

Contextualizing the well-being of transgender youth in Spain:

Indicators of lifestyles, developmental contexts, victimization at school, and mental health



Esther Ciria Barreiro



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Universidad de Sevilla

Departamento de Psicología Evolutiva y de la Educación



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Tesis doctoral

Esther Ciria Barreiro

Sevilla, 2022

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Para Carmen y Fernando, que me dieron la vida.

Para Mari Carmen, Fran y Conchi, que confiaron en mí.

You don't have to be a ghost here amongst the living.

You are flesh and blood. You deserve to be loved and you deserve what you are given.

Florence + The Machine – Third Eye (How Big, How Blue, How Beautiful, 2015)

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*Y ya está todo listo para la siguiente foto
La familia, los de siempre, mis queridísimos locos
En resumen todas y todos los que hicisteis que valiera la pena
Saltar a esta piscina sin saber si estaba llena*

Izal – Fotografías (Hogar, 2021)

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PRESENTACIÓN

En los últimos años se ha puesto de manifiesto la necesidad de considerar la perspectiva de género en los marcos teórico, metodológico y aplicado de la investigación científica. Una de las vertientes del estudio del género se aprecia con el creciente interés por conocer la realidad de las personas transgénero, lo que se ve reflejado en un aumento exponencial en la publicación de investigaciones científicas en los últimos quince años.

Indiscutiblemente, las personas transgénero se enfrentan a situaciones de victimización y discriminación graves en un sistema social cis-hetero-patriarcal que afecta a su salud y bienestar, explicado en profundidad desde el modelo de estrés de minorías de Ian Meyer (I. Meyer, 2003) y sus ulteriores actualizaciones (e.g., Hendricks & Testa, 2012; I. Meyer, 2020). Esto ha propiciado que la investigación se haya focalizado en perfiles de salud patologizados, en los que destacan tópicos como las conductas de riesgo (por ejemplo, el consumo de sustancias o la prevalencia de infecciones de transmisión sexual) o problemas graves de salud mental (desde el desarrollo de trastornos del estado del ánimo a conductas suicidas). Estudiar esta faceta de la salud es innegablemente crucial, pero la investigación adolece al mismo tiempo de estudios sobre elementos que generan resiliencia o que, al menos, ofrezcan una visión más normalizadora de la salud de las personas transgénero.

Otra cuestión importante es que la mayoría de las investigaciones trata datos de personas adultas. Por ello, cabría preguntarse cuáles son las vivencias del desarrollo de la identidad y del ajuste psicosocial de los, las y les adolescentes transgénero en la actualidad, especialmente siendo una generación en la que hay mayor cabida para la reflexión sobre la fluidez de la identidad de género, más allá de los sistemas binarios tradicionales. Desconocer la proporción de los, las y les adolescentes transgénero en el conjunto poblacional oculta las situaciones de riesgo a las que se ven expuestos y las consecuencias para su desarrollo saludable, aunque la evidencia empírica de la que se dispone en la actualidad revela que los, las y les jóvenes transgénero sufren a menudo diferentes tipos de victimización, discriminación y exclusión, que los lleva a presentar peores indicadores de salud mental y física.

Respecto a otras limitaciones metodológicas, habitualmente las muestras suelen obtenerse a partir de muestreos no probabilísticos, por ejemplo, muestreos por conveniencia en centros clínicos o asociaciones LGBTQ+, lo que lleva a cuestionar la generalización de los resultados y conclusiones. Paralelamente, pocas investigaciones de carácter masivo incluyen preguntas para detectar la identidad de género de los, las y les participantes con el objetivo de



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profundizar en el conocimiento de su estado. Puede suceder que grandes investigaciones consigan recabar información sobre las personas transgénero, pero incorporándolo dentro del colectivo LGBTQ+, lo que permite tener datos, pero no de forma distinguida y clara respecto a los, las y les participantes incluidos por su orientación sexual, una variable que no es equivalente a la de identidad de género. En el caso de disponerse de muestras aleatorias y de mayor tamaño, suelen provenir de países angloparlantes, como Estados Unidos, Canadá o Nueva Zelanda, por lo que se tiende a generalizar los resultados de las personas que viven en estos contextos a otros países, cuya legislación o sensibilidad acerca de la diversidad de género puede ser distinta. Por último, los ítems que se utilizan para detectar la identidad de género pueden estar erróneamente planteados o formulados, sucediendo que estén evaluando otras dimensiones, como la expresión de género.

Pareciera entonces que existen todavía varias trabas para comprender la realidad de las personas transgénero durante la adolescencia, pero se constatan los esfuerzos por intentar acercarse a la misma. Esto se observa en la investigación internacional, aunque cabría preguntarse qué sucede en España. Si bien algunas investigaciones se han realizado en nuestro país con población transgénero, las metodologías suelen utilizar muestras por conveniencia. Por ello, ¿qué sabemos sobre los, las y les adolescentes transgénero? ¿Qué sabemos sobre ellos, ellas y ellos? ¿Presentan perfiles similares a los, las y les participantes de las investigaciones angloparlantes? Esta situación de desconocimiento, junto al reciente impulso de la Ley Trans y su impacto social, hace que sea imprescindible la salud transgénero en adolescentes en España.

Por lo tanto, el objetivo de la presente investigación es analizar los perfiles de salud y desarrollo de la adolescencia en España desde una perspectiva sensible e inclusiva, desentrañando de esta forma diferencias y similitudes entre los, las y les adolescentes según su identidad de género. Este objetivo global se concreta en seis preguntas de investigación o tópicos:

- 1) Examinar cuál es la opción más adecuada para indagar en la identidad de género en la adolescencia;
- 2) Estudiar los estilos de vida de los, las y les adolescentes en función de su identidad de género;
- 3) Comparar la calidad de los contextos de desarrollo más cercanos en función de su identidad de género;
- 4) Analizar los niveles de ajuste y bienestar de los, las y les adolescentes en función de su identidad de género;



- 5) Conocer la prevalencia de participación en episodios de bullying y cyberbullying entre los, las y les adolescentes en función de su identidad de género;
- 6) Averiguar el efecto que ejercen los contextos de desarrollo más cercanos ante situaciones de victimización y violencia sobre el bienestar en función de la identidad de género.

Algunos de los objetivos de la Agenda 2030 para el Desarrollo Sostenible de las Naciones Unidas se ven reflejados en los temas tratados en esta tesis, como la promoción del bienestar y la vida sana (ODS 3), la igualdad de género (ODS 5), la reducción de todas las desigualdades dentro de cada uno de los países (ODS 10), o la promoción de sociedad justas e inclusivas (ODS 16).

A estos objetivos se contribuye mucha de la investigación desarrollada en el marco del estudio internacional Health Behaviour in School-aged Children (HBSC), colaborador de la Organización Mundial de la Salud (OMS). El objetivo principal de esta red es conocer los estilos de vida, los contextos de desarrollo y la salud, bienestar y calidad de vida en la adolescencia. Esta investigación, cuya recogida de datos se realiza cada cuatro años, se inicia en 1982 con la fundación del proyecto gracias a investigadores de Noruega, Inglaterra y Finlandia, e incorpora a más de 50 países en la actualidad, tanto europeos como de América del Norte y Asia. España se incorpora a la red internacional en el año 1985 y colabora regularmente desde entonces, exceptuando la edición 1998. Desde el año 2002 el equipo español del HBSC está dirigido por la profesora doctora Carmen Moreno, Catedrática del Departamento de Psicología Evolutiva y de la Educación de la Universidad de Sevilla, y Francisco Rivera, Profesor Titular del Departamento de Psicología Experimental de la Universidad de Sevilla, co-dirige el equipo desde 2020. El proyecto está financiado por el Ministerio de Sanidad.

Una de las características de esta red internacional es la organización de las áreas de trabajo en grupos focales. Uno de los grupos se centra en la investigación sobre conductas sexuales en la adolescencia y en los últimos cinco años ha desarrollado innovadoras líneas de investigación sobre la diversidad sexo-afectiva dentro de la red.

Dentro de esta red internacional, países como Alemania, Luxemburgo o Bélgica han realizado intentos por conocer las experiencias de los, las y les estudiantes sobre su género. No obstante, precisamente la línea de trabajo sobre diversidad de género en el grupo focal se empieza a consolidar con el trabajo realizado para esta tesis doctoral. En la edición española del estudio HBSC 2018 se incorpora por primera vez una medida de dos pasos para indagar en el sexo y en el género autopercibido de los, las y les adolescentes. A partir de la experiencia pionera



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del equipo español, otros países contemplan la posibilidad de incluir en siguientes ediciones del estudio un protocolo similar. Así, este compromiso con la investigación sobre minorías sexuales y de género comienza con la publicación del pilotaje sobre salud sexual en 2016. Continúa en la actualidad con la formación de un grupo de investigación que lidera un pilotaje sobre la exploración de las preguntas sobre identidad de género y orientación sexual más adecuadas para incluir en metodologías de encuesta.

En cuanto a esta tesis doctoral, los datos que se presentan en este trabajo son de la edición del 2018 del estudio HBSC España. Para la selección de la muestra se aplicó un muestreo aleatorio polietápico estratificado por conglomerados, en el que se tiene en cuenta la edad, el hábitat (rural o urbano) y la titularidad del centro educativo (público o privado) de los, las y les adolescentes, con la finalidad de obtener una muestra nacionalmente representativa de la población española de estas edades. En dicha edición participaron 40.495 adolescentes de entre 11 y 18 años. Para la actual tesis se cuenta con los datos de 17.678 jóvenes de entre 15 y 18 años (quienes respondieron a la pregunta de identidad de género). De este grupo, 303 jóvenes se consideran transgénero. De los 17.375 restantes, en un proceso de remuestreo, cuyo objetivo es facilitar estadísticamente la comparación entre grupos, se extraen datos de 909 chicos y chicas cisgénero que se emparejan aleatoriamente con los, las y les 303 adolescentes transgénero, teniendo en cuenta la edad, titularidad del centro educativo, zona geográfica y capacidad adquisitiva familiar. De esta forma, la muestra final es de 1.212 adolescentes.

Respecto los aspectos formales, se trata de una tesis por compendio de estudios. La memoria de esta tesis doctoral se divide en cinco secciones.

La primera de ellas corresponde a la introducción teórica de la investigación que, a su vez, se divide en tres capítulos. En el primer capítulo se describen conceptos fundamentales para comprender qué es el género y la identidad de género, y se presenta el modelo de estrés de minorías como marco teórico principal de esta investigación. A continuación, en el segundo capítulo, se define qué es la adolescencia, cómo acontece el desarrollo de la identidad de género en la infancia y la adolescencia y cuáles son opciones metodológicas para preguntar por la identidad de género en estudios científicos. Finalmente, en el tercer capítulo en que se subdivide la primera sección de la tesis se realiza una exhaustiva revisión del concepto de salud en todas sus dimensiones, específicamente en la etapa de la adolescencia. Para ello, se analiza cómo los estilos de vida, la salud mental y los contextos de desarrollo influyen en el bienestar durante la adolescencia, especialmente para la adolescencia transgénero. En este mismo capítulo, como ejemplo práctico del modelo de estrés de minorías, se reflexiona sobre cómo los episodios de



victimización en el entorno escolar afectan a la salud de los, las y les adolescentes transgénero, y cómo los contextos de desarrollo pueden amortiguar su impacto.

Tras establecer el marco teórico, en el segundo bloque se explican los objetivos e hipótesis de investigación, así como la metodología empleada. En esta sección se profundiza en la historia del Estudio HBSC y en la metodología que lo caracteriza como proyecto internacional. Asimismo, se describen el proceso de recogida de datos y las características de la muestra, los instrumentos usados y los diferentes análisis estadísticos para cada uno de los estudios que conforman esta investigación. Para facilitar la comprensión de los contenidos, se establece una relación entre las medidas empleadas y los análisis ejecutados por cada estudio.

Una vez descrita la metodología de la investigación, en el tercer bloque se representan los datos analizados de la tesis. En total, se han realizado seis estudios. Cada capítulo presenta cada uno de los estudios e incluye un breve resumen del contenido, un listado de las publicaciones y otras contribuciones científicas a través de las cuales se han divulgado datos de cada estudio, un recordatorio de la metodología empleada (incluyendo las variables usadas y los análisis estadísticos) y, finalmente, los resultados. En el primer estudio se calcula la proporción de adolescentes transgénero y cisgénero en la muestra total y nacionalmente representativa del estudio HBSC a partir de un proceso de dos pasos para obtener información sobre la identidad de género en la adolescencia. En el segundo estudio se comparan diferentes estilos de vida entre los, las y les adolescentes, abarcando alimentación, actividad física, patrones de sueño e higiene buco-dental. En el tercer estudio se contemplan diferentes medidas de salud mental y bienestar, desde la satisfacción vital al desarrollo de sintomatología psicósomática. En el cuarto estudio se analiza la influencia de los contextos de desarrollo sobre la calidad de vida relacionada con la salud de los, las y les adolescentes. En el quinto estudio se muestran las prevalencias de acoso escolar y ciberacoso según la frecuencia y el tipo de violencia. En el último estudio se observa cómo la identidad de género modera el efecto de mediación del apoyo percibido de los contextos de desarrollo entre ser víctima de acoso o ciberacoso y la calidad de vida relacionada con la salud.

En la cuarta sección se expone la discusión de los resultados de esta tesis. En este bloque se resumirán las principales conclusiones por cada estudio y de forma global para el conjunto de la tesis, señalando las aportaciones más relevantes de este trabajo, fortalezas, limitaciones y futuras líneas de investigación. La tesis doctoral concluye en la quinta sección con los apartados de las referencias bibliográficas y los anexos. Para finalizar, con el objetivo de optar al Grado de Doctora con Mención Internacional, el texto está redactado íntegramente en inglés, una de las



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las lenguas habituales para la comunicación científica en el campo de conocimiento, acorde al artículo 15 del Real Decreto 99/2011, de 28 de enero, por el que se regulan las enseñanzas oficiales de doctorado.

SUMMARY

The need to consider the gender perspective in theoretical and methodological research frameworks, as well as in interventions, has become apparent in recent years. In this regard, there is a growing interest in learning about the reality of transgender people, which is reflected in the exponential increase in publications of scientific research in the last 15 years.

Undeniably, transgender people face severe victimization and discrimination with in a cis-hetero-patriarchal social system that affects their health and well-being, as explained in depth by Ian Meyer's Minority Stress Model (I. Meyer, 2003) and its subsequent updates (e.g., Hendricks & Testa, 2012; I. Meyer, 2020). This has led research to focus on health from a pathological perspective, with a prominence of topics such as risk behaviors (e.g., substance use or prevalence of sexually transmitted infections) or serious mental health problems (e.g., mood disorders or suicidal behaviors). Studying this area of health is undeniably crucial, but at the same time there is a lack of research on elements that build resilience or at least offer a more normalizing view of the health of transgender people.

Another important issue is that most of the existing research involves data from adults. Therefore, we should ask ourselves what the experiences of identity development and psychosocial adjustment of transgender adolescents are today, especially in a generation in which there are more opportunities for discussing the notion of gender fluidity, beyond the conventional gender binary system. Not knowing the proportion of transgender adolescents in the overall population conceals the risk situations to which they are exposed and the consequences for their healthy development, even though the empirical evidence currently available reveals that transgender youth often suffer different types of victimization, discrimination, and exclusion, which lead to worse mental and physical health.

Other methodological limitations include the fact that samples are usually obtained with non-probabilistic sampling—for example, convenience sampling in healthcare centers or LGBTQ+ associations—which leads to a questioning of the generalizability of the results and



conclusions. At the same time, few large-scale studies include questions relating to gender identity of the participants. Large studies occasionally manage to collect information on transgender people; however, this involves the overall LGBTQ+ community, which allows us to access data but not in a distinguished and clear way. As for studies conducted with random and large samples, they tend to come from western and English-speaking countries, such as the United States, Canada or New Zealand, so there is a tendency to generalize the results of people living in these contexts and apply them to countries whose legislation or sensitivity to gender diversity might differ. Finally, the items used to ask about one's gender identity may be erroneously formulated, and they also might refer to other dimensions, such as gender expression.

It would seem, then, that there are still several obstacles standing in the way of understanding the reality of transgender people during adolescence, but efforts are being made to come closer. This can be observed in international research, but what is the situation in Spain? While some research has been conducted in our country regarding the transgender population, the methodology used is often based in convenience samples. Thus, what do we know about transgender adolescents? Are their profiles similar to those of participants in English-speaking research studies? This lack of knowledge, together with the recent promotion of the law on transgender rights Trans Law and its social impact, makes up the perfect opportunity to analyze transgender adolescent health in Spain.

Therefore, the aim of this research is to analyze the health and development profiles of adolescents in Spain from a sensitive and inclusive perspective, thus unraveling differences and similarities between adolescents according to their gender identity. The main research questions that guide this doctoral dissertation are the following:

- 1) What is the most appropriate measure to get to know the gender identity of an adolescent?
- 2) How are the lifestyles of transgender adolescents?
- 3) What is the mental health status of transgender adolescents?
- 4) How do transgender adolescents perceive support and satisfaction within their developmental contexts?
- 5) Are transgender adolescents involved in bullying and cyberbullying episodes?



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6) Can developmental contexts act as positive assets or resources that protect adolescents from the effects of stressful life events?

The topics covered in this thesis reflect some of the goals of the United Nations 2030 Agenda for Sustainable Development, such as the promotion of well-being and healthy lives (SDG 3), the achievement of gender equality (SDG 5), the reduction of inequality within and among countries (SDG 10), or the promotion of justice and inclusive societies (SDG 16).

These objectives are reflected in the research conducted by the study Health Behaviour in School-aged Children (HBSC), a research collaboration with the World Health Organization (WHO). The main objective of this network is to understand lifestyles, developmental contexts, health, and well-being in adolescence. This research, whose data collection is carried out every four years, began in 1982 with the foundation of the project upon the initiative of researchers from Norway, England and Finland; it currently includes more than 50 countries in Europe, North America and Asia. Spain joined the international network in 1985 and has collaborated regularly ever since, except for the 1998 edition. As of 2002, the Spanish HBSC team is led by Carmen Moreno, Professor in the Department of Developmental and Educational Psychology at the University of Seville, and since 2020 is co-directed by Francisco Rivera, Associate Professor in the Department of Experimental Psychology at the University of Seville. The project is funded by the Ministry of Health.

One of the features of this international network is the organization of the work areas in focus groups. One of the groups works on research on sexual behavior in adolescence; in the last five years, it has developed innovative lines of research on sexual-affective diversity within the network.

Countries such as Germany, Luxembourg or Belgium have looked into the experiences of students regarding their gender identity. However, the gender diversity work area in the focus group began to consolidate with the research carried out for this doctoral thesis. In the Spanish edition of the 2018 HBSC study, a two-step measure was incorporated for the first time to inquire into the sex and self-perceived gender of adolescents. Based on the pioneering experience of the Spanish team, other countries are considering the inclusion of a similar protocol in subsequent editions of the study. Thus, this commitment to research on sexual and gender minorities began with the publication of a pilot study on sexual health in 2016, and it continues at present with the setting up of a research group leading a pilot on exploring the most appropriate questions on gender identity and sexual orientation to include in survey methodologies.



Coming back to this project, the data presented in this dissertation came from the 2018 edition of the HBSC Spain study. The sample was selected using a random multistage stratified cluster sampling, which took into account the age of the participants, the type of habitat (urban or rural), and the type of school (public or private), in order to obtain a nationally representative sample of the Spanish population of adolescents between 11 and 18 years old. In this edition, 40,495 adolescents participated. For the current dissertation we used data from 17,678 young people aged between 15 and (those who answered both measures on sex and self-perceived gender identity). Of this group, 303 were identified as transgender adolescents. Resampling based on matching from the remaining 17,375 cisgender participant was used to facilitate sample equalization, taking into consideration the variables of age, country of birth, socioeconomic status, type of school, and type of habitat. The final sample comprised 303 transgender adolescents and 909 cisgender adolescents with a comparable profile. Thus, the final sample is 1,212 adolescents.

With respect to the formal aspects, this is a monograph-style thesis divided into five sections. The first section corresponds to the theoretical introduction of the research which, in turn, is divided into three chapters. The first chapter describes fundamental concepts for the understanding of sex, gender and gender identity, and introduces the minority stress model as the main theoretical framework for this research. The second chapter provides a definition of adolescence and describes how the development of gender identity occurs in childhood and adolescence, as well as the methodological options for asking about gender identity in the context of academic studies. Finally, the third chapter provides an exhaustive review of the concept of health in all its dimensions, specifically in the stage of adolescence. To this end, I examine how lifestyles, mental health and developmental contexts influence well-being during adolescence, especially for transgender adolescents. In this same chapter, as a practical example of the minority stress model, I explore how episodes of victimization in the school environment affect the health of transgender adolescents and how development contexts can mitigate their negative impact.

The second section explains the research aims and hypotheses, and the methodology employed. In this section, the history and methodology of the HBSC Study are described in depth, as well as the data collection process and the characteristics of the sample, the instruments used and the different statistical analyses for each of the studies that make up this research. To facilitate the understanding of the contents, a summary table explains the relationship between the measures used and the analyses carried out for each study.



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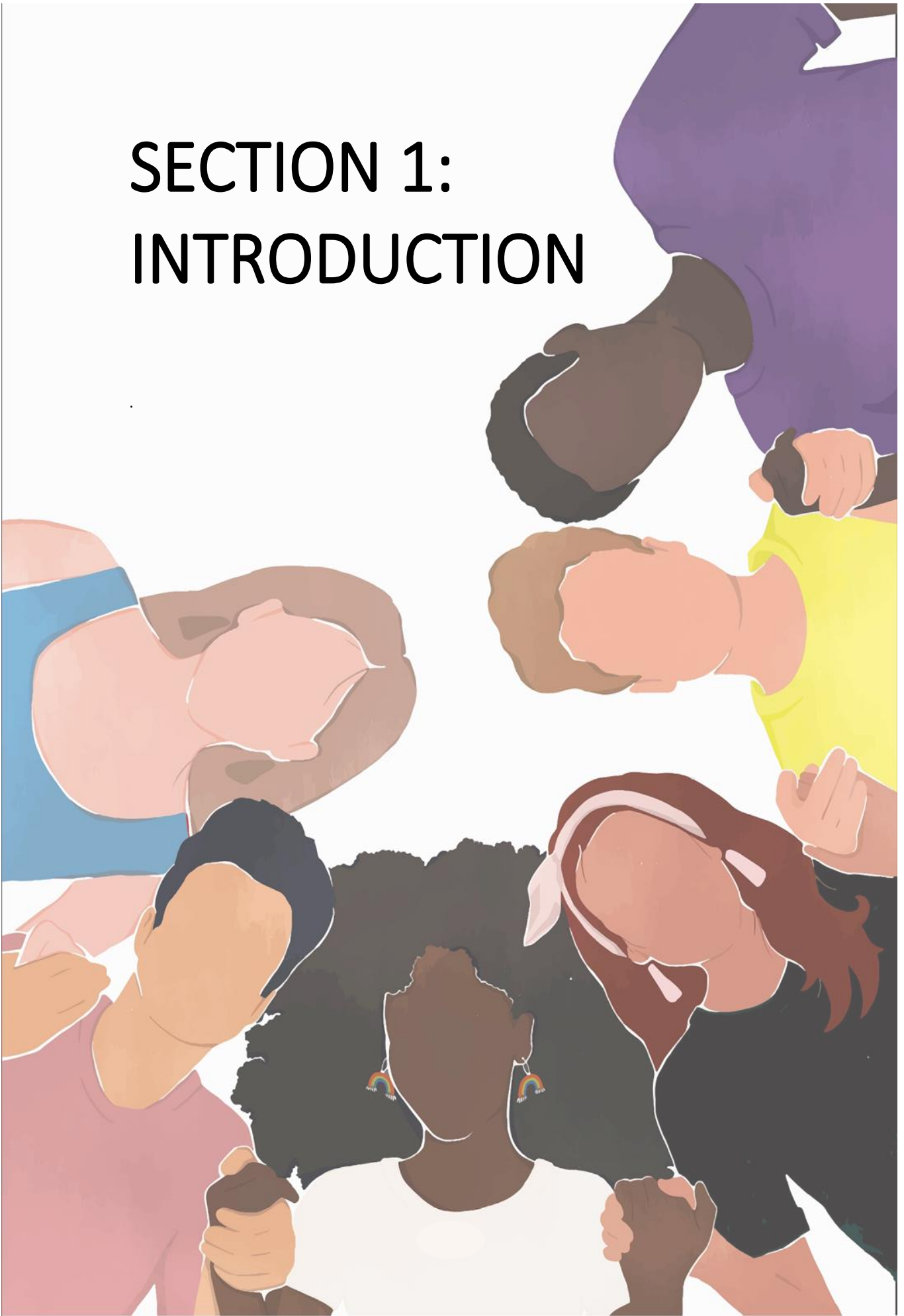
The third section compasses the results of the dissertation. In total, six studies have been carried out. Each chapter presents one of the studies and includes a brief summary of the content, a list of the data-based publications, a reminder of the methodology employed and, finally, the results. In the first study, the proportion of transgender and cisgender adolescents in the overall, nationally representative sample of the HBSC study is estimated from a two-step process to obtain information on gender identity in adolescence. The second study compares different lifestyles among cisgender and transgender adolescents, including diet, physical activity, sleep patterns, and oral health. The third study considers different measures of mental health and well-being, from life satisfaction to psychosomatic symptomatology, and examines its prevalence among transgender and cisgender adolescents. The fourth study analyzes the influence of development contexts on the health-related quality of life of cisgender and transgender adolescents. The fifth study shows the frequency and type of bullying and cyberbullying suffered by cisgender and transgender adolescents. The last study shows how gender identity moderates the mediation effect of the perceived support from developmental contexts between suffering bullying or cyberbullying and the health-related quality of life.

The fourth section provides a discussion of the results of this dissertation. This section summarizes the main conclusions for each study and for the overall thesis, pointing out the most relevant contributions of this work, its strengths, limitations, and future lines of research. The doctoral thesis concludes in the fifth section with the reference list and annexes.

Finally, in order to obtain the International Mention, the text is written entirely in English, one of the usual languages for scientific communication in the field of knowledge, in accordance with Article 15 of Royal Decree 99/2011, of 28 January, which regulates official doctoral studies.



SECTION 1: INTRODUCTION



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CHAPTER 1: STARTING POINTS

This introductory chapter serves to select and clarify key concepts that will be used throughout the document, reflect on the hegemony of the cis-hetero-normative, binary, and Western system to understand these concepts, and delve into the minority stress model as a fundamental theoretical framework for this research.

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1.1 Terminological and conceptual considerations: sex and

gender

Over the last two decades, Spain has been the setting of social advances regarding the recognition of the rights of lesbian, gay, bisexual, transgender, and questioning (LGBTQ+) people¹. This national law grants transgender people the right to change their sex registration and their name without genital surgery or forced sterilization. However, other mandatory conditions are required, such as certifying the diagnosis of gender dysphoria disorder and undergoing two years of medical treatment (Aparicio-García et al., 2018; Platero, 2020). In the last five years, we have witnessed a controversial public discussion on the development and passage of a new national transgender legislative proposal that would have allowed legal gender recognition based on self-determination without medical requirements (López, 2021).

Social movements of this kind show that transgender people in our country are gradually becoming visible and, above all, that opportunities are emerging to open up the conversation about their needs and realities (Castro-Peraza et al., 2019). Furthermore, different debates have been raised about the constructs, definitions, and meanings of terms such as sex, gender, and identity. In fact, defining these terms is a complex and delicate task that must be approached through disciplines such as anthropology, biology, philosophy, psychology, or sociology.

The aim of this thesis is to provide an overview of the health status of transgender adolescents in Spain; but before addressing this goal, it is important to outline its conceptual background. Therefore, we will discuss some key terms and present the minority stress model, which is the main theoretical framework of this thesis.

Defining the constructs of sex and gender is a delicate and controversial task because of the tangled relationship between the terms. The most simplified definition of sex would involve biological characteristics (molecules, chromosomes, hormones, or internal and external genitalia) and aspects relating to reproduction and sexuality, used for sexual differentiation and for sex assignment at birth (Hyde et al., 2019; Sánchez-López & Limiñana-Gras, 2017). Although gender theorists appear to concur on sexual characteristics, they have not been able to agree on a single or universal definition (Fausto-Sterling, 2019).

¹ According to the recommendations of the American Psychological Association (2020), the form “LGBT” is considered outdated. Due to the lack of consensus about which abbreviation to include, we propose talking about lesbian, gay, bisexual, transgender, and questioning (LGBTQ+) adolescents, unless the authors and scholars cited in the text use other specific labels (e.g., LGB only for referring to the specific sexual minority group).



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The term gender refers to the sociocultural systems and includes the attitudes, feelings, behaviours, norms, and expectations that a given culture associates with a person's biological sex. These characteristics vary from society to society and are constructed historically and culturally. Whereas sex is a biological difference, gender is used to define the social construction of what behaviour is considered normal for each of the sexes in relation to the feminine or masculine nature (American Psychological Association, 2020; Hyde et al., 2019; Sánchez-López & Limiñana-Gras, 2017).

Thus, to simplify, it is usually observed in the literature that sex is used for biology-based differences between males and females, whereas gender is used for differences between women and men that are produced socioculturally (Hyde et al., 2019)

Even when attempting to provide clear definitions for each term, controversy is inevitable. The concepts of sex and gender, although related, are not interchangeable; however, they are sometimes misunderstood and used interchangeably in contemporary scientific literature and in everyday usage (Sánchez-López & Limiñana-Gras, 2017; United Nations Economic Commission for Europe, 2019). Nevertheless, as we shall now see, there are some conceptual proposals for the combined use of the terms.

Several women philosophers and writers of the second half of the 20th century criticise, from different points of view, the imposition of oppressive systems based on sex and gender as political categories and advocate the need to break with them. To name but a few, Gayle Rubin (1975) was the first to define the "sex/gender system" as a set of arrangements by which a society transforms biological sexuality into products of human activity and claimed that gender is a socially imposed division of the sexes. Donna Haraway (1985) proposed a break with classical definitions of sex through the introduction of the idea of "cyborg". Monique Wittig (1992) pointed out that sex and heterosexuality are not natural categories but political categories that are socially instituted and socially regulated. Judith Butler (1999) is one of the authors who are most critical of the imposition of naturalized categories by society to justify oppression, arguing that social discourse constructs create sex in the same way that they create gender.

One of the major problems in the usage of these concepts is the assumption that sex and gender are binary and exclusive experiences, especially given that both sexual (e.g., hormone levels) and cultural (e.g., gender expression through clothing) elements are actually a continuum rather than exclusive dichotomous categories (Joel, 2021). It is not surprising, then, that other authors have proposed terms to better understand the relationship we establish as a society between sex and gender. Sari van Anders combined gender and sex into a unifying



concept called Gender/Sex to define “whole people/identities and/or aspects of women, men, and people that relate to identity and/or cannot really be sourced specifically to sex or gender” (van Anders, 2015, p. 1181). Anne Fausto-Sterling (2019) also discusses the circularity of defining sex and gender, as the biological and sociocultural domains are inseparable for they affect each other. In essence, there is growing evidence of the variability that affects the components of sex and gender, and the reality is much more intricate than a consideration of sex and gender as binary categories (Hyde et al., 2019).

1.2 Terminological and conceptual considerations: gender identity

Defining gender encompasses many features such as gender roles, gender expressions, or gender identity. Gender identity refers to someone’s sense of being female, male, or another gender different from the traditional binary classification. Gender identity can be congruent (cisgender) or incongruent with one’s biological sex assigned at birth (transgender) (American Psychological Association, 2015a; Hancock & Greenspan, 2010).

Transgender is used as an adjective to refer to persons whose gender identity does not conform to what is culturally associated with their sex assigned at birth (American Psychological Association, 2020). This is an umbrella term for the experiences of a community, but other labels also exist. If we review the background of these labels (Platero, 2017), the word ‘transgender’ emerged in the 1980’s as a safe space for people who differed from the social norms about gender and sexuality, with the intention of including as many gender and sexual dissidents as possible. However, this term has been criticized because it can be used maliciously to distinguish between people who undergo hormonal or surgical treatment for transitioning and those who do not.

