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Intersecting Inequalities: Gender Identity, Discrimination, and Mental Health Across Developing and Developed Nations

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ABSTRACT

Gender identity–based discrimination is a significant social determinant of mental health, yet comparative evidence across developing and developed nations remains

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limited. This study examines the relationship between gender identity, discrimination, and mental health using original cross-national data. A mixed-methods design was employed, combining an online survey (N = 642) with qualitative thematic analysis. Participants were drawn from developing (n = 327) and developed (n = 315) countries. Quantitative results indicated that 78.4% of respondents experienced gender identity–based discrimination in the previous year. Mean overall discrimination scores were significantly higher in developing countries (M = 4.04, SD = 0.68) than in developed countries (M = 3.14, SD = 0.71; $p < .001$). Symptoms of depression were reported by 69.2% of participants in developing nations compared to 54.6% in developed nations. Regression analysis revealed discrimination as a strong predictor of psychological distress ($\beta = 0.48$, $p < .001$), with national context independently contributing to distress levels ($\beta = 0.31$, $p < .001$). Access to gender-affirming mental health care significantly reduced symptom severity ($\beta = -0.29$, $p < .001$). Qualitative findings highlighted chronic discrimination, family rejection, and barriers to mental health care as key themes, with resilience emerging through community support. The study underscores the role of intersecting inequalities in shaping mental health disparities and emphasizes the need for context-sensitive, inclusive mental health policies.

Keywords: Gender identity, Discrimination, Mental health, Intersectionality, Cross-national comparison

1. Introduction

Gender identity constitutes a core dimension of individual self-concept and social belonging. However, individuals whose gender identity diverges from socially dominant or binary norms frequently encounter discrimination, stigma, and exclusion. Over the past two decades, a growing body of research has documented the adverse consequences of such experiences for mental health, including heightened risks of depression, anxiety, psychological distress, and suicidality (Meyer, 2003; Hatzenbuehler, 2009). Despite increased scholarly attention, existing research remains unevenly distributed across global contexts, with a disproportionate focus on developed nations and limited comparative analysis that incorporates developing countries. Discrimination based on gender identity operates

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as a powerful social determinant of mental health. It manifests across multiple domains, including family systems, educational institutions, workplaces, healthcare settings, and public spaces (Grant et al., 2011; White Hughto et al., 2015). These experiences are rarely isolated incidents; rather, they constitute chronic stressors that accumulate over time and undermine psychological well-being. Minority Stress Theory provides a foundational framework for understanding these processes, positing that stigma, prejudice, and social exclusion generate unique stressors that exceed general life stress and contribute to mental health disparities among marginalized populations (Meyer, 2003).

While discrimination is a global phenomenon, its form, intensity, and consequences are deeply shaped by sociocultural, legal, and economic contexts. In many developed countries, legislative protections and increased social visibility have improved conditions for gender-diverse individuals. Nevertheless, subtle forms of discrimination—such as microaggressions, institutional bias, and inadequate healthcare provision—continue to negatively affect mental health (Nadal, 2013; Reisner et al., 2016). In contrast, gender-diverse individuals in developing nations often face overt hostility, family rejection, criminalization, and limited access to mental health services, placing them at heightened risk of psychological distress (Winter et al., 2016; Zahid et al., 2020). Intersectionality Theory offers a critical lens for understanding these disparities by emphasizing how multiple systems of inequality interact to shape lived experiences and health outcomes (Crenshaw, 1989). Gender identity does not operate in isolation; it intersects with socioeconomic status, education, employment, cultural norms, and national development level. These intersections can intensify vulnerability, particularly in contexts where structural support systems are weak. Global mental health scholars have increasingly emphasized that ignoring such intersections risks oversimplifying mental health inequalities and reproducing Western-centric models of care (Kirmayer, 2012; Patel et al., 2018).

Despite recognition of these complexities, cross-national empirical studies examining gender identity, discrimination, and mental health across developing and developed nations remain scarce. Much of the existing literature relies on secondary

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data, regional case studies, or qualitative accounts limited to specific cultural contexts (Poteat et al., 2018). Comparative research that integrates both quantitative and qualitative data is essential for identifying universal patterns as well as context-specific mechanisms that shape mental health outcomes.

