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Mentalizing stigma: Reflective functioning as a protective factor against depression and anxiety in transgender and gender-nonconforming people

Cristiano Scandurra[1] | Pasquale Dolce[2] | Roberto Vitelli[1] | Giovanna Esposito[3] | Rylan J. Testa[4] | Kimberly F. Balsam[5] | Vincenzo Bochicchio[6]

[1]Department of Neuroscience, Reproductive Sciences and Dentistry, University of Naples Federico II, Napoli, Italy

[2]Department of Public Health, University of Naples Federico II, Napoli, Italy

[3]Department of Humanistic Studies, University of Naples Federico II, Napoli, Italy

[4]Center for LGBTQ Evidence-Based Applied Research (CLEAR), Palo Alto University, El Cerrito, California

[5]Department of Psychology, Center for LGBTQ Evidence-Based Applied Research (CLEAR), Palo Alto University, Palo Alto, California

[6]Department of Humanistic Studies, University of Calabria, Rende, Italy

Correspondence
Cristiano Scandurra, Department of Neuroscience, Reproductive Sciences and Dentistry, University of Naples Federico II, Via Sergio Pansini 5, 80133 Napoli, Italy.
Email: cristiano.scandurra@unina.it

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Abstract

Objective: The current study examined the role of internalized transphobia (IT) as a mediator between gender-related rejection and mental health, and reflective functioning (or mentalization) as a resilience factor moderating the relationship between both rejection and IT with mental health.

Method: This online study included 203 Italian transgender and gender-nonconforming (TGNC) individuals ranged in age from 18 to 66 years old ($M = 30.70$; standard deviation = 10.79). Moderated-mediation analysis was performed using a structural equation modeling approach.

Results: Both rejection and IT were positively associated with mental health, and IT mediated the relationship between rejection and mental health. Mentalization moderated the relationship between rejection and IT with mental health. The indirect effect of rejection on mental health through IT was moderated by mentalization.

Conclusions: Findings highlight psychological paths that may inform individual- and group-level mentalization-based

interventions to reduce minority stress in TGNC individuals.

KEYWORDS
mental health, mentalization, minority stress, stigma, transgender

1 | INTRODUCTION

Transgender and gender-nonconforming (TGNC) people are those whose gender identities or expressions differ from typical societal expectations based on their sex assigned at birth (American Psychological Association [APA], 2015). TGNC people may have a binary (e.g., identifying as a woman if male assigned at birth or man if female assigned at birth) or nonbinary (e.g., identifying with neither exclusively masculine nor feminine gender, rejecting the gender binary, etc.) identity.

On the basis of minority stress theory (MST; Meyer, 2003)—and, specifically, within its clinical extension (i.e., the psychological mediation framework, PMF; Hatzenbuehler, 2009)—the current study aimed to understand whether mentalization (or reflective functioning, RF), that is the ability to understand one's and other's behaviors in terms of intentional mental states (Allen & Fonagy, 2006), may protect TGNC individuals against the risk of developing mental health problems. Specifically, this study analyzed the role of RF as an individual-level resilience factor buffering the effects that distal minority stressors (in particular, experiences of rejection) have on mental health (e.g., depression and anxiety) through the mediating role of the most proximal stressor (i.e., internalized transphobia [IT]).

In the following sections, we will first provide an overview of research on minority stress, resilience factors, and health in TGNC people. We will then address the concept of RF, as well as its relationship with resilience and stress.

1.1 | Minority stress, resilience, and mental health in TGNC people

TGNC individuals experience significant health disparities compared to their cisgender counterparts. These disparities have been empirically linked to stigmatization due to gender identity and nonconformity (Lefevor, Boyd-Rogers, Sprague, & Janis, 2019), which elevate the risk of developing mental health problems, such as depression and anxiety (Hughto, Reisner, & Pachankis, 2015). One of the theoretical perspectives most capable of explaining the psychosocial processes that lead to developing negative mental health outcomes in TGNC people is MST (Meyer, 2003).

MST posits that lesbian, gay, bisexual, and transgender people experience chronic and socially-based stress which originates from the stigmatizing social contexts in which they daily life. Stressors might be distal (e.g., objective stressors, such as rejection) or proximal (e.g., subjective stressors, such as IT, that is the internalization of negative societal values within one's own TGNC identity), and both increase the risk of developing mental health problems (Hendricks & Testa, 2012). Evidence suggests that TGNC individuals experience high rates of gender-based distal stressors, such as rejection within families of origin or healthcare settings (James et al., 2016; Testa, Habarth, Peta, Balsam, & Bockting, 2015). In applying MST to investigate outcomes of these negative experiences, previous research highlighted the direct link between rejection and mental health (e.g., depression and anxiety) in TGNC populations (e.g., Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013).

The PMF (Hatzenbuehler, 2009), a recent extension of MST, incorporates a more clinical and nuanced view of minority stress, recognizing that minority stressors do not have the same impact on all individuals. This framework sheds light on how stigma-related chronic stressors might lead to negative health outcomes, assuming that distal stressors (e.g., rejection) would affect mental health through the mediating action of the proximal stressors (e.g., IT). Indeed, if MST assumes that stress mediates the relationship between social status/structure and mental health, PMF posits that stress represents the initial starting point that would lead to negative mental health outcomes through psychological mediators. On the basis of PMF, recent TGNC health research has explored potential mediators which might explain the link between distal stressors and negative mental health outcomes among TGNC populations (e.g., Timmins, Rimes, & Rahman, 2017). Indeed, recent evidence suggests that many proximal stressors serve to mediate the effects of stigma on mental health (e.g., Testa et al., 2017).

