthermore, the effects of social support on depression were demonstrated among transgender individuals by the research as well (Boza and Perry, 2014; Budge et al., 2013). Regarding the sources of support, studies showed that support from friends, significant others, and family were all significantly related to depression (Alsubaie et al.,2019; Kleinberg et al., 2013; Lilympaki et al., 2016; Rundell, 2012; Tezel, Karabulutlu and Şahin, 2011). The present study found significant associations between support from friends and significant others and depression, however, the relationship between social support from family and depression was not significant. There may be a few potential reasons for not finding a significant association between them. Transgender individuals often face unique challenges related to acceptance and rejection from their biological family members and they are vulnerable to rejection within their families (Factor and Rothblum, 2007; Whittle et al., 2007). The issue of rejection from family among transgender leads to a lack of adequate social support from their family members. Accordingly, low support from families among transgender people was reported (Budge et al., 2013; Tantirattanakulchai and Hounnaklang, 2021). Therefore, if the participants have experienced rejection from family members due to their gender identity, a lack of support weakens the potential beneficial impact it could have on reducing depression.

Furthermore, Başar and Öz (2016) argue that there is a fundamental distinction in the relationship between individuals belonging to sexual minority groups and their families, compared to other discriminated groups. They discuss that unlike other stigmatized identity features such as race, ethnic origin, and religion, gender identity (specifically, the experience of being transgender) is not a commonly shared feature within the family. This could be a potential reason for why depression and support from friends have a significant association, yet there is no significant relationship between support from family. Accordingly, they may perceive social support from their peers to higher degrees than from their families due to the reasons discussed above. Moreover, the mean of perceived social support from family was the least compared to friends and significant others according to the present findings. Another factor for the non-significant association between support from family and depression may be related to the conception of family among transgender individuals. Because transgender individuals are vulnerable to rejection from their biological families, the support received from a group of individuals accepting the individuals as they are, referred to as chosen family, may become significant in sexual and gender minority groups (Başar and Öz, 2016; Davey et al. 2014). Even though the scale used in the study assesses the perception of support from family, it mainly refers to biological family, therefore, it may not reflect the perception of support from the participants' chosen families. Future studies, in addition, may investigate the perceptions of support from one's chosen family, especially when conducting a study with a minority sample.

Cognitive Emotion Regulation Strategies and Depression

The findings indicated that depression had significant positive correlations with "catastrophizing", "acceptance", "self-blame", and "putting into perspective". As the frequency of engaging in these strategies increased, depression levels also increased. "Catastrophizing" and "self-blame" are assumed to be maladaptive strategies, therefore, these findings are consistent with the literature (Garnefski et al., 2001).

"Acceptance" and "putting into perspective" are generally assumed to be more adaptive strategies. However, the study's findings indicated that "acceptance" and "putting into perspective" was positively associated with depression, which is not consistent with the literature, as a negative relationship was expected. Even though "acceptance" as a cognitive coping strategy is broadly considered an adaptive strategy, some researchers argue that it could be considered as a maladaptive one (Martin and Dahlen, 2005). Accordingly, a number of studies supported this argument by

demonstrating the positive association between “acceptance” and depression (Garnefski and Kraaij, 2006; Huh et al., 2017; Kraaij et al., 2002; Liu et al., 2020; Martin and Dahlen, 2005). The present study’s findings also supported this argument. One of the possible explanations for these findings might be that “acceptance” could be understood as surrendering to negative experiences rather than coming to terms with them. Therefore, acceptance as a way of surrendering may be associated with depression, as it is possibly more related to the feeling of hopelessness. Surrendering to negative experiences may intervene in the motivation to cope with them or it may intervene with reaching necessary support resources to cope. Furthermore, there may be some cultural differences between the items of the original scale and the Turkish-adapted scale. This difference could indicate a linguistic difference or a socio-cultural difference. Future studies may focus on this possible cultural difference. In addition, “putting into perspective” was positively associated with depression, which is consistent with the literature (Garnefski, Boon and Kraaij, 2003; Garnefski and Kraaij, 2006; Schroevers, Kraaij and Garnefski, 2007).

Despite being considered a more adaptive strategy, some studies have indicated that “putting into perspective” may not necessarily be an effective strategy for regulating emotions (Oikawa, Nakano and Tabuchi, 2017; Schroevers et al., 2007). Even though “putting into perspective” is associated with positive cognitions, downplaying the seriousness of an event may be considered a less adaptive coping strategy (Schroevers et al., 2007). Similarly, Garnefski et al. (2003) argue that the cognitive strategy of minimizing the seriousness of an event may not always be regarded as an adaptive coping strategy. Furthermore, other studies have indicated that “putting into perspective” may be a significant issue related to well-being. (Allen and Gilbert, 1995). Transgender individuals face frequent discrimination, therefore, in the face of discrimination, playing down the seriousness of the negative events may not be an effective or adaptive way of coping. Furthermore, minimizing the seriousness of an event may prevent individuals from reaching the necessary resources of support to cope with them. Therefore, these may be some of the possible explanations for the positive relationship between “putting into perspective” and depression.

Consistent with the literature, the study’s findings also revealed that depression had a significant negative association with “refocus on planning”, therefore it is described as adaptive (Garnefski et al., 2001). Studies have demonstrated the negative association between “refocus on planning” and depression (Martin and Dahlen, 2005;

Öngen, 2010; Garnefski et al., 2004). In addition, "refocus on planning" was found associated with higher resilience (Min et al., 2013).

4.3. Mediation Analyses

4.3.1. Discussion of the Mediating Role of Perceived Social Support in the Relationship Between Perceived Discrimination and Depression

The first mediation model aimed to examine the mediation effect of perceived social support on the association between perceived discrimination and depression. The results indicated that perceived social support significantly mediated the influence of perceived discrimination on depression, as hypothesized. According to the findings of the first mediation model, perceived discrimination predicted depression positively and social support negatively. Furthermore, perceived social support predicted depression negatively. The strength of the relationship between perceived discrimination and depression was weakened when the mediator was included in the model. In other words, the influence of perceived discrimination on depression is weaker when the perceived social support levels are higher. Overall, these findings indicated that perceived social support is an important mechanism in explaining perceived discrimination and depression's association among transgender people. These findings are consistent with the literature. For example, Kim's (2014) study found that social support mediated the association between racial discrimination and depression among Asian Americans, supporting the mediating role of social support among minority groups. Another study's findings also supported this by showing that social support played a significant role in mediating the association between perceived discrimination and suicidality (Mao et al., 2022). Furthermore, it was found that perceived discrimination predicted suicidal ideation positively, indicating that perceiving discrimination raises the probability of having suicidal thoughts. Although the current study is not aiming to focus on suicidal ideation, it is still significant considering its association with depression. A study carried out with Romanian immigrants indicated that social support significantly mediates the association among discrimination and better mental health (Fernández et al., 2015). Another study reported that the adverse impact of stigmatization on depressive symptoms among people who struggle with substance use is significantly mediated by social support (Chang et al., 2021). Other studies demonstrated that social support significantly mediates the association among life satisfaction and stressful events (Yang et al., 2018; Wang et al., 2017).

When investigating the subscales of the Perceived Discrimination Scale with the same predictor and outcome variables, according to the second mediation model, it was found that there was a significant mediating role of social support among the group discrimination and depression association, but this role was not significant among the individual discrimination and depression association. There may be a few possible explanations for this difference. The first possible explanation is that the influence of discrimination on depression may vary depending on the perceived source of discrimination. Accordingly, perceived group discrimination may have a stronger impact on depression compared to perceived individual discrimination. Furthermore, considering the discriminative atmosphere of Turkey against transgender individuals, discrimination's impact on the mental health of transgender individuals may be stronger at a group level compared to on a personal level. The second possible explanation is that perceived social support may have greater importance when it comes down to perceived group discrimination than perceived individual discrimination. Accordingly, when individuals perceive discrimination against their group, perceiving that they have access to social resources may have greater importance. Lastly, the lack of a significant mediating role for perceived social support in the association among individual discrimination and depression may indicate that individual experiences of discrimination may affect depression more directly, potentially bypassing the mediation effect of social support.

4.3.2. Discussion of the Mediating Role of Maladaptive Cognitive Emotion Regulation Strategies in Relation between Perceived Discrimination and Depression

The third mediation model aimed to investigate the mediation effect of maladaptive strategies among the association between perceived discrimination and depression. The results showed that maladaptive strategies played a significant role in mediating the association among perceived discrimination and depression, as hypothesized. The findings of this mediation model showed that perceived discrimination predicted depression and maladaptive strategies positively. The greater the perceived discrimination one perceives, the greater their depression and use of maladaptive strategies. Furthermore, maladaptive strategies predicted depression positively. The more maladaptive strategies one uses, the greater their depression. Engaging in maladaptive strategies in the face of discrimination may be harmful to one's mental health. Overall, these findings indicated that engaging in maladaptive strategies as a way of regulating emotions is an important process for explaining the association

among perceived discrimination and depression. These findings are consistent with the literature. According to Hatzenbuehler's (2009) "psychological mediation model", which extends "the minority stress model" proposed by Meyer (2003), psychological processes such as cognitive emotion regulation have a mediating effect in the association among prejudiced related stress and negative mental health outcomes. Accordingly, a study revealed that the impact of negative experiences on depression is mediated by maladaptive strategies (Stikkelbroek et al., 2016). In other words, individuals who utilized maladaptive strategies to regulate more often were more likely to experience depressive symptoms in response to negative experiences. Another study demonstrated that the impact of childhood trauma on depression was by maladaptive strategies (Huh et al., 2017). A study conducted with transgender individuals found that avoidant coping, which can be described as maladaptive, had a mediating role in the association among victimization and depressive symptomatology (Hughto et al., 2017). The mediation role of maladaptive strategies was demonstrated among the association between weight stigma and depressive symptoms (Koball and Carels, 2011). The authors argue that a potential explanation for this phenomenon is that depressive symptoms can disrupt cognitive functions, thereby impairing the individual's ability to effectively employ adaptive cognitive strategies for regulating emotions (Huh et al., 2017; Santorelli and Ready, 2015). This disruption in cognitive functioning may play a mediating role in the utilization of both maladaptive and adaptive strategies.