‘Trans’ without an asterisk is a term that emerged in the 1990s from social movements wishing to distance themselves from the pathologisation implicit in the word transsexuality, although it may not be sufficiently sensitive and inclusive towards people who experience non-binary expressions, identities and embodiments (Platero, 2017). Nowadays one of the most popular terms is ‘trans*’, as the community considers it to be the most inclusive way of encompassing all realities. This label renders the great heterogeneity of experiences and activism visible, showing that the people who use ‘trans*’ may not always pursue the same



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goals. The term trans with an asterisk is also not without criticism, as reading it and pronouncing it can be difficult, and it has even been used to insult other people (Platero, 2017).

The umbrella term of transgender identity includes binary experiences (the person identifies with the gender which is opposite to the sex that was assigned or registered at birth) and non-binary experiences (moving between the two genders, feeling partially identified with one of the genders, rejecting the binary system, etc.). These individuals may refer to themselves as third gender, gender non-conforming, genderqueer, gender fluid, gender creative, independent, or gender non-binary (M. J. Barker, 2016; Tate et al., 2013; Vance et al., 2014). Throughout the text, the term 'binary transgender' will be used to describe individuals who self-label differently than their birth-assigned category, and 'non-binary transgender' to refer to individuals who self-identify in ways outside the two categories of female/girl and male/boy.

This doctoral dissertation privileges the term 'transgender', and uses the word to refer to the widest range of gender-variant practices and identities, as other authors have also done (Stryker, 2020).

1.3 The binary system in Western societies

Many languages reflect the binary system through which we understand society, reality, embodiment, and performativity. The binary discourse artificially divides acceptable expression of gender into masculine or feminine: it is one or the other, there are no other options (Diamond, 2020; Fausto-Sterling, 2019; Rider et al., 2018; Wiseman & Davidson, 2012). As a result, people feel the pressure (through family, peers, culture, etc.) to adjust to roles, expressions, and expectations according to the sex assigned at birth.

A binary discourse of reality limits the experience of fluidity, especially for the young people who do not conform with the strict gender patrons or who consider their gender to be different from the sex assigned at birth. Again, this polarization forces people to conform rigidly to extreme masculine or feminine roles according to the binary standard about what it means being a man or a woman, without considering alternative forms of gender expression.

In the past, words such as "queer" could be self-deprecating or pejorative; therefore, using them to label "baby boomers" could be impolite, disrespectful, or inadequate in surveys aimed at older people (S. J. Ellis et al., 2019, Chapter 11; Reisner, Biello, et al., 2014). At present,



terms such as “non-binary”, “agender”, “gender neutral”, “neutrois”, “gender fluid”, or “pangender” are becoming popular for younger generations such as Gen Y and Gen Z (Glick et al., 2018; Porta et al., 2020; Twist & de Graaf, 2019). Access to the Internet and to social media allows young people to realize the possibilities existing outside the strict categories woman/man or to consider them as a spectrum in which identity flows. So, receiving information about other experiences and realities has led today’s young people to adopt non-binary, rather than binary, gender identities to a much larger extent than older generations (Diamond, 2020).

Even if these concepts are socially accepted in Western societies, they cannot be used in all contexts. Genderqueer or transgender are umbrella terms to describe gender identity or gender expression that do not conform to the assigned birth sex or to the dominant societal norms. Nevertheless, many cultures understand gender in terms differing from the gender binary without sharing the nuances that these Western constructs could imply (M.-J. Barker & Iantaffi, 2019; Gómez, 2010; Gutiérrez, 2017). Such is the case of the Native American *Two-Spirit* People, the *Muxes* from Mexico, *fa’Aafine* from Samoa, *Hijra* people from India, or the *Kathoei* from Thailand. All these realities show social models that are disruptive according to the Western paradigm, transcend the binary gender system, and contemplate the plurality of sexes and genders (Gómez, 2010; Gutiérrez, 2017; Raymond, 2016).

The development of gender identity in the post-industrial Western world occurred within a system based on “cis-hetero-normativity” and cisgenderism. The former refers to the belief that heterosexuality and cisgender identity are superior to other sexual orientations or gender identities. The central feature of the latter is that sex and gender are treated as binary experiences; male sex corresponds to identifying as a boy/man and female sex is equated to having the identity of a girl/woman. Anything that goes against this convention is banned and censored (Worthen, 2016). However, both reality and research show that gender is more complex and challenge the automatic assumption regarding the gender binary (Diamond, 2020). Experiences that can be considered as “non-binary” in Western societies are common in other cultures (B. Vincent & Manzano, 2017). As of the past decade, non-binary identities and non-binary gender expressions seem to be more common and visible among young people in the Western world too (Nolan et al., 2019; Whyte et al., 2018).

The imposition of a binary view of sex and gender and the assumption that there is only one correct gender or sexual orientation lead to the discrimination of people who transgress these social standards (Puckett et al., 2021). Heteronormativity refers to the assumption that heterosexuality is the only sexual orientation possible (Geist et al., 2017; Toomey et al., 2012).



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Cisnormativity refers to the assumption that both sex and gender are only binary and aligned. This leads to cisgenderism, that is, the presupposition that everyone's gender identity is cisgender and that there are only two genders, which are associated with specific physical and psychological features (Ansara & Hegarty, 2012). Ultimately, these ideas take the form of misgenderism or microaggressions against dissident gender identity or gender expression. (Ansara & Hegarty, 2014; Lindqvist et al., 2021). Hetero-cis-normativity comprises system of practices and structures which prioritize the privileges of heterosexual cisgender individuals (Worthen, 2016).

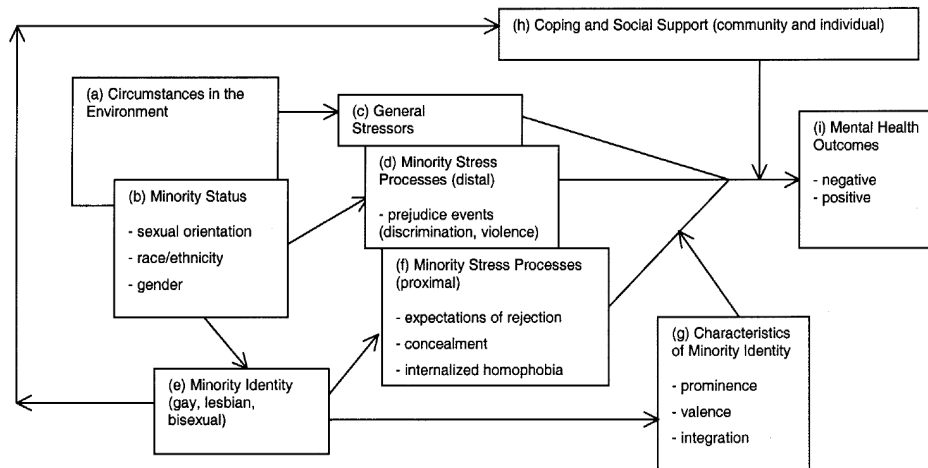
1.4 The Minority Stress Model

As we will see and comment in Chapter 3, significant health inequalities could be found among cisgender and transgender adolescents. One of the most popular theoretical models used to analyse this phenomenon is Ian Meyer's minority stress model (I. Meyer, 2003). This model was originally developed for gay, lesbian and bisexual adults, and explained that higher prevalence of mental disorders and the discrimination experienced by sexual-minority adult populations because of social stressors related to stigma and prejudice (Figure 1). Society's oppressive structures presuppose people's heteronormativity and attack those who do not conform to it (Mijas et al., 2021).

Meyer (2003) highlighted two main types of stressors that explained the health problems of sexual minority groups: (a) distal minority stressors (e.g., victimization and harassment experienced in society because of the sexual minority condition), and (b) proximal minority stress (e.g., expectations of distal minority stress that lead to anticipating rejection and discrimination). Three processes of minority stress are involved: (a) external, objective stressful events and conditions, (b) expectations of such events, and (c) the internalization of negative societal attitudes (I. Meyer, 2003).

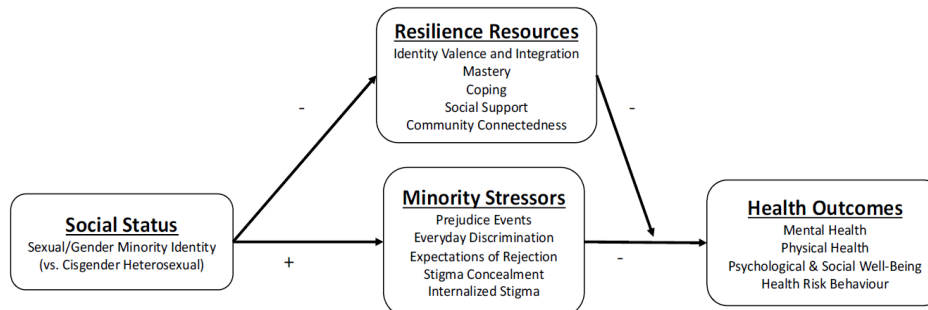


Figure 1. Original minority stress model. Reproduced from Meyer (I. Meyer, 2003)



In addition to identifying social conditions and structures that cause stress, discrimination, harassment and violence against LGB people, the minority stress model also identifies individual factors (e.g., identity & related characteristics) and group-level resources (e.g., social support) that buffer the effects of such stressors (Hoy-Ellis, 2021). This model then recognizes the importance of both stressors and resources for health (Figure 2). Like all stress theories, it also includes mediating and buffering effects on the health outcome (I. Meyer, 2020).

Figure 2. Minority stress mediates the relationship between minority condition and health. Reproduced from Meyer (2020)



For ten years, Meyer's model was used as a theoretical framework to explain disparities in the health of sexual and gender minority groups, although the theory was formulated for sexual minorities. This changed when Michael Hendricks and Rylan Testa (2012) adapted Meyer's model and developed their own conceptual framework for working with transgender adults (Figure 3). According to the gender minority stress model (Hendricks & Testa, 2012), a hostile and stressful social environment set against their minority condition leads transgender and gender-diverse people to develop higher prevalence of mental health issues or risky

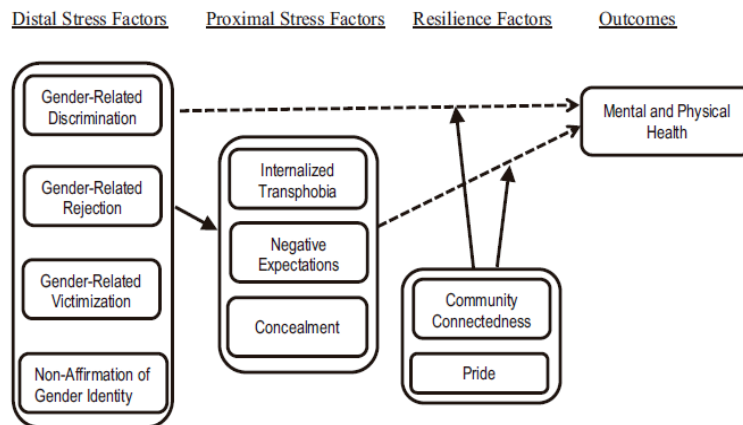


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behaviours. The model describes multiple instances along a continuum of experiences in which gender minority groups might experience minority stress: from distal or external stressors, which are typically defined as objective events and conditions, to proximal or internal processes, which rely on individual perceptions and appraisal (Testa et al., 2015; Toomey, 2021). This adaptation was necessary in order to include stressors and processes that specifically and uniquely affect transgender people (Puckett et al., 2021). Following this first study, the model was also extended to look further into which variables build resilience.

Regarding the application of the minority stress model in this thesis, a word of caution is in order. The studies that encompassed this dissertation included measures that assessed distal stressors (e.g., bullying), distal resilience factors (e.g., social support), and measures of physical and mental health (e.g., health-related quality of life). Proximal factors will also be mentioned throughout this introduction, even if they have not been directly studied, due to the research design and methodology of this doctoral dissertation.

Figure 3. Minority stress model adapted by Testa et al 2015, based on the original minority stress Model by Meyer (2003). Dashed line indicates inverse relationships



1.5 Summary

The objective of this first part of the introduction was to define key theoretical concepts for understanding gender identity and how the pressure for normativity, which censors any identity that does not conform to the cisgender and binary standard, is one of the most relevant theoretical models for analysing the health disparities experienced by transgender people.



CHAPTER 2: IDENTITY DEVELOPMENT AND ASSESSMENT THROUGH ADOLESCENCE

This chapter will review adolescence as a developmental stage, the development of identity from classical models and, specifically, the development of gender identity in childhood and adolescence. Finally, we will present some strategies for asking about gender identity and discuss some of the most common methodological shortcomings when investigating transgender adolescents in academic studies.

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2.1 Classic models of identity development

Adolescence is a developmental stage between childhood and adulthood, spanning from the age of 10-13 years old until approximately the end of the second decade of life. However, in recent years, sociodemographic changes have led to an extension of adolescence (Goossens, 2006) and the definition of a new developmental stage, that of emerging adulthood (Arnett, 2000).

Beyond its delimitation, adolescence is associated with a range of biological, cognitive, emotional, and social changes that are crucial for an individual's development. In the research field, adolescence has been studied as a time of conflict and particular vulnerability. However, this negative view of adolescence has been replaced by a global conception: although adolescence may be a period of risks (Andersen, 2003; Nightingale & Fischhoff, 2002), it is also a period of opportunities (Steinberg, 2014). Multiple studies have explored how the changes and tasks that boys and girls face during this time impact on certain key components of adult development. Among them, the development of identity has a privileged position.

The search for identity is one of the main challenges facing adolescents. According to Erik Erikson (1950, 1968), adolescence is the fifth stage of development. During this stage, adolescents have to answer certain questions, such as who they are or what they want to accomplish in their lives. During this period of search (or psychosocial moratorium), the adolescent experiments with different roles or personalities. The achievement of this stage through experimentation will lead to an achievement of identity. If this task is not accomplished, the individual will have, according to Erikson's theory, a diffuse identity, associated with a withdrawal from society or the family and a loss of identity.

James Marcia (Marcia, 1980, 1994) added to Erikson's theory of identity development and suggested that this phase of identity search is composed of four statuses. Specifically, these statuses are identity diffusion, identity foreclosure, moratorium identity, and identity closure. Marcia classified adolescents as pertaining to one status or another according to the existence of crisis (the adolescent explores alternatives on a particular issue) and achievement (when the person identifies with an identity). The combination of crises and achievements will result in one status or the other.

In contrast to these theories, other more recent authors have suggested that Erikson and Marcia's approaches only allow for a superficial analysis of adolescent identity development. Thus, identity development has recently been studied through a narrative



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approach, in which individuals are asked to tell their life stories and assess the extent to which their stories are meaningful and integrated (Adler et al., 2017; Maher et al., 2017).

The development of gender identity, as one of many areas of adolescent development, actually begins in early childhood. Another classic author in the analysis of identity development is Lawrence Kohlberg (1966), who studied the cognitive components of gender identity and concluded that gender learning starts early, is a gradual process spanning many years, and passes through various stages (Steensma, Kreukels, et al., 2013).

2.2 The development of gender identity through childhood and adolescence

Beyond the cultural or structural analysis of gender, the development of gender identity is an individual experience. In this sense, developmental psychology has studied identity as a complex process which occurs in parallel with physical, cognitive, and social development (e.g., Steensma et al., 2013). Most children become aware of the first signs of gender identity between 18 and 24 months of age, manifested in behaviour such as playing with gender-typed toys. Taking into account the classical models of developmental psychology, the stability of the gender constancy will vary from childhood to adolescence (Martin et al., 2002).

The development of gender identity is a complex process that begins in early childhood and evolves iteratively in social dynamics. It can be influenced by one-on-one interactions with other individuals, cultural effects, biological factors (e.g., hormone levels) and cognitive abilities (e.g., gender knowledge) (Fausto-Sterling, 2019; Hyde et al., 2019; Olson et al., 2015). Research on gender stereotyping has shown that a categorical distinction such as gender is recognized as important by the child at age two. Stereotypes and beliefs regarding gender become rigidly applied by children aged 5–7, and then become more flexible by pre-adolescent age (Martin & Ruble, 2010; Perry et al., 2019; Ruble et al., 2007).

Socialization and cognitive and biological processes play a significant role in gender development (Galambos et al., 2009; Martin & Ruble, 2010). Biological approaches focus on evolutionary aspects as well as genes, and hormones are present from prenatal life and influence physical, sexual and psychological changes during puberty and adolescence. Cognitive theories underline the ways in which gender-related thinking emerges and develops in childhood and



adolescence. This process determines how information in the environment is assimilated and motivates gender-related behaviours and preferences. Socialization theories focus primarily on social learning processes such as the observation and reinforcement of gender roles, behaviours, and attitudes. Boys and girls are treated in different ways during everyday social exchanges from the moment that their sex is known to their parents and to others, and this also shapes the development of their gender identity (Galambos et al., 2009; Gould & Chwast, 1978; Kane, 2006). Theories such as the gender intensification hypothesis (Hill & Lynch, 1983) integrate all these dimensions to explain how adolescents acquire the knowledge of gender categories. According to this theory, puberty changes mark the onset of sexual maturity, which triggers reactions from socialization agents and also modifies the self-perception of adolescents regarding gender behaviours, stereotypes or attitudes.

These explanatory models of the development of the notion of gender and of one's own gender identity according to stages are still applicable (Bussey, 2011). In contrast to the recognition of these classical models, dynamic models focusing on the processes and structures that affect the development of transgender identity are less known (Diamond et al., 2011). Perhaps the most comprehensive approach to theorizing transgender identity development has been one which analyses identity as a fluid process that is continually constructed and reconstructed over time and shaped by social dynamics, rather than a fixed set of stages that every child must go through (Pullen Sansfaçon et al., 2020).

In this sense, dynamic systems models have tried to explain how complex patterns emerge, are kept up, change, and stabilize again over time (Diamond et al., 2011). For example, according to Anne Fausto-Sterling (Fausto-Sterling, 2020, 2021), gender identity development might be placed in a dynamic embodied system framework. In this formulation, identity is a dynamic process that emerges over time from daily experiences, and new behaviours are constantly linked in time to older phenomena so as to understand the origins of a behaviour of interest (Fausto-Sterling, 2021). Therefore, dynamic systems models posit that transformative and bidirectional interactions among endogenous factors (e.g., genes, hormones, thoughts, or feelings) and exogenous factors (e.g., relationships, experiences, or social norms) prevail, rather than dynamic person–environment interactions (Diamond et al., 2011).

These models do not simply define the development of the identity as a process of self-discovering, recognizing and revealing identity. The advantage of these models is their ability to understand gender identity development as a self-reflexive and constantly transforming process (Diamond et al., 2011). In this transformative and continuous process, identity development can



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be expected to be a flexible, potentially recursive and non-linear process—applicable to both binary and non-binary young people—in which gender, influenced by individual and social factors, can be explored and expressed in new ways (Pullen Sansfaçon et al., 2020). Hence, models relating to dynamic theories advocate the recognition of the autonomous and active role of each person in the process of identity development, integrating information on the meaning of one’s self in the different contexts in which the person participates (Diamond et al., 2011)

Adolescence is an important period for the exploration of gender identity (Steensma, Kreukels, et al., 2013). Adolescents start using different types of labels to define their gender identity or their sexual orientation (Diamond, 2020; Porta et al., 2020). Gender development and the consolidation of gender identity stand out in early adolescence because of physical puberty, changing gendered behavioural expectations, and shifts in peer groups from predominantly sex-segregated to more integrated (Potter et al., 2021). The physical changes which start at puberty lead to a more in-depth understanding (or confusion) of gender throughout adolescence. At the final stage of pubertal development, sex and gender become more distinct entities and self-gender identity solidifies (Weiselberg et al., 2019)

It has been suggested that the challenges of early adolescence (e.g., physical maturation and pubertal timing, the influence of relevant social figures such as parents or peers, the first romantic relationships) pressure young people to adhere to gender conformity (Perry & Pauletti, 2011). However, trajectories of gender flexibility in adolescence are not totally clear: cognitive theories suggest an increased flexibility, and gender intensification theories predict a decrease in flexibility, at least for some time, around puberty (Galambos et al., 2009).

Adolescence is one of the most active parts in a person’s lifetime, including the exploration of roles and values matching one’s personality and identity across many areas of life. Therefore, the application of the binary perspective of sex and gender could lead to hear opinions about the inconsistency of the transgender status during adolescence. Children and adolescents are cognitively prepared to understand that gender identity is not necessarily aligned with the sex assigned at birth, as well as possible differences with the gender behaviour and roles that society expects from them (Gülgöz et al., 2019; Olson et al., 2015; Potter et al., 2021).

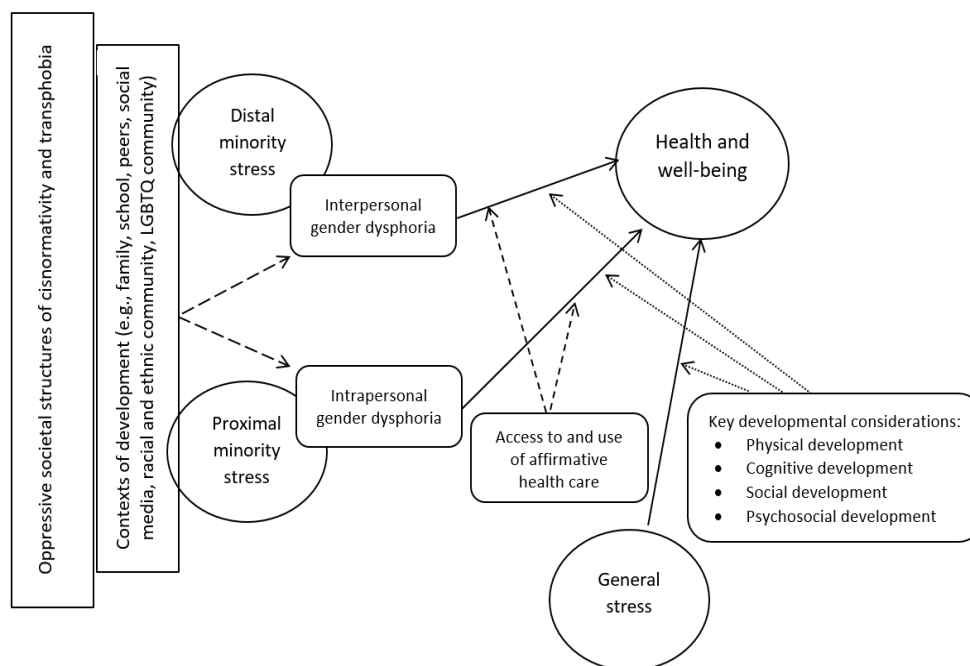


2.3 Minority stress and resilience in transgender adolescents

Adolescents face and cope with general life stressors that may expose them to discrimination or rejection. However, adolescents who belong to minority groups, such as gender minority groups, are subjected to alarmingly high rates of violence and stigma related to their sexual orientation and gender identity.

The use of the minority stress models proposed by Meyer (2003) and Henry and Testa (2012) has provided insight into how different distal and proximal stressors impact on their health and increase inequalities with respect to cisgender adolescents. However, these models were conceived to explain health and inequalities in groups of adults belonging to sexual and gender minorities. Thus, contributions such as the revisions made by Russell Toomey (2021) are of great value, as the model explains the existence of disparities posited by all prior minority stress models because of cisnormativity and transphobia, as well as highlights developmental nuances that may alter the use of minority stress models in understanding health inequalities (Figure 4).

Figure 4. Adapted model of gender-minority stress among children and adolescents. Reproduced from Toomey (2021)



Theoretical models focused on adolescence highlight issues and characteristics that specifically affect transgender adolescents. The application of the minority stress model must consider that adolescents are in a developmental process with a series of cognitive, physical,



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and social changes that in some way will also be reflected in distal and proximal stressors, resources, and conditions (Toomey, 2021). For example, transgender adolescents face pubertal changes for the first time, which could lead to intrapersonal and interpersonal gender dysphoria, and they are highly dependent on social support and family consent to access to affirmative health care until they reach the legal age to make decisions (Toomey, 2021).

2.4 Prevalence of transgender adolescents

Concerns about the ability to understand the meaning of concepts such as “gender identity”, “transsexualism”, or “transgender” are common. Nonetheless, cognitive testing is a valuable technique to assess measurement performance. Researches who relied on this methodology to study the understanding of the meaning of concepts related to gender identity find that adolescents and young adults, regardless of whether they belong to the LGBTQ+ community or not, can differentiate between the meaning of sex and gender (Conron et al., 2008; Glick et al., 2018; Michaels et al., 2017; Reisner, Conron, et al., 2014).

Likewise, concerns have been expressed on whether transgender children and adolescents are capable of understanding the meaning of gender identity and of their own experiences. Such is the example of the “desistance” experiences of adolescents who identify with the gender they were designated at birth, even if they were previously considered as transgender or gender non-conforming (Hildebrand-Chupp, 2020). Again, all these changes occur in a social context that has a fundamentally binary perspective on sex and gender, which is reflected in the theories applied to understand and explain the phenomena, and is characterized by a range of social and linguistic practices (Clemans et al., 2010; Diamond, 2020; Hyde et al., 2019; Worthen, 2016).

Estimate the proportion of transgender youth in general adolescent population varies depending on criteria such as the dimension evaluated and where the studies were held. Most of the research that has provided information on estimating the proportion of transgender adolescents in population survey studies comprising from approximatley 3000 to 300,000 individuals, and it has been estimated that between 0.17 and 6.4% of adolescents and young adults identify as transgender (Kaltiala-Heino & Lindberg, 2019).

In the Youth Risk Behavior Survey, Shield et al. (2013), found that 1.3% of the adolescents from San Francisco were transgender. Clark et al. (2014) found in the Youth’12 from



New Zealand—the first survey of a nationally representative sample of high school students that included information about gender identity—that 1.2% of the adolescents reported being transgender, 2.5% reported being not sure about their gender, and 1.7% did not understand the question. In the Growing Up Today Survey, a prospective cohort study of the United States, Reisner et al. (2014) found that 0.3% of the cohort 2010 participants were gender minority. Eisenberg et al. (2017) reported in the Minnesota Student Survey that 2.7% of the responders identified as transgender and nonconforming. The Williams Institute used data from state-level, population-based surveys in the United States and reported that 0.7% of youth ages 13 to 17 identified as transgender (Herman et al., 2017). Another of the first representative population-based studies that included a measurement of gender identity in the United States—the California Healthy Kids Survey—pointed out that 1.33% of youth identified as transgender. Kaltiala-Heino and Lindberg (2019) saw in the Finland’s 2017 School Health Promotion Survey that 0.7% of the adolescents expressed that their perceived gender opposite was opposite to their reported sex, 4.2% mentioned other or non-binary gender identity, and 1.5% had not responded to the question on perceived gender.

More and more surveys are including questions that ask about gender identity in adolescence. However, neither the dimensions of gender identity assessed nor the design of the gender identity measure are always consistent across studies. Below we will review some recommendations and suggestions on how to include measures of gender identity and other methodological concerns.

2.5 Measuring gender identity on adolescence: what are the options?

If we want to understand how lived gender identity develops in adolescence, either in line with sex assigned at birth or not, we must reflect on how data on sex and gender are collected. As mentioned above, one of the first issues that researchers must keep in mind is the dimension they want to evaluate, for this may affect the estimates of the evaluated groups (G. R. Bauer et al., 2017; Geary et al., 2018). It is not the same to ask if adolescents consider themselves transgender, which reflects their perceived gender identity, as it is to ask if they have been diagnosed with “gender dysphoria” or what gender pronouns they prefer (Collin et al., 2016).



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Asking about gender identity is not a trivial issue, especially in studies involving adolescents. The chosen measures must be reliable, feasible, and meet standards of research ethics. Potential pitfalls and constraints, linked to the study design or the sociodemographic characteristics of the participants should also be considered. The final decision on the question format depends on the characteristics of the study, such as the methodology used (quantitative or qualitative), available resources and time, the size and composition of the sample, and the dimensions that will be explored (roles, identity, etc.).

Gender identity consists of three dimensions which can be congruent or incongruent with the assigned sex: *gender expression* (presentation of gendered behaviours, such as pronouns, social processes, or dressing); *gender identity* (how persons have defined their gender); and *self-identified transgender status* (whether the sex assigned or registered at birth corresponds to one's gender identity or not) (T. Jones, 2019). Although all these dimensions are related, it is important to recognize that they might not overlap entirely. A methodologically sound empirical study should consider and assess all three dimensions (and the extent of their overlapping) in order to determine the participants' gender.

In this sense, one of the most important ideas that researchers must keep in mind is the dimension of gender identity that will be asked, as well as the format of the question which can be used. There is no consensus on the best way to assess gender identity dimension (how persons have defined their gender). As this doctoral thesis focuses on this dimensions, we present different proposals that will be briefly summarized below.

2.5.1 Single open-ended item

Using an open-ended question (e.g., "I identify my gender as: _____") allows participants to self-identify freely and write whatever they want without restrictions (Cameron & Stinson, 2019). Researchers can classify the answers according to current terminology referring to gender identity (avoiding old-fashioned or scientifically incorrect tags). Nevertheless, these types of questions are not generally recommended for they are difficult to code. Moreover, open-ended measures may invite inappropriate responses (G. R. Bauer et al., 2017; Fraser, 2018).



2.5.2 Categorical lists

Questions using a categorical list in the response options may minimize rates of missing data as a tick box measure is quick and easy for participants to complete. Also, adding an open-ended option (“Other: _____”) is recommended, which allows participants to choose labels which best describe their identity (Fraser, 2018). For example: “What is your gender identity? Select all that apply” with options “Male”, “Female”, “Trans male/trans man”, “Trans female/trans woman”, “Nonbinary”, and “Not listed (please state)” (Fraser, 2018). If the question is used in an online survey, it can be presented in a “forced choice” format, which reduces the ratio of missing responses (Lavrakas, 2008). Another format in which categorical lists can be presented is the “mark-all-that-apply” approach (e.g., people assigned female at birth could mark “woman” and “a trans girl or woman” at the same time) (Pinto et al., 2019). This approach respects the many ways in which individuals may identify themselves (Brenner & Bulgar-Medina, 2018). However, forced choices may be oppressive (Lavrakas, 2008), while the mark-all-that-apply option can be confusing for participants. This highlights the difficulty of finding a single solution that is appropriate for young people in different developmental stages and respects the various ways in which they might describe their gender experience.

A further difficulty is that even a single item with many response options may not be sensitive enough to reflect all identities (G. R. Bauer et al., 2017; Fraser, 2018). Researchers must select the options carefully and respectfully, but, even then, the options may not reflect the gender experience of all participants. Therefore, this format is only recommended if the researchers do not want to delve deeper into the different dimensions of gender identity and the correspondence (or lack thereof) between the sex assigned at birth and gender identity. Finally, there are limitations: the “forced choice” format might not be exhaustive; if there are many options, participants might not read the entire list and select the first option that appeals to them; and if a mark-all-that-apply approach is used, it will pose difficulties in the analysis (Brenner & Bulgar-Medina, 2018).

2.5.3 Single item of transgender status

Participants may be directly asked if they are transgender or not, which would correspond to the dimension of *self-identified transgender status*. An instruction on what transgender is, including locally used terms, may also be added to the question. For example: “Do you think you are transgender? This is a girl who feels like she should have been a boy, or a boy who feels like he should have been a girl (e.g., Trans, Fa’faffine, Whakawahine, Tangata ira Tane,



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Genderqueer)?” with the options “Yes, “No”, “Not sure” and “Do not understand the question” (T. C. Clark et al., 2014). Another example might be: “When a person’s sex and gender do not match, they might think of themselves as transgender. Sex is what a person is born. Gender is how a person feels. Which one response best describes you?” with the response options “I am not transgender,” “I am transgender and identify as a boy or man,” “I am transgender and identify as a girl or woman” and “I am transgender and identify in some other way” (Veale, Watson, et al., 2017). In both examples the statement included a detailed definition about what means being transgender. However, also in these examples it seems that gender was defined within the binary system, so it would be important to talk about non-binary realities as well.

This kind of single-item measure discriminates well between transgender and cisgender people, especially for projects which are mainly focused on identifying transgender participants. However, there is insufficient evidence on the reliability of such measures (Fraser, 2018). If the meaning of “transgender” is not explained clearly and in a developmentally appropriate fashion, it could be confusing for the participants. Such a question should not confound (trans)gender identity and sex, and it should include local cultural identities (T. Jones, 2019), which can limit cross-cultural comparability.

2.5.4 Scales

An example of a continuum approach is the Gender Identity Scale (Ho & Mussap, 2019). It measures gender identity by asking “To what extent do you identify with the following genders?” and the three dimensions (female/woman/girl, male/man/boy, and other gender) are scored from 0 (not at all) to 100 (very strongly).