Resilience factors may also play a crucial role in the relationship between minority stress and mental health by buffering the detrimental effects of stress and stigma on outcomes (Freese, Ott, Rood, Reisner, & Pantalone, 2018; Meyer, 2015; Puckett, Maroney, Wadsworth, Mustanski, & Newcomb, 2020). Resilience is broadly defined as "a dynamic process encompassing positive adaptation within the context of significant adversity" (Luthar, Cicchetti, & Becker, 2000, p. 543). According to Matsuno and Israel (2018), TGNC individuals may benefit from both group- and individual-level resilience factors. Specifically, group-level resilience factors refer to the ways in which social groups or communities provide resources to individuals, helping them to cope with stress and highlighting the environmental influences on health. On the contrary, individual-level resilience factors refer to personal qualities that individuals may use to develop resilience in the face of stress. These types of resilience may differentially serve as buffers, with group-level resilience factors buffering the effects of only distal stressors on proximal stressors and health, while individual-level resilience factors of both distal and proximal stressors on health (Matsuno & Israel, 2018). However, there is growing evidence that both group- (e.g., social support and political activism; Budge, Adelson, & Howard, 2013; Singh & McKleroy, 2011) and individual-level resilience factors (e.g., identity pride; Bockting et al., 2013) are effective in ameliorating the detrimental effect of stressors on health.

The sociocultural context of Italy, where the current study was conducted, is not highly supportive for TGNC individuals (e.g., Bochicchio et al., 2019; Cussino et al., 2017; Prunas et al., 2015). For example, no antidiscrimination social policies protecting from hate crimes or social stigma exist to date and the gender-affirming surgery (GAS) process is still highly medicalized. With respect to the latter point, although the sentence 15,138 delivered by the Court of Cassation in 2015 allowed some TGNC people to change their name at the civil registry without having undergone GAS, the official legislation on GAS is still unchanged since 1982, the year in which the law regulating GAS was promulgated. This legal situation may be viewed as an example of structural stigma in Italy, preventing Italian TGNC people from benefitting from the right to self-determination. Furthermore, in Italy, few studies have focused on exploring minority stress in the Italian TGNC population. Notwithstanding, Italian researchers have demonstrated that both MST (e.g., Scandurra, Amodeo, Bochicchio, Valerio, & Frost, 2017b) and PMF (e.g., Scandurra, Bochicchio et al., 2018) are useful theoretical models which can be utilized to understand the negative effects that rejection and victimization have on the mental health of Italian TGNC individuals. Similarly, evidence also suggests that Italian TGNC individuals may benefit from both individual- and group-level resilience strategies (e.g., Amodeo, Picariello, Valerio, & Scandurra, 2018; Scandurra, Vitelli, Maldonato, Valerio, & Bochicchio, 2019). However, although RF ability has been considered as a powerful protective factor against both severe psychopathology and psychological symptoms in general populations (Fonagy & Bateman, 2016), no previous studies assessed if such an ability may represent an individual-level resilience factor against the development of negative mental health outcomes specifically among TGNC populations.

1.2 | Mentalization, resilience, and stress

RF refers to the ability to understand one's own and others' mental states, as well as their connections with behaviors (Fonagy, Gergely, Jurist, & Target, 2002). In other words, RF is the ability to understand and interpret

one's own and others' behaviors as expressions of intentional mental states (e.g., feelings, desires, or needs; Allen & Fonagy, 2006). This ability is crucial in mutual understanding of relationships, motivation, self-control, and understanding of what happens in the world around (Bateman & Fonagy, 2016). Previous studies of RF demonstrated links between RF impairments and psychopathology, such as borderline personality disorder (BPD; Bateman & Fonagy, 2004) and depression symptoms (Luyten, Fonagy, Lemma, & Target, 2012).

However, a genuine RF is characterized by the recognition of the opaqueness of mental states, as it is not possible to be completely sure about one's own or others' mental states. On the contrary, there are two types of impairments in RF that have been shown to increase the vulnerability for psychopathology (Fonagy et al., 2002; Fonagy & Luyten, 2016). The first impairment has been called *hypomentalizing*, which reflects an inability to consider complex models of one's own mind and/or that of others. The second impairment has been named as *hypermentalizing*, which consists of the production of mentalistic representations of actions without appropriate evidence supporting them, thus representing the tendency to develop inaccurate models of one's own and others' minds.

According to Fonagy and Bateman (2016), RF is strongly related to resilience. Indeed, thinking about actions in terms of thoughts and feelings—and, above all, using the knowledge of these mental states to master the life challenges—serves the purpose of creating a higher order process above cognition, enabling people with a genuine RF to overcome both daily challenges and severe adversity (Fonagy & Bateman, 2016). Along the same line, in questioning on how RF may promote resilience, Stein (2006) talked about a sort of *intrapsychic filtering system*, a system developed thanks to early secure attachment relationships which would allow children to metabolize painful experiences, avoiding that these experiences would affect their self-concept or expectations of others.

RF is also strongly related to stress, as the quality of mentalizing depends on stress and arousal (Luyten & Fonagy, 2015; Luyten, van Houdenhove, Lemma, Target, & Fonagy, 2012). Indeed, as stress and arousal increase, mentalizing ability decreases (Freda, Gonzàlez-Monteagudo, & Esposito, 2016). Thus, stress-related conditions may negatively affect RF, so that it may become rigid and involve biased and nonreflective assumptions about the self and others. As minority stress is a form of chronic stress experienced by TGNC people, it seems plausible to hypothesize that more resilient people who are able to maintain a genuine RF under chronic stressful life conditions would be at lower risk of developing negative mental health outcomes than those less resilient. In other words, it is possible that TGNC individuals understanding one's own behavioral reactions to stigmatizing experiences, as well as stigmatizing behaviors acted by others—that is, "mentalizing stigma"—would be more capable of buffering the negative effects that such experiences may have on their mental health than those who do not maintain such a mentalizing ability level. This means that RF, as a factor promoting resilience, may function as a protective factor against the minority stress effects.

Despite the promise of RF for understanding links between minority stress and mental health among TGNC people, research on RF in TGNC individuals to date is very scarce, and the few existing studies focused exclusively on early stages of life and on the experience of gender nonconformity (Esposito et al., 2019), leaving out the exploration on how RF may be linked to the chronic stress TGNC individuals live in adulthood. For example, from a clinical and speculative point of view, Lemma (2013) stated that it would be quite frequent that TGNC individuals experienced in the very early stage of life different degrees of psychological rejection from their caregivers, who may have had difficulties in mirroring the early experiences of *gender incongruity* (Lemma, 2013) of their children. This means that caregivers may have been lacking in attributing a mental state to such experiences and, in turn, this may have determined an impairment in mentalizing the experience of incongruity.