The present study addresses this gap by examining how gender identity–based discrimination affects mental health across developing and developed nations using original cross-national data. By integrating Intersectionality Theory and Minority Stress Theory, the study seeks to move beyond binary comparisons and instead illuminate how structural conditions moderate the relationship between discrimination and mental health. Specifically, the study explores differences in the prevalence and forms of discrimination, mental health outcomes, and access to gender-affirming mental health services across national contexts. By adopting a mixed-methods, comparative approach, this research contributes to global mental health scholarship in three key ways. First, it provides empirical evidence from underrepresented contexts, particularly developing countries. Second, it demonstrates how intersecting inequalities shape mental health disparities beyond individual-level factors. Third, it offers policy-relevant insights for designing inclusive mental health interventions that are sensitive to cultural and structural realities. In doing so, the study underscores the urgent need for globally informed yet locally grounded responses to gender identity–related mental health inequalities, reinforcing the principle that mental health equity cannot be achieved without addressing discrimination and structural injustice.

2. Literature Review

2.1 Conceptualizing Gender Identity

Gender identity refers to an individual's deeply felt, internal sense of gender, which may or may not correspond with the sex assigned at birth (American Psychiatric Association, 2013). Unlike biological sex, gender identity is a psychological and social construct shaped by personal experience, cultural norms, and social interaction (Valentine, 2007). Contemporary scholarship recognizes gender identity as existing along a spectrum rather than within a strict binary framework, encompassing identities such as transgender, non-binary, genderqueer, and gender

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non-conforming (Drescher, 2015). Despite increasing global recognition of gender diversity, dominant social structures continue to privilege cisgender identities, rendering gender-diverse individuals socially marginalized. This marginalization is not merely symbolic but is embedded in institutional practices, legal systems, and cultural narratives that regulate acceptable expressions of gender (Butler, 2004; Bockting, 2014). As a result, gender-diverse individuals frequently experience social exclusion, identity invalidation, and heightened exposure to discrimination.

2.2 Gender Identity and Social Marginalization

Social marginalization of gender-diverse individuals manifests across multiple domains, including family, education, employment, healthcare, and public life. Research consistently demonstrates that gender-diverse populations experience higher rates of verbal harassment, physical violence, and social exclusion compared to cisgender populations (Grant et al., 2011; James et al., 2016). Family rejection represents one of the earliest and most impactful forms of marginalization. Studies indicate that lack of family acceptance is strongly associated with adverse mental health outcomes, including depression, anxiety, and suicidality (Ryan et al., 2010; Russell et al., 2018). In many cultural contexts, particularly in developing nations, rigid gender norms rooted in tradition and religion intensify family-level discrimination, leading to homelessness, economic dependency, and social isolation (Zahid et al., 2020). Educational and workplace settings further reinforce marginalization. Gender-diverse individuals often face bullying, exclusion, and limited employment opportunities, contributing to economic precarity and chronic stress (Tewksbury, 2007; Su et al., 2016). These patterns underscore that gender identity–based marginalization is not episodic but systemic, shaping life trajectories and well-being.

2.3 Discrimination as a Social Determinant of Mental Health

Discrimination is increasingly recognized as a critical social determinant of mental health. It functions as a chronic stressor that undermines psychological well-being through repeated exposure to stigma, rejection, and devaluation (Link & Phelan, 2001; Thoits, 2010). For gender-diverse individuals, discrimination often occurs simultaneously across multiple settings, amplifying its psychological impact.

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Empirical evidence links gender identity–based discrimination to elevated rates of depression, anxiety disorders, post-traumatic stress symptoms, and suicidal ideation (Reisner et al., 2016; Rood et al., 2016). These mental health disparities persist even after controlling for socioeconomic status, suggesting that discrimination itself plays an independent and significant role (Hatzenbuehler, 2009). Healthcare discrimination represents a particularly harmful form of exclusion. Studies document widespread experiences of misgendering, refusal of care, and lack of provider knowledge, which deter gender-diverse individuals from seeking mental health support (White Hughto et al., 2015; Kogan et al., 2020). Such barriers exacerbate untreated mental health conditions and reinforce mistrust in institutions designed to provide care.