Likert or point scales allow respondents to indicate their agreement without decreasing test–retest reliability. Researchers can present the diversity of gender identities of participants without needing to summarize lists of self-designated labels (Ho & Mussap, 2019). Furthermore, this approach allows respondents to provide their gender identity beyond the binary male/female spectrum.

The format of the scales may cause misinterpretation by making respondents assume that the gender dimensions are exclusive to each other: they may think that if they agree very much with one dimension, they have to score the minimal value on the other scale. The “other gender(s)” scale may introduce potential confounds. Further research would be needed to test the reliability and feasibility of the scale approach.



2.5.5 Multidimensional measures

One of the complex measures is the Multi-gender Identity Questionnaire (Jacobson & Joel, 2019). It includes 24 questions that are either gender neutral or presented twice, once as if meant for a female participant and once as if meant for a male participant. The questionnaire measures different aspects of gender identity; such as being satisfied with the affirmed gender or perceiving the gender as performative. The degree to which a participant's response pattern deviates from the response pattern expected of a participant with a "binary" gender identity is also evaluated. Another example is the Multidimensional Sex/Gender Measure (G. R. Bauer et al., 2017). It includes two simple items which are completed by all participants (sex assigned at birth and current gender identity). A third item (lived gender) is asked only to those who indicated that their current gender identity differs from their sex assigned at birth.

The multi-item measures are popular due to their ability to capture different gender identity dimensions (current gender identity, self-identity, gender expression, pronouns, etc.). The literature suggests a multi-item measure is best practice for educational studies where gender diversity is a central topic (T. Jones, 2019).

Researchers who pursue this option need to define the terms they use, as some participants may be unfamiliar with some of them (Cameron & Stinson, 2019). Also, researches may find that dimensions may not align due to non-binary or fluid identity, developmental changes, stigma, socio-cultural values, legal, or economic issues (T. Jones, 2019). In addition, more space is required on the questionnaire to include all the items. Analysis of such complex items also poses difficulties.

2.5.6 Two-step approach

The two-step approach uses two separate items, one to measure sex assigned at birth and a second item to assess gender identity. Thus, cisgender and transgender participants can be identified by the match or mismatch between their responses across the two items. Currently, this is the most employed (Hart et al., 2019; Reisner, Conron, et al., 2014; Rider et al., 2018) and recommended measure to examine gender identity (Fraser, 2018; T. Jones, 2019; Stats NZ, 2020a; The GenIUSS Group, 2014). Also, different studies show that LGBTQ+ organizations, as well as study participants who are either cisgender/heterosexual or identify as LGBTQ+, agree that is one of the best method to measure the gender identity (Broussard et al., 2018; Puckett et al., 2020; Stats NZ, 2020b).



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Although many transgender people may not self-identify as such, respondents can be classified as transgender using this approach if their registered sex differs from their gender identity. It has high sensitivity when compared to single-item measures, and including non-binary / genderqueer options increases the accuracy of classifying participants' gender identity (Tordoff et al., 2019). Therefore, it is the most appropriate measure of gender identity in population-based studies. It has been used in research in different settings, as clinic treatment (Tordoff et al., 2019), health services (Grasso, Goldhammer, et al., 2019; Pega et al., 2017), and studies with adolescents (Kaltiala-Heino & Lindberg, 2019).

In spite of the many advantages it presents, there are risks to incorrectly identify intersex people as transgender (Fraser, 2018). Likewise, asking about an individual's assigned sex at birth may be uncomfortable for some transgender participants, thus increasing the likelihood of missing responses (The GenIUSS Group, 2014).

2.5.7 More methodological concerns

Another relevant element in research is the type of sampling. Most studies based their conclusions on samples acquired through non-probabilistic strategies (such as the snowball method or convenience sampling) (Veale, Watson, et al., 2017; Wheldon et al., 2019). Many conclusions on the health of the transgender community were drawn from narrative studies (e.g., Eisenberg et al., 2018; Shelton et al., 2018) or specific groups, such as clinical samples or members of LGBTQ+ associations (Grasso, Goldhammer, et al., 2019; C. Ryan et al., 2010; Twist & de Graaf, 2019; Watson et al., 2019).

Qualitative research with transgender adolescents provides rich and specific indicators to understand their realities from their perspective (J. Taylor et al., 2019), but many studies that include transgender participants lack statistical power, particularly when they attempt to compare transgender and cisgender populations (Walch et al., 2020). In the case of samples obtained on social media (e.g., Facebook, Twitter, Instagram or Tik Tok), even though the latter are efficient spaces for recruiting hard-to-reach populations (such as transgender adolescents), the design of the posts and advertisements has an impact on the quality of the data (Stern et al., 2022). Generally speaking, the conclusions that are drawn are generalized; however, there might be contextual conditions that are not considered.

In addition, most studies on the health of transgender people, using random sampling, are conducted in Canada and the United States (Toomey, 2021; Zhang et al., 2020), and few



European large-population studies exist regarding the life of transgender communities (e.g., European Union Agency for Fundamental Rights, 2020b). Due to the specificity of legal and cultural contexts, it is not clear whether the conclusions of these studies can be generalized to other countries. This lack of population-based data jeopardizes the possibilities to determine the size of the transgender population, identify health disparities between transgender and cisgender people, and design effective policies to meet their needs.

2.6 Summary

Adolescence is a stage of life in which many changes occur, including changes and challenges that affect gender identity. In addition to the classical theories that explain the development of gender identity by stages, other dynamic models are emerging to delve into the identity of transgender people. There are different ways of asking questions to approach gender identity in adolescence. There is no “golden standard” for selecting the right items and their format, for every option has advantages and disadvantages. The measure must be tailored to the aims and characteristics of the given study.

Given the evidences, this doctoral dissertation will explore a variation of the two-step approach to evaluate self-perceived gender identity and will present the results of applying it to a nationally representative sample of Spanish adolescents. This will be described in more detail in the **Study 1** of the thesis.



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CHAPTER 3: TRANSGENDER ADOLESCENT HEALTH

This chapter will provide an extensive overview of the concept of health in its multiple facets (physical, mental, and social health). For each part of this chapter, present global data on adolescent health, and then comment on the existing literature on the health of transgender adolescents in these dimensions.

The first part presents an exhaustive definition of the concept of health, a definition that encompasses all the dimensions evaluated in this doctoral thesis. The second part describes healthy lifestyles for adolescents, data that will be covered in the **Study 2**. The mental health is further explored and the theoretical frameworks of pathologisation and positive health will be addressed in the third part, information that is included in the **Study 3**. Then, some of the most important developmental contexts for adolescents are shown and their implications for health, relevant to the **Study 4**, are discussed. Finally, applying the minority stress model and from an ecological perspective, we will exemplify through the experience of bullying and cyberbullying how violence and the role of social support affect the health of transgender adolescents, which will be shown in the **Study 5** and the **Study 6**.

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3.1 So, what is health?

The Sustainable Development Goals were adopted by the United Nations in 2015 as a universal call to action to end poverty, protect the planet, and improve the lives of all people (United Nations, 2021c). The third objective of the 17 Goals included on the Agenda is to ensure healthy lives and promote well-being for all at all ages (United Nations, 2021a). However, defining health and well-being is a challenge because of all the dimensions and indicators involved (Newby et al., 2021).

Among the most widespread and widely used definitions of health is the one proposed in the Constitution of the World Health Organization (WHO) as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organization, 1948). This definition has been ratified and continues to incorporate new elements that define in a more precise and sophisticated way the areas of life concerned.

This also leads to the need to distinguish between health and well-being. When speaking of well-being, theoretical models consider two approaches: objective and subjective well-being (Voukelatou et al., 2021). Objective approaches assess well-being in terms of people’s material living conditions and the quality of their lives, such as material resources (e.g., household income, nutrition, and housing) and social attributes (access to education and healthcare systems, civic engagement, social networks) (Voukelatou et al., 2021). Subjective constructs refer to one’s cognitive and affective evaluation of one’s own life and experiences (Cunsolo, 2017), which include eudaemonic well-being (e.g., finding meaning in life), or hedonic well-being (e.g., being satisfied with one’s own life) (Ross et al., 2020).

Many frameworks of well-being have been proposed and most mention categories such as mental well-being, physical health, and life skills (UNICEF Innocenti, 2020). For example, Walker and Avant (2019) suggest a theoretical model applied to the field of nursing, in which adolescent well-being is a complex, holistic, and multi-dimensional state relating to four key elements: the existence of positive and supportive human relations; competence to make decisions about one’s physical, social, spiritual, and psychological domains of life; autonomy to have the freedom to make choices; and optimism to maintain a positive perspective despite uncertainties.



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Another recent framework propose five interconnected domains for adolescent well-being (Ross et al., 2020):

1. Good health and optimum nutrition: access to opportunities for adequate physical activity; to an acceptable, diversified, balanced, and healthy diet; and to valid and relevant information and welcoming health services.
2. Connectedness, positive values, and contribution to society: access to opportunities to become part of positive social and cultural networks and to develop positive, meaningful relationships; to be involved in decision-making; to develop personal responsibility, a sense of ethics, and empathy; and to be socially, culturally, and civically active.
3. Safety and a supportive environment: protection from all forms of violence in social and virtual environments; the right to guarantee material conditions such as food, water, housing, heating, or clothing; the right to protect the privacy of personal information, views, interpretations, fears, and decisions; the implementation of positive social norms, including gender norms, to ensure equal rights and opportunities for all adolescents; and the freedom to practice personal, cultural, and spiritual beliefs and to express their identity in a non-discriminatory environment.
4. Learning, competence, education, skills, and employability: access to formal education or further training; support to develop the motivation for continual learning; opportunities to develop vocational, business, and creative skills; and opportunities to develop the resources, life skills, and competencies needed to thrive.
5. Agency, identity, and resilience: opportunities to develop the ability to handle adversities both now and in the future; opportunities to develop a sense of agency, to make meaningful choices and to influence their social, political, and material environment; and the right to have the safe space to grow into their own self, including their physical, cultural, social, sexual, and gender identity.

Therefore, adolescent well-being could be considered as amounting to thriving in a context of secure and healthy relationships (Ross et al., 2020). Thus, the analysis of health and well-being requires looking at different levels within a holistic and comprehensive analysis, ranging from societal levels (e.g., social and community environments) and the biological level (e.g., biological and physiological mechanisms involved in management of stress) to the psychological level (e.g., life events interact with individual characteristics) (Sigfusdottir et al., 2017).



Analysing and understanding the well-being of transgender adolescents can be done from various approaches. As already mentioned, the main theoretical model of this thesis is the minority stress model (Hendricks & Testa, 2012; I. Meyer, 2003). This stress model highlights how different social stressors within the environment and within the individual explain the higher prevalence of health problems because of the stigma and prejudice related to the gender minority status. In chapter 3.4 we will describe some theoretical frameworks of human functioning from ecological and bio-psycho-social perspectives to provide a broader and more comprehensive view of health and its explanatory factors for transgender adolescents. However, before proceeding to the next chapter, it seems appropriate to mention also another model of interest to understand how structural mechanisms arise inequalities on health.

The Commission on Social Determinants of Health (CSDH) established a framework of how intermediary and structural determinants are the basis of social determinants of health, summarized in figure 5 (Solar & Irwin, 2010).

Structural determinants, basis of processes of the socioeconomic and political context, are those that generate social class divisions in the society and that define individual socioeconomic position within hierarchies of power and access to resources. One of the most important structural stratifiers is gender, recognized as a social stratifier linked to systematic forms of discrimination, together with social class or ethnicity. This model does not explicitly include gender identity as a social stratifier, but it could easily be extrapolated to all other social stratifiers. Structural determinants also include all social, cultural, and political mechanisms that configure and maintain social hierarchies, including societal values, the educational system, political institutions, or the welfare state and its redistributive policies.

Intermediary determinants of health are material circumstances (e.g., housing, financial means to buy healthy food); psychosocial circumstances (e.g., stressful living circumstances, social support, coping styles); behavioral and/or biological factors (e.g., nutrition, physical activity, substance use); and the health system itself as a social determinant.

This model presents an approach to the relationships between the different determinants: social, economic and political mechanisms give rise to a set of sociodemographic and socioeconomic positions that stratified populations according to these factors, such as income, education, gender, or race/ethnicity. At the same time, these sociodemographic and socioeconomic positions influence specific determinants of health status (intermediary determinants) reflective of people's place within social hierarchies. According to the social status, individuals experience differences in exposure and vulnerability to health-compromising

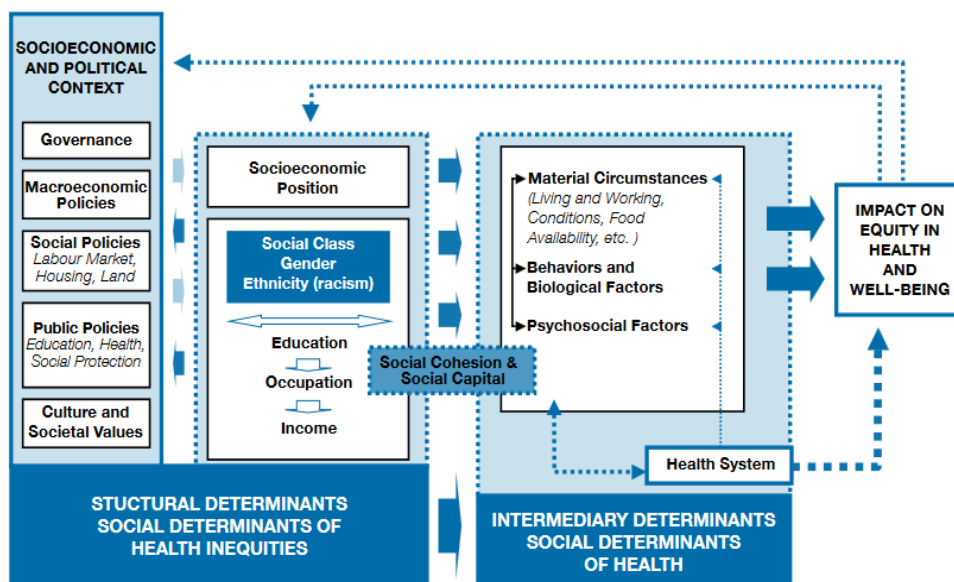


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conditions. Thus, intermediary and structural determinants shape health outcomes and underscore the causal priority of the structural factors. In addition, the proposed model attributes a central role to social capital as a connector between structural and proximate determinants.

Viner et al. (2012) adapted this model to the adolescent population and also highlighted gender inequalities as structural factors in the social determinants of health. Therefore, gender (and we can assume gender identity) are structural factors that influence health and are closely linked to other social and individual factors that shape health and well-being, such as engagement in healthy lifestyles, enjoyment of support from development contexts, access to the education system, or the creation of policies that protect the rights of transgender people.

Figure 5. CSDH conceptual framework. Reproduced from Solar and Irwin (2010)



In short, measuring adolescent health is a complex task in a vast scenery, which must necessarily take into account individual and social factors and consider, from an ecological and *intersectional* approach, how other factors (such as gender identity) may influence the development of their well-being.

The following chapters will review different dimensions of adolescent health, especially delving into the reality of transgender adolescents according to the available literature. To this end, we will examine lifestyles, mental health and well-being, the quality of developmental contexts, and school victimization as an example of a situation of stigma and discrimination.



3.2 The impact of a healthy lifestyles on adolescent health

Adolescence is one of the most critical periods in human development due to the intensity of the physical, emotional, cognitive, and psychosocial changes in both the short and long term (World Health Organization, 2020c). Physical changes might be the most visible, including the increase in height, the growth of muscle mass, or the distribution of body fat; however, emotional, cognitive, and psychosocial changes also take place, such as the development of reasoning skills and abstract thinking, and the autonomy to make decisions and also assess their consequences (World Health Organization, 2020c). These changes are the result of the sophisticated interaction of individual elements (e.g., hormonal development, including the regulation of oxytocin and leptin) and environmental factors (e.g., availability of socioeconomic resources or political policies to foster healthy behaviours). Therefore, an ecological or systemic framework is essential to understand and track adolescent trajectories (Blum et al., 2012).

The acquisition of a more or less healthy lifestyle—which could be upheld over time—depends on the interaction between individual factors and the characteristics of the contexts in which people grow up (World Health Organization, 2020c). Nutrition, physical activity, sleep patterns, or oral care practices begin in childhood and are linked to a healthy quality of life or to health complaints (Marconcin et al., 2021; Ramos, 2009). For example, nutrition during childhood impacts on growth during adolescence, and experiences with food during this transition period can affect the dietary intake choices in adulthood (Lake et al., 2006). In addition, research has shown a decrease of fruit and vegetable consumption from early to late adolescence (A. Marques et al., 2020). Moreover, being physically active in adolescence is associated with a smaller decline in physical activity in young adulthood (Corder et al., 2019). These behaviours are established and modified by individual, social, economic, and cultural variables, and are the main determinants of people’s health throughout their entire life (Viner et al., 2012).

3.2.1 Which are the criteria that define a healthy lifestyle?

Having a healthy lifestyle is crucial for enjoying a good physical and psychological health, although there is no consensus regarding the key determinant to define a healthy lifestyle (A. Marques, Peralta, Martins, et al., 2019). Establishing a comprehensive or global composite lifestyle score to determine what is the healthiest lifestyle is complicated, but any kind of healthy behaviour, either individual or combined into a composite score, is associated with health outcomes (G. Chen et al., 2014; Sevil-Serrano et al., 2019). Thus, from childhood, physical



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activity, sedentary behaviours, sleep patterns or nutrition are linked to the health-related quality of life or to health complaints.

Overall, evidence shows that healthy eating patterns are associated with positive health outcomes. A healthy diet could include a high consumption of olive oil, fruits, vegetables, legumes or whole grains, and a low consumption of meat, fat, and sugar; an example of this is the Mediterranean diet (U.S. Department of Health and Human Services and U.S. Department of Agriculture, 2015).

For example, the daily intake of fruit and vegetables is linked to weight loss and decreases the risk of obesity, cardiovascular diseases, and diabetes (Muros et al., 2017). Moreover, eating fruit and vegetables daily is linked to less psychosomatic symptoms and a higher quality of life (A. Marques, Demetriou, et al., 2019). Also, healthy habits and diets have a positive effect on bone density and the growth process (Goldhammer et al., 2019). On the contrary, emerging evidence suggests that bad eating habits (i.e., excess of sugar and fat intake) are linked to certain neurocognitive disorders and congenital anomalies (U.S. Department of Health and Human Services and U.S. Department of Agriculture, 2015). For instance, sugar drinks and energy drinks could relate to adverse health and behavioural outcomes in adolescence, such as daily health complaints, poor self-rated health, low academic achievement, or smoking and drunkenness (Holubcikova et al., 2017).

Healthy eating patterns also include how we eat our meals: despite the fact that many adolescents try to skip meals as a weight-control strategy, the scientific literature suggests that adolescents who regularly consume breakfast have a lower body fat percentage, higher cardiorespiratory fitness, and a healthier cardiovascular profile (L. A. Moreno et al., 2014).

In regard to physical activity, as the WHO recommends, adolescents should do at least an average of 60 minutes per day of moderate to vigorous physical activity throughout the entire week, as well as vigorous physical activity at least 3 days a week (World Health Organization, 2020a). This includes aerobic activities and muscle- and bone-strengthening activities.

Results from observational and experimental studies indicate that engaging in even modest amounts of moderate physical activity can have numerous positive effects in the physical and psychological health of children and adolescents, although vigorous activities may provide even greater benefits. It is well-documented that physical benefits have included weight control and obesity prevention, improved bone health and physical fitness (cardiorespiratory and muscular fitness), and reduced risk of cardiovascular and metabolic disease (blood pressure, glucose, and insulin resistance) (Guthold et al., 2020; Janssen & LeBlanc, 2010). Additionally,



participation in physical activity can ensure good mental health and positive cognitive development: it reduces symptoms of anxiety, depression, and emotional distress, improves one's mood, impacts positively on academic performance and executive function, and promotes prosocial behaviour (Guthold et al., 2020; Janssen & LeBlanc, 2010; World Health Organization, 2020a).

Likewise, sleep is a paramount indicator of a healthy development and a prerequisite for a good physical and mental health. Traditionally, sleep duration (an objective index) has been applied in the analysis of sleep habits (Chaput et al., 2016) and implies the actual time during which the individual is asleep, although other indicators, such as sleep quality (a subjective index), can also be included (Dewald et al., 2010). International institutions recommend sleeping between 9–11 hours per night for school-aged children (ages 6–13 years) and 8–10 hours every night for adolescents (ages 14–17 years) to maximize overall health and well-being (Hirshkowitz et al., 2015).

A large body of evidence has constantly shown that chronic sleep deprivation can cause serious threats to the social, cognitive, and physical function of children and young people. Sleep disturbances at adolescence are associated with long-term neurological development problems, morbidity, cardiovascular disease, immune dysfunction, excess adiposity and obesity, higher allostatic load, and poor general health (E. S. Butler et al., 2020). At the same time, shorter sleep duration (including sleep fragmentation, late bedtimes, or early awakenings) seriously affect neurobehavioural functioning, learning capacity, educational achievement, and executive functioning (Chaput et al., 2016; Dewald et al., 2010). Finally, disruption in sleep timing may be related to high-risk behaviours, such as substance use, suicidal tendencies, and drowsy driving, behavioural problems, anxiety and depressive symptoms (Buxton et al., 2015).

Oral health care is the most overlooked health need in children and adolescents, although there is increasing evidence that poor oral health contributes to various illnesses, including diabetes or oral cancer (Peres et al., 2019). Adolescents have very specific oral health needs and concerns: high rates of dental caries (tooth decay), orthodontic care, or periodontal (gum) disease. There are also other broader health issues that affect the mouth during those years, such as poor dietary habits, increased aesthetic awareness, potential alcohol and drug use, or eating disorders (Silk & Kwok, 2017). Adequate oral hygiene is one of the most important protective factors for dental and oral disease prevention, the universal recommendation being to brush one's teeth at least twice a day (Thornton-Evans et al., 2019).



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In addition to the individual effect of each of these health-related behaviours, clustering them could help to better understand their impact on general health in adolescence (Sevil-Serrano et al., 2019). However, the creation of composite factors can be a controversial issue because of the multidimensional nature of health related behaviours. That is, on the one hand, the synergistic effect of different healthy lifestyles on health can be taken into account (Moreno-Maldonado et al., 2019); on the other hand, some lifestyles may be healthier than others or may not always compensate for each other (e.g. doing regular physical activity, but smoking and eating sugary products). It may be useful to employ indices summarizing individual scores on health behaviours, classified as more or less healthy (H. de Vries et al., 2008; J. L. Walsh et al., 2013), according to national and international standards

Considering the cognitive and personality development occurring during this stage, adolescents learn to make decisions about their diet and self-care which may include skipping meals, a high consumption of empty calories in sugary foods and drinks, and less care for their dental hygiene; all this can lead to dental caries or teeth demineralization (Silk & Kwok, 2017). Likewise, a poor diet (based on sugar and fat intake) together with a sedentary lifestyle increase the chance of body fat accumulation and obesity in adolescents (Lake et al., 2006). On the contrary, adolescents who consume healthy diets and do physical activity show lower total and central adiposity compared with those who are inactive, as well as significantly higher cardiorespiratory fitness (Cuenca-García et al., 2014). Adolescents with higher physical activity levels are more likely to experience good nocturnal sleep and better sleep quality (Lang et al., 2016). On the contrary, short sleep duration or inadequate sleep are positively associated with excessive screen time, obesity, and unhealthy diet (M. Chen et al., 2006; Felsó et al., 2017; Mei et al., 2018).

Despite the existing scientific evidence on lifestyles which is adopted in national policies or international guidelines, a significant amount of adolescents have made poor lifestyle choices that compromise their health (Avedissian & Alayan, 2021). Previous international surveys provided evidence of this. For example, the Health Behaviour in School-aged Children (HBSC) study collects data every four years on the well-being, social environments and health behaviours of adolescents aged 11 to 15. Approximately 50 countries and regions across Europe and North America have collaborated on the cross-national survey for more than 30 years (Inchley, Currie, Cosma, & Samdal, 2018). This doctoral thesis is conducted within the framework of this international project.



The general conclusion of the last wave of the study (Inchley et al., 2020) highlighted insufficient optimal habits among adolescents: two fifths of adolescents (40%) ate fruit every day, less than two fifths of adolescents (38%) ate vegetables every day, one in four adolescents (25%) ate sweets every day, and one in six (16%) adolescents consumed sugary soft drinks every day. Additionally, the proportion of young people meeting the global physical activity recommendation of 60 minutes of moderate to vigorous physical activity every day was low: fewer than one in five adolescents (19%) met the current recommendation. Finally, one in four adolescents (24%) had difficulties sleeping, and two thirds of adolescents (65%) brushed their teeth at least twice a day.

3.2.2 Sociodemographic variables related to the development of healthy lifestyles

Findings presented in this type of report showed that adolescents can often struggle to engage in and keep healthy behaviours. Assuming that these issues take place only because of the “moment in the life span” is insufficient, considering that there are many individual and social variables that should be taken into account. For instance, the influence of socioeconomic status (Elgar et al., 2015; Moreno-Maldonado et al., 2019) or the gender (Boraita et al., 2020; Madison & Söderlund, 2018) in research has been manifested recently, especially in the intersectional model (Fehrenbacher & Patel, 2020).

Gender powerfully shapes greatly affects all aspects of health and well-being (Kennedy et al., 2020). Gender norms influence the acquisition of habits and personality development from childhood (Egan & Perry, 2001; Ericsson, 2018). Even though traditional gender roles are changing, there are many references that show traditional masculinity as force and resistance, and traditional femininity as delicacy and softness (Sánchez-López & Limiñana-Gras, 2017; Wood & Eagly, 2015). Because of the pressure coming from the mass media, peers, or social networks, girls usually pay more attention to body image and weight control, which is reflected in a higher prevalence of healthy diet patterns (Wardle et al., 2004) or a higher probability of skipping meals (L. A. Moreno et al., 2014). At the same time, studies report higher engagement in physical activity in boys (Guthold et al., 2020), probably due to the masculinized model of sport. These attitudes can also have a negative impact on the acquisition of healthy habits.



3.2.3 LGBTQ+ adolescents and healthy lifestyles

Although adolescence is a significant stage of physical and psychosocial maturation, it is also a critical time for the development of sexuality and gender identity. Thus, considering how far-reaching the consequences of establishing a healthy lifestyle during adolescence are, little has been published in relation to this among sexual and gender minorities. Thus, we are only beginning to scratch the surface regarding the lifestyles of LGBTQ+ populations, and results can be ambiguous or inconsistent.

In relation to diet and weight control, Lucassen et al. (2019) found that a sexual and gender minority youth sample consumed more fast food and takeaway than the heterosexual sample. However, that contrasts with results from other studies that suggest that sexual minority students are more likely to meet recommendations for fruit and vegetable consumption (Rosario et al., 2014). Other studies reflected no significant differences in fruit and vegetable consumption between lesbian, bisexual, and sexuality-questioning female college students and their heterosexual peers (McElroy & Jordan, 2014).

Butler, McGlinchey, and Juster (2020) made a narrative review of research studies that examined sleep habits among lesbian, gay, bisexual, and transgender populations; they concluded that the sexual and gender minority status, especially for adolescent and young adult populations, predicted shorter sleep duration and poorer sleep quality, although sleep disturbances affected LGBTQ+ subgroups differently based on sex/gender and diverse sexual orientations. As Patterson and Potter (2019) also comment, many sleep problems are more appreciable under stressful conditions, and because sexual minority individuals often experience greater stress than their heterosexual peers, they can suffer from more sleep difficulties (less sleep time and quality) than heterosexual individuals.

More research is available in regard to participation in sports and physical activity. Overall, sexual minority young people reported less physical activity and involvement in sports than their heterosexual peers, even though gender can moderate some results. For instance, Greenspan et al. (2019) found that sexual and gender minority youth specifically avoided athletic spaces (e.g., physical education class or locker rooms) due to the potential stigma or the lack of safety in family, school, or community settings, which results in lower participation rates in physical activity. Moreover, Calzo et al. (2014), as well as Mereish and Poteat (2015), showed that sexual minority adolescents consistently reported less physical activity and less participation in team sports than heterosexual youth. Rosario et al. (2014) detected no



significant differences by sexual orientation among adolescent girls for physical activity; however, sexual minority boys engaged in less physical activity than heterosexual boys.

3.2.4 The lifestyles of transgender adolescents

It seems that little by little there are more evidences about lifestyle in LGBTQ+ adolescence, but there are many remained obstacles to face. Among them, few studies have addressed diet, physical activity, sleep behaviors, or oral health among gender-diverse people. There is more research carried out on the sexual orientation of the participants, so the available information about the health of LGBTQ+ people in most of the cases was based on the experiences of gay, lesbian, and bisexual adolescents; nevertheless, transgender people have different health and life experiences (Institute of Medicine, 2011; Sweileh, 2018).

Mixed results were to be found in the study of food and drink consumption for transgender youth. A previous study led by Bishop et al. (2020), which aimed to understand diet behaviours in transgender youth, found that transgender and gender non-conforming adolescents reported a less frequent consumption of fruit, vegetables, and milk, and a more frequent consumption of fast food and soft drinks than cisgender students. However, another study suggested that there were no significant differences between transgender and non-transgender college students in the intake of fruit and vegetables, breakfast, soda, diet soda, fast food, and restaurant food (Vankim et al., 2014). Moreover, transgender or gender minority youth also engage in unhealthy methods of weight control, including purging, vomiting, caloric restriction, fasting, or using pills or laxatives (S. R. Roberts et al., 2021; Watson et al., 2017).

Research into the life experiences of transgender people in sports and physical activity is more consistent. Overall, gender non-conforming and transgender youth are less likely than cisgender youth to meet recommendations for adequate strenuous and strengthening physical activity (Vankim et al., 2014), to participate in regular physical activity or physical education classes (Bishop et al., 2020), or to be involved in extracurricular activities at school (Aparicio-García et al., 2018). Furthermore, even when transgender people do appear to be motivated to engage in physical activity, they are insufficiently active (B. Jones et al., 2017). This could happen because they are more likely to avoid Physical Education classes or facilities traditionally segregated by gender (e.g. bathrooms, locker rooms) given that they feel unsafe or uncomfortable (Hargie et al., 2017; Kosciw et al., 2020). In spite of this, one previous study (Kulick et al., 2019) reported higher levels of physical activity for transgender students compared to cisgender females, however not in comparison to cisgender males.



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Regarding sleep habits, little research has examined sleep disparities or sleep quality in transgender and gender non-conforming individuals, especially amongst minors. The systematic review by Butler et al. (2020) concluded that transgender adults experience high rates of poor sleep-quality and sleep disturbances related to distress or anxiety. Moreover, Levenson et al. (2020) examined sleep habits using a nationwide survey of transgender and cisgender adolescents, who reported sleeping fewer hours, higher odds of being a “poor sleeper”, and lower odds of getting the ideal amount of sleep and getting “enough sleep” than cisgender youth.

Furthermore, there is a significant lack of research into the oral health of transgender adolescents. One qualitative study found that transgender adolescents do not believe there is a connection between oral health and their gender transition (Macdonald et al., 2022), however their oral health was not explored.

In addition to the general lack of available information regarding transgender adolescents’ lifestyles, there are also methodological concerns. Most research into LGBTQ+ adolescence was conducted from a pathological perspective, linking general habits to physical or mental issues, such as eating disorders, obesity, mood disorders, drug use, self-harm, or bullying victimization (Schrager et al., 2019).

For example, although it is not a lifestyle explored in this dissertation, and in contrast to the information available on other lifestyles such as oral health, drug use among transgender adolescents has been widely explored and discussed. The prevalence of substance use, initiation of substance use at an early age, and substance use in school settings is two to four times higher for transgender youth than for cisgender youth (Day et al., 2017; Mereish, 2019; Valentine & Shipherd, 2018). Moreover, transgender youth can be more than twice as likely to use heavy drugs as their cisgender peers (e.g., cocaine and methamphetamine) and nearly three times as likely to report recent inhalant use (De Pedro et al., 2017).

Applying the minority stress model (Hendricks & Testa, 2012; I. Meyer, 2003) one could understand how the exposure of gender or sexually diverse minorities to harassment and discrimination in cis-hetero-normative contexts could have negative repercussions on their integral health. However, it is equally meaningful to continue studying all these health disparities between transgender and cisgender adolescents, as well as to explore health outcomes from a more normative or positive-development perspective.