In this study, the emphasis was placed on maladaptive strategies over adaptive strategies due to a growing body of literature that highlights the significance of maladaptive coping strategies in the relationship between prejudice and psychological distress (Szymanski et al., 2014). For example, it was reported that maladaptive coping strategies mediated the association among ethnic-stress and psychological distress, whereas, adaptive strategies did not (Szymanski and Obiri, 2011). Furthermore, it was demonstrated that maladaptive coping styles had a significant role in mediating the association among heterosexism and distress, meanwhile, adaptive coping styles did not (Szymanski and Henrichs-Beck, 2014). In parallel with these, in the present study, adaptive strategies did not significantly mediate the impact of perceived discrimination on depression, while maladaptive strategies did. The non-significant mediating role adaptive strategies suggests that these strategies may not have been effective in mitigating the detrimental effects of perceived discrimination on individuals'

depressive symptoms in our sample. In contrast, the significant mediation effect of maladaptive strategies highlights their amplifying role among the association between perceived discrimination and depression.

Lastly, the present study aimed to examine which specific strategies played a significant role in mediating the impact of perceived discrimination on depression. The results of the mediation analyses revealed that only “acceptance” significantly mediated the impact of perceived individual discrimination on depression. According to the findings of the final mediation model, perceived individual discrimination predicted depression and acceptance positively. The more discrimination one perceives on an individual level, the greater their depression and the frequency of engaging in “acceptance”. Furthermore, acceptance predicted depression positively. The more acceptance as a coping strategy one uses, the greater their depression. As discussed earlier, the positive relationship between acceptance and depression is not consistent with the literature, as acceptance is generally considered an adaptive strategy (Garnefski et al., 2001). However, some studies found a positive association among “acceptance” and depression, indicating it may not always be an adaptive strategy (Garnefski and Kraaij, 2006; Huh et al., 2017; Kraaij et al., 2002; Liu et al., 2020; Martin and Dahlen, 2005). There is not much evidence regarding the mediating effect of “acceptance”, especially regarding the perceived discrimination and depression association. However, a study demonstrated that acceptance significantly mediated the association between traumatic experiences and post-traumatic stress in Tibetan refugees, supporting the mediating effect of “acceptance” (Hussain and Bhushan, 2011).

Furthermore, the mediator role of "acceptance" was significant among the association between depression and individual discrimination exclusively. These findings indicate a difference regarding how individuals attribute the discrimination they perceive. This finding suggests that people who report greater depression levels are more likely to engage in “acceptance” as a cognitive coping strategy, and in turn, “acceptance” amplifies their depression in response to individual discrimination experiences. In contrast, the lack of a significant mediating role of “acceptance” among the association between depression and perceived group discrimination indicates that “acceptance” may not always play an important role regarding the impact of individual discrimination on depression. It is possible that the unique effect of group discrimination, which often involves systemic and institutionalized forms of stigma,

may render the effects of “acceptance” in relation to negative psychological consequences associated with these experiences. These findings shed light on the role of “acceptance” in the context of the effect of discrimination on depression among transgender individuals.

The present study’s finding indicated that maladaptive coping strategies played a mediating role regarding the impact of perceived discrimination on depression, while most cognitive strategies did not significantly play a mediating role in this relationship on their own, except for “acceptance”. These findings suggest that engaging in a combination of maladaptive strategies has a more significant impact on the association between perceived discrimination and depression, rather than engaging in particular coping strategies. Accordingly, engaging more in maladaptive strategies may hinder engaging in more adaptive strategies, thus, making individuals less immune to the harmful impacts of perceived discrimination.

In summary, the study’s overall results indicate that transgender individuals tend to perceive discrimination directed against their group at higher levels compared to perceiving it as discrimination targeting themselves individually. The findings suggest that as the levels of perceived total, group, and individual discrimination increase, depression levels also increase. In addition, it was found that as the perceived social support levels increase, the depression levels decrease. The findings revealed that depression had positive associations with “catastrophizing”, “putting into perspective”, “acceptance”, and “self-blame”. The greater frequency of engaging in these strategies was correlated with higher levels of depression. In contrast, depression had a negative association with “refocus on planning”, indicating that engaging in refocus on planning more was correlated with lower levels of depression. The findings of the study also demonstrated that maladaptive cognitive emotion regulation strategies and perceived social support mediate the influence of perceived discrimination on depression, indicating that the indirect influence between perceived discrimination and depression goes through perceived social support and maladaptive coping strategies. The study also investigated which particular strategies mediated the association between perceived discrimination and depression. The findings revealed that only “acceptance” significantly played a mediator role in this association on its own. These findings shed light on the impacts of perceived discrimination on depression as well as the roles of perceived social support and cognitive emotion regulation strategies among transgender individuals.

4.4. Strengths of the Present Study

The present study is the first to investigate the mediating roles of cognitive emotion regulation strategies in the association between perceived discrimination and depression. Overall, studies regarding the experiences of LGBTQ+ individuals are limited, globally and in Turkey. Furthermore, even though the research exploring the experiences of LGB individuals is growing, studies regarding the experiences of transgender individuals are relatively more limited. In addition to this, it was noted by the author that not all of the studies investigating the experiences of LGBTQ+, especially the experiences of transgender individuals, are sensitive in their approach and language. This study has made an effort to overcome this by addressing LGBTQ+ issues with care and sensitivity, aiming to avoid objectifying the experiences of LGBTQ+ individuals. It was also noted by the author that the majority of the research regarding transgender individuals tackles the concept of gender in a binary construct, dismissing the experiences of non-binary individuals. The present study's sample consisted of non-binary and binary transgender individuals, therefore, making the study more inclusive. Moreover, considering that being subjected to discrimination is a significant risk factor for depression, and taking into account the high rates of discrimination towards transgender individuals, it is significantly important to examine the potential impact of discrimination on the mental health of transgender individuals. In sum, the present study's findings contribute to the relatively limited literature regarding the experiences of transgender individuals by highlighting the importance of perceived social support and cognitive emotion regulation strategies in the association between perceived discrimination and depression with an inclusive sample.

4.5. Limitations and Future Suggestions

Despite the strengths of the present study, there are also a few limitations. First, 112 participants took part in the present study, reached by convenient sampling. Even though the sample of the study is a minority group, which makes reaching higher numbers of participants harder; a higher number of participants could increase the generalizability of the study. Moreover, it is important to note that convenient sampling, even though commonly used, does not guarantee the generalizability of the findings as random sampling would. However, as Owens et al. (2020) discuss, when planning a sampling procedure specifically among LGBTIQ+ participants, it is crucial to consider factors such as cost, feasibility, and the ability to reach a large number of

participants in addition to generalizability concerns. One of the inclusion criteria was being 18 years old and above, with no upper age limit. As a result, the age range is relatively wide. The reason for this approach was to be more inclusive. However, it can also be argued that keeping the age range wide is a limitation, considering that each developmental stage entails unique experiences and challenges. Future studies may conduct a study with a transgender sample, but with a limited age range. In addition, all scales used in the study were self-report scales that introduce the potential risk of social desirability bias, as individuals may be concerned about their self-presentation, which could influence their responses on the scales (Wood, 1996). Furthermore, the distribution of genders was uneven, with a significant proportion of participants identifying as non-binary. However, the study aimed to focus on the experiences of individuals who identify under the trans+ umbrella, it did not aim to focus on the differences among different gender groups. Finally, the items of the family subscale of the MSPSS, which assess the degree of perceived social support from family, exclusively focus on support from one's biological family. However, given that chosen family holds significant importance for LGBTQ+ individuals, the results obtained from this specific subscale might not accurately capture the experiences of participants who define the concept of family in terms of their chosen family rather than their biological one. Another limitation is that over half of the participants reported having a psychological diagnosis. In this study, having a psychological diagnosis was not used as an exclusion criterion to maintain a higher sample size, especially as it is challenging to reach a sufficient number of participants who belong to minority groups. Additionally, the study focused on depression; therefore, excluding participants who reported having depression would not have been meaningful, considering that the majority of participants reported experiencing depression. Furthermore, it should be noted that participants self-reported their diagnoses, which may affect the validity of the diagnoses. Nonetheless, the presence of these diagnoses could potentially act as a confounding factor, and this may be regarded as a limitation. Future studies may choose to exclude participants who report having a diagnosis to overcome this limitation. Lastly, while examining depression as a variable, the study sample does not necessarily consist of individuals diagnosed with depression. Only the scores of specific participants from the Beck Depression Inventory, which is frequently employed in studies involving diagnosed samples, are close to the scores obtained by individuals diagnosed with depression.

Considering these limitations, future studies may reach higher numbers of participants who identify as transgender and prefer random sampling when collecting data to increase the generalizability of the study. Different types of measurement such as experimental methods may overcome the limitations of self-report measurement. Furthermore, future studies may collect data that is more even in its gender distribution to obtain information about the experiences of different gender identities and their differences. Future studies, especially when conducting a study with LGBTQ+ individuals, may also focus on perceived social support from the participants' chosen families rather than focusing only on their biological family. Lastly, the present study focused only on the cognitive aspect of emotion regulation, therefore, future studies may focus on other aspects of emotion regulation regarding the relationship between perceived discrimination and depression.

CHAPTER 5: CONCLUSIONS

The aim of this study was to investigate the mediating roles of perceived social support and cognitive emotion regulation strategies in the relationship between perceived gender identity based discrimination and depression. Furthermore, the study also investigated the relationships between these variables as well as the difference between perceived individual and group discrimination. The study's findings showed that perceived social support and maladaptive cognitive emotion regulation strategies significantly mediated the association between perceived discrimination and depression, highlighting that the effect of perceived discrimination on depression goes through perceived social support and maladaptive coping strategies. Results of the study showed that depression had a positive association with perceived discrimination, whereas, it was negatively correlated with perceived social support, consistent with the Minority Stress Model (Meyer, 2003). Moreover, it was shown that the greater frequency of engaging in self-blame, catastrophizing, acceptance, and putting into perspective as coping strategies was related to higher levels of depression, whereas, engaging in refocus on planning was related to lower levels of depression. The study's findings further revealed that transgender individuals are frequently subjected to various forms of discrimination, including verbal and sexual harassment, loss of relationships due to their gender identities, discrimination in educational and work environments, and difficulties accessing healthcare services. Moreover, they were intensely vigilant toward potential instances of discrimination. Lastly, the study's findings revealed that individuals who identify themselves under the trans+ umbrella tend to perceive higher levels of discrimination directed at their group as a whole, compared to the discrimination they personally experience as individuals within that group, consistent with Personal/Group Discrimination Discrepancy Theory (Taylor et al., 1990).