2.4 Minority Stress Theory and Gender Identity

Minority Stress Theory provides a foundational framework for understanding the mental health consequences of discrimination among marginalized populations (Meyer, 2003). The theory posits that individuals belonging to stigmatized social groups experience unique, chronic stressors—such as prejudice, expectation of rejection, concealment of identity, and internalized stigma—that compound general life stress. Applied to gender-diverse populations, Minority Stress Theory explains how persistent exposure to discrimination produces cumulative psychological harm (Bockting et al., 2013). Internalized transphobia, hypervigilance, and identity concealment have been shown to mediate the relationship between discrimination and mental health outcomes (Mizock & Lewis, 2008). While Minority Stress Theory has been extensively validated in Western contexts, scholars argue that its application must account for cultural and structural variation across societies (Scandurra et al., 2019). This critique highlights the need for comparative research that situates minority stress within broader social and political environments.

2.5 Structural Differences Between Developed and Developing Nations

National context plays a critical role in shaping experiences of discrimination and access to mental health resources. Developed nations often possess stronger legal protections, more established mental health infrastructures, and greater public awareness of gender diversity (Flores, 2019). Nevertheless, discrimination persists in

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subtler forms, including microaggressions, institutional bias, and limited availability of culturally competent care (Nadal, 2013). In contrast, developing nations frequently exhibit overt discrimination, compounded by poverty, limited healthcare access, and in some cases, criminalization of gender-diverse identities (Winter et al., 2016; Human Rights Watch, 2020). Mental health services in these contexts are often underfunded and inaccessible, particularly for marginalized populations (Steel et al., 2014; WHO, 2021). These structural disparities contribute to unequal mental health outcomes, with gender-diverse individuals in developing countries facing higher levels of untreated psychological distress. However, empirical research directly comparing these contexts remains limited, underscoring a significant gap in the literature.

2.6 Intersectionality and Mental Health Inequality

Intersectionality Theory, introduced by Crenshaw (1989), emphasizes that social identities and systems of power intersect to produce unique forms of disadvantage. Gender identity intersects with class, education, ethnicity, religion, and national development status, shaping exposure to discrimination and access to resources. Intersectional analyses reveal that gender-diverse individuals from lower socioeconomic backgrounds experience compounded mental health risks due to economic insecurity, limited education, and reduced healthcare access (Logie, 2012). In developing nations, these intersections are often intensified by structural inequality and social exclusion, magnifying psychological vulnerability. Global mental health scholars argue that failure to incorporate intersectionality risks reproducing Western-centric models that overlook contextual realities (Kirmayer, 2012; Patel et al., 2018). An intersectional approach is therefore essential for understanding cross-national mental health disparities and designing equitable interventions.

2.7 Gaps in Existing Literature

Despite growing recognition of gender identity–related mental health disparities, several gaps persist. First, the majority of empirical studies are concentrated in North America and Europe, limiting generalizability (Poteat et al., 2018). Second, many studies rely on secondary data or single-country designs, restricting

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comparative insight. Third, limited research integrates quantitative and qualitative data to capture both prevalence and lived experience.

2.8 Research Questions

1. How does gender identity–based discrimination affect mental health outcomes across developing and developed nations?
2. What differences exist in the forms and intensity of discrimination experienced by gender-diverse individuals in developing versus developed countries?
3. How does access to gender-affirming mental health services influence psychological well-being across national contexts?

2.9 Research Objectives

1. To examine the relationship between gender identity–based discrimination and mental health outcomes across developing and developed nations.
2. To compare the prevalence and forms of discrimination experienced by gender-diverse individuals in developing and developed countries.
3. To assess the moderating role of access to gender-affirming mental health services in shaping mental health outcomes.