1.3 | The current study

Drawing from three theoretical frameworks—MST (Hendricks & Testa, 2012; Matsuno & Israel, 2018; Meyer, 2003), PMF (Hatzenbuehler, 2009), and mentalization framework (e.g., Bateman & Fonagy, 2016;

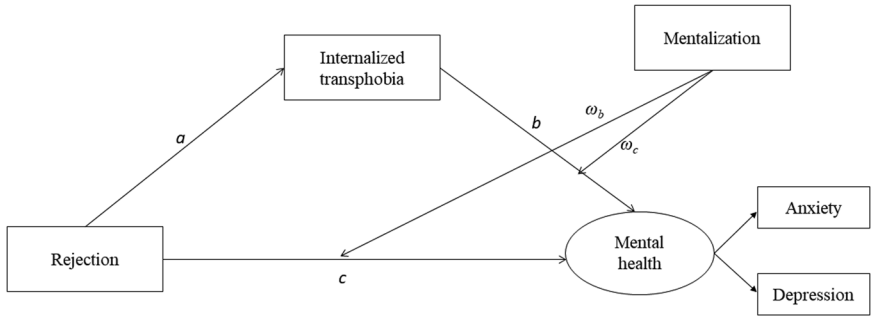

FIGURE 1 The hypothesized moderated-mediation model. For simplification reasons, covariates were not reported in the figure

Fonagy et al., 2002)—the current study is aimed to empirically examine whether mentalizing ability may act as an individual-level protective factor against the negative effects of distal and proximal minority stressors on the health of a group of Italian TGNC individuals.

Specifically, within the MST, we hypothesized that rejection (i.e., distal stressor) and IT (i.e., proximal stressor) would be positively associated with negative mental health outcomes (i.e., depression and anxiety; Hypothesis 1). Then, informed by the PMF, we hypothesized that IT would act as a mediator between rejection and negative mental health outcomes (Hypothesis 2).

In addition, on the basis of the relationship between resilience and mentalization, as well as on MST resilience theory, we hypothesized that a genuine RF would moderate the relationship between rejection and mental health, as well as between IT and mental health (Hypothesis 3). Furthermore, we tested whether the effect of rejection on mental health mediated by IT was moderated by a genuine RF (Hypothesis 4). The hypothesized moderated-mediation model is depicted in Figure 1.

2 | METHOD

2.1 | Procedures

Data in the current study were collected as part of a larger project, "Stress and Resilience in Trans Population Survey," an Italian study aimed at examining minority stress, resilience, and mental health within Italian TGNC people. Specifically, the main aim of the project was to evaluate the psychometric characteristics of an Italian version of the gender minority stress and resilience (GMSR) measure (Testa et al., 2015), that is, to date, the only scale comprehensively assessing the minority stress in TGNC population (Scandurra et al., 2019). Thus, although the current manuscript takes root in the same theoretical model of the first one (i.e., MST), it addresses new dimensions (e.g., mentalization), completely falling outside the statistical evaluation of a scale.

This study used a cross-sectional online survey administered via Qualtrics survey software. Participants were recruited through a snowball sampling recruitment procedure by contacting national TGNC social media channels, LISTSERVS, and local stakeholders, encouraging them to spread the survey. By clicking on the link provided, participants were directed to the first page of the survey containing the informed consent of the study, its objectives, benefits, and risks, information about researchers, and their emails and telephone numbers. Furthermore, participants were informed about the right of skipping any questions they considered as inappropriate or sensitive or stopping the survey in any point they wanted. Participants were also informed about the time needed to complete the survey (approximately 40 min).

The study was funded by the Italian Observatory on Gender Identity, and we gave to 10 participants the chance to enter into a lottery to receive €50 each. Thus, participants who completed the survey could opt to give their personal email, which was separated by the principal investigator (PI) from the questionnaire. At the end of the recruitment, emails were extracted, and participants were contacted by PI to ask them to provide their bank details, to which only the PI had access. To guarantee privacy, according to the EU General Data Protection Regulation, collected data were protected by a secure gateway to which only the PI had access. The PI removed all IP addresses and saved the emails of participants who decided to participate in the lottery on a separate sheet. Only after these procedures, the PI shared data with other scholars.

This study was approved by the Ethical Committee of the University of Calabria and was designed to respect all principles of the Declaration of Helsinki on ethical principles for medical research involving human subjects.

2.2 | Participants

Participants were recruited in Italy between November 2018 and April 2019. Inclusion criteria were: (a) self-identifying as TGNC (transgender, nonbinary, gender nonconforming, etc.); (b) being at least 18 years old, the Italian age of consent; and (c) living in Italy at least for 10 years. A total of 203 Italian TGNC participants completed the survey. Participants ranged in age from 18 to 66 years old (M = 30.70; standard deviation [SD] = 10.79). A total of 156 participants had a binary transgender identity, while the remaining 47 participants had a nonbinary transgender identity. Full demographic characteristics are reported in Table 1. Binary and nonbinary participants showed significant differences only in political activism, with binary transgender participants showing higher engagement in TGNC activism.

TABLE 1 Sociodemographic characteristics of Italian TGNC participants (N = 203)

Demographics	Binary	Nonbinary	Total sample	p
Sample size; n (%)	156 (76.8)	47 (23.2)	203 (100)	–
Age; M (SD)	30.98 (10.67)	29.79 (11.23)	30.70 (10.79)	.507
Sex assigned at birth; n (%)				.296
Male assigned at birth	56 (27.6)	13 (6.4)	69 (34)	
Female assigned at birth	100 (49.3)	34 (16.7)	134 (66)	
Ethnicity; n (%)				.071
Caucasian	150 (73.9)	42 (20.7)	192 (94.6)	
Non-Caucasian	6 (3)	5 (2.5)	11 (5.4)	
Education; n (%)				.778
≤High school	80 (39.4)	23 (11.3)	103 (50.7)	
≥College or other	76 (37.4)	24 (11.8)	100 (49.3)	
Size of community; n (%)				.186
Urban	109 (53.7)	28 (13.8)	137 (67.5)	
Nonurban	47 (23.12)	19 (9.4)	66 (32.5)	
TGNC political activism; n (%)				.001
Yes	69 (34)	34 (16.7)	103 (50.7)	
No	87 (42.9)	13 (6.4)	100 (49.3)	

Note: Group differences in age were assessed through the Student's t test. Group differences in all other variables were assessed through the χ^2 test.