The present study was the first to investigate the mediating roles of cognitive emotion regulation strategies in the association between perceived gender identity discrimination and depression among transgender individuals. Furthermore, it was the first to investigate the roles of cognitive emotion regulation strategies on depression among transgender individuals residing in Turkey. Moreover, it was the first study to examine these relationships with a sample mostly consisting of non-binary individuals. Overall, the study's findings emphasized the importance of social support and roles of

cognitive emotion regulation strategies, especially the roles of maladaptive strategies, in the link between perceived discrimination and depression among transgender individuals.

5.1. Clinical Implications

The study's findings have important clinical implications. First, the study highlights that transgender individuals perceive higher levels of discrimination directed at their group than at themselves as individuals. This finding emphasizes the importance of increasing awareness and understanding of the unique challenges and discrimination faced by transgender individuals within the clinical setting while being sensitive to the effects of institutionalized discrimination. Therefore, mental health professionals should be sensitive to these experiences and offer adequate support. Secondly, in line with this, as there is a positive relationship between perceived discrimination and depression, mental health professionals should recognize the impact of perceived discrimination on mental health outcomes, such as depression in this context, and develop interventions that aim to reduce discrimination and its negative effects. In order to reduce discrimination's adverse effects on the mental health of transgender individuals, mental health professionals may focus on promoting social support networks and provide interventions to enhance perceived social support to provide a buffer against depressive symptoms, as suggested by the study's findings. The study also suggests that perceived social support and maladaptive cognitive emotion regulation strategies mediate the relationship between perceived discrimination and depression. This finding highlights the significance of addressing these mediating factors in therapeutic settings. Accordingly, mental health professionals may try to enhance social support and help individuals challenge individuals' maladaptive strategies and develop healthier strategies when working with transgender individuals. In return, this may reduce perceived discrimination's impact on depression. Lastly, the study emphasizes the importance of personalized interventions that acknowledge and address the diverse experiences within the transgender population. It is crucial to be aware of the fact that individuals may differ in their levels of perceived discrimination, social support, and coping strategies. Therefore, when conducting a treatment, it is crucial for mental health professionals to acknowledge the specific needs of each individual considering their unique experiences and challenges, and plan a treatment accordingly.

REFERENCES

Aldao, A., Nolen-Hoeksema, S.d Schweizer, S. (2010) *Emotion-regulation strategies across psychopathology: A meta-analytic review*. Clinical Psychology Review, Vol. 30(2), pp. 217–237.

American Psychiatric Association (2013) *Diagnostic and statistical manual of mental health disorders: DSM-5*, 5th edition, Washington D.C.: American Psychiatric Publishing.

American Psychological Association. (2011) Answers to your questions about transgender people, gender identity, and gender expression [Online] Available at: http://www.apa.org/topics/ lgbt/transgender.aspx (Accessed 20 April 2023)

American Psychological Association. (2015) *Guidelines for psychological practice with transgender and gender-nonconforming people.* American Psychologist, Vol. 70(9), pp. 832-864.

Anderson, C. S., Miller, R. S., Riger, A. L., Dill, J. C., and Sedikides, C. (1994) B*ehavioral and characterological attributional styles as predictors of depression and loneliness: Review, refinement, and test*. Journal of Personality and Social Psychology, Vol. 66(3), pp. 549–558.

Andrea, S. B., Siegel, S. A., and Teo, A. R. (2016) *Social Support and Health Service Use in Depressed Adults: Findings From the National Health and Nutrition Examination Survey*. General Hospital Psychiatry, Vol. 39, pp. 73–79.

Aypar, G., and Tanyaş, B. (2017) *İstanbul'da yaşayan transların dışlanma ve ayrımcılık deneyimleri üzerine nitel bir çalışma*. Aurum Sosyal Bilimler Dergisi, Vol. 2(1), pp. 71-90.

Başar, K., and Öz, G. (2016) *Resilience in individuals with gender dysphoria: Association with perceived social support and discrimination*. Turkish Journal of Psychiatry, Vol. 27(4), pp. 225-234.

Başar, K., Öz, G., and Karakaya, J. (2016) P*erceived Discrimination, Social Support, and Quality of Life in Gender Dysphoria.* The Journal of Sexual Medicine, Vol. 13(7), pp. 1133–1141.

Baumeister, R. F., and Leary, M. R. (1995) *The need to belong: Desire for interpersonal attachments as a fundamental human motivation.* Psychological Bulletin, Vol. 117, pp. 497–529.

Beck, A. T., Ward, C., and Mendelson, M. (1961) *Beck depression inventory* (BDI).

Arch Gen Psychiatry, Vol. 4(6), pp. 561-571.

Bockting, W. O., Miner, M. H., Swinburne Romine, R. E., Hamilton, A., and Coleman, E. (2013) *Stigma, mental health, and resilience in an online sample of the US transgender population.* American journal of public health, Vol. 103(5), pp. 943–951.

Bockting, W., Huang, C., Ding, H., Robinson, B., and Rosser, B. R. S. (2005) *Are transgender persons at higher risk for HIV than other sexual minorities? A comparison of HIV prevalence and risks.* International Journal of Transgenderism, Vol. 8, pp. 123–131.

Bolger, N., and Amarel, D. (2007) *Effects of social support visibility on adjustment to stress: Experimental evidence.* Journal of Personality and Social Psychology, Vol. 92(3), pp. 458–475.

Bourguignon, D., Seron, E., Yzerbyt, V., and Herman, G. (2006) *Perceived group and personal discrimination: Differential effects on personal self-esteem.* European Journal of Social Psychology, Vol. 36, pp. 773–789.

Boza, C., and Perry, K. N. (2014) *Gender-Related Victimization, Perceived Social Support, and Predictors of Depression Among Transgender Australians.* International Journal of Transgenderism, Vol. 15(1), pp. 35–52.

Brown G. W. and Harris T. O. (1978) *Social Origins of Depression: A Study of Psychiatric Disorder in Women*, 1st Edition, The Free Press. New York.

Budge S.L., Rossman H.K., and Howard K.A.S. (2014) *Coping and psychological distress among genderqueer individuals: The moderating effect of social support*. Journal of LGBT issues in counseling, Vol. 8, pp. 95–117.

Budge, S. L., Adelson, J. L., and Howard, K. A. (2013) *Anxiety and depression in transgender individuals: the roles of transition status, loss, social support, and coping.* Journal of consulting and clinical psychology, Vol. 81(3), pp. 545–557.

Budge, S. L., Katz-Wise, S. L., Tebbe, E. N., Howard, K. A. S., Schneider, C. L., and Rodriguez, A. (2012) *Transgender emotional and coping processes: Facilitative and avoidant coping throughout gender transitioning.* The Counseling Psychologist, Vol. 41(4), pp. 601–647.

Carver, C. S., Scheier, M. F., and Weintraub, J. K. (1989) *Assessing coping strategies: A theoretically based approach*. Journal of Personality and Social Psychology, Vol. 56(2), pp. 267–283.

Cava, P. (2016) *Cisgender and Cissexual*. The Wiley Blackwell Encyclopedia of Gender and Sexuality Studies, pp. 1–4.

Chan Y. K., and Rance P. L. L. (2005) *Network size, social support, and happiness in later life: A comparative study of Beijing and Hong Kong.* Journal of Happiness Studies, Vol. 7, pp. 87− 112.

Chang, C., Chang, K., Griffiths, M. D., Chang, C., Pakpour, A. H., and Pakpour, A. H. (2021) *The mediating role of perceived social support in the relationship between perceived stigma and depression among individuals diagnosed with substance use disorders.* Journal of Psychiatric and Mental Health Nursing, Vol. 29(2), pp. 307–316.

Chioqueta, A. P., and Stiles, T. C. (2005) *Personality traits and the development of depression, hopelessness, and suicide ideation. Personality and Individual Differences*, Vol. 38(6), pp. 1283–1291.

Choenarom, C., Williams, R. A., and Hagerty, B. M. (2005) *The Role of Sense of Belonging and Social Support on Stress and Depression in Individuals With Depression.* Archives of Psychiatric Nursing, Vol. 19(1), pp. 18–29.

Chopp, R. M. (2011) Identification as Lesbian and Judgments of Personal Versus Group Discrimination, Ph.D. Thesis, George Mason University.

Cicchetti, D., Ackerman, B. P., and Izard, C. E. (1995) *Emotions and emotion regulation in developmental psychopathology.* Development and Psychopathology, Vol. 7(1), pp. 1–10.

Clements-Nolle, K., Marx, R., and Katz, M. (2006) *Attempted suicide among transgender persons: The influence of gender-based discrimination and victimization.* Journal of Homosexuality, Vol. 51, pp. 53– 69.

Cohen, S. (1988) *Psychosocial models of the role of social support in the etiology of physical disease.* Health Psychology, Vol. 7(3), pp. 269–297.

Cohen, S. (2004) *Social Relationships and Health*. American Psychologist, Vol. 59(8), pp. 676–684.

Cohen, S., and Wills, T. A. (1985) *Stress, social support, and the buffering hypothesis.* Psychological Bulletin, Vol. 98, pp. 310–357

Colton Meier, S. L., Fitzgerald, K. M., Pardo, S. T., and Babcock, J. (2011) *The effects of hormonal gender affirmation treatment on mental health in female-to-male transsexuals.* Journal of Gay and Lesbian Mental Health, Vol. 15, pp. 281–299.

Cooperman, N. S., Simoni, J. M., and Lockhart, D. W. (2003) *Abuse, social support, and depression among HIV-positive heterosexual, bisexual, and lesbian women*. Journal of Lesbian Studies, Vol. 7(4), pp. 49–66.

Crocker, J., and Major, B. (1989) *Social stigma and self-esteem: The self-protective*

properties of stigma. Psychological Review, Vol. 96(4), pp. 608–630.

Crosby, F. J. (1984) *The denial of personal discrimination*. American Behavioral Scientist, Vol. 27, pp. 371–386.

Davey, A., Bouman, W. P., Arcelus, J., and Meyer, C. (2014) *Social Support and Psychological Well-Being in Gender Dysphoria: A Comparison of Patients With Matched Controls*. The Journal of Sexual Medicine, Vol. 11(12), pp. 2976–2985.

Deveci, F. (2011) *Ergenlerde Karar Verme Stilleri İle Algılanan Sosyal Destek Düzeyi Arasındaki İlişkinin İncelenmesi*. Unpublished Master's Thesis. Çukurova Üniversitesi/Sosyal Bilimler Enstitüsü, Adana.