3.2.5. Summary

Lifestyles are an essential part of people's overall health because of their relation to other objective and subjective indicators of well-being, both during childhood and adolescence and in the long term in adulthood. The existing literature on the health-related behaviours of transgender adolescents is scarce and sometimes incomplete, but given its relevance for health, more research exploring lifestyles habits in transgender adolescents is needed. The lifestyles of transgender adolescents will be analysed in the **Study 2** of this thesis.

3.3 Toward a definition of mental health

As in the case of health and well-being, it is difficult to delimit the concept of mental health. Mental health is described by the WHO as the state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to the community (World Health Organization, 2001).

It is not only a matter of stating that mental health is more than just the absence of discomfort, mental disorders, or disabilities (Keyes, 2005; World Health Organization, 2018), nor can good mental health be equated with permanent feelings of joy or happiness; people in good mental health experience negative emotions such as sadness, unhappiness, or anger, and this is part of a fully lived life for a human being (Galderisi et al., 2015).

Mental health could be composed by categories such as emotional well-being (including happiness, peace, or interest in life), social well-being (contributing to society with a personal sense of value and belonging), and functioning or psychological well-being (including the development of skills to manage the responsibilities of daily life and make positive decisions) (Keyes, 2014). Therefore, good mental health is linked to feeling positive emotions (which could be subjective indicators of well-being) and to being able to adapt to one's life circumstances.

As discussed in the introduction, health in all its aspects must also consider factors external to the individual, such as socioeconomic and environmental factors. Thus, a good approach to defining the concept of mental health is the one proposed by Galderisi et al. (2015): "Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society." And that involves applying social, emotional and cognitive skills to navigate effectively through life and the world (United Nations Children's Fund, 2021).



3.3.1 Theoretical models for unravelling mental health: from risk and pathology to salutogenesis and health promotion

Over the course of the 20th century, many theoretical models have been developed to understand how problematic behaviours or stressful events can result in health problems, with a predomination of frameworks emphasizing pathology or risk.

The paradigms that focus on diseases, known as the pathogenic perspective, tend to emphasize the role of individual and environment risk factors on ill health, including disease, objective disorders, subjective sickness, malfunctioning, and impairment (G. Bauer et al., 2006).

For instance, the Problem Behaviour Theory was proposed in the 1950s to explain that risk behaviours can compromise the life, health, and successful development of individuals. Risk factors can initiate new risk behaviours or intensify engagement in risk behaviours. Risk factors can be present in interrelated domains such as biology, the social environment, or one's own behaviour, and increase the likelihood of risk behaviours such as early sexual intercourse, drug use (e.g., tobacco, alcohol and other substances), or delinquency (Jessor, 2016).

Nevertheless, the historical importance of disorder- or deficit-based models is surprising when considering that the WHO views health as a complete state of physical, psychological, and social well-being.

In the presence of theoretical frameworks focused on pathology and risk, other approaches to understanding what makes people healthy have emerged. This is the case of the salutogenesis model. The author of the model, Aaron Antonovsky, noted that health is an active, dynamic process of self-regulation and that chaos and stress are a part of life (Antonovsky, 1987). Thus, salutogenesis posits that health oscillates within a continuum spanning from well-being to sickness (or ease/dis-ease), pointing out that even stressors can have a positive effect on people under certain circumstances, and focusing on salubrious factors that actively promote health (Antonovsky, 1987; Mittelmark, Sagy, et al., 2017).

This theoretical model has been so popular in the field of public health that it has been incorporated by other models to provide evidence of a shift from pathogenic thinking in health promotion research and intervention. For example, the salutogenesis theory is explicit in models like the Health Development Model or the Asset Model as an analytical approach and theoretical basis (G. Bauer et al., 2006; Pérez-Wilson et al., 2021). The goal of these models is to emphasize the importance of an individual's health in specific contexts and to understand the factors that foster successful adaptation to one's own circumstances (Mittelmark, Bull, et al., 2017).



In sum, understanding adolescent mental health is not benefited from leaving aside deficit or pathogenic models (which usually study risk factors and are aimed at vulnerable populations), for they offer valid and useful information for certain analyses and interventions; but also required incorporating positive models (such as the salutogenic model) which focus on studying the resources available to individuals to promote adolescent health (Oliva et al., 2017).

3.3.2 Mental health and adolescence

The two kinds of models previously described (pathogenic and salutogenic perspectives) and seem to suggest that adolescents will most likely experience, at some moment in their lives, different gradations of mental health problems or disorders and different degrees of positive mental health; sometimes, positive mental health and mental problems may happen at the same time (United Nations Children’s Fund, 2021). However, it is important to clarify that both protective and risk factors are not usually causally related to one’s mental health status. Instead, the effect of risk and protective factors varies depending on the social, economic, and environmental circumstances of the individual, and some environments can even introduce both negative and positive determinants of health (Ungar, 2017).

3.3.2.1 Risks and mental health conditions

Identifying and comprehending the factors that contribute to mental health problems from adolescence onwards is crucial because of their long-term impact. It is worth noting that mental health problems exist within a continuum spanning from varying degrees of temporary discomfort or distress to severe chronic conditions. The most common and prevalent mental health conditions during childhood and adolescence include depressive disorders, bipolar disorders, anxiety disorders, psychotic disorders, eating disorders, drug use disorders, childhood behavioural disorders, or autism and Asperger syndrome (World Health Organization, 2020b).

According to the Global Burden of Disease study conducted by the Institute for Health Metrics and Evaluation, more than 13% of the world’s adolescents aged 10 to 19 lived with a mental disorder between 1990 and 2019 (Institute for Health Metrics and Evaluation, 2021). Other reviews, based on data from the WHO, the European Public Health Alliance, and the Centres for Disease Control and Prevention, also indicated that between 10% and 20% of children and adolescents face mental health problems (Sakellari et al., 2020; Wickramasinghe et al., 2020).



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The State of the World’s Children 2021 report (United Nations Children’s Fund, 2021) included a review based on systematic reviews or meta-analyses describing the link between exposure to risk factors and the subsequent onset of any mental health outcomes across the first two decades in a child’s life. It concluded that some of the most common risk factors associated with poor mental health identified were peer relationship problems (not having close friends or being a victim of bullying), lack of physical activity, being overweight or underweight, substance use (e.g., heavy alcohol use or marijuana use), lack of secondary school attendance, or intimate partner violence. In addition to these factors that compromise mental well-being, other authors also identified emerging behaviours and risk factors of the 21st century, such as increased use of social media, changes in levels of social support as a result of online interaction replacing face-to-face communication, or cyberbullying (S. D. Walsh et al., 2020).

An excellent way to illustrate the effect of risk factors on health is the experience of stressful events. Two good examples can be found in the global financial crisis of 2007-2008 and the COVID-19 pandemic. Regarding the former, different studies concluded that adolescents who suffer from poverty—measured through family material wealth or the occupational status of both parents—were more likely to have more health complaints and worse self-perceived health (Chzhen et al., 2018; Moreno-Maldonado et al., 2019; Sakellari et al., 2020; S. A. Silva et al., 2020). As for the effect of the COVID-19 pandemic on the mental health of adolescents, a systematic review looked into different studies on adolescent health before and after the first lockdown measures and found that adolescents experienced more loneliness, a higher prevalence of psychosomatic symptoms, increased depressive and anxious symptoms, and a declining trend in overall mental health during the pandemic compared to the pre-pandemic period (Samji et al., 2022).

Some factors that are associated with anxiety or depression disorders are a poor lifestyle, low socioeconomic status, or bad-quality social relationships (Molarius et al., 2009; M. Silva et al., 2016). It is important to be aware of these factors because of the negative impact they have on the mental health of adolescents: different studies have concluded that the decline in adolescent mental health (e.g., suffering mood disorders or psychosomatic complaints) over the last years is a serious public health concern (Bor et al., 2014; Hagquist et al., 2019; S. D. Walsh et al., 2020). In fact, to compile a few data, the global prevalence of depressive and anxiety disorders in adolescents was between 25% and 31%, depending on the cut-off point, according to a meta-analysis performed with 43 studies (S. A. Silva et al., 2020). Furthermore, approximately 40% of the mental disorders included in the Global Burden of Disease study were



anxiety and depression disorders among adolescents aged 10–19 (Institute for Health Metrics and Evaluation, 2021).

Mental health complaints (e.g., feeling low or irritable) and somatic health complaints (e.g., headache, backache, stomach ache) are correlated but disaggregated health problems that are also common during adolescence (Dey et al., 2015). Evidence of increasing psychosomatic health complaints has created further concern about deteriorating adolescent mental health problems in more recent birth cohorts (Patton et al., 2016; Potrebny et al., 2017). This increase in the prevalence of psychosomatic problems in adolescence may impact on health in different ways. On the one hand, because of the experience of distress itself and, on the other hand, because of its relationship with other problems, such as functional impairment in daily life at school and in family, social and physical activities (van Geelen & Hagquist, 2016). Empirical research has shown that adolescents involved in health-risk and externalizing behaviours show increased depression symptoms or psychosomatic symptoms. For example, adolescents that were more likely to smoke, drink alcohol, get drunk or be involved in fights, displayed the highest level of psychosomatic health complaints (S. D. Walsh et al., 2016). The lack of strong connections (parental, peer, and teacher support), high levels of problematic social media use, exposure to bullying, and the consumption of sugary foods and drinks were also strong predictors of psychosomatic complaints (S. D. Walsh et al., 2020).

Mental health conditions have dreadful consequences on the lives of young people, leading to isolation, stigmatization, and the inability to adjust individually and socially (Wickramasinghe et al., 2020). However, probably the most concerning mental health problems are self-harm, suicidal ideation, or suicide attempts. Self-harm largely occurs among older adolescents. Data estimated by the WHO suggested that suicide is the fourth most prevalent cause of death globally in young people aged 15–29, both boys and girls (World Health Organization, 2021). Risks factors for suicide included depression symptoms, alcohol abuse, sexual or physical abuse, lack of support, and poor relationships with family and friends (Patton et al., 2016)

3.3.2.2 *The other side of the coin: positive mental health*

In addition to these mental health conditions, which traditionally might be related to the pathological view of health, it is also interesting to focus on the assets and skills actively involved in the enhancement of one's own positive mental health and subjective well-being. Subjective well-being represents people's perceptions, beliefs, and feelings about their life, especially



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whether they consider their life desirable and rewarding. Subjective well-being is a positive outcome for the health and quality of people's life, both present and future (Diener, 2012). Thus, the most suitable indicators of positive mental health and subjective well-being could include satisfaction with life, a health-related quality of life, or a sense of coherence.

We can define life satisfaction as the cognitive appraisal and evaluation of one's overall quality of life (Diener & Diener, 1996; Veenhoven, 1996). Life satisfaction is a remarkable indicator of adolescent mental and physical health: the perception of the satisfaction with life contributes valuable information over and above more direct health-related measures such as chronic diseases (Due et al., 2019). For example, in a longitudinal study using a sample of middle and high school students it was found that adolescents with positive life satisfaction were less likely to develop externalizing behaviors against the negative effects of stressful life events (Suldo & Huebner, 2004). Moreover, the perception of life satisfaction impacts on other aspects of well-being and positive adjustment, such as self-efficacy or academic achievement (Baile et al., 2020; E. S. Huebner et al., 2004; S. C. Marques et al., 2011)

Different studies suggested that the strongest predictor of life satisfaction among adolescents was social support from family, followed by social support provided by other social environments including teachers, classmates, and friends (Bi et al., 2021; Calmeiro et al., 2018; Moreno-Maldonado et al., 2020; S. D. Walsh et al., 2020). Individual assets such as limited social and academic competence (Calmeiro et al., 2018) and risk factors such as high levels of problematic social media use, insufficient nutrition (S. D. Walsh et al., 2020), or lower levels of family affluence are also associated with a low satisfaction with life (Moreno-Maldonado et al., 2020; Zaborskis et al., 2019; Zaborskis & Grincaite, 2018).

Secondly besides life satisfaction, another commonly used and appropriate health indicator is self-rated health, a measure widely validated in epidemiological studies to show the subjective experience of health quality and status (Mavaddat et al., 2014). Many studies showed that the adolescents' view of self-rated health is associated with a wide spectrum of health behaviours and medical, psychological, and social factors. For example, a perception of "excellent" self-rated health protected against mortality risk compared to a "poor" evaluation of health (DeSalvo et al., 2006). Moreover, self-rated health predicted health outcomes including disability, all-cause mortality, disease-specific mortality, future morbidity, use of health services, and health-promoting activities (Breibdablik et al., 2008; Mavaddat et al., 2014).

Thirdly, self-rated health reflects the subjective experience of health, and this is linked to health-related quality of life, which is a complex and multidimensional measure of health



(Mavaddat et al., 2014). In fact, health-related quality of life is a complex and broad construct that relates to the effects of health, illness, and life quality in ways that are complicated (Ferrans et al., 2005), and many definitions can be used to describe it.

For example, health-related quality of life might be understood as the personal and subjective perception of health with regards to physical, psychological, and social functioning (Ravens-Sieberer et al., 2008). Other definitions exclude external aspects of the individual's health, such as economic and political circumstances (Ferrans et al., 2005). Moreover, definitions of health-related quality of life include elements corresponding to different health states and to the aspects of life that are most commonly found in self-perceived well-being (Karimi & Brazier, 2016).

This construct stands out as an outcome variable for its ability to encompass different dimensions of health and quality of life (Gaspar et al., 2012). Therefore, it is of interest to know what individual and social factors influence the health-related quality of the life of adolescents. Adolescents with a healthy lifestyle—who engage in physical activity, get enough sleep, consume fruit and vegetables daily, and do not use drugs—had a significantly better health-related quality of life and self-rated health than those who were not engaged in all healthy behaviours (A. Marques, Peralta, Santos, et al., 2019). Obesity also affected health-related quality of life and life satisfaction (Baile et al., 2020). As with life satisfaction, the relation with parents and peers and the perceived support from them are also strong predictors, as well as other personal elements, such as optimism, self-perception, and autonomy (Gaspar et al., 2012).

At this point, it is interesting to highlight one of the key concepts of the salutogenesis model, which can help us understand what makes people healthy: the sense of coherence, defined as a person's overall orientation to understand how their life is organized and how they position themselves with regards to the world, being able to manage their life, and channel it towards the goals that they wish to achieve (Antonovsky, 1987, 1993). The sense of coherence acts as a protective factor for health, having a positive impact on a person's physical and psychological well-being, quality of life and life satisfaction (Eriksson & Lindström, 2007; Eriksson & Mittelmark, 2017).

Sense of coherence is related adolescents to health in terms of life quality, health-related behaviour, mental health, and social relationships (García-Moya, 2014; Länsimies et al., 2017). Many studies have explored this association in adolescents. For example, it has been found that the sense of coherence is a positive predictor of perceived health, such as physical, emotional, and social functioning for adolescents. Moreover, a high or strong sense of



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coherence was associated with better self-rated health, a lower frequency of psychosomatic complaints, and a higher life satisfaction or quality of life (García-Moya, Moreno, et al., 2013; Luyckx et al., 2012; Moksnes et al., 2013). At the same time, one's sense of coherence protected against risk behaviours and factors such as substance use (García-Moya, Jiménez-Iglesias, et al., 2013; Mattila et al., 2011) and moderates the association between distress/stress, and depressive and anxiety symptoms (García-Moya, Rivera, et al., 2013; Moksnes et al., 2014).

3.3.2.3 Sociodemographic variables and mental health

In addition to the risk and protective factors described in this chapter, understanding adolescents' mental health makes crucial considering gender and age as two main determinants.

Measures of mental health need to consider the physical, cognitive, social, and emotional development that leads to changing health needs in adolescents between different genders and ages (Guthold et al., 2021). Almost unanimously, cross-cultural studies and state-of-art reviews noted that, overall, girls tend to have worse mental health than boys, older adolescents tend to score worse than younger adolescents in well-being measures, and girls in their late adolescence are the group most at risk of developing mental health problems (Currie & Morgan, 2020; Gobina et al., 2019). Indeed, more gender-equal countries have larger gender gaps across all mental health outcomes, with girls being more likely to experience mental health issues, defined as psychological distress, multiple health complaints, and a lack of life satisfaction, or of a sense of flourishing and happiness (O. L. K. Campbell et al., 2021; Heinz et al., 2020).

Therefore, it is not surprising that results of mental health research concluded that the prevalence of multiple psychosomatic complaints (Gobina et al., 2019; Hagquist et al., 2019; S. D. Walsh et al., 2020) and the internalization of problems such as fear, anxiety, or depression (Bor et al., 2014; Samji et al., 2022; S. A. Silva et al., 2020) was higher among girls than among boys. Likewise, many empirical studies and systematic reviews noted that girls were less likely to display a high level of satisfaction with life (X. Chen et al., 2020; Due et al., 2019; S. D. Walsh et al., 2020) or benefit from the protective sense of coherence when facing stress, depression or anxiety (Moksnes et al., 2011, 2012, 2014) are lower in girls compared to boys.



3.3.3 Transgender mental health

Recent research studies have made attempts to understand the health of transgender people—beyond the clinical focus associated with gender dysphoria—by employing a wide spectrum of methodological tools, including the use of more precise instruments and more complex designs with different age cohorts (M. D. Connolly et al., 2016).

Similar to the study of lifestyles among transgender adolescents, as mentioned previously, certain methodological problems within research conducted with transgender populations stand out. The study of the mental health of transgender populations is often marginalized within LGBTQ+ communities, because their experiences and health needs are frequently overlooked due to the attention given to sexual identities rather than gender identities (Gahagan & Colpitts, 2017). On the other hand, the mental health of transgender individuals is typically explored from a pathological and biomedical perspective (Glick et al., 2018). In fact, health topics studied most frequently for transgender people are, among others, mental health, physical health, sexual health, or the use of mental health services (Marshall et al., 2019). This negative approach is further emphasized in transgender research that focuses on adolescence, a developmental stage which includes a gender-diverse identity and pressure to conform to social norms (Clemans et al., 2010; Diamond, 2020).

Nevertheless, results are consistent regarding the mental health of transgender adolescents: high prevalence of emotional distress or anxiety disorders (McCann & Brown, 2018; Veale, Watson, et al., 2017), dietary problems and eating disorders (Lucassen et al., 2019; S. R. Roberts et al., 2021), substance use (Raynor et al., 2020), sexual risk behaviours (Herbst et al., 2008; Van Schuylenbergh et al., 2018), and suicidal ideation (Liu & Mustanski, 2012; Vigny-Pau et al., 2021).

Transgender youth disproportionately experience the burden of isolation, unhappiness, anxiety, depression and mood disorders, self-harm, and suicidality (ideation, plan, attempt) compared with cisgender peers (Aparicio-García et al., 2018; Becerra-Culqui et al., 2018; T. C. Clark et al., 2014). Specifically, transgender youth had a twofold to threefold increased possibility of being involved in risk outcomes, including depressive symptoms, non-suicidal self-injury, suicidal ideation, and suicide attempt compared with cisgender youth (Eisenberg et al., 2017; Perez-Brumer et al., 2017; Reisner, Vettes, et al., 2015). Approximately 50% of transgender youth reported engaging in non-suicidal self-injury behaviour (Taliaferro et al., 2019). Thirty-one percent of transgender youth have reported attempting suicide at least once in their lifetime, four times more than their cisgender counterparts (Eisenberg et al., 2017).



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Between 30% and 50% of transgender adolescents reported having attempted suicide in their lifetime, compared to 10% to 18% of cisgender youth (Toomey et al., 2018).

A heterogeneity and diversity of experiences in the mental health outcomes of transgender youth is appreciated within the LGBTQ+ community. Mental health disparities for transgender young people were more extreme than the mental health disparities facing lesbian, gay, and bisexual youth (Mackie et al., 2021). For instance, transgender youth had higher rates of depressive symptoms, non-suicidal self-harm, and suicidal ideation than other sexual minority youth groups (Day et al., 2017; Perez-Brumer et al., 2017; Taliaferro et al., 2019). However, the differences that can be found within the transgender community were even more significant.

The comparison of the mental health of non-binary young people to that of binary transgender young people is becoming increasingly popular. Within the transgender community, adolescents with a non-binary identity are apparently more likely to report overall poorer mental health than binary transgender adolescents (Chew et al., 2020; Price-Feeney et al., 2020). In a sample of participants who attended a national transgender health service, adolescents identifying as non-binary had significantly higher levels of anxiety, depression, and lower self-esteem than the binary transgender individuals, although no significant differences were found in the likelihood of engaging in non-suicidal self-injury behaviour (Thorne et al., 2019). In other studies conducted with non-probability samples of transgender adolescents and young adults, the non-binary transgender group reported significantly higher rates of suicide behaviours (Toomey et al., 2018), traumatic experiences, and suicidal ideation (Newcomb et al., 2020), more psychological health problems, more feelings of hopelessness (Veale, Watson, et al., 2017), greater isolation, and significantly less happiness (Aparicio-García et al., 2018) than the cisgender and binary transgender groups.

In contrast to the abovementioned, few research studies suggested a lack of evidence of higher rates of mental illness among non-binary participants compared to binary participants. For example, in another community study comparing binary and non-binary transgender adolescents and young adults (Rimes et al., 2017), no significant group differences were found regarding suicidal ideation over the past year, smoking, weekly drug use, or alcohol consumption; however, binary transgender participants had significantly lower ratings in life satisfaction than non-binary participants. It has also been suggested that there were no differences in health outcomes typically explored in these populations (e.g., having seriously considered or attempted suicide in the past year, alcohol consumption), but there were differences regarding access to the health care system: non-binary youth can be significantly



more likely to experience barriers to accessing hormone therapy than binary youth (B. A. Clark et al., 2018).

In contrast, there is little evidence on mental health from a positive perspective, centred on well-being or the sources of health. Constructs linked to positive psychology models have been proved to provide a global view of adolescent health (Joffer et al., 2016). Although some studies evaluate well-being from a less clinical perspective—such as health-related quality of life (Nascimento et al., 2020; Zou et al., 2018)—research is scarce and conclusions are similar: transgender people showed lower levels of quality of life (Bockting et al., 2016).

Above all, it is important to note that a better comprehension of these alarming results requires the theoretical framework of the minority stress model, which explains that the distress that transgender adolescents experience is not due to their gender identity per se, but to the fact that the stigma and victimization to which they are subjected because of their gender identity has a negative impact on their health (Hendricks & Testa, 2012; Toomey, 2021). Moreover, vulnerability to the impact of minority stress on psychosocial and physical health outcomes increases during adolescence, due to the changes experienced in the context of social environments in which binary roles and rules prevail (Delozier et al., 2020).

3.3.4 Summary

Mental health, mental well-being, subjective well-being, perceived health... Many labels and indicators can be used to describe and assess adolescent mental health. From an ecological approach, it is not possible to obtain a complete picture of their mental health without analysing the role of risk and protective factors, both individual and social, that significantly shape the course of this dimension of their health and well-being. There is broad consensus within the literature that transgender adolescents have elevated rates of mental health issues, including severe mental health distress conditions. Therefore, understanding the mental health of transgender adolescents through ecological models, and not only from a pathologizing perspective, is necessary to obtain an integral and complete view of their health. The mental health of transgender adolescents will be analysed in the **Study 3** of this thesis.



3.4 Social environments: an overview

Adolescence is a period associated with a wide range of physical, cognitive, emotional, social, and neurological changes that will impact in the quality of life, well-being, and psychosocial adjustment during adulthood. Different psychological models analyse the variables linked to a healthy adolescence and an adequate transition to adulthood. In this sense, some of the tasks that adolescents must take on during this time is the development of a coherent self-concept and self-identity (Waterman, 1982), and that can depend on the establishment of satisfactory and safe relationships with other people (Nurmi, 2004).

3.4.1 Models and frameworks for understanding the influence of social environments on health and development

3.4.1.1 Attachment theory

The attachment theory is one of the most solid theoretical approaches in the field of socio-emotional development, and it postulates that children establish an internal working model as a mental representation of the self and of the environment through interactions with reference figures (Ainsworth & Bowlby, 1991; Main & Hesse, 1990). John Bowlby formulated the inception of the attachment theory through the discussion of the child's tie to the mother and its disruption through separation, deprivation, and bereavement; and Mary Ainsworth contributed the concept of the attachment figure as a base from which an infant can explore the world, especially the concept of maternal sensitivity towards infant signals and its role in the development of infant-mother attachment patterns (Bretherton, 1992). Much of the research based on these models is rooted in the notion that individuals develop a foundation in early life, one which provides a model of the ways in which attachment-related events typically unfold (Cassidy et al., 2013).

One of the core propositions of attachment theory is that proximity to an attachment figure reduces fear in the presence of a possible or real threat. Bowlby argued that the mechanism that explained this link is children's experience-based cognitive representation of the availability of an attachment figure. Specifically, securely attached infants are more likely to have mental representations of caregiver availability and responsiveness than insecurely attached infants; this enables them to interpret a threat as manageable and respond to it with less fear and anxiety (Cassidy et al., 2013). Ainsworth identified three strategies of attachment (secure, avoidant, and ambivalent/resistant), to which Mary Main and Judith Solomon added an



extra pattern of attachment, the disorganized (Main & Solomon, 1986). The work of these authors has contributed to the understanding of differential strategies within intimate relationships, as well as of child and adult psychopathology (Marvin et al., 2016).

The internal working model regulates behaviours of children in regard to the response of their primary caregivers in risky or stressful situations. Under conditions of distress or fear, children use information about the availability of an attachment figure to regulate their response system at both the behavioural and physiological levels (Cassidy et al., 2013; Marvin et al., 2016).

Individuals who have had a secure attachment during childhood with significant others who were sensitive and responsive will most likely develop a basic attitude of trust in the people with whom they establish relationships. On the contrary, those who have had negative experiences with attachment figures will tend to expect rejection or non-gratifying responses in stressful situations or help-seeking (Main et al., 2005). A key aspect of this model, in addition to the affective and cognitive components linked to who the attachment figures are and what can be asked of them, is the information about oneself: whether one is a person that deserves to be loved or cared for by attachment figures, and how that builds one's self-esteem or self-concept (Oliva, 2004).

Attachment problems can reach clinical levels when experiences of early adversity are so severe (e.g., abuse and severe neglect, domestic violence, living far away from parents or family, repeated changes of caregivers...) than these episodes make more difficult for the children to form stable emotional relationships with the caregivers (Román, 2010). Two disorders of attachment share common etiology, but show different features. Reactive Attachment Disorder are characterized by inhibited behaviors (e.g., minimal social and emotional responsiveness to others, limited positive affect, and excessive discomfort reactions during non-threatening interactions with caregivers). On the other hand, Disinhibited Social Engagement Disorder is characterized by disinhibited behaviors (e.g., overly familiar behavior, active approaches and interactions with unfamiliar adults, absence of reticence in interactions with unfamiliar adults) (American Psychiatric Association, 2013). Although the experiences of early adversity are part of the etiology of these disorders, they are not enough explicative of the development of the disorders. Not all children who have suffered such experiences present these disorders, as adequate environmental support may imply remissions or considerable improvements for these children (Román et al., 2021).



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The mechanisms of attachment, their influence on the development of one's identity and the transfer of this bond to other attachment figures (such as friends or romantic partners) has been studied not only in childhood but in adolescence and adulthood too. Other studies have also examined the development of attachment in profiles of children and adolescents exposed to early and chronic adversity, such as adopted children (Cáceres et al., 2016) or children in residential and foster care (Carrera et al., 2021; Román et al., 2021).

Regardless of the moment in a person's lifespan, attachment links are necessary to guarantee survival. Specifically, adolescence is supposed to be a period when internal working models may finally stabilize, although help-seeking mechanisms are different, and people are more likely to communicate feelings and concerns to the caregivers instead of seeking direct physical proximity (Zimmermann & Becker-Stoll, 2002).

Research shows patterns of attachment are significant but of limited stability from infancy to late adolescence (J. P. Allen et al., 2004; Groh et al., 2014; Zimmermann & Becker-Stoll, 2002). However, adolescent attachment is a multifactorial outcome of a range of earlier developmental processes, and it should not be perceived simply as the same construct as infancy attachment (Groh et al., 2014). For example, relationships among peers, in which each person may serve at different times as both care-seeker and caregiver, may be a context that fundamentally alters the meaning of attachment behaviours that were previously directed toward a caregiver such as a family member (J. P. Allen & Tan, 2016).

Although the attachment relationship with caregivers in adolescence is distinct from the attachment relationship in early childhood, it is just as important since the adolescent still relies on the attachment figure for care and support (M. McConnell & Moss, 2011). The position of peers, romantic partners, and parents in the support-seeking hierarchy depends not only on the developmental stage of the adolescent, but also on the particular stressor facing the adolescent (J. P. Allen & Tan, 2016). In non-emergency situations of stress, adaptive support-seeking behaviours with peers are more strongly linked to adolescent attachment states of mind and are often preferred over parental support (J. P. Allen & Manning, 2007). However, as we shall discuss in the following subsections, parents are at the top of the attachment hierarchy under conditions in which adolescents are likely to need to draw strongly on the attachment system (J. P. Allen & Tan, 2016).



3.4.1.2 Bioecological model

Urie Bronfenbrenner (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 2006) used the bioecological model to explain that the process of human development is framed within different systems of influences. Four are the key concepts of the model. 'Process' that encompasses particular forms of interaction between organism and the environment, that operate over time, and are posited as the primary mechanisms producing human development. However, the power of such processes to influence development varies substantially according to the characteristics of the developing 'Person', of the immediate and more remote environmental 'Contexts', and the 'Time' periods, in which the proximal processes take place.

The context in which the person lives includes factors at various levels, more or less related and overlapping, which have a direct and/or indirect impact on the person. The theory identifies five environmental systems (Santrock, 2019), (Figure 6):

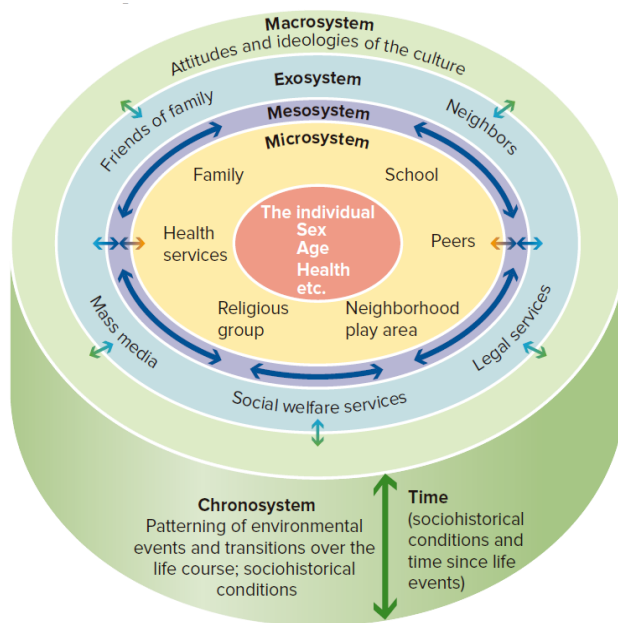
- The microsystem is the closest level to the person, and it includes the behaviours, roles, and relationships that are characteristic of the environments in which the person lives. It is the place where the person can easily interact face-to-face—with parents, peers, and teachers, for example. In this interaction, the qualities of the person shape developments within the nested systems across all levels of contexts.
- The mesosystem represents the connection between the different microsystems in which the person actively participates. Examples include the relation of family experiences to school experiences and of family experiences to peer experiences.
- The exosystem consists of the network of social settings in which individuals do not have an active role, but which can have an influence on them through their immediate context. For example, other relatives or the workplace of the parents.
- The macrosystem involves the culture in which individuals live. There are countless definitions, especially within anthropology, but culture can be understood as the products that are widely shared by members of a social group and passed on from generation to generation in virtue of belonging to that group, including symbols, beliefs, behaviour, rules, artefacts, or customs (Prinz, 2020). This set of common elements influences the perception that the individual and the different contexts have on any phenomenon. At the same time, the macrosystem is simultaneously established by the people who belong to the culture and has an impact on higher layers, such as social attitudes, legislation, or global policies.
- Finally, the chronosystem refers to events over the life course as well as sociohistorical circumstances. These changes and continuities include normative life transitions (e.g.,



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going to school), non-normative life transitions (e.g., parents' divorce), and the cumulative effects of the entire sequence of transitions over the life course.