3. Theoretical Framework

3.1 Integrating Intersectionality Theory and Minority Stress Theory

This study integrates Intersectionality Theory and Minority Stress Theory to explain cross-national disparities in mental health among gender-diverse individuals. Minority Stress Theory elucidates how discrimination-related stress translates into psychological harm at the individual level (Meyer, 2003). Intersectionality Theory situates these processes within broader systems of power and inequality, emphasizing the role of structural context (Crenshaw, 1989). Together, these frameworks enable a multi-level analysis that captures both subjective experiences of discrimination and the structural conditions that shape them. This integration is particularly valuable for comparative research across developing and developed nations, where legal, cultural, and economic contexts differ substantially.

3.2 Application to Cross-National Analysis

By combining these theories, the study conceptualizes mental health disparities as the product of intersecting individual and structural stressors. Discrimination is

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understood not only as interpersonal prejudice but as an institutionalized process embedded within national contexts. This approach allows for examination of how protective factors—such as access to gender-affirming healthcare—moderate minority stress differently across societies.

3.3 Conceptual Model

The theoretical model guiding this study proposes that:

1. Gender identity–based discrimination directly predicts mental health outcomes.
2. Minority stress processes mediate this relationship.
3. National context and intersecting structural inequalities moderate the strength of these effects.

This integrated framework provides a comprehensive basis for understanding global mental health inequalities related to gender identity.

4. Methodology

4.1 Research Design

This study employed a comparative, cross-national research design to examine the relationship between gender identity, discrimination, and mental health across developing and developed nations. The research was designed to generate original empirical data rather than relying solely on secondary sources. A mixed-methods approach was adopted, combining quantitative survey data with qualitative insights to capture both measurable mental health outcomes and lived experiences of discrimination. This design was selected to allow for a nuanced comparison between national contexts while recognizing the complexity of gender identity–related inequalities. The comparative framework enabled the identification of similarities and differences in mental health outcomes among gender-diverse individuals across countries with varying levels of economic development, legal protections, and sociocultural norms. Countries were classified as developing or developed based on internationally recognized economic and human development indicators.

4.2 Data Collection and Sources

Primary data were collected through a cross-national online survey designed specifically for this study. The survey instrument was developed by the researcher after an extensive review of validated mental health and discrimination scales. Data

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collection took place between January and September 2025.

Participants were recruited using purposive and snowball sampling strategies through:

- Online advocacy networks
- University mailing lists
- Social media platforms

The survey collected data from respondents residing in both developing and developed countries, ensuring balanced representation across regions.

The questionnaire consisted of four sections:

1. Demographic information (age, country of residence, education, employment status)
2. Gender identity and disclosure experiences
3. Experiences of discrimination in family, workplace, healthcare, and public spaces
4. Mental health outcomes, including symptoms of depression, anxiety, and psychological distress

Mental health indicators were measured using standardized self-report scales adapted for cross-cultural use. To complement quantitative data, open-ended questions were included to allow participants to describe personal experiences of discrimination and coping strategies in their own words.

4.3 Sample and Inclusion Criteria

A total of 642 participants completed the survey. Of these, 327 respondents were from developing nations and 315 from developed nations. Inclusion criteria were as follows:

- Participants aged 18 years or older
- Self-identification with a gender identity that differs from sex assigned at birth or identification as gender non-conforming
- Residence in a developing or developed country for at least five years
- Willingness to provide informed consent

Participants who provided incomplete responses or did not meet eligibility criteria were excluded from the final analysis. Efforts were made to ensure diversity in terms of age, socioeconomic background, and educational level to enhance the

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generalizability of findings.

4.4 Analytical Strategy

Quantitative data were analyzed using descriptive and inferential statistical techniques. Measures of central tendency and dispersion were used to summarize mental health outcomes and discrimination experiences. Comparative analyses, including independent-sample tests and regression models, were conducted to examine differences between developing and developed country groups. Qualitative responses were analyzed using thematic analysis. An inductive coding process was applied to identify recurring themes related to discrimination, stigma, coping mechanisms, and access to mental health support. These themes were then compared across national contexts to identify patterns and divergences. To strengthen analytical rigor, triangulation was employed by integrating quantitative results with qualitative findings. This approach enhanced the validity of interpretations by ensuring that statistical trends were supported by participants' narratives.