Dour, H. J., Wiley, J. F., Roy-Byrne, P., Stein, M. B., Sullivan, M. G., MD, Sherbourne, C. D., Bystritsky, A., Rose, R. D., and Craske, M. G. (2014) *Perceived social support mediates anxiety and depressive symptom changes following primary care intervention*. Depression and Anxiety, Vol. 31(5), pp. 436–442.

Eldeleklioğlu, J. (2006) *The Relationship between the Perceived Social Support and the Level of Depression and Anxiety in University Students*. Kuram Ve Uygulamada Egitim Bilimleri, Vol. 6(3), 742.

Epkins, C. C., Gardner, C., and Scanlon, N. (2013) *Rumination and anxiety sensitivity in preadolescent girls: Independent, combined, and specific associations with depressive and anxiety symptoms.* Journal of Psychopathology and Behavioral Assessment, Vol. 35, pp. 540–551.

Escobar, D. F. S. S., Noll, P. R. E. S., De Jesus, T. F., and Noll, M. (2020) *Assessing the Mental Health of Brazilian Students Involved in Risky Behaviors.* International Journal of Environmental Research and Public Health, Vol. 17(10), 3647.

Faber, A. D., and Wasserman, S. (2002) *Social support and social networks: Synthesis and review.* Advances in Medical Sociology, Vol. 8, pp. 29−72.

Factor, R. J., and Rothblum, E. D. (2007) *A study of transgender adults and their non-transgender siblings on demographic characteristics, social support, and experiences of violence*. Journal of LGBT Health Research, Vol. 3, pp. 11–30.

Fernández, I., Silván-Ferrero, P., Molero, F., Gaviria, E., and García-Ael, C. (2015) *Perceived Discrimination and Well-Being in Romanian Immigrants: The Role of Social Support. Journal of Happiness Studies*, Vol. 16(4), pp. 857–870.

Finch, J. F., Okun, M. A., Pool, G. J., and Ruehlman, L. S. (1999) *A comparison of the influence of conflictual and supportive social interactions on psychological distress*. Journal of Personality, Vol. 67, pp. 581–621.

Fredriksen-Goldsen, K. I., Cook-Daniels, L., Kim, H. J., Erosheva, E. A., Emlet, C. A., Hoy-Ellis, C. P., Goldsen, J., and Muraco, A. (2014) *Physical and mental health of transgender older adults: an at-risk and underserved population*. The Gerontologist, Vol. 54(3), pp. 488–500.

Gapka, S., and Raj, R. (2003) Trans health project: A position paper and resolution adopted by the Ontario Public Health Association (OPHA) [Online] Available at: http://www.opha.on.ca/our_voice/ppres/papers/2003-_06_pp.pdf (Accessed 20 April 2023)

Garnefski, N., and Kraaij, V. (2006) *Relationships between cognitive emotion regulation strategies and depressive symptoms: A comparative study of five specific samples*. Personality And Individual Differences, Vol. 40(8), pp. 1659-1669.

Garnefski, N., Boon, S., and Kraaij, V. (2003) *Relationships between cognitive strategies of adolescents and depressive symptomatology across different types of life events.* Journal of Youth and Adolescence, Vol. 32, pp. 401–408.

Garnefski, N., Kraaij, V., and Spinhoven, P. (2001) *Negative life events, cognitive emotion regulation and emotional problems.* Personality and Individual Differences, Vol. 30(8), pp. 1311–1327.

Garnefski, N., Legerstee, J., Kraaij, V., Van den Kommer, T., and Teerds, J. (2002) *Cognitive coping strategies and symptoms of depression and anxiety: A comparison between adolescents and adults.* Journal of Adolescence, Vol. 25, pp. 603–611.

Garnefski, N., Teerds, J., Kraaij, V., Legerstee, J. S., and Van Den Kommer, T. (2004) *Cognitive emotion regulation strategies and depressive symptoms: differences between males and females.* Personality and Individual Differences, Vol. 36(2), pp. 267–276.

Garnefski, N., Teerds, J., Kraaij, V., Legerstee, J., and van den Kommer, T. (2004) Cognitive emotion regulation strategies and Depressive symptoms: differences between males and females. Personality and Individual Differences, Vol. 36(2), pp. 267–276.

Goffman, E. (1963) *Stigma: Notes on the management of spoiled identity,* 1st Edition, Englewood Cliffs, NJ: Prentice-Hall.

Goleman, D. (1996) *Emotional Intelligence*. London: Bloomsbury Publishing.

Göregenli, M., and Karakuş, P. (2011) *Türkiye'deki LGBT bireylerin günlük yaşamlarında maruz kaldığı heteroseksist ayrımcı tutum ve uygulamalar.* Kaos GL.

Gottlieb, B. H., and Bergen, A. (2010) *Social support concepts and measures. Journal*

of Psychosomatic Research, Vol. 69(5), pp. 511–520.

Grant, J. M., Lisa, A., Mottet Justin, T. J., and Harrison Jody, H. L., and Keisling, M. (2011) Injustice at every turn: A report of the National Transgender Discrimination Survey. National Center for Transgender Equality and National Gay and Lesbian Task Force [Online] Available at: http://endtransdiscrimination.org/PDFs/NTDS_Report.pdf (Accessed 20 April 2023)

Grav, S., Hellzen, O., Romild, U., and Stordal, E., (2012) *Association between social support and depression in the general population: the HUNT study, a cross-sectional survey*. Journal of Clinical Nursing, Vol. 21, pp. 111–120

Gross, J. J. (1998) *The Emerging Field of Emotion Regulation: An Integrative Review.* Review of General Psychology, Vol. 21 2(3), pp. 271–299.

Gross, J. J., and Thompson, R. A. (2007) *Emotion Regulation: Conceptual Foundations*. In J. J. Gross (Ed.), Handbook of emotion regulation (pp. 3–24). The Guilford Press.

Haber, M. G., Cohen, J. S., Lucas, T., and Baltes, B. B. (2007) *The relationship between self-reported received and perceived social support: A meta-analytic review*. Deep Blue (University of Michigan), Vol. 39(1–2), pp. 133–144.

Hallgren, M., Lundin, A., Tee, F. Y., Burström, B., and Forsell, Y. (2017) *Somebody to lean on: Social relationships predict post-treatment depression severity in adults.* Psychiatry Research-neuroimaging, Vol. 249, pp. 261–267.

Harrison-Quintana, J., and Herman, J. L. (2013) *Still serving in silence: Transgender service members and veterans in the National Transgender Discrimination Survey*. LGBTQ Policy Journal, Vol. 3(1), pp. 1-13.

Hatzenbuehler, M. L. (2009) *How does sexual minority stigma "get under the skin"? A psychological mediation framework*. Psychological Bulletin, Vol. 135, pp. 707–730.

Henderson, S. W., Byrne, G. J., Duncan-Jones, P., Scott, R. J., and Adcock, S. (1980) *Social Relationships, Adversity and Neurosis: A Study of Associations in a General Population Sample.* British Journal of Psychiatry, Vol. 136(6), pp. 574–583.

Hendricks, M. L., and Testa, R. J. (2012) *A conceptual framework for clinical work with transgender and gender non-conforming clients: An adaptation of the Minority Stress Model.* Professional Psychology: Research and Practice, Vol. 43(5), 460.

Henry, A., Tourbah, A., Camus, G., Deschamps, R., Mailhan, L., Castex, C., Gout, O., and Montreuil, M. (2019) *Anxiety and depression in patients with multiple sclerosis: The mediating effects of perceived social support.* Multiple Sclerosis and Related

Disorders, Vol. 27, pp. 46–51.

Herek, G. M. (2009) *Hate Crimes and Stigma-Related Experiences Among Sexual Minority Adults in the United States.* Journal of Interpersonal Violence, Vol. 24(1), pp. 54–74.

Hoffman B. (2014) *An Overview of Depression among Transgender Women.* Depression research and treatment, Vol. 2014, 394283.

Hölzel, L., Härter, M., Reese, C., and Kriston, L. (2011) *Risk factors for chronic depression--a systematic review*. Journal of affective disorders, Vol. 129(1-3), pp. 1–13.

House, J. S., and Kahn, R. L. (1985) *Measures and concepts of social support*. In S. Cohen and S. L. Syme (Eds.), Social support and health (pp. 83–108). New York: Academic Press.

Huh, H. J., Kim, K., Lee, H. C., and Chae, J. (2017) *The relationship between childhood trauma and the severity of adulthood depression and anxiety symptoms in a clinical sample: The mediating role of cognitive emotion regulation strategies.* Journal of Affective Disorders, Vol. 213, pp. 44–50.

Hussain, D., and Bhushan, B. (2011) *Posttraumatic stress and growth among Tibetan refugees: the mediating role of cognitive-emotional regulation strategie*s. Journal of Clinical Psychology, Vol. 67(7), pp. 720–735.

ILGA-Europe. (2021) Rainbow Europe country index [Online] Available at: https://www.ilgaeurope.org/rainboweurope (Accessed 20 April 2023)

Irwin, J. (2002) *Discrimination against gay men, lesbians, and transgender people working in education.* Journal of Gay and Lesbian Social Services, Vol. 14, pp. 65–77.

Izard, C. E. (2006) *Experts' definitions of emotion and their ratings of its components and characteristics.* Unpublished manuscript, University of Delaware, Newark.

Izard, C. E. (2009) *Emotion Theory and Research: Highlights, Unanswered Questions, and Emerging Issues*. Annual Review of Psychology, Vol. 60(1), pp. 1–25.

Kawachi, I., and Berkman, L. F. (2001) *Social ties and mental health.* Journal of Urban Health: Bulletin of the New York Academy of Medicine, Vol. 78, pp. 458–467.

Kendler K. S. (2016) *The Phenomenology of Major Depression and the Representativeness and Nature of DSM Criteria*. The American journal of psychiatry, Vol. 173(8), pp. 771–780.

Kendler, K. S., and Gardner, C. O. (2016) *Depressive vulnerability, stressful life events*

and episode onset of major depression: a longitudinal model. Psychological medicine, Vol. 46(9), pp. 1865–1874.

Kendler, K. S., Karkowski, L. M., and Prescott, C. A. (1998) *Stressful life events and major depression: risk period, long-term contextual threat, and diagnostic specificity.* The Journal of nervous and mental disease, Vol. 186(11), pp. 661–669.