Figure 6. Bronfenbrenner's ecological theory of development. Reproduced from Santrock (2019)

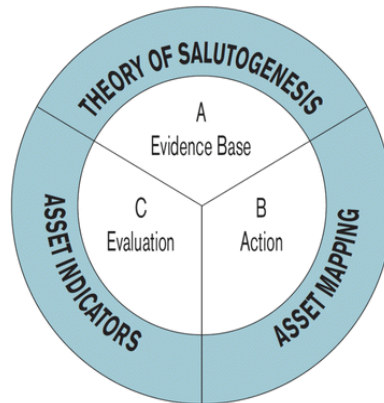


3.4.1.3 Assets Model

The model proposed by Bronfenbrenner is not the only one that analyses the influence of close contexts on people's well-being and development. For instance, the Assets Model (Morgan & Ziglio, 2007) highlights the importance of positive social networks of different types in bringing about social, economic, and health development between different groups, hierarchies, and populations. Three interrelated pillars define this model, summarized in figure 7 (Mittelmark, Bull, et al., 2017): The first part of the Model is "Theory of salutogenesis", which focuses on explaining the generation of health as compared to the pathogenesis focus on disease generation (Antonovsky, 1987). The second part is an action-oriented calling for a mapping of existing resources of communities and persons in public health initiatives. The third slice of the Model focuses on an evaluation which includes assets-based public health indicators. A 'health asset' can be defined as any factor which enhances the ability of individuals, groups, communities, populations, social systems, or institutions to maintain health and well-being and to help to reduce health inequities (Morgan, 2014). For example, family or friend networks are included in the community level. These assets can operate at any level as protective (or promoting) factors that act as buffers against life's stressors (Morgan & Ziglio, 2007).



Figure 7. An asset model of public health. Reproduced from Morgan and Ziglio (2007)



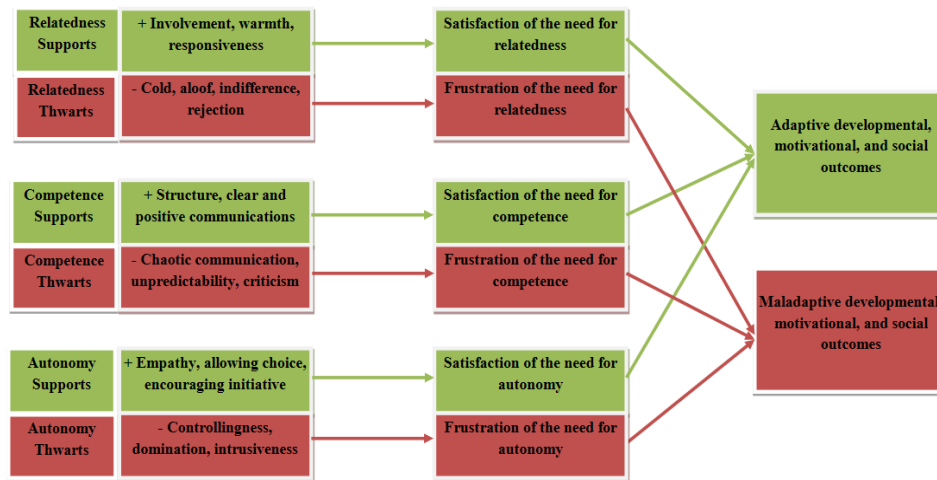
3.4.1.4 Self-determination theory

Most theories of human motivation have also focused on the effects of social environments in the individual's behaviour. One of the best-known theories on motivation is the self-determination theory (R. Ryan & Deci, 2000), which suggests that people need to feel competent; experience relatedness to other people; and feel autonomy with respect to their own lives (R. Ryan & Deci, 2000).

According to this theory, the social contexts within which people operate, both proximal (e.g., a parents) and distal (e.g., cultural norms), have an impact on individuals by facilitating or impairing the satisfaction of these basic psychological needs (Deci & Ryan, 2008), which have been consistently shown to be associated with psychological growth, wellness, and effective performance (Deci & Ryan, 2012). Thus, the quality of behaviours, emotional experiences, cognitive development, and psychological and physical health depends on the relation between the individual's own motivational states and how social environments satisfy these needs (R. Ryan & Deci, 2000). For example, parents can contribute to the psychological growth process by supporting the needs of children and adolescents for relatedness (e.g., by being warm and responsive), competence (e.g., by giving positive feedback and help), and autonomy (e.g., by encouraging initiative). When parents thwart these very same needs, they risk forestalling their child's development or even increasing vulnerability to psychopathology, as seen in figure 8 (Soenens et al., 2017). On the other hand, social environments that thwart the satisfaction of these needs yield less optimal forms of motivation and have deleterious effects on a wide variety of well-being outcomes (Deci & Ryan, 2012).



Figure 8. Conceptual Model of the Associations among Parental Support for Children’s Needs, Needs Experiences, and Developmental Outcomes. Reproduced from Soenens et al. (2017)



3.4.2 Social support

3.4.2.1 A definition of “social support”

In all the models described above, social contexts operate at different levels and can act as risk or protective elements. Research about adolescent populations emphasizes the importance of protective factors, that is, characteristics, conditions, and behaviours that improve positive health outcomes for individuals or reduce the negative effects of risks or hazards on individual health (Fergus & Zimmerman, 2005).

One of the most important assets for the positive development of adolescents is social support. Although social support is a key element for successful development throughout the life span, its conceptualization can be complicated due to the breadth of the concept. *Social support* refers to the emotional qualities of relationships (e.g., a sense that one is loved, cared for, and listened to) (Umberson & Karas Montez, 2010). Social support is not only emotional, as it also includes the provision of social company, of tangible and material assistance (e.g., giving money), and practical help (e.g., offering advice or information), that tends to facilitate how individuals cope with biological, psychological, and social stressors (American Psychological Association, 2015b; S. Cohen & Wills, 1985). Social support is important for psychological well-being in general (as main effect) and even more where the level of stress exposure is relatively high (as a buffer or moderation effect) (Turner & Brown, 2016).



As the buffering hypothesis postulates (S. Cohen & Wills, 1985), social support can decrease perceived threats in stressful situations and improve coping, which can be protective for mental health. Therefore, adolescents need supportive relationships throughout their cognitive, emotional, and social development which promote an optimal well-being and a successful adjustment in both their current and future health (DiClemente et al., 2013).

A high social support from different sources in adolescence is fundamental to attain higher levels of subjective well-being and better mental and physical health. High social support is associated with decreased internalizing problems such as anxiety or depression symptoms, decreased risky behaviours such as substance abuse, and decreased involvement in bullying episodes (Heerde & Hemphill, 2018; Rueger et al., 2016). At the same time, it promotes physical, psychological, and social aspects of subjective health and life satisfaction (Bi et al., 2021; Chu et al., 2010; Jiménez-Iglesias, Camacho, et al., 2017), and can have a positive impact on diet, physical activity, sedentary behaviour, and weight status (Draper et al., 2015).

Although it can be deduced that social support is an asset for the positive development of adolescents, it is not a universal or homogeneous element, since other variables—such as the cultural context, the source of support, or the lifespan—influence the impact of the support on health.

The following subsections will present some of the results regarding the impact of social support from the most relevant social environments on the health of adolescents.

3.4.2.2 *Social environments: family*

As observed in the previous section, the family plays a crucial role in the adjustment and development of children and adolescents. The family is a bidirectional, dynamic, and interactive system of reciprocal relationships, framed within multiple contexts of influence. Family is the main agent of socialization for children because it is the first social context where children develop and interact. It is the social environment for growth and socialization par excellence: here, its where members experience well-being; face conflicts and challenges; take on responsibilities; develop diverse identities and roles; acquire different cognitive, personal, emotional or social competencies; and provide as well as enjoy support and protection in order to overcome difficulties that arise both within and outside this social setting (Á. Parra & Oliva, 2015; Rodrigo & Palacios, 1998).



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Adults in the family, especially the parents—as the main caregivers—meet the needs of their children in order to guarantee their healthy development: nurture and material needs, attachment and affection, cognitive stimulation, opportunities to socialize, emotional support, etc. (Hidalgo et al., 2008).

When children reach adolescence, parents and caregivers face a whole new set of tasks that require new approaches to their changing needs (American Psychological Association, 2009). Early adolescence is characterized by rapid transitions across multiple domains, experiencing the exploration of personal identity. This results in discrepancies in the expectations of parents and adolescents regarding the behaviour of the latter, leading to the negotiation of autonomy in the parent–adolescent relationship (Smetana et al., 2006; Steinberg & Morris, 2001).

Perceptions of parental support often begins to decline since early adolescent (Furman & Buhrmester, 1985) and preferences shift to other social contexts, as peers and friends. Despite this endeavor for autonomy, the importance of strengthening family social support networks has been long recognized (Heerde & Hemphill, 2018) and adolescents need to feel connected to their family (Oliva, 2006). In fact, parental or family support is more related to life satisfaction than support from other sources (Bi et al., 2021; Jiménez-Iglesias, Camacho, et al., 2017), and is the most stable source of support throughout adolescence (Viejo et al., 2019) to face stress and deal with internalizing and externalizing behaviours (Attar-Schwartz et al., 2019; Pössel et al., 2018).

Research has found that parents and caregivers that maintain adequate levels of communication, connectedness with their children raise teenagers who have higher rates of socially competent behaviour, lower prevalence of risky behaviours, less emotional distress, and less externalizing behaviour problems (American Psychological Association, 2009; Resnick et al., 1997; Smetana & Rote, 2019; White & Renk, 2012).

In addition to the evidence suggesting the direct and central relation between family support and adolescent adjustment (Oliva, 2006; Steinberg, 2001), different studies also provide data on the moderating effect of family support on well-being. High-quality relationships between parents and adolescents—characterized by solid support, affection, and communication—protect the latter against the negative consequences of stressful life events on externalizing symptoms (Oliva et al., 2009).

These protective effects are observed during adolescence, throughout transition to adulthood, and into the midlife of individuals who have benefited from families who have been



supportive during stressful life events. Support in early family life is likely to encourage the development of skills for coping with changing and cumulative stressors and promote mental health throughout the life course from early adolescence to midlife (P. Chen & Harris, 2019).

However, family interactions during adolescence are not always positive. Family relationships can be a source of support that protects against distress; however, they can also be a source of stress (Camara et al., 2017). Early negative family experiences—characterized by very low levels of support and high levels of negative interactions—may have short-term consequences on risky behaviours, such as the emergence of adolescent delinquency (Keijsers et al., 2009) or substance abuse (Mathibela & Skhosana, 2021), as well as deleterious long-term consequences on one’s ability to develop and maintain quality social relationships over the life course (Gayman et al., 2011). Then real or perceived lack of parental support is an important risk factor in the development of health issues.

Several studies have indicated that positive family relationships, based on affection or ease communication, are associated with better mental health and greater life satisfaction in a similar way for both boys and girls since early adolescence (P. Chen & Harris, 2019; Jiménez-Iglesias et al., 2015; Jiménez-Iglesias, García-Moya, et al., 2017). Indeed, studies point out that both girls and boys in early adolescence perceive that the mother is the main source of emotional, instrumental, and informational support, followed by the father (Hombrados-Mendieta et al., 2012). However, from a developmental perspective and as mentioned on other occasions, throughout adolescence boys and girls perceive less support from their parents while the relevance of other reference figures increases (Furman & Buhrmester, 1992). For example, support from classmates becomes similar to or greater than that provided by the parents from 15 years of age onwards (Hombrados-Mendieta et al., 2012).

3.4.2.3 Social environments: friends

The relationship between adolescents and their families changes as a result of the increased independence and of the cognitive and personality development and these transformations are also observed in the relevance of relationships with other social environments. For instance, peers start to act as a significant source of influence on adolescent attitudes, activities, and emotional well-being (B. B. Brown & Larson, 2009).

Peer relationships can be conceptualized as complex patterns of discrete interactions with friends of similar age. There is considerable variability in the nature and type of peer interactions (Fabes et al., 2009). For example, interactions may be lengthy or brief. They may be



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positive (e.g., positive affection or prosocial behaviours), negative (e.g., conflicts or aggressions), or neutral. In addition, there is substantial variability in the nature of interactions depending on the setting (e.g., intimate friends or classmates) and the age (childhood, adolescence, or adulthood).

Therefore, a distinction must be made between relationships with peers and relationships with friends, a bond that is deeper and more committed. Friendship can be defined as the strong, positive affective bonds that exist between two persons and that are intended to facilitate the accomplishment of socioemotional goals. Friendship is based on egalitarian interactions and expectations of shared time, availability, mutual help, companionship, security, and emotional support (Bukowski et al., 2009).

Changes in the physical, cognitive, and social skills of children and adolescents facilitate their ability to interpret, respond to, and reason about their peer interactions. Thus, throughout childhood there will be a more sophisticated understanding of appropriate social behaviours that elicit positive reactions from peers. There will be an increasing interest in cohesion, affiliation, and engagement through the acquisition of skills necessary for reciprocal and interactive play. This includes prosocial behaviours such as cooperating or sharing, and learning about emotional experiences, social norms (e.g., to take turns), or emotion regulation strategies (Compas et al., 2017; Fabes et al., 2009).

With the onset of adolescence, friends begin to surpass parents as source of social support (Bokhorst et al., 2010; Furman & Buhrmester, 1992). Peers become a relevant social and instrumental support to cope with stressful events and to share social life (Compas et al., 2017; Fabes et al., 2009; Uink et al., 2017). Moreover, adolescents begin to value loyalty, commitment, and intimacy, and they look for these values in their social relationships. In addition, the development of identity is especially influenced by peers in this period, as they become a reference for decision making or a setting for experiencing different identities (Gini, 2008).

Although friends are particularly relevant during adolescence, research studies have been ambivalent regarding their effect on the adolescent's well-being and adjustment (B. B. Brown & Larson, 2009). Many studies conclude that the behaviour of friends in this age is a predictor of antisocial behaviour or risky behaviour, such as substance use (Sánchez-Queija & Sánchez-Jiménez, 2015).

However, friendship and friends offer many benefits, as for example, a high-quality and supportive friendships serves as a protective factor against social withdrawal (Barzeva et al.,



2022). Moreover, adolescents with supportive friendships report higher self-esteem in social, behavioural, and school-related domains (Erdley & Day, 2017). Well-accepted children were more likely to develop greater social competence in issues such as facing conflicts and social challenges with more an assertive and prosocial behaviour or participating in group interaction than rejected children (McDonald, K. L., & Asher, 2018). Positive and supportive relationships with friends helps to avoid loneliness (Vanhalst et al., 2014), have a sense of belonging to a group of reference with same interests and needs (K. Miller et al., 2017), and experiment with different social roles and skills (Güroglu et al., 2014). The support of friends acts as a resource that promotes successful adaptation during adolescence, including a high self-esteem, better social competence, sense of unity, and self-efficacy, and less internalizing symptoms (Bukowski et al., 2010; Marion et al., 2013; Salado et al., 2022; Sánchez-Queija & Sánchez-Jiménez, 2015).

Conversely, many studies have found that low-quality friendships—in which the presence of conflict is more prominent than other qualities such as the provision of help, security, or closeness—is related to poor well-being and adjustment problems for adolescents. For example, adolescents who reported high levels of negative qualities in their friendships (e.g., exclusion, pressure, or conflicts) were more depressed and socially anxious (La Greca & Harrison, 2005). Being alone after a stressful event was associated with higher levels of sadness, worry, and jealousy compared to adolescents who were with friends (Uink et al., 2017). Another research showed that adolescents who were chronically without friends were at risk of anxiety, loneliness, and withdrawal from school (A. M. Ryan & Shin, 2018).

Apart from the direct influence of the support of friends on the well-being of adolescents, friendship serves as a protective buffer against negative social, emotional, behavioural, and academic outcomes linked to risk situations such as peer victimization (Bagwell & Bukowski, 2018). The multiple dimensions of friendship—including having high-quality friendships and receiving emotional support from them—have been found to moderate the associations between victimization and internalizing distress (Yeung Thompson & Leadbeater, 2013) and link between negative parenting and externalizing behaviour problems (Lansford et al., 2003).

Regarding gender differences, inequalities in the way in which adolescents build their friendships are found. Research indicated that boys and girls presented different trajectories throughout adolescence concerning peer-group attachment. While girls start out from a high level of peer closeness from early adolescence, boys begin to increase their level intimacy from middle adolescence. At the final stages of adolescence, the importance of friendship tends to be



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equal for boys and girls (Gorrese & Ruggieri, 2012; Sánchez Queija & Oliva, 2015; Viejo et al., 2019). Girls' friendships are characterized by a greater exchange of emotional support, intimacy, affection, and social validation compared with those between boys (Erdley & Day, 2017). At the same time, girls are more sensitive than boys to conflict and to the positive quality of the friendship. It might be because of socialization: girls are typically taught to avoid conflict so as to not damage the quality of the intimacy; therefore, they might find it more distressing than boys (Demir & Urberg, 2004). These gender differences are also reflected in the purpose of building friendships: while the relationships of boys are more instrumental-oriented and seek power and authority, those of girls are more emotional-oriented and share their intimacies, affections, and company to a greater extent (Delgado et al., 2011; Steinberg & Morris, 2001).

3.4.2.4 Social environments: romantic partners

Being accepted by peers in the different possible relational configurations (as dyadic relationships or within the group) is important for the psychological development and well-being of adolescents (Gini, 2008). Inherent to the growing importance of peers, romantic relationships emerge in adolescence (B. B. Brown & Larson, 2009).

According to Collins (Collins, 2003), romantic relationships are ongoing voluntary interactions that are mutually acknowledged, characterized by a peculiar intensity marked by expressions of affection—including the expectation of sexual intercourse.

The first romantic relationships begin within the mixed-gender groups of peers and friends during middle adolescence (J. Connolly et al., 2014; Diamond & Savin-Williams, 2009). For example, in the 2018 edition of the HBSC survey in Spain, in response to the question “Do you currently have a partner?”, 25% of participants aged 15-18 years answered “yes” (C. Moreno, Ramos, et al., 2019). Most of the participants (40.3%) reported that the duration of their current romantic relationship was less than six months, 22.4% mentioned six months to one year, and 37.3% declared a year or more.

Romantic relationships and sexuality are conceptualized as a normative part of adolescent development (Espinosa-Hernández et al., 2020). Although most romantic partners during adolescence will not become stable relationships in adulthood, these new social experiences—especially those which are related to conflict and support management—are critical first steps to develop working models of intimate relationships and skills for future intimate partnership (J. Connolly et al., 2014; J. A. Connolly & Mclsaac, 2009; Diamond & Savin-Williams, 2009; Kansky & Allen, 2018).



Research has highlighted the unquestionable importance of early romantic experiences at this moment in the lifespan because of their impact on the development of the identity or the prioritization of family or peer relationships (Collins et al., 2009; Greene et al., 2015). However, the support of a romantic partner has been understudied compared to that of family or friends (Kansky & Allen, 2018). Moreover, conclusions regarding the association of well-being and romantic experiences are more controversial or mixed because of the complex relationship between both processes (Gómez-López et al., 2019): romantic relationships have been linked to both negative behaviours and psychosocial well-being (A. Meier & Allen, 2009).

The complexity of the role of the partner in adolescent development is based on two factors: on the one hand, the quality of the relationship (e.g., whether the relationship is a source of support or of conflict), the history of the shared experiences, the sense of attachment, and the beliefs which arise from the whole experience; however, on the other hand, the very fact of having or not having a partner during this age already has a short- and medium-term impact on the well-being of the adolescent (Gómez-López et al., 2019). For example, adolescents who do not date at all during their adolescence experience greater social dissatisfaction and lower self-esteem (Gonzalez Avilés et al., 2021) or are more socially anxious (La Greca & Harrison, 2005) than those who reported having had at least one relationship during this stage. That may happen because dating contributed to their status and sense of belonging in their peer group (La Greca & Harrison, 2005).

As happens with peer relationships, partner-related conflict tends to be associated with the development of internalizing behaviours such as anxiety, sadness, guilt, and worry (Kansky & Allen, 2018), as well as externalizing symptoms and risky behaviours such as intimate violence, delinquency, or substance use (J. Connolly et al., 2013; Furman & Collibee, 2014). Apparently, dating during adolescence can have negative consequences for the well-being of at least some adolescents, particularly for early adolescents and females (Gonzalez Avilés et al., 2021). To understand these negative effects, we must consider the influence of age and gender (J. Connolly et al., 2013; Davila, 2008).

Some studies concluded that having a romantic partner can be associated with greater levels of substance use, externalizing symptoms, and internalizing symptoms in adolescence, but was associated with lower levels in young adulthood. This pattern of results was consistent with the developmental task theory, which predicts that romantic involvement in early adolescence undermines development and adaptation, but romantic involvement was associated with positive adjustment in adulthood (Furman & Collibee, 2014). This can happen because romantic



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relationships in adolescence may also be emotionally challenging and overwhelming as they require levels of communication and problem-solving skills to deal with non-normative development events (such as arguing with your partner), and maybe adolescents are new to navigating these types of relationships and may not have developed healthy coping strategies yet (Davila, 2008; Furman, 2018; La Greca & Harrison, 2005).

Nevertheless, in regard to help- or support-seeking behaviours (Jorgensen-Wells et al., 2021; Kansky & Allen, 2018), romantic relationships can provide mental and physical health benefits too, such as fostering relational skills or eliciting autonomy. Furman and Wehner (1994), based on the insights about social needs of Sullivan's (1953) theory, explained that romantic partners fulfil different functions linked to attachment, caregiving, affiliative, and sexual behavioural needs. The affiliative function of adolescent romantic relationships offers company and aid. The caregiving system is represented by support and assistance. The attachment system includes love, closeness, bonding, and protection. And the sexual system includes physical intimacy and sexual intercourse (Furman, 2018). Thus, the positive effects of engaging in romantic relationships during adolescence have included friendship, support, intimacy, and sexuality (Gonzalez Avilés et al., 2021), as well as the development of life satisfaction, self-esteem, or social skills in the short and long term (Baams et al., 2014; Sánchez-Queija & Sánchez-Jiménez, 2015).

Little research has explored the role of the partner from a gender perspective. Perhaps more research has been conducted on sexism, social norms, or violence (Ramiro-Sánchez et al., 2018), but not about the meaning of bonding with a romantic partner for boys and girls. It seems that the experience of romantic relationships in boys and girls during adolescence follows a somewhat similar pattern to that of friendships: boys tend to view their romantic relationships as less intimate compared to girls, which is consistent with findings that girls are more aware and give more importance and value to close relationships (Kansky & Allen, 2018; Viejo et al., 2019). Nevertheless, other findings have supported that late adolescents in general rate closeness with romantic partners as more important than closeness with family members or friends (La Greca & Harrison, 2005). For girls, romantic relationships are important and meaningful because of the mutual caring, intimacy, friendship, company, emotional commitment, and support, attributes which are protective against internalizing symptoms such as depression (Volpe et al., 2014). Although it seems that the romantic partner fulfils socialization and care functions for girls at an earlier age, certain boys also reported similar levels of emotional engagement as girls, especially those who held less traditionally gendered patterns and relationship styles (P. C. Giordano et al., 2006).



3.4.2.5 Social environments: school

Attending school is one of the most relevant experiences for the adjustment and the development of the personality of adolescents. This setting is not only one of the places where they spend most of their time; it also offers different opportunities to achieve academic and professional outcomes (A. M. Ryan & Shin, 2018) and learn new social skills, and it influences their social and cognitive development, as well as physical and mental health (Graybill & Proctor, 2016; Löfstedt et al., 2020).

The relevance of this context can be found in two main aspects: on the one hand, its importance in the socialization process and, on the other, the fact that, in school, adolescents become integrated into new social groups and create relationships with other adults, such as the teachers (Estévez et al., 2008).

A school context enabling a successful trajectory through the educational system is essential for a healthy development (Horanicova et al., 2020). Although there is no consensus regarding which dimensions are essential to measure a school's climate, it has been described as based on five essential areas of focus: (a) Safety (e.g., rules and norms, physical safety); (b) Relationships (e.g., respect for diversity, school connectedness, social support); (c) Teaching and Learning (e.g., civic, emotional and ethical learning, support for academic learning); (d) Institutional Environment (e.g., physical surroundings, resources, supplies); and (e) The School Improvement Process (e.g., implementation of programs, parent-school-community ties) (Thapa et al., 2013).

Overall, a positive climate facilitates a feeling of belonging, safety, connectedness, acceptance and of being respected by others at school; this has a range of direct and indirect effects on development, and it is an asset for health-enhancing behaviours, life satisfaction and academic, interpersonal, and health outcomes (Aldridge & McChesney, 2018). Even longitudinal studies have shown that a students' feeling of belonging predicts an increase in engagement, positive affect, and achievement over time, as well as improved motivation during the transition to middle school (Song et al., 2015).

On the contrary, a non-supportive school environment and school-related stress (e.g., harassment, discrimination and bullying) can be risk factors for developing unhealthy behaviours and academic failure (Graybill & Proctor, 2016; Löfstedt et al., 2020).

One of the key factors to evaluate the quality of the school climate is the relationship established with the people in the school, i.e., schoolmates and teachers. A school climate based on social support can help adolescents explore their identity or the implications of the new



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ideas, activities ,or possibilities they are introduced to at school (Verhoeven et al., 2019). For many young people, attending school is a positive experience if they learn in safe and supportive environments and can develop trusting relationships with their classmates and educators.

3.4.2.5.1 Teacher support

Satisfactory relationships with teachers and schoolmates may be considered important assets to the extent that they contribute to a good mental health. For instance, a school climate based on positive peer and teacher support relationships increases positive attitudes towards school and education (Horanicova et al., 2020). Solid and positive relationships at school may increase school satisfaction by helping adolescents feel safer, respected, and heard. For example, social support mediates the connection between exposure to violence at school and symptoms of depression, anxiety, and somatization, acting as a protective factor which reduces the negative effects that exposure to violence has on the mental health of adolescents (Duru & Balkis, 2018).

Research on school climate indicates that higher connectedness with supportive adults was associated with improved mental health outcomes, and marginalized students did not always have the benefit of these relationships (Marraccini & Brier, 2017). The main benefit of teacher support is related to academic performance and satisfaction with school and education (Fredrick et al., 2017; Horanicova et al., 2020; Wit et al., 2011). However, the findings were not so consistent regarding the role of teachers in the emotional regulation of adolescents. Research often portrayed teachers as the least frequent source of support for adolescents (Hombrados-Mendieta et al., 2012) and, therefore, their protective effect to buffer the negative effects of internalizing problems of well-being or emotional adjustment may not be enough (Fredrick et al., 2017; Wit et al., 2011). Nevertheless, there are studies which showed that the role of educators is crucial in the school experiences of all young people, and having a positive relationship with teachers can protect adolescents from social exclusion (Arslan, 2018) and foster socio-emotional regulation and well-being, ameliorating depressive symptoms and increasing self-esteem (García-Moya et al., 2015; Spilt et al., 2012).

3.4.2.5.2 Classmate support

Relationships with peers in the school context may be limited to sharing the physical space of the classroom or school centre and the activities in the daily routine, but at other times friendships are built with schoolmates and classmates. Indeed, perceiving peers in the classroom



as friends is a relevant protective factor in the development of misbehaviours and has been linked to adolescent psychosocial and behavioural adjustment at school (Estévez et al., 2008).

Friendships provide students with a context in which they can feel relatedness and obtain social support at school. Students can feel better about stressful social and academic events after discussing them with friends. Feeling supported by friends in the school context was associated with greater school satisfaction, increased academic engagement, higher motivation, less test anxiety, and better academic performance (A. M. Ryan & Shin, 2018; Song et al., 2015). In addition case, the support of classmates makes a unique contribution to reducing internalizing behaviours among adolescents and to protecting them from the negative effects of peer victimization on externalizing behaviours (Attar-Schwartz et al., 2019; Coyle & Malecki, 2018). Moreover, student perceptions of declining classmate support were associated with declining self-esteem, increased depression, and social anxiety (Wit et al., 2011).

As with other sources of social support, age and gender influence its value and its protective effects on health. In terms of age, research finds that the perception of teacher support tends to decrease with age (Bokhorst et al., 2010; Fredrick et al., 2017). However, from middle adolescence onwards, the importance of the relationships with classmates increases and, therefore, classmates start being perceived as equally supportive as parents (Bokhorst et al., 2010; Hombrados-Mendieta et al., 2012).

Overall, girls are usually more satisfied and perceive higher teacher and classmate support than boys (Bokhorst et al., 2010; Hombrados-Mendieta et al., 2012), although some studies find that gender does not modify the associations between teacher or classmate support and engagement or satisfaction with school (Horanicova et al., 2020). Moreover, girls are more sensitive to the support of classmates and teachers. Although social support from classmates and teachers is a significant predictor of well-being, mental health, or academic performance, this association is usually stronger for girls. For example, the frequency of social support at school is more strongly related to social anxiety for girls than for boys (Coyle & Malecki, 2018). The relationship between the support of classmates and internalizing difficulties has been demonstrated to be significantly negative for adolescents, but it was statistically significantly stronger for girls (Attar-Schwartz et al., 2019). Furthermore, school support moderates the effect of social exclusion on psychological well-being for girls (Arslan, 2018).



3.4.2.6 Summary

Social environments, especially proximal social contexts, are spaces in which adolescents grow and develop social, affective, cognitive, and physical skills. The support of the contexts is a crucial element to foster positive development and functioning. The value, importance, and impact of the support of each context are dynamic and even serve as assets which compensate for any shortcomings that may occur in other social settings.

3.4.3 Transgender adolescents and social support

3.4.3.1 The role of stigma and prejudice on transgender health

As commented previously, different systematic and literature reviews consistently concluded that mental health issues, maladjustment, risky behaviours, and violence and victimization experiences were the most commonly studied areas of transgender health (Collier et al., 2013; Mackie et al., 2021; Reisner et al., 2016; S. T. Russell & Fish, 2016; Valentine & Shipherd, 2018). International studies unfailingly concluded that transgender youth report elevated rates of substance abuse (Newcomb et al., 2020; Raynor et al., 2020), emotional distress and symptoms related to mood and anxiety disorders (T. C. Clark et al., 2014; M. D. Connolly et al., 2016; Eisenberg et al., 2017), suicidal ideation, and suicidal and non-suicidal self-injury (Perez-Brumer et al., 2017; Veale, Watson, et al., 2017) compared to cisgender peers.

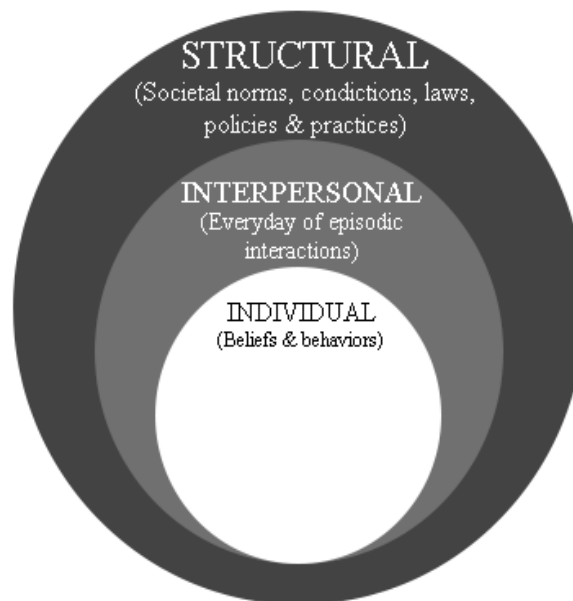
When Ian Meyer first drafted the minority stress model (2003), he explicitly mentioned that it was inferred from several sociological and social psychological theories on stress, stigma, and consequences on health. Meyer specifically referenced, among others, the original work of Bruce Link and Jo Phelan (2001), who were the first to expose the influence of structural stigma beyond the analysis of the individual and social interactions levels.

For Link and Phelan (2001), stigma exists when: 1) people distinguish and label human differences; 2) dominant cultural beliefs link labelled persons to undesirable characteristics; 3) labelled persons are placed in distinct categories to accomplish some degree of separation of “us” from “them.”; 4) labelled persons experience a loss of status and a discrimination that lead to unequal outcomes; 5) stigmatization is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labelled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination.



Other authors have used this theoretical contribution, and other models which further explore the interrelation between stigma and prejudice at different levels (Hatzenbuehler et al., 2010; Hebl & Dovidio, 2005; Phelan et al., 2008; Stewart et al., 2018), to advance the revision and integration of the concepts of stigma, prejudice, and discrimination. White Hughto, Reisner, and Pachankis (2015) from one side, and King, White Hughto, and Operario (2020) from another, made a critical review to integrate the literature on stigma on transgender people in the US, and applied ecological models to operationalize stigma according to the three levels that operate together (Figure 9).