Abbreviations: M, mean; SD, standard deviation; TGNC, transgender and gender nonconforming.

2.3 | Measures

2.3.1 | Sociodemographic characteristics

Sociodemographic variables assessed in the current study included gender identity (women, men, transwomen, transmen, genderqueer, cross-dresser, and other with specification), age, sex assigned at birth (male, female, or other with specification), ethnicity (0 = Caucasian; 1 = non-Caucasian), level of education (0 = high school or less; 1 = college or more), size of community (0 = urban; 1 = nonurban), and political activism (0 = no; 1 = yes). With regard to gender identity, participants were categorized as binary (e.g., women, men, transwomen, and transmen) and nonbinary (e.g., genderqueer) transgender participants. No individuals who identified as cross-dresser took part in the study, and all participants who answered "other gender identity" specified having a nonbinary identity.

2.3.2 | Experiences of rejection

To assess experiences of rejection by TGNC individuals, we used the subscale *gender-related rejection* (GRR) of the GMSR (Testa et al., 2015; Italian version by Scandurra et al., 2019). This 6-item scale assesses relevant forms of GRR (i.e., from partner, religious community, ethnic/racial community, friends, school contexts, and family). An example item is "have been rejected at school or work because of my gender identity or expression." Response options are "never," "yes, before age 18," "yes, after age 18," and "yes, in the past year." Respondents are instructed to check all that apply to them. Responses are then coded as 1 if "yes" at any point, and 0 if "never," so that each participant score may range from 0 to 6. The α coefficient for the current sample was .64.

2.3.3 | Internalized transphobia

To assess IT, we used the subscale *IT* of the GMSR (Testa et al., 2015; Italian version by Scandurra et al., 2019). This 8-item scale assesses the shame towards one's own TGNC identity, as caused by internalization of negative societal view about being TGNC. An example item is "my gender identity or expression makes me feel like a freak." Response options are from "strongly disagree" to "strongly agree" on a 5-point Likert scale. The total score is obtaining by summing the score of each answer, so that each participant score may range from 0 to 32. The α coefficient for the current sample was .90.

2.3.4 | Anxiety

Anxiety was measured with the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) Severity Measure for Generalized Anxiety Disorder—Adult (Craske et al., 2013), a 10-item questionnaire which assess the severity of anxious symptoms over the last 7 days using a 5-point Likert scale ranging from "never" to "all of the time." An example item is "during the past 7 days, I have felt moments of sudden terror, fear, or fright." The total score is calculated by dividing the raw total score by the number of items, ranging from 0 to 4, with higher scores indicating greater severity of anxiety. The α coefficient for the current sample was .90.

2.3.5 | Depression

Depression was measured with the short version of the DSM-5 Severity Measure for Depression–Adult (Spitzer, Williams, & Kroenke, 2001), a 9-item scale assessing the severity of depressive symptoms over the last 7 days on a

4-point Likert scale ranging from "not at all" to "nearly every day." The initial question is "over the last 7 days, how often have you been bothered by any of the following problems?" An example item is "little interest or pleasure in doing things." The total score is obtaining by summing the score of each answer and can range from 0 to 27, with higher scores reflecting greater severity of depression. The α coefficient for the current sample was .90.

2.3.6 | Mentalization

Mentalization (or RF) was measured with the Reflective Functioning Questionnaire (RFQ; Fonagy et al., 2016; Italian version by Morandotti et al., 2018), an 8-item scale evaluating the quality of RF. RFQ is composed of two subscales—RFQ certainty (RFQc) and RFQ uncertainty (RFQu) about mental states. Each scale is constituted by six items, among which two are unique and four shared across the subscales. The response options ranged from 1 (strongly disagree) to 7 (strongly agree). An example item of the RFQc is, "people's thoughts are a mystery to me," while of the RFQu is, "sometimes I do things without really knowing why." Fonagy et al. (2016) rescored RFQc items so that lower agreement on the statements reflected hypermentalizing, while higher agreement a more genuine mentalizing. Similarly, RFQu was rescored so that higher agreement on the statements reflected hypomentalizing, while lower agreement a genuine mentalizing. The α coefficient for the current sample was .68 for RFQc and .72 for RFQu.

2.4 | Statistical analyses

All statistical analyses were performed using *R*, setting the level of significance at .05. Considering the specific variables used in the current study, no missing data were found.

As data had skewed distributions, bivariate correlations between the main variables of the study (minority stressors, mental health, and RF) were calculated through the Spearman's coefficient. Then, as sociodemographic variables may influence both stressors and mental health (e.g., Bockting et al., 2013; Hendricks & Testa, 2012), we adjusted models including different potential confounding variables, including gender identity (binary vs. non-binary), age, sex assigned at birth (female vs. male), ethnicity (Caucasian vs. non-Caucasian), educational level (≤high school vs. ≥college or other), size of community (urban vs. nonurban), and political activism (yes vs. no), as an indicator of the group-level resilience factor. Because of the categorical nature of all sociodemographic variables (with the exception of age, whose relationship with the main variables was calculated through the Spearman's correlation coefficient), we tested for statistically significant differences between groups (e.g., binary vs. nonbinary) with respect to the main variables using the Mann–Whitney U test. We included as covariates in the final models only the variables showing a significant difference, which included age, gender identity, sex assigned at birth, and political activism.

Moderated-mediation analysis was conducted to test all the study's hypotheses. Moderating and mediating effects were specified and tested according to the recommendations provided by Holmbeck (1997). The structural equation modeling approach was performed using the weighted least squares estimation with robust standard errors and required sample size of at least 200 participants (Kline, 2011). All analyses were preformed using the Lavaan (Rosseel, 2012) R package.

First, we specified in the model depression and anxiety as measures of a common latent factor (i.e., mental health). Then, a mediation model was fitted, with rejection as a predictor, mental health as an outcome, and IT as mediator. Finally, a moderated-mediation model was performed, with RF as a moderator. In particular, two models were tested, which differ by RF subscales: RFQc and RFQu.