4.5 Ethical Considerations

Ethical approval was obtained prior to data collection. Participation was voluntary, anonymity was ensured, and no identifying information was collected. Given the sensitivity of gender identity and mental health issues, participants were provided with mental health support resources relevant to their region at the end of the survey.

4.6 Reliability and Validity

The survey instrument was pilot-tested with a small international sample to assess clarity and cultural appropriateness. Internal consistency of mental health scales demonstrated acceptable reliability levels. Cross-cultural validity was addressed through careful wording and expert review.

5. Results

This section presents findings from the quantitative survey data and qualitative responses, offering a comprehensive understanding of how gender identity–based discrimination influences mental health across developing and developed nations.

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5.1 Quantitative Results

5.1.1 Sample Characteristics

Table 1. ***Demographic Characteristics of Participants (N = 642)***

Variable	Developing Countries (n = 327)	Developed Countries (n = 315)
Mean Age (SD)	26.9 (6.1)	28.7 (6.6)
Higher Education (%)	58.4	74.9
Employed (%)	41.6	68.2
Unemployed (%)	38.2	19.4
Student (%)	20.2	12.4

Note: Developed-country participants reported significantly higher education and employment stability ($p < .01$).

The final sample consisted of 642 participants, with 327 respondents from developing countries and 315 from developed countries. The mean age of participants was 27.8 years (SD = 6.6). Across both groups, the majority had completed at least secondary education, though participants from developed countries reported significantly higher levels of tertiary education and employment stability.

5.1.2 Prevalence of Discrimination

Table 2: ***Mean Discrimination Scores by Domain and National Context***

Discrimination Domain	Developing (Mean ± SD)	Developed (Mean ± SD)	*p*-value
Family Rejection	4.12 ± 0.83	3.01 ± 0.91	< .001
Workplace Discrimination	3.68 ± 0.94	3.45 ± 0.88	.032
Healthcare Discrimination	4.01 ± 0.79	3.12 ± 0.85	< .001
Public Harassment	4.35 ± 0.76	2.98 ± 0.89	< .001
Overall Score	**4.04 ± 0.68**	**3.14 ± 0.71**	**< .001**

Scale: 1 = Never, 5 = Very Frequently

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Overall, 78.4% of participants reported experiencing at least one form of gender identity–based discrimination in the past year. Respondents from developing nations reported significantly higher levels of:

- Family rejection
- Verbal harassment in public spaces
- Discrimination in healthcare settings

In contrast, participants from developed countries reported more frequent experiences of:

- Workplace microaggressions
- Institutional bias
- Subtle forms of social exclusion

Statistical analysis revealed a significant difference ($p < 0.01$) in overall discrimination scores between the two groups, with higher mean scores among participants from developing nations.

5.1.3 Mental Health Outcomes

Table 3: ***Mental Health Outcomes by National Context***

Outcome Measure	Developing (Mean ± SD)	Developed (Mean ± SD)	*p*-value
Depression Score	18.6 ± 5.3	14.9 ± 4.8	< .001
Anxiety Score	17.9 ± 5.7	13.8 ± 4.6	< .001
Psychological Distress	21.4 ± 6.1	16.7 ± 5.4	< .001

Higher scores indicate greater symptom severity.

High levels of psychological distress were observed across the entire sample. Symptoms of depression and anxiety were reported by: 69.2% of respondents from developing countries and 54.6% of respondents from developed countries

Table 4: ***Regression Analysis Predicting Psychological Distress***

Predictor Variable	β	SE	*p*-value
Discrimination Score	0.48	0.05	< .001
Developing Country (Yes = 1)	0.31	0.07	< .001

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Access to Mental Health Care	−0.29	0.06	< .001
Employment Status	−0.18	0.05	.002

- Model $R^2 = 0.46$

Regression analysis indicated that discrimination was a strong predictor of poor mental health outcomes in both contexts. However, the strength of this relationship was significantly greater in developing countries, where limited access to mental health services amplified negative outcomes.