Kessler, R. C., Birnbaum, H. G., Shahly, V., Bromet, E., Hwang, I., McLaughlin, K. A., Sampson, N., Andrade, L. H., de Girolamo, G., Demyttenaere, K., Haro, J. M., Karam, A. N., Kostyuchenko, S., Kovess, V., Lara, C., Levinson, D., Matschinger, H., Nakane, Y., Browne, M. O., Ormel, J., … Stein, D. J. (2010) *Age differences in the prevalence and co-morbidity of DSM-IV major depressive episodes: results from the WHO World Mental Health Survey Initiative*. Depression and anxiety, Vol. 27(4), pp. 351–364.

Kessler, R. C., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., and Wittchen, H.-U. (2012) *Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States*. International journal of methods in psychiatric research, Vol. 21(3), pp. 169–184.

Kim, I. (2014) *The role of critical ethnic awareness and social support in the discrimination–depression relationship among Asian Americans: Path analysis.* Cultural Diversity and Ethnic Minority Psychology, Vol. 20(1), pp. 52–60.

King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., and Nazareth, I. (2008) *A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people*. BMC Psychiatry, Vol. 8(1).

Kleinberg, A., Aluoja, A., and Vasar, V. (2013) *Social support in depression: structural and functional factors, perceived control and help-seeking. Epidemiology and psychiatric sciences,* Vol. 22(4), pp. 345–353.

Koball, A. M., and Carels, R. A. (2011) *Coping responses as mediators in the relationship between perceived weight stigma and depression*. Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity, Vol. 16(1), pp. 17–23.

Kraaij, V., and Garnefski, N. (2012) *Coping and depressive symptoms in adolescents with a chronic medical condition: A search for intervention targets.* Journal of Adolescence, Vol. 35, pp. 1593–1600

Kraaij, V., and Garnefski, N. (2015) *Cognitive, behavioral and goal adjustment coping and depressive symptoms in young people with diabetes: A search for intervention targets for coping skills training*. Journal of Clinical Psychology in Medical Setting,

Vol. 22, pp. 45–53.

Kraaij, V., Pruymboom, E., and Garnefski, N. (2002) *Cognitive coping and depressive symptoms in the elderly: A longitudinal study*. Aging and Mental Health, Vol. 6(3), pp. 275–281.

Landers S., and Gilsanz P. (2009) *The health of lesbian, gay, bisexual, and transgender (LGBT) persons in Massachusetts*. Massachusetts Department of Public Health.

Lehavot, K., Simpson, T. L., and Shipherd, J. C. (2016) *Factors associated with suicidality among a national sample of transgender veterans.* Suicide and Life-Threatening Behavior, Vol. 46(5), pp. 507-524.

Leskelä, U. S., Rytsälä, H., Komulainen, E., Melartin, T., Sokero, P., Lestelä-Mielonen, P. S., and Isometsä, E. (2006) *The influence of adversity and perceived social support on the outcome of major depressive disorder in subjects with different levels of depressive symptoms.* Psychological Medicine, Vol. 36(6), pp. 779–788.

Li, H., Ji, Y., and Chen, T., (2014) *The roles of different sources of social support on emotional well-being among Chinese elderly*. PloS ONE Vol. 9(3).

Lilympaki, I., Makri, A., Vlantousi, K., Koutelekos, I., Babatsikou, F., and Polikandrioti, M. (2016) *Effect of Perceived Social Support on the Levels of Anxiety and Depression of Hemodialysis Patients.* Materia Socio-medica, Vol. 28(5), 361.

Lim, G. Y., Tam, W. W., Lu, Y., Ho, C. S., Zhang, M. W., and Ho, R. C. (2018) *Prevalence of Depression in the Community from 30 Countries between 1994 and 2014.* Scientific reports, Vol. 8(1), 2861.

Liu, C., Chen, L., and Chen, S. (2020) *Influence of Neuroticism on Depressive Symptoms Among Chinese Adolescents: The Mediation Effects of Cognitive Emotion Regulation Strategies.* Frontiers in Psychiatry, Vol. 11.

Lombardi, E., Wilchins, R. A., Priesing, D., and Malouf, D. (2002) *Gender Violence*. Journal of Homosexuality, Vol. 42(1), pp. 89–101.

M. M. Alsubaie, H. J. Stain, L. A. D. Webster and R. Wadman (2019) *The role of sources of social support on depression and quality of life for university students*. International Journal of Adolescence and Youth, Vol. 24(4), pp. 484-496.

Maguen, S., Shipherd, J. C., and Harris, H. N. (2005) *Providing culturally sensitive care for transgender patients.* Cognitive and Behavioral Practice, Vol. 12, pp. 479–490.

Mao, Y., Liu, L., Lu, Z., and Wang, W. (2022) *Relationships between Perceived Discrimination and Suicidal Ideation among Impoverished Chinese College Students:*

The Mediating Roles of Social Support and Loneliness. International Journal of Environmental Research and Public Health, Vol. 19(12), 7290.

Martin, R., and Dahlen, E. R. (2005) *Cognitive emotion regulation in the prediction of depression, anxiety, stress, and anger.* Personality and Individual Differences, Vol. 39(7), pp. 1249–1260.

Matsumoto, D., and Juang, L. (2016) *Culture and psychology.* Cengage Learning.

Matsuno, E., and Budge, S. L. (2017) *Non-binary/Genderqueer Identities: a Critical Review of the Literature.* Current Sexual Health Reports, Vol. 9(3), pp. 116–120.

Mauss, I. B., Levenson, R. W., McCarter, L., Wilhelm, F. H., and Gross, J. J. (2005) *The Tie That Binds? Coherence Among Emotion Experience, Behavior, and Physiology.* Emotion, Vol. 5(2), pp. 175–190.

Meyer, I. H. (2003) *Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence*. Psychological bulletin, Vol. 129(5), 674.

Meyer, I. H. (2015) R*esilience in the study of minority stress and health of sexual and gender minorities.* Psychology of Sexual Orientation and Gender Diversity, Vol. 2(3), 209.

Meyer, I. H., and Frost, D. M. (2013) *Minority stress and the health of sexual minorities.* In C. J. Patterson and A. R. D'Augelli (Eds.), Handbook of psychology and sexual orientation (pp. 252–266). New York, NY: Oxford University Press

Min, J., Yu, J. I., Lee, C., and Chae, J. (2013) *Cognitive emotion regulation strategies contributing to resilience in patients with depression and/or anxiety disorders.* Comprehensive Psychiatry, Vol. 54(8), pp. 1190–1197.

Moriya, J., and Takahashi, Y. (2013) *Depression and interpersonal stress: The mediating role of emotion regulation.* Motivation and Emotion, Vol. 37(3), pp. 600–608.

Nemoto, T., Bodeker, B., and Iwamoto, M. (2011) *Social support, exposure to violence and transphobia, and correlates of depression among male-to-female transgender women with a history of sex work*. American Journal of Public Health, Vol. 101(10), pp. 1980–1988.

Nemoto, T., Operario, D., Sevelius, J., Keatley, J., Han, L., and Nguyen, H. (2004) Transphobia among transgenders of color [Online] Available at: http://caps.ucsf.edu/uploads/pubs/presentations/pdf/AP HA Nemoto.pdf (Accessed 20 April 2023)

Nolen-Hoeksema, S., Parker, L., and Larson, J. (1994) *Ruminative coping with*

depressed mood following loss. Journal of Personality and Social Psychology, Vol. 67(1), pp. 92–104.

Nurullah, A.S. (2012) *Received and provided support: a review of current evidence and future directions*. American Journal of Health Studies, Vol. 27(3), pp. 173–188.

Nuttbrock, L., Hwahng, S., Bockting, W., Rosenblum, A., Mason, M., Macri, M., and Becker, J. (2010) *Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons. Journal of sex research,* Vol. 47(1), pp. 12–23.

Ochsner, K. N., and Gross, J. J. (2005) *The cognitive control of emotion. Trends in Cognitive Sciences*, Vol. 9(5), pp. 242–249.

Oikawa, M., Nakano, A., and Tabuchi, R. (2017) *A Comparison of the Effects of Different Perspectives in Terms of Reappraisal Subtypes on Affect: Positive Reappraisal and Putting into Perspective.* Psychology, Vol. 8, pp. 2047-2057.

Omran, M. P. (2011) *Relationships between cognitive emotion regulation strategies with depression and anxiety.* Open Journal of Psychiatry, Vol. 1(03), pp. 106–109.

Öngen, D. E. (2010) *Cognitive emotion regulation in the prediction of depression and submissive behavior: Gender and grade level differences in Turkish adolescents*. Procedia - Social and Behavioral Sciences, Vol. 9, pp. 1516–1523.

Paradies, Y. C. (2006) *Defining, conceptualizing and characterizing racism in health research. Critical Public Health*, Vol. 16, pp. 143–157.

Park, H. S. (2007) *Effects of social support, coping strategies, self-esteem, mastery, and religiosity on the relationship between stress and depression among Korean immigrants in the United States: Structural equation modeling*. Unpublished Doctoral Thesisi.The University of Texas at Austin

Pascoe, E. A., and Smart Richman, L. (2009) *Perceived discrimination and health: A meta-analytic review.* Psychological Bulletin, Vol. 135, pp. 531–554.

Paykel, E. S. (1994) *Life events, Social support and depression.* Acta Psychiatrica Scandinavica, Vol. 89(377), pp. 50–58.

Pflum, S. R., Testa, R. J., Balsam, K. F., Goldblum, P. B., and Bongar, B. (2015) *Social support, trans community connectedness, and mental health symptoms among transgender and gender nonconforming adults.* Psychology of Sexual Orientation and Gender Diversity, Vol. 2(3), pp. 281–286.

Pinto, R. M., Melendez, R., and Spector, A. (2008) *Male-to-female transgender individuals: Building social support and capital from within a gender-focused network.* Journal of Gay and Lesbian Social Services, Vol. 20, pp. 203–220.

Pitts, M. K., Couch, M., Mulcare, H., Croy, S., & Mitchell, A. (2009). Transgender People in Australia and New Zealand: Health, Well-being and Access to Health Services. *Feminism & Psychology*, Vol. 19(4), 475–495.

Reisner, S. L., and Hughto, J. M. W. (2019) *Comparing the health of non-binary and binary transgender adults in a statewide non-probability sample*. PLoS ONE, Vol. 14(8), e0221583.

Ribeiro, J. D., Huang, X., Fox, K. R., and Franklin, J. C. (2018) *Depression and hopelessness as risk factors for suicide ideation, attempts and death: meta-analysis of longitudinal studies.* The British journal of psychiatry: the journal of mental science, Vol. 212(5), pp. 279–286.