Figure 9. Socio-ecological model of transgender stigma and interventions. Reproduced from White Hughto et al. (2015)



Structural

Types of Stigma

- Gender conformity to natal sex norms
- Stigmatizing policies
- Lack of provider training and education
- Healthcare access barriers
- Economic inequality
- Gender inequality

Interventions

- Non-discrimination policies
- Access to care policies
- Transgender health content in curricula

Interpersonal

Types of Stigma

- Healthcare discrimination
- Workplace discrimination
- Family rejection
- Hate crimes
- Sexual assault
- Physical assault

Interventions

- Family/partner support groups
- Healthcare provider trainings
- Intergroup contact

Individual

Types of Stigma

- Concealment of stigma
- Avoidance of stigma
- Internalization of stigma

Interventions

- Counseling/therapy
- Self-affirmation
- Transgender support groups
- Collective activism



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The structural level—the macrosocial form of stigma—refers to community norms, environmental conditions, and institutional practices (e.g., law and policies) that limit the access of transgender people to resources, opportunities, respect, and well-being because their identity challenges the hegemony maintained by hetero-cis-normativity in society. Societal norms and beliefs are integrated in the individual level (e.g., transphobia), as well as the relationships with the social environment (e.g., rejection and violence from family, peers, neighbours, etc.) which reinforce the legitimacy of rejection and violence and the internalization of stigma. The systematic undervaluation of transgender people limits their access to structural and social resources for well-being.

The interpersonal level—the microsocial level of stigma—refers to the interactions between stigmatized victims and the people at the communities which are mediated by the structural conditions that establish what is acceptable or unacceptable in the cis-hetero-normative society. Transgender people are targeted by negative attitudes and beliefs towards them, including rejection, discrimination, harassment, assault, and aggression because of their gender identity or expression. Whether they come out as transgender individuals or do not conform to sex and gender expectations, transgender people are exposed to individuals who have embedded society's norms in their personal value systems and express their rejection consciously or unconsciously. In fact, violence and rejection against transgender people is often perpetuated by people related to the victim, including family members, friends, or schoolmates/workmates. This translates into a lack of support or difficulties to access resources such as medical gender affirmation procedures, which can in turn have negative consequences such as isolation and mood disorders.

At the individual level, the direct consequences of stigma shape the person's cognitive, affective, and behavioural processes. Being exposed to continuous experiences of rejection triggers an anxious expectation of avoidance, generalizable to any situation or relationship, and reduced self-efficacy to cope with stigma-related stressors and, therefore, to build strong and healthy interpersonal relationships. Moreover, transgender people assimilate the structural and interpersonal forms of antitrans stigma and internalize anxiety, discomfort, and even self-hatred when they interpret, through the norms of the society to which they belong, that they have no right to be respected.

The minority stress model offers a framework to explain how social structures characterized by homophobia and transphobia impact the health of sexual and gender minorities (Hendricks & Testa, 2012; I. Meyer, 2003). Stigma and prejudice against sexual and



gender minorities are unique sources of stress presented at any level of society. On the contrary, social support and coping strategies help to moderate the impact of stress. This theory points out that pathology is not inherent in the gender identity status, but it is suffered as a result of the constant risks and attacks against transgender rights (I. Meyer, 2020; Testa et al., 2015).

Individual-level stigma factors are strongly activated by interpersonal and structural stigma to harm psychosocial health (Hatzenbuehler, 2016). Based on this premise, analysing the role of the social environments is important to understand the health of transgender adolescents. For instance, the European Union Agency for Fundamental Rights conducted one of the largest survey on LGBTI people in the EU in 2019 to analyse the quality of their lives and the situations of stigma and prejudice they still come up against (European Union Agency for Fundamental Rights, 2020a). This survey shows in different ways that transgender people face challenges related to discrimination in everyday life: regarding transgender adolescents aged 15 to 17, 50% of the sample had not disclosed to family members, 11% had not come out to friends, 32% had not disclosed to classmates, and 40% hid their LGBTI identity at school (European Union Agency for Fundamental Rights, 2020c).

The literature concludes extensively and comprehensively that for transgender people, no matter the age, lack of support is associated with isolation, low self-esteem, mood disorders, or risky behaviours, and may also lead some transgender individuals to transition later in life (White Hughto et al., 2015). The next pages provide a review of the previous research on social support, as was done in the previous section, discussing separately the social support from different contexts (that is, family, friends, teachers, classmates, and romantic partners) regarding the transgender community.

3.4.3.2 Family support and transgender adolescents

Considering the developmental perspective, the role of the family as a provider of affection and support changes throughout childhood and adolescence. It has been previously commented that its influence decreases in favour of other social contexts, but parents and family always play a crucial role in the development of adolescents. Indeed, parents are the most generally protective across a range of health outcomes for transgender youth (Gower, Rider, Brown, et al., 2018).

However, the vast majority of studies conducted over the last decade indicated that transgender people have continued to experience lack of support or rejection from family members, or were less likely to have strong family relationships compared to cisgender peers



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(C. Brown et al., 2020; Lefevor, Sprague, et al., 2019). Many transgender individuals reported receiving little family or caregiver support during their adolescence (Bockting et al., 2013; James et al., 2016). For example, Ryan et al. (2010) showed that transgender participants reported the lowest perception of family and social support in a diverse sample of LGBT young adults.

Studies conducted with transgender adolescents have shown similar results. For example, Clark et al. (2014) reported that transgender students were less likely to get along with their family, although about three quarters of transgender students reported that they had at least one parent who cared a lot about them. Eisenberg et al. (2017), in one of the first large-scale population-based studies on transgender adolescents in the United States, found that average levels of family or social support were lower for transgender adolescents than for their cisgender peers, even though transgender adolescents could also experience family connectedness as a protective factor and buffer against poor health outcomes in stressful or oppressive environments. The situation is even more delicate and complicated for adolescents who identify their gender as non-binary, who in other research studies have reported being less likely to have family support or even adult support outside the family when compared to their cisgender and binary transgender peers (Aparicio-García et al., 2018; Chew et al., 2020).

The main consequence of this low perception of support is the loss of the opportunity for transgender adolescents to use this asset as a protective element to buffer the impact of negative experiences on their well-being. Therefore, the perceived lack of family support of transgender adolescents leads to more psychological distress in this population (E. A. McConnell et al., 2016).

For transgender adolescents, experiencing high levels of family rejection is associated with higher odds of substance abuse compared to those who do not experience family rejection (Klein & Golub, 2016). Moreover, among transgender high-school students, higher parent connectedness was associated with lower odds of depression, self-injury, suicidal ideation, and suicide attempts (Gower, Rider, Brown, et al., 2018; Klein & Golub, 2016; Ross-Reed et al., 2019). Furthermore, parent connectedness and support can act as a critical protective factor among adolescents who engaged in non-suicidal self-harm and those who additionally had attempted suicide (Taliaferro et al., 2019).

In reverse, family support and parental connectedness have consistently been found to constitute one of the strongest factors which foster well-being and protect against psychological distress among gender minorities (K. C. Johnson, LeBlanc, Sterzing, et al., 2020). For example, in a small sample of 33 families with transgender youths, higher levels of family communication



and satisfaction perceived by the transgender participants was negatively associated with self-harm, depressive symptoms and anxious symptoms, and was positively associated with self-esteem and resiliency (Katz-Wise et al., 2018). In a study conducted with 129 transgender youth aged 15-25, family rejection was associated with higher levels of depression symptoms and suicidal thinking (Yadegarfar et al., 2014).

Considering the interiorized stigma described in the minority stress model, transgender adolescents might be less likely than cisgender peers to ask their families for help when facing both the particular changes of adolescence as a stage in the lifespan (e.g., youth acting out behaviours, hot and cold thinking) and the specific challenges facing transgender adolescents, such as coming out or seeking help for affirmative therapy.

Although one of the best predictors of well-being and adjustment in the childhood and adolescence may be the affirmative therapy process, especially for children who live in a manner that is consistent with their gender identity (Olson et al., 2016) or youth with gender dysphoria who seek hormone therapy (Olson-Kennedy et al., 2018), some studies concluded that family acceptance better predicted psychological functioning for transgender adolescents (Sievert et al., 2021; L. Simons et al., 2013).

Parents may be the first microsocial context where transgender individuals disclose their gender identity (Grossman & D'Augelli, 2006). Identifying as transgender may cause several changes in cis-hetero-normative expectations and family roles. These changes can be sometimes deeply emotional and even problematic but also positive and empowering (Dierckx & Platero, 2018). Transgender adolescents may confront several obstacles when coming out to their families.

First, the parental responses to the disclosure of the gender identities of transgender and gender nonconforming youths can be a stressful experience for the adolescents. For example, Grossman et al. (2021) observed that more than one-third of the fathers and mothers in their research reported a negative or a very negative initial response to their son's and daughter's transgender identity. Thus, transgender adolescents sometimes face fears around the opinion of parents and relatives such as being unsure about a relative's beliefs around gender identity (Lewis et al., 2021), fear of rejection or harassment, which may even end dramatically in depressive symptoms, homelessness, or self-harm (Grossman et al., 2021; K. C. Johnson, LeBlanc, Sterzing, et al., 2020; Shelton et al., 2018; Wilson & Cariola, 2020).

Families that are more accepting of sexual and gender minorities express a higher frequency of microaffirmations regarding gender identity, such as subtle interpersonal and



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environmental validations (Sterzing et al., 2019). In those cases, family acceptance of the transgender status and identity predicted greater self-esteem, resilience, or life satisfaction, and protects against emotional distress, depression, substance use, or suicidal ideation and suicidal attempts (C. Brown et al., 2020; Fuller & Riggs, 2018; Olson et al., 2016). For example, the odds of suicidal ideation demonstrated being significantly lower among young transgender women if they perceive their mothers as supportive and respectful of their gender identity (Jin et al., 2020). In a study of 66 transgender adolescents pursuing hormone therapy in USA, parental support was negatively associated with perceived burden of being transgender and depressive symptoms, and positively associated with life satisfaction (L. Simons et al., 2013).

Second, there can be a dependence on the parents to make decisions and access gender affirming medical care (Berg & Edwards-Leeper, 2018; K. C. Johnson, LeBlanc, Sterzing, et al., 2020; Tankersley et al., 2021). This might be mainly because parents have a crucial role regarding the authority over the extent to which the transgender children and adolescents can express their identity (e.g., social transition through name, gender pronouns, or clothing) (McLaughlin & Sharp, 2018) and also the legal authority to allow them to engage in the appropriate medical intervention, such as undergoing puberty suppression or hormone therapy (Lev & Wolf-Gould, 2018).

In sum, family support and mainly parental support could be a positive source of well-being for transgender adolescents, especially for advocating and protecting the identity development and decision-making process related to the experience of living according to one's own and personal view of gender (K. C. Johnson, LeBlanc, Sterzing, et al., 2020; Weinhardt et al., 2019).

3.4.3.3 Friends support and transgender adolescents

The role played by peers, especially friends, is also relevant to understand the support networks for transgender adolescents. Because of the developmental stage of adolescence explained before, the group of friends can be one of the most important affective and social relationships for their well-being. Some research studies even indicated that friends can be the most likely context to be identified as helpful, exceeding family support (Lewis et al., 2021; A. Taylor et al., 2020)

Because of the relative lack of social or family support for transgender adolescents, friendships take on an increased significance (Galupo, Henise, et al., 2014). Friends, whether they belong to the LGBTQ+ community or not, can be seen as a chosen family that makes



transgender adolescents feel loved and respected, enabling them to express their identity and to overcome stressful situations (Bower-Brown et al., 2021; Bry et al., 2018). Friends can even serve as role models and often provide counselling and instrumental support (Galupo, Bauerband, et al., 2014; Galupo, Henise, et al., 2014). Sometimes transgender adolescents do not need explicit support from their peers to find a valuable and safe space in friendship; receiving tacit acceptance of their identity could be enough (L. R. Allen et al., 2020).

In fact, current teenagers and young adults belonging to Generation Z (those born from the mid-to-late 1990s to the early 2010s) (Dimock, 2019; McCrindle, 2014) are more likely to adopt non-binary rather than binary gender identities than the youth of previous generations (Diamond, 2020). Moreover, Gen Z youth are much more likely to show concern about a lack of respect for sexual and gender diversity than older generations (Rivera et al., 2021) and to defend the rights of LGBTQ+ people (Deloitte, 2021; R. P. Jones et al., 2018). For example, they are more likely to demand that forms or online profiles include additional gender options apart from “man” and “woman” (Parker & Igielnik, 2020).

Friend support can benefit transgender and gender non-conforming youth in many ways. Different studies pointed out that supportive friends improve the positive sense of self and self-esteem (Bry et al., 2018; Singh, 2013; Singh et al., 2014) and promote more meaning in life and a future-oriented outlook (Johns et al., 2018). In an indirect way, connectedness to caring friends and peer contact served as buffers against the effects of stress and stigma on health outcomes (Johns et al., 2018; A. H. Johnson & Rogers, 2020) and against unhealthy behaviours such as binge drinking and nicotine use (Gower, Rider, Brown, et al., 2018). Also, studies conducted both with transgender adolescents and transgender adults reported that social support from friends could be a protective factor which reduces non-suicidal self-injury (Ross-Reed et al., 2019) and suicide risk (Tebbe & Moradi, 2016).

Friendship groups may offer emotional support by providing an open space to talk about various topics relating to gender identity and the experience of living as transgender (Lewis et al., 2021). In this sense, friendships with other transgender peers within the LGBTQ+ community can be particularly relevant and empowering.

These spaces foster the building of affective bonds in which a feeling of belonging and a genuine understanding of similar or common experiences is established. For transgender people, attending transgender and non-binary support groups allows them to communicate needs and experiences that maybe cisgender friends do not understand, such as the discomfort associated to gender dysphoria (Stone et al., 2020). Thus, connecting with this community gives



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them the opportunity to learn more about their gender identity, meet people who are going through similar challenges and difficulties, and share their knowledge and resources in dealing with the same problems, such as finding the courage to come out to their families (L. R. Allen et al., 2020; Lewis et al., 2021).

However, transgender youth may have more difficulty in accessing to supportive networks (Lefevor, Sprague, et al., 2019) because of the lack of general societal acceptance of their needs and experiences, which translates into stigma and discrimination at the different socioecological levels (White Hughto et al., 2015). This lack of support has an impact on their health and well-being. For example, disclosing transgender identity to friends can sometimes result in emotional and social isolation, which threatens the development of personal assets such as resilience and flourishing (Singh et al., 2014).

Along these lines, poor peer relations might be a high risk factor for the mental health of the transgender youth (Tankersley et al., 2021). Transgender adolescents who reported less peer support tended to have significantly higher rates of self-harm ideation and peer self-harm (C. Butler et al., 2019). In addition, frequent microaggressions by peers were found to be associated with a increased suicidal ideation for transgender youth (Parr & Howe, 2019; Perez-Brumer et al., 2017; Strauss et al., 2020). Problems with peers increased the risk of externalizing/behavioural problems and internalizing/emotional symptoms among transgender and gender non-conforming children (Cohen-Kettenis et al., 2003; Munroe et al., 2020) and adolescents (Levitan et al., 2019; Steensma et al., 2014) who attend gender identity clinics. Moreover, it seems that the quality of peer relationships indirectly affected the health-related quality of life of transgender adolescents by influencing the extent of internalizing and interpersonal problems (Röder et al., 2018).

In addition, transgender adolescents sometimes deal with subtle forms of daily behavioural, verbal, or environmental discrimination against their identity in their most supportive relationships (Pulice-Farrow, Clements, et al., 2017). When microaggressions based on the identity of transgender adolescents happen, they tend to rate the microaggressions as more upsetting when they occur within the friendship context and when the aggressions come from friends of similar identities (Galupo, Henise, et al., 2014).

This experience of discomfort caused by the lack of sensitivity and acceptance of friends is also appreciated in the heterogeneity of realities within the transgender community. Some studies conclude that children (Kualanka et al., 2017) and adolescents identifying as non-binary



or gender non-conforming (Aparicio-García et al., 2018; Chew et al., 2020) are less likely to have good peer relations and high support from friends than binary transgender peers.

3.4.3.4 Romantic partner support and transgender adolescents

While the processes of individual and social development may be similar for heterosexual and cisgender LGB youth, transgender youth could experience differences due to the cis-hetero-normative environments which sustain homophobia and transphobia (Smollin, 2014). One of the areas in which young transgender people may be vulnerable is the building of romantic relationships.

Historically, little attention has been paid to the romantic relationships of gender minority youths (Clemans et al., 2010; Smollin, 2014). Although there has been increased interest in the past decade in exploring the romantic relationships of transgender people, the literature has focused mostly on transgender adults and on the impact of intimate violence on health (Araya et al., 2021; Pulice-Farrow et al., 2019), rather than on the positive effects of the support that romantic partners can provide for transgender adolescents.

Intimate partner violence can be defined as any kind of coercive control, physical, psychological, or sexual violence by a current or former intimate partner (Breiding et al., 2015). Making a brief note on the issue of intimate victimization for transgender people, it is undeniable that transgender populations are significantly more likely to experience intimate partner violence in a more dramatic and worrying way when compared with general cisgender samples and sexual minority cisgender people (W. M. King et al., 2021). A meta-analysis conducted on intimate partner violence in transgender populations concluded that transgender people were 1.7 times more likely to experience any kind of intimate partner violence, 2.2 times more likely to experience physical intimate partner violence, and 2.5 times more likely to experience sexual intimate partner violence than cisgender adults (Peitzmeier et al., 2020).

Partner victimization was linked to worse sexual health (e.g., unprotected sex), mental health (e.g., depression or avoidant coping strategies), and substance abuse outcomes in transgender individuals (W. M. King et al., 2021; Peitzmeier et al., 2020). For instance, identity abuse and physical abuse were related to greater illicit substance use among gender minority young adults with lower cognitive reappraisal to cope with the episodes of abuse (Scheer & Mereish, 2021).



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Similar prevalence data were found in studies conducted with transgender youth. For example, in a study performed with transgender adolescents and young adults, 45% of the sample reported a lifetime history of intimate partner violence (Goldenberg et al., 2018). Furthermore, an analysis of a representative sample of high-school students from Colorado (USA) (Walls et al., 2019) using the intersectional approach showed that transgender adolescents, in particular those who were both transgender and non-heterosexual, had the highest risk of partner violence.

In addition to the more explicit forms of abuse such as those described above, transgender people also face subtler ways of violence and microaggressions in intimate relationships because of their transgender status.

Cisnormativity refers to the assumption that both sex and gender are only binary and aligned, which includes an “ideal standard” in which gender identity reflects the physical sex assigned at birth in the expected way through stereotypical roles and behaviours (Geist et al., 2017; Tan et al., 2020). Cisgenderism describes a prejudicial ideology which naturalizes cisgender identity and delegitimises the individual’s self-designated gender based on the assumption that appearance and bodily characteristics are linked to gender identity (Ansara & Hegarty, 2014; Lindqvist et al., 2021; Nicholas, 2019).

The presence of these gender-binary and cisgender status expectations affects all aspects of the relationships. That is, romantic partners might sometimes misgender transgender people (e.g., using gendered language that does not match how people identify themselves, such as incorrect pronouns) threaten them (e.g., with revealing the transgender identity and forcing the disclosure) or blackmail them with dissolving the relationship, saying they will never find another partner because of their transgender identity (Peitzmeier et al., 2020). These microaggression are present not only in romantic relationship, but in the negotiation of the relationship when interacting with other people as well, such as not knowing how to explain the partner’s gender to friends or family (Pulice-Farrow, Brown, et al., 2017).

Offensive comments questioning gender identity can even come from supportive partners (Puckett et al., 2021). For example, transgender people often struggle with getting their partners to respect their gender identity and expectations regarding their bodies (Lindley et al., 2021). Microaggressions might be particularly hurtful, not only because of the content or the intention behind the action, but because of the significance of the relationship (Pulice-Farrow, Brown, et al., 2017).



Despite this scenario, there is also research that recognizes the positive impact of romantic relationships on the well-being of transgender people, although these studies were less frequent and referred mostly to adults. Among them, different studies conducted with transgender adults have shown that perceived social support from the romantic partner was found to impact directly and indirectly on self-esteem, positive mental health or well-being. For example, in a sample of transgender men, perceived social support from the romantic partner, rather than the fact of being in a relationship or having a partner, influence the odds of suffering symptoms of depression and anxiety (S. C. Meier et al., 2013).

On the other hand, qualitative studies have shown that microaffirmations of identity in different ways within a romantic relationship were an important source of support and satisfaction. Microaffirmations through verbal or behavioural acknowledgements served to endorse and validate individuals on the basis of their gender identity (Pulice-Farrow et al., 2019). For instance, transgender adults appreciated when their partners supported them in any kind of social transition (e.g., choosing new clothes, participating in the election of the new name or the pronouns), medical transition (e.g., attending medical appointments together, encouraging them in any step of the process), or simply allowed them the emotional space to negotiate their gender identities (Pulice-Farrow et al., 2019). In another qualitative study (Galupo et al., 2019), non-binary transgender adults felt they were affirmed in intimate relationships through daily validations, demonstrating the positive benefits of having partners that understood the nuances of non-binary identities.

The few studies carried out from a more positive framework also pointed out that transgender adolescents and young adults can engage in a developmentally appropriate exploration of romantic relationships (Araya et al., 2021). In spite of the fear of being rejected due to a transphobia or homophobia interiorized by potential romantic partners, transgender adolescents also report positive experiences of engaging in romantic relationships and developing the skills needed to disclose their identity safely before and during social and/or medical transitioning (Araya et al., 2021).

Also, romantic relationships may be a broad protective factor for mental health among young transgender people. For example, being in a romantic relationship appears to reduce drinking and other illicit drug use among sexual and gender minority youth (Whitton et al., 2018). More evidence suggests that romantic involvement may protect against depressive symptoms, anxiety symptoms, and problematic alcohol use among sexual- and gender-minority



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emerging adults assigned female at birth, no matter their sexual orientation (Whitton et al., 2020).

Therefore, although the vast majority of the literature focuses on the adverse effects of intimate partner violence, there is also evidence that establishing romantic relationships can be a positive and normative developmental milestone for transgender adolescents, in which they may feel their identity and gender expression are supported and affirmed.

3.4.3.5 School support and transgender adolescents

The experiences of transgender adolescents in the school setting have been studied in depth in multiple ways. Most of the research have focused on the prevalence and consequences of school victimization against transgender adolescents (Domínguez-Martínez & Robles, 2019; Martín-Castillo et al., 2020). This phenomenon will be described in detail in the following chapter. In this subsection, the perception of support from different agents belonging to the school environment (e.g., classmates/peers, teachers, and school staff) and its effect on the adolescent's overall health and adjustment will be defined.

Schools should be effective in both teaching academic knowledge and fostering the acquisition of emotional, cognitive, and social skills by the students in order to promote their optimum adjustment and achievement of present and future academic goals (Lasarte et al., 2020). The problem arises when school environments are hostile against transgender and gender non-conforming adolescents for the reasons that have been documented throughout the chapter as, for example, paying poor attention to their specific needs for recognition of their identity, characterized by a lack of understanding of their gender expression or gender roles which defy society's expectations, etc. (Cederved et al., 2021). Any form of rejection, no matter how subtle or direct, makes transgender adolescents feel unsafe and unwelcomed (Colvin et al., 2019; Johns et al., 2021; Kosciw et al., 2018). Therefore, transgender adolescents face an increased risk of being bullied (Hatchel, Valido, et al., 2019; Heino et al., 2021), skipping school (Day et al., 2018), or dropping out of school (Grossman & D'Augelli, 2006); this also causes them to suffer from emotional distress (Gower, Rider, Coleman, et al., 2018) or risky behaviours such as substance use (Reisner, Greytak, et al., 2015).

On the other side, research have also documented benefits from having positive and safe climate at school for transgender adolescents (Tankersley et al., 2021). The perception of school safety and school belonging among transgender adolescents was associated with better academic and psychosocial adjustment. The perception of a safe school climate influenced



academic achievement (Anhalt et al., 2016) and reduced symptoms of depression, feelings of stress and despair, self-harm, or suicidal attempts (Gower, Rider, Coleman, et al., 2018; Taliaferro et al., 2019; Veale, Peter, et al., 2017).

The perception of a safe school climate depends on different variables. For example, rendering sexual and gender diversity visible through the design of inclusive curricular materials (Kjaraan, 2017; Luecke, 2018) or implementing trans-specific policies and sex and gender equality policies (Martino et al., 2020; Venegas et al., 2020).

The presence of Gender and Sexuality Alliances (or Gay Straight Alliances) within the school environment positively influences the physical, emotional, social, and academic well-being of sexual and gender minority youth (Marx & Kettrey, 2016). Gender and Sexuality Alliances are extracurricular school programs or clubs that bring together youth across sexual orientations and gender identities within an inclusive space free of stigma. These groups can foster a sense of belonging and connectedness to the school, offer support so that one can address issues related to sexual or gender status, and create a community within the schooling environment (Myers et al., 2020; V. P. Poteat et al., 2020). The presence of these alliances is associated with less school victimization and marginalization for LGBTQ+ youth (Marx & Kettrey, 2016) and with the reduction of negative mental health outcomes resulting from bullying such as depression and anxiety symptoms (Colvin et al., 2019; Day et al., 2020).

Therefore, one of the key factors that contribute to transgender youth having positive educational experiences is receiving social and emotional support from the school staff and schoolmates (McBride, 2021), emphasizing the need to consider how the support of classmates and teachers can independently promote adjustment, well-being, and positive development in school for transgender adolescents.

3.4.3.5.1 Teacher support

Perceived socio-emotional support and affirmation and validation from teachers can promote wellness, safety, and academic success among transgender adolescents. Teachers can be the first adult to whom the adolescent might turn for help in the school because of their closeness and daily interaction, especially when transgender adolescents have little support in this environment, or act as a bridge between the transgender adolescents and other resources available at school, such as school counsellors (L. R. Allen et al., 2020).



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One of the most consistent research studies on the role of teachers and school staff on the well-being of transgender adolescents is the National School Climate Survey (GLSEN, 2020). This project began in 1999 after identifying that lesbian, gay, bisexual, transgender, and queer youth were nearly absent from national studies of adolescents in USA. Since then, this survey documents the school experiences of LGBTQ students every two years and identifies interventions that can improve school climate (Kosciw et al., 2020).

In the last edition of the study, conducted in 2019 (Kosciw et al., 2020), LGBTQ high-school students reported that having supportive staff made them feel more comfortable in school, miss fewer days of school because of feeling unsafe, or feel less unsafe regarding their sexual orientation or gender expression. Moreover, supportive staff members promoted a safe learning environment that engaged students and encouraged them to strive academically. For example, LGBTQ students who felt comfortable at school also reported plans to pursue post-secondary education, higher grade outcomes, or greater educational aspirations. Additionally, LGBTQ students in schools with more supportive staff reported higher levels of self-esteem and lower levels of depression. Thus, having supportive teachers is a protective factor for mental health. These positive effects are accentuated by the presence of a LGBTQ-inclusive curriculum, Gender and Sexuality Alliances at school, or LGBTQ teachers who are out or open at school about their sexual orientation and/or gender identity, all of which make it easier for LGBTQ students to identify supportive staff members.

The National School Climate Survey is giving good examples of the pivotal role that teachers play in the overall well-being and safety of transgender adolescents, especially through support for issues related to the expression of their sexuality or identity. However, there is more research that helps to elucidate the different schools' dimensions that reveals to be more important for transgender youth.

For example, when the school staff (e.g., teachers or school counsellors) engaged in LGBTQ-supportive practices (e.g., defending the students against harassment or enforcing supportive policies and inclusive curricula), LGBTQ+ students perceived a lower frequency of victimization and a safer school climate (Gower, Forster, et al., 2018; Ioverno et al., 2022; V. P. Poteat et al., 2021). Additionally, the feeling of being in a safe environment through teacher support and advocacy also facilitates engagement at school, which is associated with less school avoidance and a higher level of self-motivation (Mereish & Poteat, 2015), and with better reported academic performance (V. P. Poteat et al., 2021) for LGBTQ+ youth.



Both directly through the perception of support and acceptance by teachers, and indirectly through the feeling of safety in the school environment, sexual and gender minority students improve their health and well-being. For example, a supportive school climate and supportive school personnel may make them less likely to report anxiety or depressive symptoms (Colvin et al., 2019). Another study found that teacher support attenuates the association between victimization and alcohol use (Watson et al., 2021).

The positive effects of teacher support and protection have also been observed in studies focused specifically on transgender adolescents. Teachers who took action to prevent and reduce bullying made students feel safer through their connection to adults (McGuire et al., 2010). Another study found a positive association between teacher positivity (i.e., encouraging students to express their gender as they like, defending students when someone made fun of the way they expressed their gender, talking about sexual and gender diversity in a positive way) and a sense of school connection, student motivation, and safety for transgender and gender-diverse students (Ullman, 2017). Yet another study, which analysed the availability of school resources and support, found that educators supportive of transgender youth were related to lower levels of victimization and to fewer days of absenteeism due to safety concerns (Greytak et al., 2013). In regards to health indicators, feeling safe at school protects against depression, suicidal ideation, and suicide attempts, and teacher connectedness can be associated with lower rates of binge drinking and of tobacco, alcohol, and marijuana use for transgender and gender-diverse youth (Gower, Rider, Brown, et al., 2018).

While some research shows that teachers are an essential figure in ensuring the well-being of transgender adolescents in the school setting, on other occasions it was observed that teachers can undermine their positive development when they show a lack of support or even participate in different forms of harassment and discrimination.

To begin with, transgender youth usually perceive school climate as more negative compared to non-transgender youth (Day et al., 2018). In addition, school support may be protective against violence victimization and other negative outcomes such as self-harm, these effects might be less robust for transgender adolescents compared to their cisgender peers (Ross-Reed et al., 2019). The case might also be that transgender adolescents receive so little social support from teachers that their feelings of isolation are exacerbated, despite the good intentions of teachers and school' staff (Harris et al., 2022).

In other cases, they expressed the feeling that their teachers would refuse to help them in situations of vulnerability in the school context. For instance, transgender adolescents



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considered that teachers were more likely to ignore harassment and threats at school against them than against cisgender adolescents, even though participants believed that teachers had the power to enhance their safety (McGuire et al., 2010). Likewise, in another study, transgender adolescents indicated that, on average, they “never” or “rarely” witnessed teachers and other students intervene against transgender harassment (Wernick et al., 2014). Furthermore, transgender adolescents can feel less comfortable talking to teachers about issues related to sexual orientation, gender identity, and gender expression compared to cisgender peers, and they feel less confident that teachers would intervene if discrimination against LGBTQ+ students occurred (Dessel et al., 2017).

One of the most significant ways in which teachers can show their support and validation is by using the pronouns and names chosen by transgender adolescents (Johns et al., 2021). In an important research involving transgender adolescents and young adults conducted in Australia (T. Jones et al., 2016; E. Smith et al., 2014), participants whose teachers forgot or disrespected pronouns were more likely to have poor educational outcomes than teachers whose teachers used appropriate language. For instance, being unable to concentrate in class (54% compared to 22%), having deteriorating grades (54% compared to 26%), missing classes (47% compared to 20%), or leaving school altogether (22% compared to 6%). In addition, there is a modelling effect whereby the supportive behaviours of the teacher are also reflected in the behaviours of peers at school. Hence, transgender students whose teachers use pronouns, name or identity inappropriately are more likely to become the target of physical, verbal or sexual harassment, or cyberbullying from their peers (T. Jones et al., 2016; E. Smith et al., 2014).

In consequence, teachers (and other school staff members) should take responsibility for providing support to enhance the quality of the experiences of learning and development for all students, especially transgender and gender non-conforming adolescents.

3.4.3.5.2 Classmate support

Exploring the way to express their gender identity and sexuality is one of the challenges where transgender teens need the most support. In fact, research has pointed out that transgender adolescents who sought to be treated as their gender identity by their school peers were more likely to suffer exclusion than those who did not seek to be treated as their gender identity by their school peers (Domínguez-Martínez et al., 2020). As a result, in order to avoid school violence and social withdrawal from the group of classmates due to their sexual orientation or gender expression, transgender adolescents sometimes try to fit into hetero-cis-normativity and



hide their own perceived gender identity or sexual orientation at the expense of their well-being (Cederved et al., 2021).

Thus, lack of support from classmates is a risk element to the safety and well-being of transgender adolescents. Nonetheless, referring once again to some of the data provided by the National School Climate Survey (Kosciw et al., 2020), almost half of the participants of the survey's last edition reported that their peers were accepting of LGBTQ+ people; this result was more common among students who attended schools with Gender and Sexuality Alliances.