The analyses of results were performed in a series of steps (see paths reported in Figure 1). We first tested the main effects of rejection on mental health (*c*) and IT on mental health (*a*) (Hypothesis 1). Then, we

examined the mediating role of IT in the relationship between rejection and mental health outcomes (a^*b) (Hypothesis 2). After, we tested the moderating effect of RF in the relationships between rejection and mental health (ω_{c1} and ω_{c2}), as well as between IT and mental health (ω_{b1} and ω_{b2}) (Hypothesis 3). To analyze the full moderated-mediation model and provide evidence of moderation of the mediation effect (Hypothesis 4), we estimated the index of moderated mediation (IMM), and then inspected the conditional indirect effects across the different levels of RF.

Finally, as GRR and RFQc showed a coefficient $\alpha < .70$, which is generally considered to be the minimum level of adequacy of internal consistency, we assessed if deleting items with the lowest weights could increase the α coefficient value. In the case of GRR, the α coefficient remained unchanged. On the contrary, in the case of RFQc, whose internal consistency of the original version was even lower than that found in the current work (.65 and .67 for the clinical and nonclinical sample, respectively; Fonagy et al., 2016), the α coefficient increased at .79 deleting the second item (i.e., I don't always know why I do what I do). Thus, we performed again the analyses included in the models the RFQc subscale without the second item, finding the same results in terms of significance. Therefore, as GRR and RFQc are the only available self-report scales measuring, respectively, anti-TGNC rejection and mentalization in the Italian context, and as we found the same results with both versions of the RFQc, we decided to maintain the original validated versions of the scales.

3 | RESULTS

3.1 | Descriptive statistics, bivariate correlations, and differences among groups

Means, *SD*s, and bivariate correlations between minority stressors (i.e., rejection and IT), mental health outcomes (i.e., anxiety and depression), and RF (i.e., RFQc and RFQu) are shown in Table 2.

The results highlighted a positive correlation between rejection and IT. Anxiety and depression positively correlated with both rejection and IT. Certainty about mental states negatively correlated with IT, anxiety, and depression (but not with rejection), indicating that hypermentalizing was associated with higher levels of IT and mental health problems. Similarly, uncertainty about mental states positively correlated with IT, anxiety, and depression (but, again, not with rejection), indicating that also hypomentalizing was associated with higher levels of IT and mental health problems.

TABLE 2 Correlations between minority stressors, mental health, and mentalization

Scales	1	2	3	4	5	6	Mean	*SD*
1. GRR	–						2.31	1.68
2. IT	.15*	–					12.14	8.69
3. SMGAD	.30***	.44***	–				1.33	0.87
4. SMDA	.25***	.45***	.83***	–			10.62	6.88
5. RFQc	−.05	−.21**	−.26***	−.23**	–		0.82	0.66
6. RFQu	.06	.14*	.18**	.21**	−.19**	–	0.69	0.42

Abbreviations: GRR, gender-related rejection; IT, internalized transphobia; RFQc, reflective function questionnaire—certainty about mental states; RFQu, reflective function questionnaire—uncertainty about mental states; *SD*, standard deviation; SMDA, severity measure for depression; SMGAD, severity measure for generalized anxiety disorder.

*$p < .05$.

**$p < .01$.

***$p < .001$.

With regard to the sociodemographic factors considered as potential confounding variables, age was negatively correlated with anxiety (r_s = −.232; p < .01), depression (r_s = −.228; p = .001), and RFQu (r_s = −.169; p < .016), and positively associated with certainty about mental states (r_s = .327; p < .001). Compared to binary respondents, nonbinary participants demonstrated higher levels of anxiety ($Mdn_{nonbinary}$ = 1.80, Mdn_{binary} = 1.1; U = 2,420; $p \leq .001$; r = .06) and depression ($Mdn_{nonbinary}$ = 13, Mdn_{binary} = 9; U = 2,449; p = .001; r = .05). Compared with participants who were assigned female at birth (AFAB), assigned male at birth (AMAB) counterparts were higher in rejection (Mdn_{amab} = 3, Mdn_{afab} = 2; U = 3,769; p = .029; r = .02), but lower in IT (Mdn_{amab} = 8, Mdn_{afab} = 13; U = 3,613; p = .011; r = .03). Finally, those who indicated they were TGNC activists (Mdn = 3) demonstrated higher levels only of rejection, U = 4,098; p = .011; r = .03, compared to those who were not engaged in political activism (Mdn = 2). All other sociodemographic variables did not show any differences between groups, and for this reason, they were excluded from further analyses.

3.2 | Direct and indirect associations between minority stressors and mental health

As shown in Figure 2 and with respect to Hypothesis 1, results indicated that both rejection, c = .876; p < .001; 95% confidence interval (CI; .451, 1.302), and IT, b = .301; p < .001; 95% CI (.212, .391), were positively associated with mental health, confirming our hypothesis.

With regard to Hypothesis 2, we found that IT significantly mediated the relationship between rejection and mental health, a^*b = .282; p = .020; 95% CI (.043, .520). Specifically, higher levels of IT increased the strength of the effect that rejection would have on mental health outcomes, confirming our hypothesis.

3.3 | The moderating role of mentalization

With regard to Hypothesis 3, we found a significant and negative interaction between rejection and certainty about mental states on mental health, ω_{c1} = −1.059; p < .001; 95% CI (−1.478, −.640), indicating that the direct effect of rejection on mental health decreases as much as people genuinely mentalize, confirming our hypothesis. Similarly, in line with our hypothesis, we found a significant and negative interaction between IT and certainty about mental states on mental health, ω_{b1} = −.187; p < .001; 95% CI (−.267, −.108), indicating that the direct effect of IT on health decreases as much as people genuinely mentalize.