Risch, N., Herrell, R., Lehner, T., Liang, K. Y., Eaves, L., Hoh, J., Griem, A., Kovacs, M., Ott, J., and Merikangas, K. R. (2009) *Interaction between the serotonin transporter gene (5-HTTLPR), stressful life events, and risk of depression: a meta-analysis*. JAMA, Vol. 301(23), pp. 2462–2471.

Ro, H., and Olson, E. N. (2020) *Gay and lesbian customers' perceived discrimination and identity management.* International Journal of Hospitality Management, Vol. 84.

Rotondi, N.K. (2012) *Depression in trans people: A review of the risk factors*. International Journal of Transgenderism, Vol. 13(3), pp. 104–116.

Rude, S., and McCarthy, C. (2003) *Emotional functioning in depressed and vulnerable-depressed college students.* Cognition and Emotion, Vol. 17, pp. 799-806.

Ruggiero, K. M., and Taylor, D. M. (1995) *Coping with discrimination: How disadvantaged group members perceive the discrimination that confronts them*. Journal of Personality and Social Psychology, Vol. 68(5), 826.

Ruggiero, K. M., and Taylor, D. S. (1997) *Why minority group members perceive or do not perceive the discrimination that confronts them: The role of self-esteem and perceived control.* Journal of Personality and Social Psychology, Vol. 72(2), pp. 373–389.

Rundell, J. R. (2012) *Factors Associated with Depression Treatment-Response in an Outpatient Psychosomatic Medicine Practice: An Exploratory Retrospective Study.* Psychosomatics.

Santorelli, G. D., and Ready, R. E. (2015) *Alexithymia and Executive Function in Younger and Older Adults.* Clinical Neuropsychologist, Vol. 29(7), pp. 938–955.

Sarason, B. R., Sarason, I. G., and Pierce, G. R. (1990) *Traditional views of social support and their impact on assessment*. In B. R. Sarason, I. G. Sarason, and G. R.

Pierce (Eds.), Social support: An interactional view (pp. 9–25). New York: Wiley.

Sarason, I. G., Levine, H. M., Basham, R. B., and Sarason, B. R. (1983) *Assessing social support: The Social Support Questionnaire.* Journal of Personality and Social Psychology, Vol. 44, pp. 127-139.

Schmitt, M. T., and Branscombe, N. R. (2002) *The meaning and consequences of perceived discrimination in disadvantaged and privileged social groups.* European Review of Social Psychology, Vol. 12, pp. 167–199.

Schmitt, M., Branscombe, N. R., Postmes, T., and Garcia, A. L. (2014) *The consequences of perceived discrimination for psychological well-being: A meta-analytic review*. Psychological Bulletin, Vol. 140(4), pp. 921–948.

Schroevers, M., Kraaij, V., and Garnefski, N. (2007) *Goal Disturbance, Cognitive Coping Strategies, and Psychological Adjustment to Different Types of Stressful Life Event.* Personality and Individual Differences, Vol. 43, pp. 413-423.

Singh, A., and Dickey, L. M. (Eds.). (2017) Introduction. In A. Singh and L. M. Dickey (Eds.), *Affirmative counseling and psychological practice with transgender and gender nonconforming clients* (pp. 3–18). American Psychological Association.

Slaughter-Acey, J. C., Talley, L. M., Stevenson, H. H., and Misra, D. P. (2019) *Personal versus group experiences of racism and risk of delivering a Small-for-Gestational age infant in african american women: A life course perspective.* Journal of Urban Health, Vol. 96(2), pp. 181–192.

Stice, E. (2002) *Risk and maintenance factors for eating pathology: A meta-analytic review*. Psychological Bulletin, Vol. 128(5), pp. 825–848.

Stikkelbroek, Y., Bodden, D. H. M., Kleinjan, M., Reijnders, M., and Van Baar, A. L. (2018) *Correction: Adolescent Depression and Negative Life Events, the Mediating Role of Cognitive Emotion Regulation.* PLOS ONE, Vol. 13(1), e0192300.

Stordal, E., Mykletun, A., and Dahl, A. A. (2003) *The association between age and depression in the general population: a multivariate examination*. Acta psychiatrica Scandinavica, Vol. 107(2), pp. 132–141.

Sullivan, M. J., Bishop, S. R., and Pivik, J. (1995) *The Pain Catastrophizing Scale: Development and validation*. Psychological Assessment, Vol. 7(4), pp. 524–532.

Tajfel, H., and Turner, J. C. (1979) *An integrative theory of intergroup conflict.* In W. G. Austin and S. Worchel (Eds.), The social psychology of intergroup relations (pp. 33– 48). Monterey, CA: Brooks/Cole

Takács, J. (2006) *Social exclusion of young lesbian, gay, bisexual and transgender*

(LGBT) people in Europe. ILGA Europe.

Tantirattanakulchai, P., and Hounnaklang, N. (2021) *Perceived social support and its relationship with depression among Bangkok's trans women.* Journal of Health Research, Vol. 36(2), pp. 365–375.

Taylor, D. S., Wright, S. J., Moghaddam, F. M., and Lalonde, R. N. (1990) *The Personal/Group Discrimination Discrepancy.* Personality and Social Psychology Bulletin, Vol. 16(2), pp. 254–262.

Tennen, H., and Affleck, G. (1990) *Blaming others for threatening events*. Psychological Bulletin, Vol. 108(2), pp. 209–232.

Testa, R. J., Michaels, M. S., Bliss, W., Rogers, M. L., Balsam, K. F., and Joiner, T. (2017) *Suicidal ideation in transgender people: Gender minority stress and interpersonal theory factors.* Journal of abnormal psychology, Vol. 126(1), pp. 125–136.

Testa, R. J., Sciacca, L. M., Wang, F., Hendricks, M. L., Goldblum, P., Bradford, J., and Bongar, B. (2012) *Effects of violence on transgender people*. Professional Psychology: Research and Practice, Vol. 43, pp. 452– 459.

Tezel, A., Karabulutlu, E., and Şahin, O. (2011) *Depression and perceived social support from family in Turkish patients with chronic renal failure treated by hemodialysis.* Journal of research in medical sciences: the official journal of Isfahan University of Medical Sciences, Vol. 16(5), pp. 666–673.

Thoits, P. A. (1986) *Social support as coping assistance.* Journal of Consulting and Clinical Psychology, Vol. 54, pp. 416– 423.

Thoits, P. A. (2011) *Mechanisms Linking Social Ties and Support to Physical and Mental Health.* Journal of Health and Social Behavior, Vol. 52(2), pp. 145–161.

Thompson R. A. (1994) *Emotion regulation: a theme in search of definition*. Monographs of the Society for Research in Child Development, Vol. 59(2-3), pp. 25–52.

Thompson, R. A. (1991) *Emotional regulation and emotional development.* Educational Psychology Review, Vol. 3(4), pp. 269–307.

Uchino, B. N. (2004) S*ocial Support and Physical Health: Understanding the Health Consequences of Relationships*, 1st Edition, Connecticut: Yale University Press.

Uchino, B. N. (2009) *Understanding the Links Between Social Support and Physical Health: A Life-Span Perspective With Emphasis on the Separability of Perceived and Received Support.* Perspectives on Psychological Science, Vol. 4(3), pp. 236–255.

Uchino, B. N., Cacioppo, J. T., and Kiecolt-Glaser, J. K. (1996) *The relationship between social support and physiological processes: A review with emphasis on underlying mechanisms and implications for health.* Psychological Bulletin, Vol. 119(3), pp. 488–531.

Verkuyten, M. (2002) *Perceptions of ethnic discrimination by minority and majority early adolescents in the Netherlands.* International Journal of Psychology, Vol. 37, pp. 321–333.

Walen, H. R., and Lachman, M. E. (2000) *Social Support and Strain from Partner, Family, and Friends: Costs and Benefits for Men and Women in Adulthood.* Journal of Social and Personal Relationships, Vol. 17(1), pp. 5–30.

Wang, J., Mann, F., Lloyd-Evans, B., Ma, R., and Johnson, S. (2018) *Associations between loneliness and perceived social support and outcomes of mental health problems: a systematic review.* BMC Psychiatry, Vol. 18(1).

Wang, Y., Huang, Z., and Kong, F. (2017) *Parenting stress and life satisfaction in mothers of children with cerebral palsy: The mediating effect of social support*. Journal of Health Psychology, Vol. 25(3), pp. 416–425.

Wareham, S., Fowler, K., and Pike, A. (2007) *Determinants of depression severity and duration in Canadian adults: The moderating effects of gender and social support.* Journal of Applied Social Psychology, Vol. 37, pp. 2951–2979.

Wester, S. R., Christianson, H. F., Vogel, D. L., and Wei, M. (2007) *Male gender role conflict and psychological distress: The role of social support.* Psychology of Men and Masculinity, Vol. 8, pp. 215–224

White Hughto, J. M., Pachankis, J. E., Willie, T. C., and Reisner, S. L. (2017) *Victimization and depressive symptomology in transgender adults: The mediating role of avoidant coping.* Journal of Counseling Psychology, Vol. 64(1), pp. 41–51.

Whittle, S., Turner, L., and Al-Alam, M. (2007) Engendered penalties: Transgender and transsexual people's experiences of inequality and discrimination: Press for change [Online] Available at: http://www.pfc.org.uk/pdf/EngenderedPenalties.pdf (Accessed 20 April 2023)

Witcomb, G. L., Bouman, W. P., Claes, L., Brewin, N., Crawford, J. R., and Arcelus, J. (2018) *Levels of depression in transgender people and its predictors: Results of a large matched control study with transgender people accessing clinical services*. Journal of affective disorders, Vol. 235, pp. 308–315.

Wood, J.V. (1996) *What is social comparison and how should we study it?* Personality

and Social Psychology Bulletin. Vol. 22, pp. 520-537.

World Health Organization. (2017) Depression and other common mental disorders: global health estimates [Online] Available at: https://apps.who.int/iris/handle/10665/254610 (Accessed 20 April 2023)

Wright, E. R., and Perry, B. L. (2006) *Sexual identity distress, social support, and the health of gay, lesbian, and bisexual youth*. Journal of Homosexuality, Vol. 51, pp. 81–109.

Yalçın, İ. (2014) *Relationships Between Well-Being and Social Support: A Meta Analysis Study.* Turkish Journal of Psychiatry.

Yang, C., Xia, M., Han, M., and Liang, Y. C. (2018) *Social Support and Resilience as Mediators Between Stress and Life Satisfaction Among People With Substance Use Disorder in China.* Frontiers in Psychiatry, Vol. 9.