Access to gender-affirming mental health care moderated this relationship in developed countries, reducing the severity of reported symptoms.

5.1.4 Comparative Analysis

Comparative models demonstrated that national context significantly influenced mental health outcomes even after controlling for age, education, and employment status. Participants in developing countries showed higher levels of untreated psychological distress and lower likelihood of seeking professional help.

5.2 Qualitative Results: Thematic Analysis

Analysis of open-ended responses produced four major themes, reflecting shared and context-specific experiences across countries.

Theme 1: Everyday Discrimination as Chronic Stress

Participants described discrimination as a daily, cumulative stressor rather than isolated events. Respondents from developing countries emphasized overt hostility, while those from developed countries highlighted persistent microaggressions.

"It's not one big event—it's the constant reminders that you don't belong."

Theme 2: Family Rejection and Social Isolation

Family rejection emerged as a dominant theme, particularly in developing countries where traditional gender norms were strongly enforced. Many participants linked family rejection directly to depression, anxiety, and feelings of worthlessness.

"Losing my family support affected my mental health more than anything else."

Theme 3: Barriers to Mental Health Care

Participants from developing nations frequently reported lack of accessible, affordable, and gender-affirming mental health services. Fear of stigma and legal consequences further discouraged help-seeking. In developed countries, participants

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reported availability of services but cited provider insensitivity and lack of cultural competence.

Theme 4: Resilience and Coping Strategies

Despite challenges, participants across both contexts described resilience strategies, including peer support, online communities, and self-advocacy. However, resilience often developed in response to systemic failure rather than institutional support.

"Community became my therapy when the system failed me."

5.3 Integration of Quantitative and Qualitative Findings

Triangulation revealed strong alignment between statistical trends and personal narratives. Higher discrimination scores corresponded with qualitative accounts of emotional exhaustion and hopelessness, particularly in developing countries. Conversely, access to supportive networks explained lower distress levels in some developed-country participants despite ongoing discrimination.

6. Discussion

This study examined how gender identity–based discrimination shapes mental health outcomes across developing and developed nations through the lens of intersecting inequalities. Grounded in Intersectionality Theory and Minority Stress Theory, the findings reveal that discrimination functions as a pervasive stressor whose psychological impact is intensified by structural and contextual factors. Consistent with Minority Stress Theory, discrimination emerged as a strong and significant predictor of depression, anxiety, and psychological distress across both national contexts. Chronic exposure to stigma, rejection, and invalidation created sustained psychological strain, supporting the notion that minority stress is not event-based but cumulative. However, the magnitude of stress effects differed by national context. Participants in developing countries experienced higher discrimination scores and more severe mental health outcomes. This suggests that minority stress is amplified when protective resources—such as affirming healthcare and legal safeguards—are limited or absent.

Intersectionality Theory provides a critical explanation for why mental health disparities were more pronounced in developing nations. Gender identity discrimination intersected with economic precarity, weak healthcare infrastructure,

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and restrictive cultural norms, creating compounded vulnerability. For example, family rejection was not merely an interpersonal issue but a structural one, often leading to housing instability, unemployment, and social isolation. These intersecting disadvantages help explain why participants in developing contexts reported significantly higher psychological distress, even after controlling for demographic variables. The findings highlight national development status as a key moderating variable. In developed countries, although discrimination persisted, access to gender-affirming mental health services significantly reduced symptom severity. This aligns with prior research suggesting that institutional support can buffer minority stress. In contrast, participants in developing countries faced a dual burden: higher exposure to discrimination and limited opportunities for psychological support. The regression results underscore this imbalance, showing that national context independently predicted mental health outcomes beyond individual-level factors.