Having supportive classmates is a significant factor of the quality of the school climate for transgender and gender-diverse students. The presence of supportive friends and classmates helps the adolescent cope during secondary school and contributes to self-acceptance (Cederved et al., 2021).

Perhaps the most visible positive effect of classmate support is reflected in protecting and defending transgender adolescents against school violence when classmates assume the role of allies (Luecke, 2011). Research points out that transgender adolescents with supportive classmates were less likely to experience harassment and discrimination at school. Even so, social rejection due to gender identity by schoolmates can lead transgender adolescents to experience verbal and physical aggressions (Domínguez-Martínez et al., 2020).

In the research conducted in Australia with transgender adolescents and young adults mentioned above (T. Jones et al., 2016; E. Smith et al., 2014), 30% of the survey participants with supportive classmates reported experiencing social exclusion, compared to 68% of those without supportive classmates. Furthermore, participants with supportive classmates were also less likely to report having rumours spread about them (36% compared to 50% without supportive classmates); being humiliated (28% compared to 53%); having people deliberately use the wrong pronoun or name (26% compared to 50%); being bullied on social media (21% compared to 47%); or having graffiti written about them (3% compared to 27%). Participants with supportive classmates were also less likely to miss classes (22% compared to 47%); hide at recess or lunch (21% compared to 50%); not use the changing rooms (17% compared to 27%); drop out of extra-curricular activities (14% compared to 27%); or move schools (7% compared to 27%).



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3.4.3.6 Mutual influences and provision of support among social contexts for transgender adolescents

So far, I have presented in separate sections some of the most immediate social environments adolescents interact with. This should not lead to the assumption that these contexts are independent from each other.

For example, family support appears to be the most relevant source of support in dealing with mental health issues and helping insulate transgender youth from negative experiences of rejection outside the family context (C. Brown et al., 2020). One study found out that transgender youth with high friend support but low family support can be at risk of worse mental health than those with high family support (E. A. McConnell et al., 2015). Thereby, family rejection could deprive transgender people of the protective buffering effects from other social environments and make them less resilient to discrimination (Klein & Golub, 2016).

However, other research studies concluded that transgender people needed to seek help and support from other sources to mitigate the disadvantage of a lack of family support in managing stressful events (Lefevor, Sprague, et al., 2019). As a result, transgender youth who had low family support but were supported by peers or romantic partners reported lower psychological distress than transgender youth with low support across all social environments (E. A. McConnell et al., 2016). Additionally, rejection by adults in different contexts (such as family or teachers) may mobilize transgender adolescents to ask for help and support in other groups such as chosen families (e.g., friends or transgender community), and this may compensate for the weak connections to other significant adults (Garcia et al., 2020; Gower, Rider, Brown, et al., 2018; Jin et al., 2020).

Research indicates that transgender people are exposed to high levels of harassment, victimization, and discrimination from childhood to adulthood. Thus, many transgender people perceive an extended lack of support in multiple major life domains (Trujillo et al., 2017). As a result, they may be at risk of lacking sources of social support and being overly dependent on the available social contexts to reach well-being. For example, having the support of a LGBTQ+ romantic partner can be a positive factor for well-being, mainly in the absence of traditional support from family (Galupo et al., 2019); however, given that some couples rely exclusively on each other for support, a harmful relationship can be built due to dependence, and resources outside the relationship should be identified (Greene et al., 2015).

It may also happen that different social environment can act as resources to foster different resiliency factors: for instance, one study indicated that both family and friend support



can be positively associated with the quality of life, but friend support can be positively associated with community connectedness, pride, and meaning in life (Weinhardt et al., 2019).

Moreover, sometimes the violence perpetrated against transgender adolescents resonates among perpetrators, such as when teachers do not respect their identity (e.g., clothing or chosen pronouns) and classmates tease and attack them due to their gender expression by modelling (Luecke, 2011).

Nevertheless, it may happen that the social agents from one social context boost the resources of other agents in the social network of transgender youth. For example, supportive parents might powerfully advocate for their gender-diverse children both with regards to extended family members as well as to school personnel to accomplish certain adjustments at school (e.g., use of the correct bathroom and more supportive responses from people belonging to other social environments) (Birnkranz & Przeworski, 2017).

In short, the relationships that are established between the social environments where transgender adolescents live are complex and mutually influencing.

3.4.3.7 Summary

In order to frame and explore the well-being of transgender adolescents, it is important to consider both the social challenges that are common for all adolescents because of the lifespan moment, and the specific stressors and risk factors they face because of their transgender status (S. T. Russell & Fish, 2016). As explained in the framework of the minority stress model, transgender adolescents may be less likely to perceive social support from their development contexts than cisgender peers and to take advantage of the support against discrimination and stigma which likely contribute to health disparities. Understanding within the family, friends, romantic partners, and school context may foster well-being and protect against challenges related to being transgender, including prejudice and stigma. The **Study 4** will explore the perception of social support from these developmental contexts among cisgender and transgender adolescents, and how social support influences mental health.



3.5 An example of minority stress and stigma for transgender adolescents: bullying and cyberbullying

The minority stress model has been indispensable to illustrate that sexual and gender minorities experience a great amount of social stigma and how oppression and violence affect their physical and mental health (I. Meyer, 2020). Transgender youth may face unique proximal or internal stressors (e.g., negative expectations or internalized transphobia) as well as distal or external stressors (e.g., everyday events of discrimination or microaggressions) (I. Meyer, 2015). For example, the latest reports launched by the Spanish Ministry of Home Affairs (2020, 2021) points out that hate crimes due to sexual orientation or gender identity are among the most common hate crimes that adolescents and young adults (up to 25 years old) suffer and perpetrate, the number of reports having increased from 256 in 2018 to 277 in 2020.

Research posits that exposure to these stressors compromises mental health and increases the risk of suffering from severe mental health conditions such as mood disorders, self-harm, or even suicidality (Delozier et al., 2020; Tan et al., 2020). It is therefore important to know, analyse, and understand specific situations of violence that stigmatize transgender youth and their consequences on physical and mental health, such as school violence, peer victimization, and bullying.

3.5.1 Violence at school: what is bullying?

Peer victimization, school violence, school aggression... Many forms of violence can happen in the school setting, but there are nuances and differences. School violence is the broadest umbrella term to refer to any violent behaviour that takes place within the school environment, including vandalism of school material and aggressions aimed at individuals (Estévez et al., 2008). Of all these behaviours, peer victimization could be considered a form of peer abuse in which the child or adolescent is recurrently the target of proactive aggressions (Kochenderfer & Ladd, 1996).

Bullying is one of the most common expressions of violence in the peer context during the school years (Menesini & Salmivalli, 2017). Research on bullying started in the 1970s and, since then, the concept is understood as a specific type of systematic peer abuse; however, it is a difficult phenomenon to characterize given that different interpretations and definitions can affect the measurement of the prevalence of bullying victimization across studies (P. K. Smith et al., 2016, 2019). Bullying is generally defined as negative actions or aggressive behaviours



intended to inflict injury or harm, in which three main features must be present: intentionality, a certain repetitiveness over time, and asymmetric power relationships favouring the perpetrator(s) (Olweus, 2013; Olweus & Limber, 2018).

For several decades now, the study of the phenomenon of bullying has not been limited to how the bully attacks the victim and to the consequences of the bullying process. As a socioecological phenomenon, bullying often takes place within a situation in which several members of the peer group are aware of what is happening, and each one of them plays a different role in the group. Therefore, the study of the bullying includes the analysis of different social roles within the groups. In this line, Salmivalli and colleagues (1996) proposed one of the most relevant typologies, in which other roles within the group were also made visible: defenders, reinforcers, assistants, and outsiders (Salmivalli & Nieminen, 2002; Yang & Salmivalli, 2013).

Thus, there is a strong connection between being bullied and perpetrating bullying. Victims can act submissively and passively to violence and exhibit a mild assertive behaviour and low levels of dominance. On the contrary, there are victims who respond actively to violence and react against the aggressions of bullies (Postigo et al., 2013). This second group of victims, known as aggressive victims or bully-victims, represent a minority but are a high-risk group, because their mechanisms to repel perceived social threats lead to a higher likeliness of being rejected and isolated by peers, showing both externalizing and internalizing problems, and having low social competence and inadequate social problem-solving skills (Cook et al., 2010; Postigo et al., 2013; Yang & Salmivalli, 2013).

Besides different actors, bullying also takes many different forms (Collier et al., 2013; Estévez et al., 2008; Låftman et al., 2021; Menesini & Salmivalli, 2017). Physical aggression comprises punching, kicking, hitting, pushing, shoving, beating, slapping, chasing, throwing objects, and damaging property. Verbal victimization involves calling names, teasing, humiliating, insulting, or threatening. Social and relational violence includes gossiping or spreading rumours about someone, telling others to stop liking someone, ignoring, being purposefully excluded by peers, or stopping talking to someone. Finally, sexual harassment encompasses verbal harassment (e.g., being the target of homophobic name-calling, sexual jokes, gestures, and unwanted comments about one's body) and non-verbal harassment (e.g., being touched or grabbed in a sexual way, being mooned, and being pressured for a date).

Different large-scale studies conducted in Western countries have suggested that approximately 4–25% of adolescents had been directly involved in bullying as perpetrators,



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victims, or both (Menesini & Salmivalli, 2017). For example, according to the data of the last edition of the HBSC Study in 2018 (Inchley et al., 2020), 10% of adolescents aged 11 to 15 years reported having been bullied at least 2–3 times in the last two months. Data from the Spanish team of this international network showed similar results: 12% of adolescents have been victims of bullying (C. Moreno, Ramos, et al., 2019).

3.5.2 The emergence of bullying on online environments: cyberbullying

Different international studies have reported a decrease in bullying and victimization over the last decade (Cosma et al., 2020; Waasdorp et al., 2017). The decrease in bullying prevalence can be linked to the implementation of programs aimed to eliminate violence and aggression at school (Gaffney et al., 2021). For instance, schools shut down for periods starting in March 2020 through May 2020 and in the first half of the 2020-2021 school year in some countries such as United States or Spain because of the COVID-19 pandemic (Bacher-Hicks et al., 2021; Trujillo Sáez, 2021). In a study conducted in United States was observed that in-person bullying decreased as in-person interactions decreased too (Bacher-Hicks et al., 2021).

An additional explanation for this drop may be the shift of social interactions toward the virtual environments where children and adolescents spend their time (Kowalski et al., 2019). Studies conducted a decade ago had already shown the interest of adolescents in social media and the time spent on the Internet. Millennial adolescents were already beginning to spend part of their free time on the Internet in different types of activities, such as the use of social networks (at that time, Fotolog, Tuenti, MySpace, or Facebook), to the point that the blurred lines of personal relationships between the online and offline environments began to merge (Oliva et al., 2012; Reich et al., 2012; Van Cleemput, 2010).

Adolescents are spending more and more time in front of screens, even exceeding the two hours/day recreational screen time recommended by the WHO guidelines (Fairclough, 2021; Odgers et al., 2020). According to a report on screen time use on online video, social media, gaming, education apps and communication apps among children and adolescents, the average daily time spent on social media before the pandemic lockdown was 83 minutes in Spain, 92 minutes in US, and 83 minutes in UK (Qustodio, 2020). On average, kids and adolescents in Spain spent most of their time on social media apps (e.g., TikTok, Instagram, Facebook), especially during the peak of the pandemic lockdowns (Qustodio, 2021). Another study from the Spanish Statistical Office showed that 94.5% of children aged 10-15 have used the Internet in the last 3 months and 69.5% had at least one mobile device of their own (Instituto



Nacional de Estadística, 2020a). Likewise, 93% of young people aged 16-24 had accounts on at least one social media network and 98.5% of them used communication apps (Instituto Nacional de Estadística, 2020b). A UNICEF study also conducted in Spain produced similar data (Andrade et al., 2021): of the total sample, one in three adolescents aged 11-17 years in Spain made problematic social media use, 90.8% used the Internet daily, 98.5% were logged into at least one social media, and Youtube, Instagram, and TikTok were the most popular social media platforms.

Undeniably, access to the Internet has revolutionized the way we interact with people and manage our time. The social relationships that take place in offline environments have also been transferred to online spaces. Thus, teenager transfer the dynamics of the relationships they have in the school context to the new information and communication technologies (Kwan et al., 2020). Moreover, online contexts give opportunities for adolescents to explore, express and develop their identity without the constraints of offline environments (Wängqvist & Frisé, 2016). However, this may be associated with risks in terms of identity development too. Considering all these data, it is not surprising that social media platforms are very popular among including aggressions and bullying (in this case, cyberbullying).

If, as we said before, the study of bullying emerged in the 1970s, the study of cyberbullying is taking place in the 21st century (Zych et al., 2016). Cyberbullying can be defined as bullying performed via electronic forms of contact or communication, including social media, emails, chat rooms or communication apps, instant messaging, or websites. These aggressions include sending purposeful and damaging messages and content (e.g., email, pictures, video, text) directly to victims or for public view (Olweus, 2013; Paez, 2020).

There are doubts as to whether cyberbullying can be considered as bullying but in electronic media because of the difficulty in applying the criteria of repetitiveness or of power imbalance. Although cyberbullying could be considered as just another type of peer violence, such as Internet harassment or bullying perpetrated through electronic devices (Zych et al., 2016), researchers agree that the traditional criteria can be applied: cyberbullying is an intentional and repeated aggression through electronic devices, there is an imbalance of power (e.g., relative anonymity, social status, number of friends), and it is perpetrated by individuals or groups on victims who cannot easily defend themselves (Bauman, 2012; Olweus & Limber, 2018; P. K. Smith et al., 2008; Tokunaga, 2010). With the increased access to and use of electronic devices, the prevalence of cyberbullying behaviours has risen dramatically among children and adolescents, taking advantage of Internet features such as the anonymity of the



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offender, a substantially wider audience, or the permeability of online content (Guo et al., 2021; Li et al., 2021).

This reflection on whether they are identical or independent types of peer aggression leads to the questioning of the degree to which cyberbullying overlaps with traditional bullying across contexts.

International studies have found a greater disparity between the prevalence of falling victim to cyberbullying than that of falling victim to bullying: depending on the methodology of the study, overall cyberbullying victimization can vary from 1.0% to 61.1% (Brochado et al., 2017). Nevertheless, cyberbullying phenomena are usually less frequent compared to bullying at school. For example, in Spain, the percentage of victims of cyberbullying was 5% in comparison to 12% of adolescents who were victims of bullying (C. Moreno, Ramos, et al., 2019). Other international studies found that approximately 1/10 of the participants reported being involved in cyberbullying, whereas about half of the participants reported being involved in bullying (Carvalho et al., 2021). In another study which combined data from 21 countries, the prevalence of cybervictimization was systematically lower than traditional victimization rates (Cosma et al., 2020).

Several other research studies indicated that victims of bullying were often also victims of cyberbullying, which may suggest that cyberbullying originates in the school setting (Olweus & Limber, 2018), although, here too, there is a heterogeneity in the data. For example, Bacher-Hicks et al. (2021) found that both in-person bullying and cyberbullying decreased dramatically during the school years affected by the pandemic in USA, consistent with prior evidence that cyberbullying reflects in-person bullying enacted through a different medium. In the study led by UNICEF on the impact of communication technologies on the well-being of adolescents (Andrade et al., 2021) the rate of bullying victimization has been estimated at 33.6% and 22.5% for cyberbullying; 72.9% of adolescents who are bullied online are also bullied offline; and 52.4% of cyberbullying victims are also cyberbullies. Therefore, cyberbullying and bullying frequently overlap. Another study—which included 21 countries to estimate cyber victimization and bullying victimization rates—revealed that, on average, 45.8% of those adolescents who reported cybervictimization also reported traditional victimization (46.5% for boys and 45.3% for girls) (Cosma et al., 2020). Moreover, in a study conducted in Portugal, 8.5% of the participants reported being involved in both bullying and cyberbullying episodes (Carvalho et al., 2021).



3.5.3 Effects of bullying and cyberbullying on adolescent well-being

Both bullying and cyberbullying are recognized as a serious public health concern due to their short- and long-term detrimental effects on the health of the victims. Bullying and cyberbullying victimization is associated with numerous severe health conditions.

In these lines, adolescents who were bullied were more likely to mention psychosomatic complaints such as dizziness or to report low self-perceived health (Hansson et al., 2020). Victims of bullying often suffer depressive and anxious responses, loneliness, or low self-esteem issues (Andrade et al., 2021; Cook et al., 2010). Adolescents who were exposed to sexual harassment at school had a lower likelihood of reporting high life satisfaction (Låftman et al., 2021). Similar outcomes can be found among cyberbullying victims: cyberbullying victimization was strongly and negatively associated with depression, anxiety, somatic complaints, low self-esteem and life satisfaction, substance misuse, self-harm, hostility, or suicidality (Bottino et al., 2015; Kwan et al., 2020; Vaillancourt et al., 2017). For instance, a follow-up study found that cybervictims and victims of cyberbullying were significantly more likely to report depressive symptoms, social anxiety symptoms, and below average well-being (Fahy et al., 2016). Also, cybervictimization reduces life satisfaction and can be especially detrimental for adolescents who also experience traditional bullying (Arnarsson et al., 2020).

Firstly, being a victim of bullying increases the risk of self-harm (Myklestad & Straiton, 2021). Secondly, physical and relational victimization at school are associated with suicide ideation and suicide attempts, particularly for adolescents with anxiety problems who perceive low social support (Barzilay et al., 2017). Finally, different reviews and studies pointed out that victims of cyberbullying were also at a greater risk of self-harm and suicidal behaviours, including suicidal thoughts and attempts (Andrade et al., 2021; Gini & Espelage, 2014; John et al., 2018).

In addition to the health consequences described in the previous paragraphs, youth who experienced bullying or cyberbullying victimization had higher rates of tobacco and illicit drug use (Carvalho et al., 2021; Moore et al., 2017), externalizing maladjustment as violent behaviours towards others (Casper & Card, 2017), isolation at school, absenteeism, and truancy (Gastic, 2008; Giumetti & Kowalski, 2016; Greytak et al., 2013; Guy et al., 2019), and lower academic achievement because of lower academic engagement and motivation (Samara et al., 2021).

The painful and acute experience of bullying during school persists for years, as prospective studies conducted with adults who were victims of bullying document that victimization in school is associated with poor long-term outcomes in adulthood, such as greater



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risk of somatization and psychiatric disorders, problematic social relationships, and poor educational and financial achievement (McDougall & Vaillancourt, 2015; Sigurdson et al., 2015).

In reference to the different socioecological models reviewed in previous chapters, bullying and cyberbullying should be understood in relation to the role of the developmental contexts. Perceptions of school safety and social support can generally serve as buffers against the negative effects of bullying on young people (Mulvey et al., 2018).

Some studies stress that support from the family or school setting may be protective against bullying and peer victimization among high school students. Moreover, social support from family and teachers mediates the relationship between exposure to violence at school and mental health among adolescents, as the adverse effects of exposure to violence at school on the mental health of adolescents may change depending on the level of social support (Duru & Balkis, 2018).

For example, adolescents who were exposed to violence at school suffer from depression, anxiety, and psychosomatic symptoms, but adolescents who got social support from their family and teachers reported better levels of mental health (Duru & Balkis, 2018). Parental support can moderate the effect of verbal victimization on suicidal ideation and attempts among adolescents who suffer from anxiety and depression, as high parental support plays a protective role against suicidal behaviours in peer victimization conditions (Barzilay et al., 2017). Social support from family, peers, and school also mediates the relationship between social exclusion and psychological well-being for adolescents (Arslan, 2018). The support of adults at home and at school can mitigate the negative effect of bullying victimization on life satisfaction (Miranda et al., 2019). In addition, similar results were observed in cyberbullying episodes: adolescents who felt supported by their parents tended to be less engaged in cyberbullying behaviours (Grunin et al., 2021). Moreover, perceived social support from family and from teachers reduced the probability of depressive and anxiety symptoms, and higher levels of family support increased the odds of higher levels of subjective well-being among adolescents who were victims of cyberbullying (Hellfeldt et al., 2019).

In addition to parental support, having protective friends and classmates can be an even more crucial asset against the harmful and pernicious effects of bullying and cyberbullying. One study found that classmate support can reduce internalizing symptoms among adolescents more than support from parents and teachers, and the association between classmate support and externalizing behaviour was fully mediated by youth victimization (Attar-Schwartz et al., 2019). Another study showed that peer support partially mediated the relation between



victimization and depression symptoms among bullied students: thus, students who were bullied at school received little peer support and suffered symptoms of depression (Du et al., 2018).

Besides main or direct effects of peers support on adolescents health who are victims of bullying or cyberbullying, the mediation effects of perceived peer support are also observed between victimization at school and academic performance adjustment (J. Wang et al., 2011). Not only the frequency, but also the importance of the support of classmates and close friends at school, are negatively and significantly associated with social anxiety (Coyle & Malecki, 2018). In addition, a significant moderating and protective effect of peer support on the associations between victimization and suicidality has been identified: adolescents with high peer support have lower likelihood for suicide ideation when they were verbally victimized (Barzilay et al., 2017). These outcomes and conclusions were also found on online peer relationships: young people who lack supportive networks in person may find online relationships crucial in supporting their well-being against online and offline violence (Ybarra et al., 2015).

When investigating the role of social support, we should not only view it as a protective asset against the pernicious effects of bullying on adolescent health, but also as an interactive process. In general, students who perceive low social support have higher odds of being victims of bullying or cyberbullying. In addition, students who are bullied and are rejected or isolated by their peers may feel less confident and have less satisfactory social skills (Pouwelse et al., 2011).

The role of gender in bullying and cyberbullying behaviours has been studied. A review based on five large cross-national data bases show that boys are more likely to engage in physical bullying as perpetrators and also tend to be victims of bullying more frequently. Girls appear to be more involved as victims of online rather than offline bullying (P. K. Smith et al., 2019). Different cross-sectional studies found the same results: boys are more likely to be perpetrators of both bullying and cyberbullying, while girls are more likely to be victims of cyberbullying (Foody et al., 2019; Guo et al., 2021; Inchley et al., 2020).

Not only do the ways in which adolescents engage in bullying episodes differ according to gender, but so do the effects on their well-being. School support moderates the association of social exclusion and psychological well-being in girls, while peer support has a moderating effect on the association of social exclusion and psychological well-being in boys (Arslan, 2018). Girls are more vulnerable to the negative effect of school victimization on academic adjustment than boys (J. Wang et al., 2011) and depend more on social support from family and teachers to



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have a better psychological adjustment against the adverse effects of exposure to school violence than boys (Duru & Balkis, 2018).

3.5.4 Summary

So far, we have reviewed the concepts of bullying and cyberbullying, discussed their prevalence in different international studies, and presented their pernicious effects on adolescent health, both directly and in relation to the protective effects of perceived support from the developmental context on buffering the negative impact of the victimization experiences on health.

3.5.5 The prevalence of school victimization for transgender adolescents

It is undeniable that there are groups of adolescents who are at greater risk and that there are risk factors for harassment, including ethnicity, sexual orientation, or gender identity (Andrade et al., 2021; Juvonen & Graham, 2014). Therefore, the following section will describe data on the rates of bullying experienced by transgender adolescents and its consequences on their development and well-being.

A growing body of research documents that transgender adolescents experience a higher rate of peer victimization than cisgender youth (Martín-Castillo et al., 2020). According to a scoping review on the mental health of transgender youth in secondary schools, between 32% and 44% of transgender adolescents reported being victimized at school, while between 17% and 80% of transgender adolescents self-identified as victims of bullying at school (Mackie et al., 2021).

In the nationwide GLSEN study conducted in the USA, Kosciw et al. (Kosciw et al., 2020) found that transgender youth were more than twice as likely to experience victimization at school based on gender or gender expression when compared to their cisgender peers. Specifically, 83.3% of transgender students and 68.7% of non-binary transgender students were victims of discrimination due to their gender, compared to 36.8% of cisgender adolescents. In addition, 82.1% of transgender students and 75.2% of non-binary transgender students were discriminated at school because of their gender expression, compared to 39.3% of the cisgender students.



Other studies in the US found similar results. For example, 72% of transgender adolescents reported being victimized by their peers in the last twelve months (Hatchel & Marx, 2018), and 82% of transgender students reported frequently hearing negative gender-based comments within the school environment (McGuire et al., 2010). Moreover, a study with transgender youth found that one in three experienced peer victimization at school (Hatchel, Valido, et al., 2019). In addition, transgender adolescents suffered more general victimization and cybervictimization, to the point of being six times more likely to be bullied due to their gender identity compared with their cisgender peers (Day et al., 2018).

In another research conducted with transgender and gender-diverse youth in Australia, 21% of participants reported experiences of physical abuse and 65% had suffered verbal abuse on the basis of their gender expression, to the point that over 90% of the survey participants had thought about suicide (T. Jones et al., 2016).

Online victimization can be especially troubling for transgender adolescents. Transgender youth sometimes need support from communities outside their immediate environments (L. R. Allen et al., 2020; Lewis et al., 2021). This includes seeking help, emotional care, or information on sensitive topics such as sexual health and gender identity in online spaces, such as social networks or specific forums (Dowers et al., 2020; Krueger & Young, 2015; Selkie et al., 2020). In fact, some studies indicate that the effects of the social capital and support offered within online communities can boost the positive impact of the support of in-person and offline contexts for transgender adolescents (Selkie et al., 2020; Ybarra et al., 2015).

However, using social media can expose adolescents to both benefits and risks. While the Internet can be a safe space, it is also common for transgender adolescents to be insulted, threatened, or humiliated on platforms such as Facebook, Instagram, or Snapchat (Henderson et al., 2022; Selkie et al., 2020). Additionally, the online support cannot protect against the negative effects of victimization or cybervictimization in all circumstances (Ybarra et al., 2015).

It is important to note that the data from most research analysing the impact of cybervictimization on health mixes gender identity with sexual orientation groups; or studies including transgender participants draw their conclusions from a small sample of participants (Abreu & Kenny, 2018). Even so, rates of online bullying and sexual victimization are high among LGBTQ+ youth (Atteberry-Ash et al., 2019; Ybarra et al., 2015). A systematic review that explores the effects of cyberbullying on LGBTQ+ youth showed that the percentage of cyberbullying among LGBTQ+ youth ranges between 10.5% and 71.3% across studies (Abreu & Kenny, 2018). And as the GLSEN study also points out (Kosciw et al., 2020), 44.9% of LGBTQ+



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students experienced cyberbullying (via text messages, emails, or on social media such as Instagram, Twitter, Tumblr, Facebook, or Snapchat).

Recent research based on nationally representative samples of high-school students in Western English-speaking contexts helps to unveil the disparities in bullying involvement between gender minority and cisgender youth. However, research with similar sampling methodologies and strategies has also been carried out in Europe.

Some findings on the discrimination facing 15-17 year-old transgender adolescents in Europe can be found in the European Union Agency for Fundamental Rights 2019 survey on LGBTI people (European Union Agency for Fundamental Rights, 2020c). Data show that 32% of participants did not disclose to their classmates, and 40% of transgender adolescents 15-17 years old hid their LGBTI identity at school. In the case of Spanish transgender adolescents, 13% of participants claimed they never received support or protection during their time at school as an LGBTI person; 27% of participants did not disclose to their classmates; 34% of adolescents hid their LGBTI identity at school; 36% of participants had been ridiculed, teased, insulted or threatened at school because of being LGBTI; and 36% of participants often or always experienced negative comments or behaviours at school because of being LGBTI.

At the same time, the Education Commission of the Madrid Lesbian, Gay, Transsexual, and Bisexual Association (Colectivo de Lesbianas, Gays, Transexuales y Bisexuales de Madrid, COGAM), together with the National Federation of Lesbians, Gays, Transsexuals, Bisexuals, Intersexuals, and more (Federación Estatal de Lesbianas, Gais, Trans, Bisexuales, Intersexuales y más, FELGTBI+), conducted a study with 7,408 adolescents between 12 and 17 years old on sexual and gender diversity in the classrooms (Martín Vela et al., 2019). They found that 1% of cisgender and heterosexual participants, compared to 12% of LGBT participants, had been insulted for looking like homosexual, bisexual, or transgender individuals. Among transgender students, the percentage of those who have suffered these insults doubles to 24%. Moreover, 1% of participants reported having suffered cyberbullying. Finally, only 1% of the LGBT participants in this sample of 7,408 students have disclosed in their schools.

Nevertheless, when studying violence and victimization episodes due to gender identity, it is necessary to consider both the situation of being bullied and of perpetrating bullying. Research on violence and bullying perpetrated by transgender and gender-diverse youth is anecdotal and scarce. For example, in a study on dating violence experiences, transgender youth reported the highest victimization rates of physical and psychological dating and cyberdating abuse; however they also reported the highest perpetration rates of physical dating violence,



cyberdating abuse, and sexual coercion (Dank et al., 2014). One of the few studies that have examined the different roles of transgender adolescents in the episodes of violence, conducted in a nationally representative sample of adolescents in Finland, showed that being bullied is more common among gender minority groups, particularly among non-binary identity groups. At the same time, transgender adolescents were more likely to perpetrate bullying than be bullied (Heino et al., 2021). Although, as the authors hypothesized, such aggressive behaviour could emerge as a strategy for coping with the consequences of being a victim and dealing with the negative emotions.

Rates of being victim of bullying are undoubtedly higher for transgender adolescents compared with cisgender adolescents, but mixed findings on the victimization profiles within the transgender community are observed.

Taking the study of Heino and colleagues (2021) as an example, it seems that non-binary or gender non-conforming transgender adolescents are bullied more often than their cisgender and binary transgender peers, and non-binary transgender youth also perpetrate bullying more times. Other research studies, although conducted with convenience samples, show similar results: non-binary transgender and gender-questioning youth, compared with cisgender and binary transgender adolescents, seem to experience higher levels of discrimination and polyvictimization, referred to school-based bullying or cyberbullying (Aparicio-García et al., 2018; Bower-Brown et al., 2021; Sterzing et al., 2017).

Other research indicates that binary transgender students are more likely to have felt unsafe and experienced higher levels of victimization at school based on their gender and their gender expression compared to cisgender and non-binary transgender students (Kosciw et al., 2020). Finally, other studies conclude that there are no significant differences regarding exposure to bullying or feelings of safety and belonging between binary and non-binary transgender adolescents, although there were differences in other indicators: non-binary young people displayed lower rates of coming out at school or higher rates of school truancy (B. J. Allen et al., 2020; Durbeej et al., 2021).



3.5.6 Why does this happen? Social sanctions based on heteronormativity and cisnormativity

Research indicates that transgender adolescents are particularly vulnerable. Firstly, transgender youth are understudied in the literature on peer relations within the LGBTQ+ community (Heck et al., 2016). Historically, transgender adolescents have been rendered invisible when sexual and gender minorities have been analysed simultaneously. In recent years, when compared with cisgender heterosexual and LGB students, transgender youth have been found to be at a considerably greater risk of suffering bullying, cyberbullying, peer victimization, and polyvictimization (Atteberry-Ash et al., 2019; Johns et al., 2019; McBride, 2021; Myers et al., 2020; Norris & Orchowski, 2020).

Transgender adolescents are not only the target of peer victimization and bullying in the school environment because of their gender identity or gender expression, as we will explain below. They are also more likely to experience a range of different types of bias-based victimization than other youth, such as victimization related to sexual orientation, spiritual beliefs, or ethnicity (Elipe et al., 2021; Kosciw et al., 2020; Price-Feeney et al., 2018). In addition to being more vulnerable to different risk factors, from an intersectional perspective, transgender adolescents also tend to suffer multiple forms of victimization or polyvictimization concurrently. A study observed that 86% of transgender youth experienced some form of peer victimization—that is, bullying victimization, unwanted sexual intercourse, sexual harassment, or dating conflict. A further 14% of transgender youth reported all types of victimization in the past year (Norris & Orchowski, 2020).

The gender minority stress model (Hendricks & Testa, 2012) explains how transgender people are subjected to alarmingly high rates of violence due to distal (e.g., being bullied) and proximal (i.e., internalized stigma) stressors related to their sexual orientation and/or gender and gender expression. The binary sex/gender structure shapes the different assumptions about what is considered 'normative'; these, in turn, are the basis of the prejudices and disadvantages that transgender people must face in an environment that is stressful and hostile towards their identity (Van Schuylenbergh et al., 2018). Thus, transgender youth deal with a marginalization in school settings which is underpinned by cisnormativity and heteropatriarchy (S. Miller, 2016).