Yılmaz, V., and Göçmen, İ. (2016) *Denied Citizens of Turkey: Experiences of Discrimination Among LGBT Individuals in Employment, Housing and Health Care. Gender, Work and Organization,* Vol. 23(5), pp. 470–488.

Yüksel, Ş., Ertekin, B. A., Öztürk, M., Bikmaz, P. S., and Oğlağu, Z. (2017) *A Clinically Neglected Topic: Risk of Suicide in Transgender Individuals*. Noropsikiyatri Arsivi-archives of Neuropsychiatry, Vol. 54(1), pp. 28–32.

Zhou, Y., MacGeorge, E. L., and Myrick, J. G. (2020) *Mental Health and Its Predictors during the Early Months of the COVID-19 Pandemic Experience in the United States*. International Journal of Environmental Research and Public Health, Vol. 17(17), 6315.

Zimet, G. D., Dahlem, N. W., Zimet, S. G., and Farley, G. K. (1988) *The Multidimensional Scale of Perceived Social Support*. Journal of Personality Assessment, Vol. 52(1), pp. 30–41.

APPENDICES

APPENDIX A. ETHICS COMITTEE APPROVAL

SAYI : B.30.2.İEÜ.0.05.05-**020**-*255* 05.01.2023

KONU : Etik Kurul Kararı hk.

Sayın Dr. Öğretim Üyesi Yasemin Meral Öğütçü ve Kaan Utkan,

"Trans+ Yetişkinlerde Algılanan Ayrımcılık ile Depresif Semptomlar Arasındaki İlişkinin İncelenmesi: Algılanan Sosyal Destek ve Bilişsel Duygu Düzenleme Stratejilerinin Düzenleyici Etkileri" başlıklı projenizin etik uygunluğu konusundaki başvurunuz sonuçlanmıştır.

Etik Kurulumuz 05.01.2023 tarihinde sizin başvurunuzun da içinde bulunduğu bir gündemle toplanmış ve Etik Kurul üyeleri projeleri incelemiştir.

Sonuçta 05.01.2023 tarihinde **"Trans+ Yetişkinlerde Algılanan Ayrımcılık ile Depresif Semptomlar Arasındaki İlişkinin İncelenmesi: Algılanan Sosyal Destek ve Bilişsel Duygu Düzenleme Stratejilerinin Düzenleyici Etkileri"** konulu projenizin etik açıdan uygun olduğuna oy birliğiyle karar verilmiştir.

Gereği için bilgilerinize sunarım.

Saygılarımla,

Prof. Dr. Murat Bengisu

Etik Kurul Başkanı

APPENDIX B. INFORMED CONSENT FORM

Değerli katılımcı,

Bu çalışma İzmir Ekonomi Üniversitesi Klinik Psikoloji yüksek lisans programı kapsamında Dr. Öğretim Üyesi Yasemin Meral Öğütçü danışmanlığında Kaan Utkan tarafından yürütülmekte olan bir tez çalışmasıdır. Bu çalışma, kendi cinsiyet kimliği trans+ (trans kadın, trans erkek, non-binary, genderqueer, genderfluid, agender) şemsiyesinde tanımlayan yetişkinlerde algılanan ayrımcılık, sosyal destek, bilişsel duygu düzenleme stratejileri ve depresyon arasındaki ilişkileri incelemeyi amaçlamaktadır.

Bu çalışmaya katılım tamamen gönüllülük esasına dayanmaktadır. Formlardaki sorulara vereceğiniz yanıtların doğruluğu çalışma için önem taşımakta ve soruları eksiksiz yanıtlamanız beklenmektedir. Bununla birlikte çalışmayı istediğiniz herhangi bir anda bırakma hakkına sahipsiniz. Çalışmada sizden kişisel bilgileriniz istenmeyecek, cevaplarınız anonim bir şekilde incelenecek ve araştırma kapsamında bilimsel amaçlarla kullanılacaktır. Çalışma yaklaşık olarak 15-20 dakikanızı alacaktır. Çalışma ile ilgili herhangi sorunuz varsa, bilgi edinmek isterseniz veya geribildirimde bulunmak isterseniz e-posta adresi üzerinden araştırmacı ile iletişime geçebilirsiniz.

Çalışmaya ayırdığınız zaman, gösterdiğiniz özen ve katkılarınız için teşekkür ederim.

Gönüllü olarak çalışmaya katılmayı kabul ediyorum.

APPENDIX C. DEMOGRAPHIC INFORMATION FORM

1. Yaşınız:

2. Cinsiyetiniz: Kadın, Erkek, Non-binary, Genderqueer, Genderfluid, Agender, Diğer

3. En son tamamlamış olduğunuz eğitim düzeyi:

□ İlkokul □ Ortaokul □ Lise □ Üniversite □ Yüksek Lisans □ Doktora

4. Yaşadığınız yerleşim birimi:

□ Köy □ Kasaba □İlçe □ İl □ Metropol (İstanbul, İzmir, Ankara)

5. Çalışma durumunuz:

□ Kamuda çalışıyor □ Özel Sektörde Çalışıyor □ Serbest Meslek □ Öğrenci □İşsiz □ Emekli

6. Kendinizi hangi gelir grubuna ait görüyorsunuz?:

□ Alt □ Orta-Alt □ Orta □ Orta-Üst □ Üst

7. Daha önce tanısı konulmuş bir psikolojik/psikiyatrik rahatsızlığınız var mı? Yanıtınız evet ise lütfen bir sonraki soruda tanınızı belirtiniz.

□ Evet □ Hayır

8. Cinsiyet kimliğinizi aşağıdakilerden hangilerine açıkladınız (Birden fazla işaretleyebilirsiniz):

□ Aile □ Yakın arkadaşlar □ Sosyal çevre (Okul, iş, vb.) □ Hiç kimse □ Diğer (belirtiniz) .....

APPENDIX D. EVENT LIST OF DISCRIMINATION

Lütfen aşağıda verilen olaylar arasından deneyimlediklerinizi işaretleyiniz:

Eğitim hayatımda trans kimliğim üzerinden ayrımcılığa uğradım.

İş bulurken trans kimliğim üzerinden ayrımcılığa uğradım.

İş yerimde trans kimliğim üzerinden ayrımcılığa uğradım.

Sağlık hizmetlerine erişmede trans kimliğim üzerinden ayrımcılığa uğradım.

Trans kimliğim sebebiyle barınacak yer bulmakta zorlandım.

Cinsiyet ifadem yüzünden sözlü tacize (laf atma, hakaret) uğradım.

Trans olduğum için fiziksel şiddete maruz kaldım.

Trans olduğum için cinsel şiddete/tacize maruz kaldım.

Trans olduğum için zorbalığa maruz kaldım.

Cinsiyet kimliğim ve ifadem nedeniyle ilişkimin koptuğu aile fertlerim oldu.

Cinsiyet kimliğim ve ifadem nedeniyle ilişkimin koptuğu arkadaşlarım oldu.

Ayrımcılığa karşı yoğun bir şekilde tetikte hissediyorum.

APPENDIX E. PERCEIVED DISCRIMINATION SCALE

Bu bölümde sizden trans bireylerle ilgili bir takım ifadeleri değerlendirmeniz istenmektedir. Bu testte geçen "trans" terimi, sahip olduğu cinsiyet kimliği doğumda kendisine atanan cinsiyetten farklı olan kişi anlamında kullanılmıştır. Bu ifadeler herhangi bir duruma ya da görüşe dayanmamaktadır. Dolayısıyla hiçbirinin doğru veya yanlış cevabı yoktur. Sadece sizin nasıl düşündüğünüz ve algınız önemlidir. Sizin görüş ve düşüncenize karşılık gelen seçeneği (rakamı) 1'den (hiç) 5'e (her zaman) kadar değerlendirilmiş ölçek üzerinde seçerek belirtiniz. Lütfen ölçekte bulunan tüm ifadeleri değerlendiriniz.

Lütfen her ifadenin karşısındaki en uygun rakamı daire içine alarak belirtiniz.

1	**2**	**3**	**4**	**5**
Hiç	Ara sıra/nadiren	Zaman zaman	Sık sık	Her zaman

Bireysel ayrımcılık

Trans olmayanlar tarafından kabul görmediğimi hissediyorum.	1	2	3	4	5
Trans olmayanların bana karşı olduklarını hissediyorum.	1	2	3	4	5
Trans olduğum için dalga geçildim ve hakarete uğradım.	1	2	3	4	5
Trans olduğum için insanlar benden uzaklaştı ya da aralarına almadılar.	1	2	3	4	5

Gruba ayrımcılık

Türkiye'de trans bireyler ne sıklıkla iş ararken ayrımcılık yaşıyor?	1	2	3	4	5
Türkiye'de trans bireyler ne sıklıkla ev ararken ayrımcılık yaşıyor?	1	2	3	4	5
Türkiye'de trans bireyler ne sıklıkla sokakta ayrımcılık yaşıyorlar?	1	2	3	4	5
Türkiye'de trans bireyler ne sıklıkla alışveriş yaparken (örneğin, giyim ya da gıda malzemesi alırken, cafe veya lokantaya gittiğinde) ayrımcılık yaşıyorlar?	1	2	3	4	5
Türkiye'de trans bireyler ne sıklıkla okulda ayrımcılık yaşıyorlar?	1	2	3	4	5
Türkiye'de trans bireyler ne sıklıkla işyerinde ayrımcılık yaşıyorlar?	1	2	3	4	5
Türkiye'de trans bireyler ne sıklıkla sağlık hizmeti alırken ayrımcılık yaşıyorlar?	1	2	3	4	5

APPENDIX F. COGNITIVE EMOTION REGULATION QUESTIONNAIRE

Hemen hepimizin yaşamında hoş olmayan kötü şeyler olabilmekte ve bu olaylara verdiğimiz tepkiler de birbirinden farklı olabilmektedir. Aşağıdaki cümlelerde başınıza gelmiş olan olumsuz ya da nahoş olaylar karşısında genellikle ne düşündüğünüz sorulmaktadır. Her bir cümleyi okuduktan sonra *sizin* durumunuza en uygun seçeneği işaretleyerek yanıt vermeniz istenmektedir.