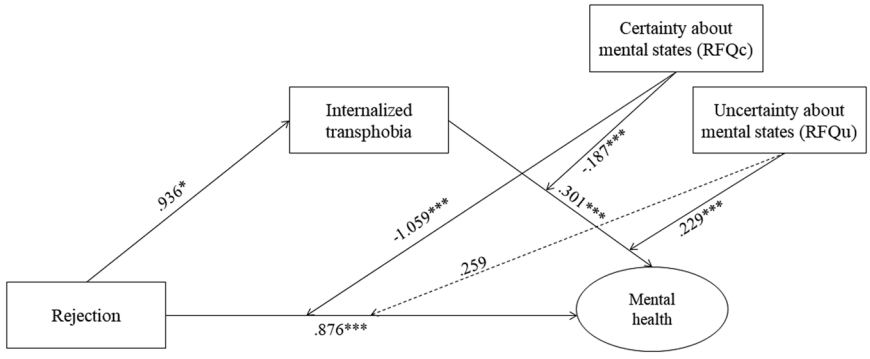

FIGURE 2 Results from the structural equation modeling of the hypothesized moderated-mediation model. Dashed lines indicate nonsignificant paths. Standardized path coefficients are reported. Covariates were not reported in the figure for simplification reasons. *p < .05; ***p < .001

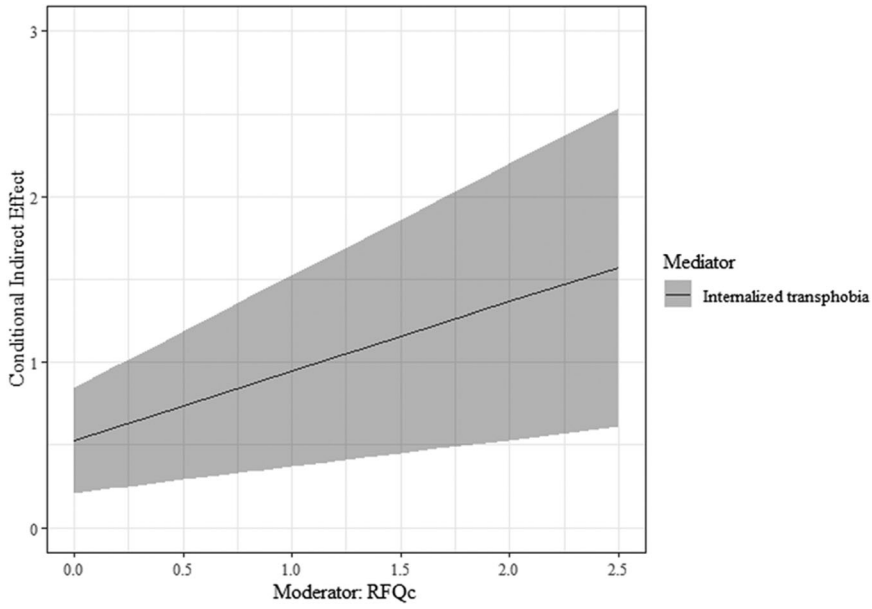

FIGURE 3 Conditional indirect effect, along with the 95% CI, of rejection on mental health through internalized transphobia as a function of certainty about mental states. CI, confidence interval

Still, with respect to Hypothesis 3, there was no evidence that uncertainty about mental states moderated the relationship between rejection and mental health, ω_{c2} = .259; p = .281; 95% CI (−.212, .729). On the contrary, and in line with our hypothesis, we found a significant and positive interaction between IT and uncertainty about mental states on mental health, ω_{b2} =.229; p < .001; 95% CI (.138, .320), indicating that the direct effect of IT on mental health increases as much as people hypomentalize.

With regard to Hypothesis 4, results indicated that the indirect effect of rejection on mental health mediated by IT was significantly moderated by certainty about mental states, IMM = −.167; p = .050; 95% CI (.000, .335), confirming our hypothesis. Specifically, the indirect effect decreases as a genuine RF increases, confirming the protective role of a genuine RF (Figure 3). Similarly, we found that the indirect relation of rejection on mental health through IT was also moderated by uncertainty about mental states, IMM = .417; p = .001; 95% CI (.160, .675). Specifically, such an indirect relation increases as hypomentalizing increases, confirming that also hypomentalizing might be a risk factor increasing the negative effects that stressors have on mental health (Figure 4).

4 | DISCUSSION

The current study, drawing from three theoretical frameworks (i.e., MST, PMF, and mentalization), explored the role of mentalizing ability as an individual-level protective factor buffering the effects of distal (i.e., rejection) and proximal (i.e., IT) minority stressors on negative mental health outcomes. The results confirmed this main hypothesis. To the best of our knowledge, this is the first study assessing the role of RF in minority stress processes experienced by the Italian TGNC population, highlighting new psychological paths that may inform the clinical practice.

First, with regard to the descriptive analyses, the results of the current study highlighted different associations between minority stressors, mental health, and RF. Indeed, according to MST, GRR and IT were positively associated with anxiety and depression, confirming the strong relationship between minority stress and mental health

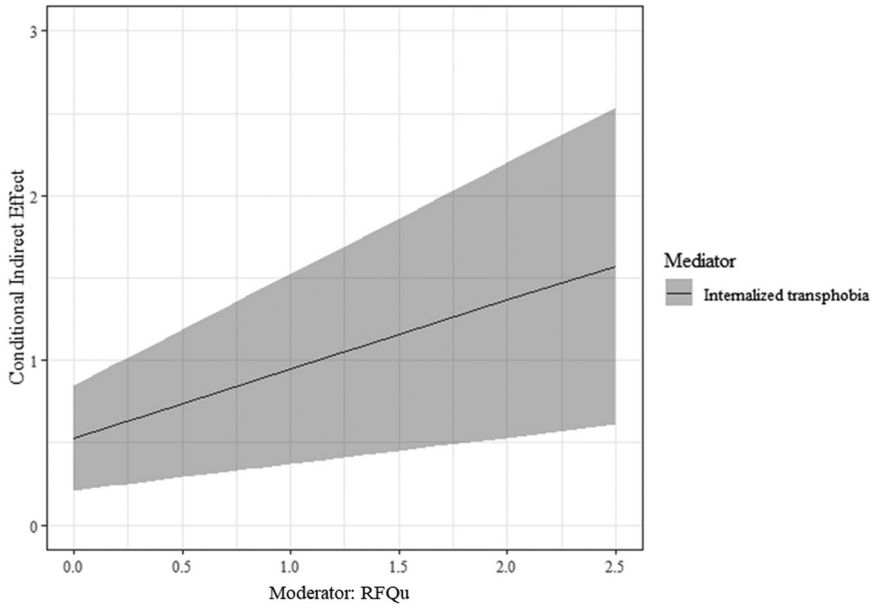

FIGURE 4 Conditional indirect effect, along with the 95% CI, of rejection on mental health through internalized transphobia as a function of uncertainty about mental states (RFQu). CI, confidence interval