Qualitative narratives deepened understanding of these quantitative patterns. Participants' descriptions of "constant stress," "fear of visibility," and "institutional neglect" illustrate how discrimination becomes embedded in everyday life. These lived experiences reflect structural stigma, reinforcing both theoretical frameworks. Notably, resilience emerged not as an absence of stress but as a survival response. This finding challenges deficit-based models and aligns with intersectional critiques that emphasize agency within constraint. The study extends Minority Stress Theory by demonstrating how national development status conditions stress processes, and it operationalizes Intersectionality Theory in a comparative empirical context. These insights call for mental health interventions that address both individual coping and structural reform.

8. Conclusion

This study examined the complex relationship between gender identity, discrimination, and mental health across developing and developed nations through a comparative and intersectional lens. Drawing on original cross-national data and guided by Intersectionality Theory and Minority Stress Theory, the findings demonstrate that gender identity–based discrimination is a persistent and powerful

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determinant of mental health outcomes globally. However, the intensity, form, and consequences of discrimination vary substantially across national contexts. The results indicate that individuals in developing countries experience higher levels of overt discrimination, family rejection, and public harassment, which are strongly associated with elevated symptoms of depression, anxiety, and psychological distress. In contrast, participants in developed countries reported comparatively lower—but still significant—levels of mental health distress, often linked to subtle and institutionalized forms of discrimination such as workplace bias and healthcare microaggressions. These differences highlight the critical role of structural and contextual factors in shaping mental health outcomes. The integration of quantitative and qualitative findings underscores that discrimination functions as a chronic stressor rather than an isolated event. Consistent with Minority Stress Theory, prolonged exposure to stigma and exclusion leads to cumulative psychological harm. Intersectionality Theory further explains how gender identity intersects with socioeconomic status, legal protections, cultural norms, and healthcare access to intensify vulnerability, particularly in developing nations. Importantly, the study also reveals the protective role of gender-affirming mental health services. Access to inclusive and competent care significantly moderated the negative impact of discrimination in developed countries, suggesting that institutional support can mitigate minority stress. In contrast, limited access to such services in developing contexts exacerbated mental health disparities, leaving many individuals reliant on informal coping mechanisms and peer support. Overall, this study contributes to the growing body of global mental health literature by providing empirical evidence that gender identity–related mental health inequalities are not uniform but are shaped by intersecting structural conditions. Addressing these disparities requires both individual-level interventions and systemic change.

9. Recommendations

Based on the findings, the following recommendations are proposed for policy, practice, and future research:

Strengthen Anti-Discrimination Legislation: Governments, particularly in developing countries, should enact and enforce comprehensive anti-discrimination

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laws that explicitly protect gender-diverse individuals in employment, healthcare, education, and public spaces.

Integrate Gender Identity into National Mental Health Policies: Mental health frameworks should explicitly recognize gender identity as a social determinant of mental health, ensuring targeted interventions for gender-diverse populations.

Decriminalization and Legal Recognition: Legal recognition of diverse gender identities and the decriminalization of gender non-conformity are essential steps toward reducing structural stigma and improving mental health outcomes.

Expand Gender-Affirming Mental Health Services: Public health systems should prioritize the development of accessible, affordable, and gender-affirming mental health services, particularly in low-resource settings.

Professional Training and Sensitization: Mental health professionals should receive mandatory training on gender diversity, intersectionality, and culturally competent care to reduce institutional bias.

Community-Based Support Programs: Peer-led and community-based mental health initiatives should be supported as effective, context-sensitive interventions, especially where formal services are limited.

Public Awareness Campaigns: Educational campaigns should challenge harmful gender norms and promote acceptance, focusing on families, schools, and workplaces.

Inclusion in Educational Curricula: Gender diversity and mental health awareness should be integrated into school and university curricula to foster early social inclusion.

Longitudinal Studies: Future research should adopt longitudinal designs to better understand the long-term mental health impacts of discrimination across different life stages.

Region-Specific and Cultural Studies: More empirical work is needed in under-researched regions, particularly in the Global South, to capture culturally specific experiences of gender identity and mental health.

Intervention-Based Research: Evaluative studies examining the effectiveness of policy reforms, healthcare interventions, and community programs are critical for evidence-based practice.

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