		Hiç	Nadiren	Ara sıra	Sıklıkla	Her zaman
BAŞIMA KÖTÜ BİR OLAY GELDİĞİNDE	1) Bunun suçlusu benim diye düşünürüm.	( )	( )	( )	( )	( )
	2) Artık bu olayın olup bittiğini kabul etmek zorunda olduğumu düşünürüm.	( )	( )	( )	( )	( )
	3) Bu yaşadığımla ilgili ne hissettiğimi düşünürüm.	( )	( )	( )	( )	( )
	4)Yaşadıklarımdan daha hoş olan şeyleri düşünürüm.	( )	( )	( )	( )	( )
	5) Yapabileceğim en iyi şeyi düşünürüm.	( )	( )	( )	( )	( )
	6) Bu olaydan bir şeyler öğrenebileceğimi düşünürüm.	( )	( )	( )	( )	( )
	7) Her şey çok daha kötü olabilirdi diye düşünürüm.	( )	( )	( )	( )	( )
	8) Yaşadığım olayın başkalarının başına gelenlerden daha kötü olduğunu düşünürüm.	( )	( )	( )	( )	( )
	9) Bu olayda başkalarının suçu olduğunu düşünürüm.	( )	( )	( )	( )	( )
	10) Bu olayın tek sorumlusunun ben olduğumu düşünürüm.	( )	( )	( )	( )	( )

		Hiç	Nadiren	Ara sıra	Sıklıkla	Her zaman
	11) Durumu kabullenmek zorunda olduğumu düşünürüm.	( )	( )	( )	( )	( )
	12) Zihnim yaşadığım olay hakkında ne düşündüğüm ve hissettiğimle sürekli meşgul olur.	( )	( )	( )	( )	( )
	13) Olayla hiç ilgisi olmayan hoş şeyler düşünürüm.	( )	( )	( )	( )	( )
	14) Bu durumla en iyi nasıl başa çıkabileceğimi düşünürüm.	( )	( )	( )	( )	( )
	15) Başımdan geçenlerin bir sonucu olarak daha güçlü bir insan haline gelebileceğimi düşünürüm.	( )	( )	( )	( )	( )
	16) Diğer insanların çok daha kötü tecrübeler geçirdiklerini düşünürüm.	( )	( )	( )	( )	( )
	17) Başıma gelen olayın ne kadar korkunç olduğunu düşünüp dururum.	( )	( )	( )	( )	( )
	18) Başımdan geçen olaydan başkalarının sorumlu olduğunu düşünürüm.	( )	( )	( )	( )	( )
	19) Bu olayda yaptığım hataları düşünürüm.	( )	( )	( )	( )	( )
	20) Bu olayla ilgili hiçbir şeyi değiştiremeyeceğimi düşünürüm.	( )	( )	( )	( )	( )
	21) Bu olayla ilgili neden böyle hissettiğimi anlamak isterim.	( )	( )	( )	( )	( )
	22) Başımdan geçen olay yerine hoş bir şeyler düşünürüm.	( )	( )	( )	( )	( )
	23) Bu durumu nasıl değiştireceğimi düşünürüm.	( )	( )	( )	( )	( )

		Hiç	Nadiren	Ara sıra	Sıklıkla	Her zaman
	24) Bu durumun olumlu yanlarının da olduğunu düşünürüm.	( )	( )	( )	( )	( )
	25)Diğer şeylerle karşılaştırıldığında bunun o kadar da kötü olmadığını düşünürüm.	( )	( )	( )	( )	( )
	26) Yaşadığım bu şeyin bir insanın başına gelebilecek en kötü şey olduğunu düşünürüm.	( )	( )	( )	( )	( )
	27) Bu olayda diğerlerinin yaptığı hataları düşünürüm.	( )	( )	( )	( )	( )
	28) Esas sebebin kendimle ilgili olduğunu düşünürüm.	( )	( )	( )	( )	( )
	29) Bununla yaşamayı öğrenmem gerektiğini düşünürüm.	( )	( )	( )	( )	( )
	30) Bu durumun bende uyandırdığı duygularla boğuşurum.	( )	( )	( )	( )	( )
	31) Hoş olayları düşünürüm.	( )	( )	( )	( )	( )
	32) Yapabileceğim en iyi şeyle ilgili bir plan düşünürüm.	( )	( )	( )	( )	( )
	33) Bu durumun olumlu yanlarını ararım.	( )	( )	( )	( )	( )
	34) Kendime hayatta daha kötü şeylerin de olduğunu söylerim.	( )	( )	( )	( )	( )
	35) Sürekli bu durumun ne kadar korkunç olduğunu düşünürüm.	( )	( )	( )	( )	( )
	36) Esas sebebin başkalarıyla ilgili olduğunu düşünürüm.	( )	( )	( )	( )	( )

APPENDIX G. BECK DEPRESSION INVENTORY

Aşağıda gruplar halinde bazı cümleler yazılıdır. Her gruptaki cümleleri dikkatli okuyunuz. Bugün dahil, geçen hafta içinde kendinizi nasıl hissettiğinizi en iyi anlatan cümleyi seçiniz.

0. Kendimi üzüntülü ve sıkıntılı hissetmiyorum.
1. Kendimi üzüntülü ve sıkıntılı hissediyorum.
2. Hep üzüntülü ve sıkıntılıyım. Bundan kurtulamıyorum.
3. O kadar üzüntülü ve sıkıntılıyım ki artık dayanamıyorum.

0. Gelecek hakkında mutsuz ve karamsar değilim.
1. Gelecek hakkında karamsarım.
2. Gelecekten beklediğim hiçbir şey yok.
3. Geleceğim hakkında umutsuzum ve sanki hiçbir şey düzelmeyecekmiş gibi geliyor.

0. Kendimi başarısız bir insan olarak görmüyorum.
1. Çevremdeki birçok kişiden daha çok başarısızlıklarım olmuş gibi hissediyorum.
2. Geçmişe baktığımda başarısızlıklarla dolu olduğunu görüyorum.
3. Kendimi tümüyle başarısız biri olarak görüyorum.

0. Birçok şeyden eskisi kadar zevk alıyorum.
1. Eskiden olduğu gibi her şeyden hoşlanmıyorum.
2. Artık hiçbir şey bana tam anlamıyla zevk vermiyor.
3. Her şeyden sıkılıyorum.

0. Kendimi herhangi bir şekilde suçlu hissetmiyorum.
1. Kendimi zaman zaman suçlu hissediyorum.
2. Çoğu zaman kendimi suçlu hissediyorum.
3. Kendimi her zaman suçlu hissediyorum.

0. Bana cezalandırılmışım gibi geliyor.
1. Cezalandırılabileceğimi hissediyorum.
2. Cezalandırılmayı bekliyorum.
3. Cezalandırıldığımı hissediyorum.

0. Kendimden memnunum.
1. Kendi kendimden pek memnun değilim.
2. Kendime çok kızıyorum.
3. Kendimden nefret ediyorum.

0. Başkalarından daha kötü olduğumu sanmıyorum.
1. Zayıf yanlarım veya hatalarım için kendi kendimi eleştiririm.
2. Hatalarımdan dolayı ve her zaman kendimi kabahatli bulurum.
3. Her aksilik karşısında kendimi hatalı bulurum.

0. Kendimi öldürmek gibi düşüncelerim yok.
1. Zaman zaman kendimi öldürmeyi düşündüğüm olur. Fakat yapmıyorum.
2. Kendimi öldürmek isterdim.
3. Fırsatını bulsam kendimi öldürürdüm.

0. Her zamankinden fazla içimden ağlamak gelmiyor.
1. Zaman zaman içinden ağlamak geliyor.
2. Çoğu zaman ağlıyorum.
3. Eskiden ağlayabilirdim şimdi istesem de ağlayamıyorum.

0. Şimdi her zaman olduğumdan daha sinirli değilim.
1. Eskisine kıyasla daha kolay kızıyor ya da sinirleniyorum.
2. Şimdi hep sinirliyim.
3. Bir zamanlar beni sinirlendiren şeyler şimdi hiç sinirlendirmiyor.

0. Başkaları ile görüşmek, konuşmak isteğimi kaybetmedim.
1. Başkaları ile eskiden daha az konuşmak, görüşmek istiyorum.
2. Başkaları ile konuşma ve görüşme isteğimi kaybetmedim.
3. Hiç kimseyle konuşmak görüşmek istemiyorum.

0. Eskiden olduğu gibi kolay karar verebiliyorum.
1. Eskiden olduğu kadar kolay karar veremiyorum.

2. Karar verirken eskisine kıyasla çok güçlük çekiyorum.
3. Artık hiç karar veremiyorum.

0. Aynada kendime baktığımda değişiklik görmüyorum.
1. Daha yaşlanmış ve çirkinleşmişim gibi geliyor.
2. Görünüşümün çok değiştiğini ve çirkinleştiğimi hissediyorum.
3. Kendimi çok çirkin buluyorum.

0. Eskisi kadar iyi çalışabiliyorum.
1. Bir şeyler yapabilmek için gayret göstermem gerekiyor.
2. Herhangi bir şeyi yapabilmek için kendimi çok zorlamam gerekiyor.
3. Hiçbir şey yapamıyorum.

0. Her zamanki gibi iyi uyuyabiliyorum.
1. Eskiden olduğu gibi iyi uyuyamıyorum.
2. Her zamankinden 1-2 saat daha erken uyanıyorum ve tekrar uyuyamıyorum.
3. Her zamankinden çok daha erken uyanıyor ve tekrar uyuyamıyorum.

0. Her zamankinden daha çabuk yorulmuyorum.
1. Her zamankinden daha çabuk yoruluyorum.
2. Yaptığım her şey beni yoruyor.
3. Kendimi hemen hiçbir şey yapamayacak kadar yorgun hissediyorum.

0. İştahım her zamanki gibi.
1. İştahım her zamanki kadar iyi değil.
2. İştahım çok azaldı.
3. Artık hiç iştahım yok.

0. Son zamanlarda kilo vermedim.
1. İki kilodan fazla kilo verdim.
2. Dört kilodan fazla kilo verdim.
3. Altı kilodan fazla kilo vermeye çalışıyorum.

0. Sağlığım beni fazla endişelendirmiyor.

1. Ağrı, sancı, mide bozukluğu veya kabızlık gibi rahatsızlıklar beni endişelendirmiyor.
2. Sağlığım beni endişelendirdiği için başka şeyleri düşünmek zorlaşıyor.
3. Sağlığım hakkında o kadar endişeliyim ki başka hiçbir şey düşünemiyorum.

0. Son zamanlarda cinsel konulara olan ilgimde bir değişme fark etmedim.
1. Cinsel konularla eskisinden daha az ilgiliyim.
2. Cinsel konularla şimdi çok daha az ilgiliyim.
3. Cinsel konular olan ilgimi tamamen kaybettim.