(Hendricks & Testa, 2012; Hughto et al., 2015). With regard to RF, our results showed that higher levels of hypermentalizing and hypomentalizing were associated with worse mental health, and this is in line with previous studies highlighting the detrimental role that impairments in mentalizing may have on mental health (Bateman & Fonagy, 2016; Fonagy, Gergely, & Target, 2007; Luyten et al., 2012). Other associations showed that younger age in TGNC participants was associated with more anxiety and depression, confirming previous studies finding that being in earlier stages of gender transition or affirmation may be a stressful life condition affecting mental health (Jackman, Dolezal, & Bockting, 2018). Furthermore, nonbinary participants demonstrated higher levels of anxiety and depression than binary counterparts, confirming previous studies (e.g., Thorne et al., 2019). Finally, AMAB participants and those practicing political activism reported higher levels of rejection than their counterparts; additionally, AMAB participants showed lower levels of IT than AFAB counterparts. These results might be explained through the greater visibility that transgender women and activists have compared with their counterparts; visibility might create more opportunities for challenging internalized and perceived stigma and simultaneously increase the likelihood of experiencing discrimination (Bockting et al., 2013; Scandurra, Amodeo, Bochicchio, Valerio, & Frost, 2017a).

In support of our first hypothesis, we found that both GRR and IT were positively associated with negative mental health outcomes. These results are consistent with previous findings on MST among TGNC people (Bockting et al., 2013). For instance, Puckett et al. (2020) found that greater exposure to discrimination was associated with higher levels of depression and anxiety, while Testa et al. (2015) found that IT was positively associated with depression and social anxiety. Thus, in line with previous scientific literature, our finding confirms the detrimental role that both distal and proximal minority stressors may have on TGNC mental health.

Regarding the second hypothesis, we found support for IT as a mediator in the relationship between rejection and negative mental health outcomes. As before, this result is consistent with previous findings on PMF among TGNC individuals (Scandurra, Bochicchio et al., 2018; Testa et al., 2017). Thus, such a result represents further evidence for the PMF as a theoretical model shedding light on psychological pathways that link stigma-related stressors to negative mental health outcomes in TGNC population.

In support of the third hypothesis, with the exception of the path between rejection and uncertainty about mental states, we found that a genuine RF represents a psychological dimension able to buffer the strength of the effect that rejection and IT may have on mental health. Specifically, our results suggested that, contrary to a genuine RF, hypermentalizing would increase the effect of both rejection and IT on mental health, while hypomentalizing would increase only the effect of IT on mental health. These findings seem to indicate that a genuine RF is able to ameliorate the negative effect that both distal and proximal stressors may have on TGNC mental health, confirming the main hypothesis of the current study, or rather that RF may be considered as an individual-level resilience factor. This result expands upon the research tradition that sheds light on the role of RF as a main dimension protecting from the development of negative mental health outcomes (Bateman & Fonagy, 2004; Luyten et al., 2012). Indeed, our finding seems to allow an expansion of both MST and PMF, as a new and uninvestigated protective factor against the effects of stigma was found. However, the inconsistency of the path concerning rejection and uncertainty about mental states seems to highlight that two RFQ subscales underlying different processes, as suggested by Fonagy et al. (2016). Future research should investigate such a difference more in detail (e.g., through qualitative studies), shedding light on possible reasons underlying different paths of mentalization on minority stress processes.

Finally, with regard to the fourth hypothesis of the current study, our results support the hypothesized moderated-mediation model. Indeed, the indirect effect of rejection on mental health through IT was moderated by a genuine RF. Specifically, rejection would increase the likelihood of developing negative mental health outcomes through the action of IT in participants with a tendency to hypermentalize or to hypomentalize, but not in those with a genuine RF. Such a result would confirm that "mentalizing stigma" may be a protective factor against the risk of developing negative mental health outcomes in TGNC people, functioning as a reliable individual-level resilience factor. Thus, it seems plausible to us to affirm again that our results expand upon the already established relationship between RF and resilience (Fonagy & Bateman, 2016; Stein, 2006), as well as RF and stress (Luyten & Fonagy, 2015), as such relationships were explored in a new population (i.e., TGNC people).

This study is innovative as it indicates that giving a psychological perspective to stigmatizing experiences (i.e., mentalizing negative experiences of rejection and IT) helps TGNC people to not be overwhelmed by social rejection and negative self-evaluations, protecting themselves from the potential development of psychological distress. Thus, using Stein's (2006) metaphor, it is plausible to assert that TGNC people with an adequate RF may be capable of developing an intrapsychic system able to filter traumatic and negative experiences. Such a filter may allow TGNC people to metabolize these painful experiences as something that does not depend on one's own identity; as a result, they are less likely than those with a low RF to undermine their self-concept and expectations of others. This result may have significant implications for clinical practice with TGNC people that will be discussed below.

However, as the sample of the current study was recruited in a specific context (i.e., Italy), our results should be read as culturally characterized. Indeed, as reported before, Italy is generally described as a highly stigmatizing sociocultural context towards gender minority groups, and Italian TGNC individuals experience high levels of rejection, as well as structural stigma due to the lack of inclusive social and health policies (e.g., Cussino et al., 2017; Prunas et al., 2015). In a context like this, it seems plausible to assert that TGNC individuals would be inclined to develop a greater level of resilience as an evolutionary response to the social rejection than those living in less stigmatizing contexts.

Another cultural issue related to the Italian social context is that compared with people living in the USA, Italian individuals leave their family home at a later age, often living close to their parents and strongly benefitting from family support (Santarelli & Cottone, 2009). Relatedly, a recent study revealed that, among different forms of support, support from family was the only protective factor for Italian TGNC individuals (Scandurra et al., 2017b). As RF is mainly developed within primary attachment relationships (Fonagy & Bateman, 2016; Fonagy et al., 2002, 2007), and as RF seems to qualitatively differ among cultures (for instance, it seems that people living in individualistic cultures tend to focus more on mental states within the self than those living in collectivistic cultures; Aival-Naveh, Rothschild-Yakar, & Kurman, 2019), it is conceivable that TGNC individuals living in different

cultural contexts may differ in the use of RF as a protection against the negative effects of rejection on health. Thus, it may be of great scientific interest to assess if mentalizing anti-TGNC stigma represents a resilience protective factor in sociocultural contexts whose characteristics differ from Italy.

4.1 | Limitations and suggestions for future research

The current study has significant limitations, which should be considered in interpreting results. The cross-sectional nature of the study does not allow to make conclusive inferences about the causality and temporality of the investigated relationships. Future studies should use a longitudinal design to discern the cause–effect relationships between rejection, IT, mental health, and RF.

Second, the sample is relatively small and nonrepresentative, and almost all participants were Caucasian, not allowing us to verify the role of the ethnic diversity among variables relationships. Future studies should try to recruit wider samples, diversified according to sociodemographic factors (gender, ethnicity, socioeconomic status, etc.).

Third, data presented in the current study were collected within a unique Western sociocultural context (i.e., Italy), thus preventing generalization across cultural contexts. Future studies should replicate our study in other Western and non-Western countries, assessing potential sociocultural differences that we are unable to capture.

Fourth, both GRR and RFQc showed an α coefficient lower than .70, while internal consistency is considered to be of an adequate level if the coefficient α is at least .70. Future studies should consider assessing these constructs with other reliable measures, if available.

Finally, as RF is a complex psychological construct, using a self-report measure to assess such an ability is a limitation. Future studies should investigate the relationships between minority stress, health, and RF through more comprehensive interview methods. For example, to verify the reliability of results obtained in the current study and to deepen the role of impairments in mentalization, researchers might construct semistructured interviews able to encourage the mentalizing activity, exploring the ability to mentalize stigmatizing experiences. On the other hand, researchers could assess RF with the traditional and reliable method—that is, through the use of the Reflective Functioning Scale for the scoring of the Adult Attachment Interview—and then quantitatively measuring minority stress and mental health, using the RF values obtained from this method as moderators.

4.2 | Implications for clinical practice

Despite limitations and the nonclinical nature of the sample, the findings of the current study might have some implications for clinical practice with TGNC people. Indeed, as all the frameworks used to inform clinical practice (i.e., MST, PMF, and RF; Allen & Fonagy, 2006; Hatzenbuehler, 2009; Matsuno & Israel, 2018), this study—that stresses the relationship between mentalization, resilience, and psychological distress among TGNC individuals—could represent a first answer to the need highlighted by Matsuno and Israel (2018) concerning the integration of psychological theories of change with MST, starting to discuss potential directions of a mentalization-based intervention for TGNC people. To this end, within the MST—and, particularly, the PMF— Matsuno and Israel (2018) suggested addressing psychological and clinical interventions to strengthen TGNC resilience factors, and to group such interventions in community-, group-, and individual-level interventions. As this study focused on RF as an individual resilience factor, we cannot ascertain from our results suggestions for community-level interventions, as they deal with structural or institutional stigmatizing processes. Furthermore, it is imperative to highlight that psychological and clinical interventions developed for TGNC people must be framed within an affirmative practice framework, approaching clinical work from a nonpathologizing clinical stance that accepts and validates all genders and rejects a binary conception of gender (APA, 2015; Scandurra, Mezza, Valerio, & Vitelli, 2019).

Regarding individual-level interventions, little research has assessed the impact of TGNC affirmative interventions on mental health. For instance, some authors theoretically discussed an interpersonal therapy model for TGNC individuals (Budge, 2013) or a cognitive-behavioral intervention aimed at reducing anxiety and depression (Austin, Craig, & Alessi, 2017). Both models were framed within an affirmative approach, widely discussing on how to reduce the negative effects of minority stressors on health. However, no studies to date have assessed the effectiveness of mentalization-based treatments (MBTs) in reducing the mental health problems in TGNC people. MBTs are evidence-based and psychodynamically-oriented therapies that have been widely applied to different mental health disorders, such as BPD (Bateman & Fonagy, 2004) or depression (Luyten et al., 2012). On the basis of our results, it seems plausible to suggest that MBT would be an effective individual intervention which can probably address the detrimental effects of minority stressors on the health of TGNC individuals, through the increase of mentalizing ability. Thus, MBT randomized-controlled trials might be a relevant application of the results of the current study, if applied to a clinical sample of TGNC individuals seeking or enrolled in psychotherapy.

Regarding the group-level interventions, Matsuno and Israel (2018) discussed particular group therapies, or support groups and family and/or couple therapy. Previous research, indeed, has shown the effectiveness of group interventions with TGNC individuals in helping them to have access to positive role models and learn how to cope with minority stress by developing resilience (e.g., Amodeo et al., 2018; Heck, Croot, & Robohm, 2015; Scandurra, Picariello et al., 2018). However, on the basis of our results, it might be of interest, both for research and clinical practice, to test the effectiveness of mentalization-based group therapy (MBT-G) in reducing the effects of minority stress on health and increasing resilience factors in TGNC people. Broadly, an MBT-G is aimed at encouraging emotional literacy, working on RF, emotion regulation, and attachment, facilitating reflection on interpersonal relationship patterns and showing clients how these dimensions affect emotional expression, behaviors, and mental health (Esposito, Freda, & De Luca Picione, 2016; Esposito, Marano, & Freda, 2018; Esposito, Karterud, & Freda, 2019; Karterud, 2015). Similarly, following the suggestions by Lemma (2013), who pointed out the fundamental role of mirroring mental states associated with the children's gender incongruity, MBT principles might also be applied to parents of TGNC children or adolescents. Future studies could apply MBT-G principles to clinical samples of TGNC individuals and/or their parents to corroborate the results of the current study.

In conclusion, these results may represent a starting point in developing a new clinical research area aiming to explore the role of RF in helping TGNC people to cope with societal oppression and, in doing so, may reduce internalized stigma and promote positive mental health and well-being in this high-risk vulnerable population.

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ORCID

Cristiano Scandurra http://orcid.org/0000-0003-1790-3997
Pasquale Dolce http://orcid.org/0000-0002-7588-6067
Roberto Vitelli http://orcid.org/0000-0001-6873-7859
Giovanna Esposito http://orcid.org/0000-0002-4926-108X
Vincenzo Bochicchio http://orcid.org/0000-0003-2788-1381

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