Heteronormativity refers to the system of practices and structures of understanding by which heterosexuality is assumed to be the universal, coherent and exclusive sexual orientation (Geist et al., 2017; Toomey et al., 2012). Cisnormativity represents the assumption that naturalizes the binary expectation of congruence between the biological sex assigned at birth



and the gender identity (Ansara & Hegarty, 2012; Tordoff et al., 2021). Hetero-cis-normativity comprises institutionalized social norms which prioritize the privileges of heterosexual cisgender individuals (Worthen, 2016). Therefore, both cisnormativity and heteronormativity are prejudicial for people who reject—or are suspected of rejecting—the upkeep of a conventional consistency among sexual orientation, genitalia, and gender presentation (Tan et al., 2020).

It is not surprising then that transgender adolescents experience high rates of transphobic bullying or violence at school when they demand to be treated as their gender identity (Domínguez-Martínez et al., 2020; Price-Feeney et al., 2018)—considered a specific type of violence against transgender people as a result of their sexual orientation, gender identity, and the way in which they express their gender identity (Domínguez-Martínez & Robles, 2019; Gallardo-Nieto et al., 2021).

For example, McGuire et al. (2010) found that 82% of transgender students heard negative comments based on gender presentation from their classmates and 31% heard negative comments by the school staff, and this harassment was negatively associated with feelings of safety. Kosciw et al. (2020) highlighted that between 53% and 68% of LGBTQ students have suffered verbal harassment (e.g., being called names or threatened), and between 9% and 25% of LGBTQ students have suffered physical harassment and assaults—e.g., being punched, shoved, or kicked—based on sexual orientation, gender expression, and gender). In addition, Peter et al. (2016) detected that 79% of transgender participants heard derogatory comments regarding male students not acting masculine enough and 62% of transgender respondents reported hearing about girls not acting feminine enough. Similar results were found by Gower, Rider et al. (2018), who observed that transgender and gender-diverse youth perceived as more gender incongruent were six to eight times more likely to suffer bullying compared with those perceived as very congruent with their biological sex.

Non-binary transgender adolescents face a unique challenge: not only is their identity not normative, it is neither legally nor socially recognized (Bower-Brown et al., 2021). Having a questioning identity that does not fit into either masculine or feminine roles may make them vulnerable to being bullied and misgendered (e.g., not having their preferred pronouns used and seeing the existence of non-binary gender identities invalidated) as a result of cisnormative control (K. C. Johnson, LeBlanc, Deardorff, et al., 2020; Rimes et al., 2017)

Furthermore, cisgender adolescents are also under this pressure of hetero-cis-normativity, especially boys. Research on social norms indicated that adolescents considered it



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was acceptable to exclude or bully peers who did not adhere to the gender expectations and stereotypes of the group (Egan & Perry, 2001; Stockard, 2006). Moreover, cisgender adolescents could be particularly vulnerable to developing depressive symptomatology due to gender-based discrimination (Price-Feeney et al., 2018). In addition, boys are more heavily sanctioned for low levels of gender typicality than girls (Jewell & Brown, 2014); and that boys are more likely to show transphobic attitudes and participate in transphobic bullying than girls (Orue et al., 2021).

Therefore, homophobic and transphobic bullying (e.g., homophobic name-calling, negative comments about physical features) may be used to punish youth who transgress the expectations of heterosexuality and the gender binary roles, and then to ‘force’ the heteronormative, gendered expectations of their peer group regarding sexuality and identity (Blondeel et al., 2018; Chew et al., 2020; Norris & Orchowski, 2020).

3.5.7 Main consequences of victimization at school for transgender

adolescents

Bullying, peer victimization, or school-based victimization among transgender adolescents are associated to a wide spectrum of severe mental health conditions and problems related to school engagement in a short and long term (Gallardo-Nieto et al., 2021; Martín-Castillo et al., 2020; Tankersley et al., 2021).

Being the victim of bullying or cyberbullying is associated with risky behaviours (e.g., Reisner, Greytak, et al., 2015), mood disorders (e.g., Hatchel, Valido, et al., 2019; Veale, Peter, et al., 2017), self-harm and suicidal behaviours (e.g., Hatchel, Ingram, et al., 2019; Taliaferro et al., 2019), and negative educational experiences (e.g., Day et al., 2018). Similar results are found when the negative effects of cyberbullying are analysed (Abreu & Kenny, 2018): psychological and emotional distress (low self-esteem, depression, suicidal ideation), behavioural problems (physical aggression, body image, isolation), or bad academic performance.

Gender minority students who report greater victimization in school also report higher rates of alcohol use, marijuana use, and illicit drug use (Day et al., 2017; Reisner, Greytak, et al., 2015). In addition, bullying mediates the elevated odds of substance use for gender minority youth compared to cisgender adolescents (Reisner, Greytak, et al., 2015). Anti-LGBTQ+ victimization in school was associated with smoking, drinking, and binge drinking (D. M. Huebner et al., 2015). Moreover, a mediation analysis proved that peer victimization is associated with



increased drug use and predicted less school belonging, whereas a greater sense of school belonging is associated with less drug use (Hatchel & Marx, 2018).

For transgender youth, the prevalence of peer victimization is linked to depressive symptomatology (Hatchel, Valido, et al., 2019), especially because of their gender expression (Price-Feeney et al., 2018). According to a study conducted at a gender clinic in the United Kingdom with transgender and gender-diverse adolescents and young adults, 86.5% of participants reported having experienced bullying (compared with 22% of the general population in 12–20-year olds), and participants who were bullied at school showed higher self-reported anxiety, depression, and low self-esteem due to bullying (Witcomb et al., 2019). Likewise, being exposed to offline and online victimization lead transgender youth to a greater experience of internalizing symptoms (i.e., depression or social anxiety) that persisted into early adulthood (Hatchel, Subrahmanyam, et al., 2019).

Qualitative studies also suggested that transgender adolescents feel emotions ranging from annoyance to anxiety due to bullying experiences (Bower-Brown et al., 2021). In addition to this, retrospective studies showed that transgender young adults faced social rejection and harassment episodes of bullying by their schoolmates during their adolescence due to a perceived or actual LGBTQ+ status; this, in turn, is linked to current higher levels of distress and social maladjustment (Robles et al., 2016), lower levels of psychosocial adjustment and higher internalizing symptoms, through to lower life satisfaction and increased depression symptoms (Toomey et al., 2010), or higher social anxiety and higher depression symptoms (Hatchel, Subrahmanyam, et al., 2019).

Other major issues that transgender adolescents who have suffered bullying face relate to school engagement in multiple ways. Transgender adolescents have greater odds of being truant and skipping classes because of feeling unsafe (Day et al., 2018; Greytak et al., 2016), having lower grades, and perceiving school climates less positively compared to their non-transgender peers (Day et al., 2018). The worst consequences of being rejected by schoolmates and feeling unprotected by school staff include moving school or home-schooling to avoid the victimization (Bower-Brown et al., 2021; McGuire et al., 2010; Sang et al., 2020), or even dropping out of school (Grossman & D’Augelli, 2006; V. P. Poteat et al., 2014). This is also observed in the GLSEN study (Kosciw et al., 2020), in which transgender students were more likely than other students to report missing school, having changed schools or not planning to complete high school because they felt unsafe or uncomfortable. In particular, 43.6% of the binary transgender students and 38.1% of non-binary transgender students had missed school



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in the past month compared to 24.9% of cisgender students, and 23.6% of transgender students and 18.5% of non-binary transgender students had even changed schools, compared to 13.1% of cisgender students.

However, the most alarming data on the impact of bullying on the mental health of transgender adolescents is reflected in the prevalence of self-harm and suicidal behaviour. Countless studies have found that transgender youth who are victims of bullying victimization and abuse are substantially more likely to have suicidal thoughts (Perez-Brumer et al., 2017), both suicidal ideation and attempts (Hatchel, Ingram, et al., 2019), non-suicidal self-injury and suicide attempts (Taliaferro et al., 2019), and even suicide-related hospitalizations (Sang et al., 2020). For example, one in five transgender adolescents had attempted suicide in the last 12 months and were 40% more likely to engage in self-harm compared with cisgender youth (T. C. Clark et al., 2014); furthermore, nearly half of the transgender adolescents who experienced victimization also reported having depressive symptoms and suicidal ideation (Hatchel, Valido, et al., 2019).

3.5.8 Feelings of safety at school mediate the effect of bullying on the well-being of transgender adolescents

Transgender adolescents may display a wide range of emotion-focused and problem-focused strategies to cope with situations of bullying and violence, ranging from self-harming or ignoring the bullying to seeking support and reporting the bullying episodes (Sang et al., 2020).

Feeling safe at school or school belonging are potential protective factors against the pernicious effects of bullying on well-being and school engagement (Gallardo-Nieto et al., 2021; Mackie et al., 2021). Overall, students who attend schools with a more supportive LGBTQ+ climate—having supportive parents, teachers, or access to LGBTQ+ Alliances or inclusive curricula—enhances greater perception of safety among transgender students and reduces the odds of bullying and harassment (Gower, Forster, et al., 2018; Greytak et al., 2013; Martín-Castillo et al., 2020; McGuire et al., 2010; Toomey et al., 2012). Moreover, different investigations found that context-specific support (e.g., classmates or teachers) or the sense of school belonging can exert mediating effects that protect LGBTQ+ or specifically transgender youth from the pernicious effect of bullying on different health behaviours. For example, feeling safe at school or feeling supported by adults such as teachers or parents can diminish the rates of social anxiety (Hatchel, Subrahmanyam, et al., 2019), drug use (Gower, Rider, Brown, et al.,



2018; Hatchel & Marx, 2018), depression (Hatchel, Valido, et al., 2019), and suicidality (Hatchel, Merrin, et al., 2019).

However, transgender adolescents often perceive school policies or social agents as not helpful in addressing the situation and, in some cases, the school staff participates in the perpetration of the violence (McBride, 2021; Sang et al., 2020). In general, transgender youth usually report poorer school safety than cisgender peers. This includes facing both difficulties in benefiting from the protective effects of family, school or peer support against violence victimization (Ross-Reed et al., 2019) and more barriers in asking for help when feeling unsafe (Day et al., 2018; D. H. Russell et al., 2020). Regarding barriers to seeking help, many adolescents point out that, although teachers and school staff have a relevant role in stopping the aggression perpetrated by classmates, they are often unhelpful or even engage in bullying behaviours. (Bower-Brown et al., 2021). Thus, transgender and gender-diverse students report a lack of teacher and school staff understanding of gender diversity, which is expressed through negative reactions, comments, and norms that deny their gender or gender expression (Gallardo Nieto & Espinosa Spínola, 2021; K. C. Johnson, LeBlanc, Deardorff, et al., 2020; McBride, 2021; D. H. Russell et al., 2020).

Therefore, the disproportionately high levels of mental health concerns and school problems among gender-diverse adolescents are not only the result of the violence based on hetero-cis-normativity perpetrated by schoolmates, but also of the lack of protection from other social agents, among others (Ullman, 2017; Wernick et al., 2014).

3.5.9 Summary

We have reviewed previous research that highlights that transgender adolescents are at a greater risk of being victim of different types of aggressions in the school environment and how these situations seriously damage their adjustment. The **Study 5** analyses data on bullying and cyberbullying involvement between cisgender and transgender youth. Furthermore, these aggressions are based partially on prejudices about gender diversity. Besides, developmental contexts play an essential role in protecting the well-being of transgender adolescents in these situations of victimization. The **Study 6** presents a model of minority stress in line with the data reviewed in the literature .



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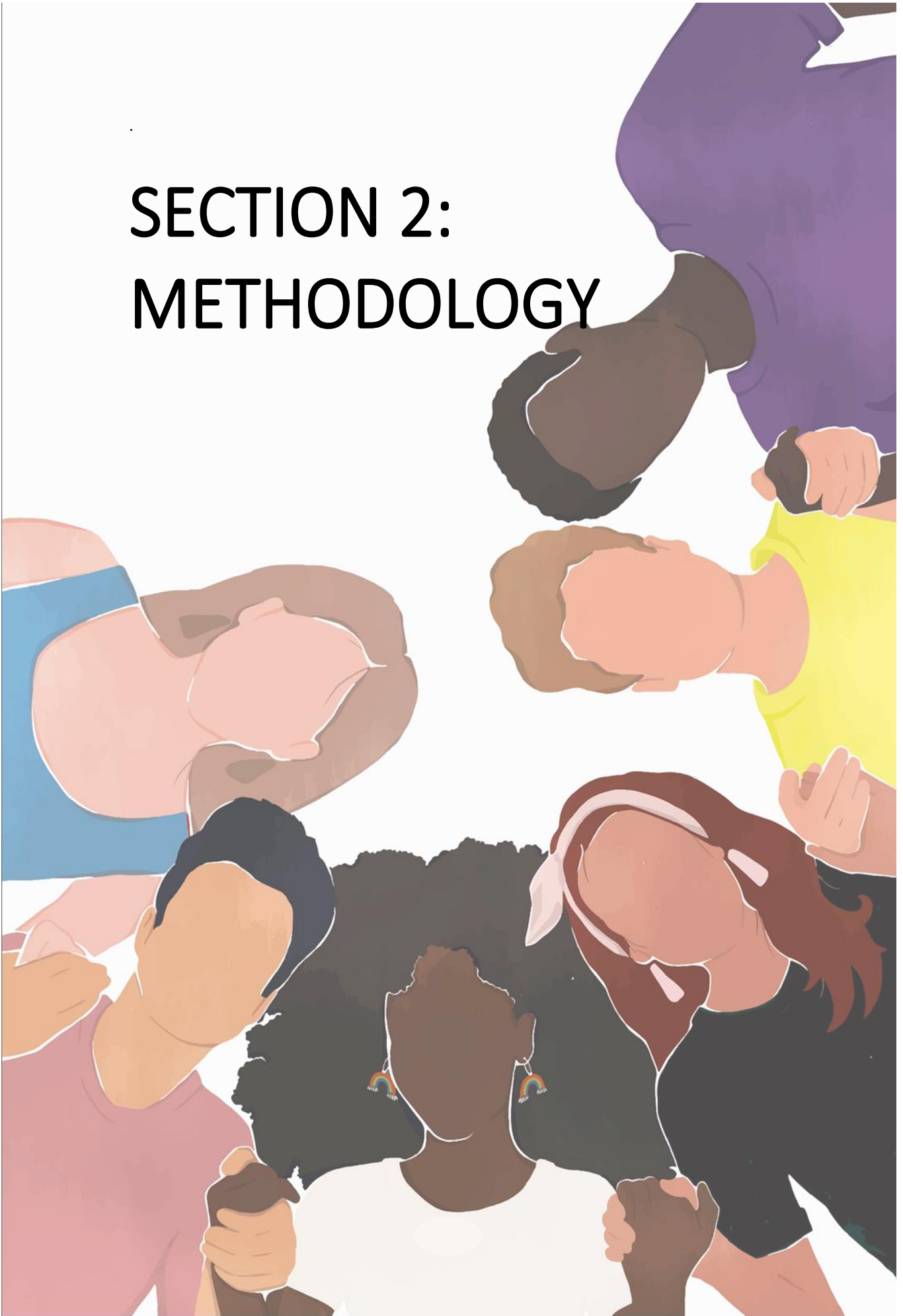
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SECTION 2: METHODOLOGY



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This introduction began with the clarification and delimitation of the meaning of terms related to gender identity. A brief historical and cultural overview of non-conforming gender identities was given, insisting on the need for caution when using the term transgender to designate all identities which challenge the cis-hetero-normative system. The minority stress model was presented as the main theoretical framework.

We also commented on the development of gender identity throughout childhood and adolescence. Furthermore, a comparative view of the available literature on the quality of life of transgender adolescents in relevant aspects as their lifestyles, their mental health and adjustment, their relationships with their developmental contexts, and the consequences of experiencing situations of victimization, such as bullying and cyberbullying, was analysed.

Finally, the minority stress model was used to analyse the health status of transgender adolescents in Spain after reviewing different theoretical frameworks on well-being, positive development, and relationships with social environments.

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Considering the theoretical framework described after the literature review, the main goal of this doctoral dissertation is to obtain an overview of the state of health, adjustment, and well-being of adolescents in Spain according to their gender identity. The main research questions that guide this doctoral dissertation are the following:

- What is the most appropriate measure to ask about gender identity in adolescence?
- How are the lifestyles of transgender adolescents?
- What is the mental health status of transgender adolescents?
- How do transgender adolescents perceive support and satisfaction in their developmental contexts?
- Are transgender adolescents involved in bullying and cyberbullying episodes?
- Can developmental contexts act as positive assets or resources to protect adolescents from the effects of bullying and cyberbullying on well-being?

Based on these general research questions, the following specific research aims were pursued in six studies included in the doctoral dissertation. The first objective was to test the two-step approach as a reliable and valid way to estimate the proportion of transgender adolescents in Spain. Specifically, the proportion of adolescents was counted based on their responses to a first item of sex, a second item of their self-perceived gender identity, and the result of combining the answers of these two measures. The second objective was to study patterns of diet, physical activity, sleep habits, and oral care in adolescents according to their gender identity. These variables were first studied by comparing the results between cisgender and transgender adolescents. Next, the group of transgender adolescents was disaggregated into binary and non-binary categories to explore similarities or differences within the group.

The third objective was to examine mental health and well-being of adolescents (i.e.: self-reported health, life satisfaction, health-related quality of life, psychosomatic complaints, and sense of coherence) according to their gender identity. As described in the previous objective, results were first compared between cisgender and transgender adolescents, and then between binary and non-binary transgender adolescents.

The fourth objective was to analyse perceived support and satisfaction with family, friends, classmates, teachers, and romantic partner according to their gender identity. First of all, the differences between the group of cisgender and transgender adolescents in relation to the satisfaction and perceived support in the different developmental contexts were studied. Secondly, the existing differences within the group of binary and non-binary transgender adolescents in relation to the aforementioned variables were also tested. Thirdly, moderation



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analyses were performed in order to test the differential effect of the perceived support on the health-related quality of life as a function of the gender identity. To facilitate moderation analyses, gender identity was recoded into two categories (cisgender and transgender adolescents).

The fifth objective was to increase awareness about the prevalence of school victimization experienced by adolescents according to their gender identity. To this end, the prevalence of perpetrating bullying and cyberbullying, and being a victim of bullying and cyberbullying among cisgender and transgender adolescents, and whether there are differences in the types of victimization experiences suffered by cisgender and transgender adolescents were estimated. In addition, for the purpose of these analyses, the group of transgender adolescents was divided into binary and non-binary transgender youth to explore further possible differences in the experience of being bullied and cyberbullied, as well as the types of victimization.

The last objective of this thesis was to assess the relation among school victimization, well-being, perceived social support, and gender identity. Several moderated mediation models were tested. The mediation effect of social support from family, friends, classmates, and teachers on health-related quality of life when adolescents are victims of bullying and cyberbullying was studied. At the same time, the moderation effect of gender identity (coded into cisgender and transgender adolescents) on every mediation models were explored.

The following hypotheses were considered on the basis of the literature described in the introduction. The research questions, objectives and hypotheses were summarized in Table 1. First, the two-step approach is a good strategy to ask about the gender identity of adolescents through combining the responses of two separate questions: sex and gender identity (e.g., T. Jones, 2019; Stats NZ, 2020b; The GenIUSS Group, 2014).

Second, transgender adolescents report a less frequent consumption of fruit and vegetables and a more frequent consumption of fast food and soft drinks, a higher frequency of skipping meals and dieting, less engagement in physical activity, poorer oral care and less hours of sleep than cisgender youth (e.g., Bishop et al., 2020; Levenson et al., 2021).

Third, transgender adolescents have worse scores on self-reported health, life satisfaction, health-related quality of life, psychosomatic complaints, and sense of coherence than cisgender adolescents (e.g., Bockting et al., 2016; M. D. Connolly et al., 2016; Delozier et al., 2020).



Fourth, transgender adolescents present less satisfaction and perceive a lower support from their families, friends, classmates, teachers, and romantic partners than cisgender adolescents. Transgender adolescents miss the opportunity of enjoying the positive effect of a strong social support on their health-related quality of life as cisgender adolescents do (e.g., Lefevor, Sprague, et al., 2019; Lewis et al., 2021; Tankersley et al., 2021).

Fifth, transgender adolescents suffer more bullying and cyberbullying victimization episodes than cisgender adolescents (Heino et al., 2021; Kosciw et al., 2020; Martín-Castillo et al., 2020).

Lastly, it is expected that families, friends, classmates, and teachers may exert a mediating effect between school victimization and health-related quality of life, and those who perceive more support from these social environments are more protected from the harmful effects of school violence. Considering gender identity, transgender adolescents do not benefit from these potential assets to the same extent as cisgender adolescents. Transgender adolescents are more vulnerable to lack of support from their developmental contexts when they are victims of bullying and cyberbullying, and this is reflected in their health-related quality of life (e.g., Hatchel, Subrahmanyam, et al., 2019; Johns et al., 2019; McBride, 2021).



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Table 1. Summary of the objectives of the present doctoral dissertation

Study	Research question	Objectives	Hypotheses
Study 1: Two-step approach	What is the most appropriate measure to ask about gender identity in adolescence?	<ul style="list-style-type: none"> - To know the sex of the participants. - To know the self-perceived gender identity of the participants. - To use (a variation of) the two step approach to evaluate gender identity in adolescents after comparing the answers on the sex and self-perceived gender identity through the two-step approach with an open-ended option. - To estimate the prevalence of transgender adolescents in Spain and to compare this prevalence with previous findings in other countries and with adults to assess its accuracy. 	The two-step approach is a good strategy to ask adolescents' gender identity.
Study 2: Lifestyles	How are the lifestyles of transgender adolescents?	<ul style="list-style-type: none"> - To study patterns of diet, physical activity, sleep habits, and oral-care in cisgender and transgender adolescents. - To study patterns of diet, physical activity, sleep habits, and oral-care among cisgender, binary transgender and non-binary transgender adolescents. 	Transgender adolescents report worse dietary patterns, less engagement in physical activity, poorer oral care and sleeping fewer hours than cisgender youth.
Study 3: Mental health and psychological adjustment	What is the mental health status of transgender adolescents?	<ul style="list-style-type: none"> - To examine self-reported health, life satisfaction, health-related quality of life, psychosomatic complaints, and sense of coherence between cisgender and transgender adolescents. - To examine self-reported health, life satisfaction, health-related quality of life, psychosomatic complaints, and sense of coherence between binary and non-binary transgender adolescents. 	Transgender adolescents have worse scores self-reported health, life satisfaction, health-related quality of life, psychosomatic complaints, and sense of coherence than cisgender adolescents.
Study 4: Social support	How do transgender adolescents perceive support and satisfaction with their developmental contexts?	<ul style="list-style-type: none"> - To analyse the level of perceived social support in family, friendships, classmates, teachers, and romantic partner in cisgender and transgender adolescents. - To analyse the level of perceived social support in family, friendships, classmates, teachers, and romantic partner among binary and non-binary transgender adolescents. - To analyse the moderation effect of gender identity on the relationship between the perceived support in the different developmental contexts on adolescent health-related quality of life. 	Transgender adolescents presents less satisfaction and perceive a lower support by their families, friends, classmates, teachers, and romantic partners than cisgender adolescents.

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Study	Research question	Objectives	Hypotheses
Study 5: School victimization	Are transgender adolescents involved in bullying and cyberbullying episodes?	<ul style="list-style-type: none"> - To establish profiles of bullying involvement among cisgender, binary transgender and non-binary transgender adolescents. - To establish profiles of cyberbullying involvement among cisgender, binary transgender and non-binary transgender adolescents. - To establish participation in different types of bullying aggressions among cisgender, binary transgender and non-binary transgender adolescents. 	Transgender adolescents suffer more bullying and cyberbullying victimization episodes than cisgender adolescents.
Study 6: The gender minority stress model	Can developmental contexts act as positive assets or resources to protect adolescents from the effects of bullying and cyberbullying on well-being?	<ul style="list-style-type: none"> - To explore the mediation effect of social support from family, friends, classmates and teachers on health-related quality of life when adolescents are exposed to episodes of bullying and cyberbullying victimization. - To explore the moderation effect of gender identity on every mediation model between bullying and cyberbullying victimization, perceived social support and health-related quality of life. 	Transgender adolescents do not benefit to the same extent from these potential assets as cisgender adolescents. Transgender adolescents are more vulnerable to lack of support from their developmental contexts when they are victims of bullying and cyberbullying, which is reflected in their health-related quality of life



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CHAPTER 5: METHOD

This chapter presents the general methodology used in this doctoral dissertation. The six studies depicted in this document are based on the *Health Behaviour in School-aged Children (HBSC)* study.

We begin by describing the design of the HBSC study, including notes on its historical background and on the ethical and quality standards that are met in the framework of this research, especially in the 2017/2018 edition on which this doctoral thesis focuses. Secondly, the procedure for data collection is expounded, including information regarding informed consent. Thirdly, the characteristics of the sampling strategies and the participants are defined. Although the first study of this doctoral dissertation focuses on the experience of collecting the indispensable data to obtain the information on gender identity, the process of obtaining the final sample that will be used in the rest of the studies is also described in this chapter. Fourthly, all instruments employed in each of the studies are explained. Finally, the statistical analysis plan is detailed.

Therefore, the general methodology employed in this Doctoral Dissertation will be described in this chapter. However, once each study is presented, a brief summary of its objectives and the specific method used will be reported for each chapter in order to facilitate the readability of this thesis.



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5.1 Study design

The Health Behaviour in School-aged Children (*Estudio sobre conductas de los escolares relacionadas con la salud*, HBSC) is a WHO collaborative cross-sectional and cross-cultural study. The study began in 1982, when researchers from England, Finland and Norway agreed to develop and implement a shared research protocol to survey school children. The HBSC study has grown rapidly in size from the original three member countries to approximately 50 countries in the last edition conducted in 2018 (on which this doctoral dissertation is based) in the geographical areas of Europe, North America, and the former Soviet region (Currie & Morgan, 2020).

The objective of the HBSC study is common to all the participating countries in the international network: to collect data every four years in order to increase understanding of health behaviours, health, well-being, lifestyles and social contexts of young people (Currie & Morgan, 2020; Inchley, Currie, Cosma, Piper, et al., 2018).

The international standard questionnaire produced for every edition enables the collection of common data across all participating countries and thus enables the quantification of patterns of key lifestyles, health indicators and contextual variables. These data allowed cross-national comparisons and, with successive surveys, trend data is gathered and may be examined at both the national and cross-national level (HBSC, n.d.). The international network is organized around an interlinked series of topics: body image and eating behaviours, physical activity and sedentary behaviour, substance use, health complaints and life satisfaction, relationships with family and peers, or school environment quality. This way, the health of adolescents is analysed in the broadest sense, incorporating physical, psychological, and social dimensions.

The international survey guidelines establish that each country must collect data on 11-13- and 15-year-old school students. However, the Spanish team does not only comply with the minimum methodological requirements but also includes the even ages (12, 14 and 16), as well as the 17-18-year-old group. For a correct interpretation of the results, it should be borne in mind that education in Spain is only compulsory up to the age of 16. Therefore, the sample used is only representative of the school-aged adolescent population between 11 and 16 years old. The 17-18 year-old adolescents are not nationally representative, they only reflect those adolescents who remain in the education system at this age.



Ethical Approval

The 2017/2018 Spanish HBSC survey has been approved by the Regional Government's Ethics in Biomedical Research Committee of the Virgen del Rocío University Hospital, a committee attached to the University of Seville (Reference: 0746-N-17). Thus, fundamental ethical requirements for research involving humans, according to current national and international regulations such as the Helsinki Declaration, were satisfied.

Funding

Spain has been participating in this project since 1986, missing only the 1998 edition. Since 2002, the study has been conducted from the *Universidad de Sevilla*. Current principal investigators are María del Carmen Moreno, Professor in the Department of Developmental Psychology and Education, and Francisco José Rivera de los Santos, Associate Professor in the Department of Experimental Psychology. This project has been carried out every four years to this date thanks to the funding and support of the Ministry of Health (*Ministerio de Sanidad*).

5.2 Participants

As mentioned above, this doctoral dissertation was based on the data collected during the 2018 HBSC study in Spain. Participants came from a sample of adolescents between the ages of 11 and 18 who were enrolled in Spanish schools. A complex procedure was followed for the selection of the participants, for random multi-stage stratified cluster sampling was used in order to ensure the representativeness of the sample. The stratification accounted for the age of the participants, habitat (urban or rural), the type of school (public or private), and the geographical area (C. Moreno, Rivera, et al., 2019). This provided a nationally representative sample of the Spanish adolescent population. The total sample obtained was comprised of 40,495 adolescents (Table 2).

In order to focus this research on gender identity, the total sample was divided from the original pool of 40,495 adolescents who participated in the survey to the 1,212 adolescents with whom the analyses of the studies of this doctoral dissertation were conducted.



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Table 2. Sample composition by region, sex and age

Autonomous Communities	Total sample	Sex				Age			
		Boys (%)		Girls (%)		11-14 (%)		15-18 (%)	
Andalusia	3071	1552	50.54%	1519	49.46%	1783	58.06%	1288	41.94%
Aragon	1684	872	51.78%	812	48.22%	956	56.77%	728	43.23%
Principality of Asturias	1820	957	52.58%	863	47.42%	1005	55.22%	815	44.78%
Balearic Islands	2612	1277	48.89%	1335	51.11%	1214	46.48%	1398	53.52%
Canary Islands	2120	1071	50.52%	1049	49.48%	1135	53.54%	985	46.46%
Cantabria	1536	788	51.30%	748	48.70%	853	55.53%	683	44.47%
Castile and León	1398	702	50.21%	696	49.79%	710	50.79%	688	49.21%
Castile–La Mancha	2832	1478	52.19%	1354	47.81%	1560	55.08%	1272	44.92%
Catalonia	3947	1978	50.11%	1969	49.89%	2031	51.46%	1916	48.54%
Valencian Community	2560	1212	47.34%	1348	52.66%	1067	41.68%	1493	58.32%
Extremadura	2303	1142	49.59%	1161	50.41%	1199	52.06%	1104	47.94%
Galicia	1494	717	47.99%	777	52.01%	749	50.13%	745	49.87%
Community of Madrid	3574	1767	49.44%	1807	50.56%	1810	50.64%	1764	49.36%
Region of Murcia	1817	922	50.74%	895	49.26%	999	54.98%	818	45.02%
Chartered Community of Navarre	2459	1243	50.55%	1216	49.45%	1140	46.36%	1319	53.64%
Basque Country	2767	1374	49.66%	1393	50.34%	1542	55.73%	1225	44.27%
La Rioja	1537	771	50.16%	766	49.84%	925	60.18%	612	39.82%
Ceuta and Melilla	964	460	47.72%	504	52.28%	575	59.65%	389	40.35%
Total	40,495	20,283		20,212		21,253		19,242	

Cisgender and transgender adolescents were identified through the HBSC questionnaire using a variation of the two-step approach that served as a filter. This process will be expanded in the first study for it focuses on analysing the validity of the approach employed to identify adolescents as cisgender, binary transgender, and non-binary transgender by combining the responses to the identity questions regarding sex and self-identified gender.

The sex measure described in the Instruments section was a mandatory item asked to all age groups, following the guidelines of the international network. The self-perceived gender identity was a national-specific questions designed by the Spanish HBSC team. This measure was asked to adolescents aged 15-18 years to ensure that they could understand the content and purpose of the measure due to their maturational and cognitive developmental. Although other research has also shown that younger adolescents, aged 13-14 years, can understand the contents of this kind of measures (Watson et al., 2020), this age group (11-14 years old) is not included in the present doctoral thesis given that they were not asked to report their gender identity. As recommended previously (T. Jones, 2019), both items appeared at the beginning of the questionnaire along with other sociodemographic questions.



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The sample selected for this thesis was composed of those adolescents who were asked to respond the two items (sex and self-perceived gender identity). Two criteria were taken into account for participants to respond to the two-step approach: their age (over 15 years old) and the academic course they were enrolled in (3rd year of secondary education or higher). Of the 19,242 participants aged 15-18 (Table 3), 17,678 participants (M = 16.33, SD = 1.07) indicated that they were in 3rd year of secondary school or higher and could therefore respond to both items. This means that 8.13% of the sample aged 15-18, although old enough to answer the two-step measure, were unable to access this content because of attending grades lower than the 3rd year of secondary education. More information about data cleansing is available in the section Processing of special data: dataset cleaning and missing values.

Table 3. Composition of the subsample of 15-18-years old adolescents who answered both measures of the two-step approach according to region, age, and sex

Autonomous Communities	Total sample	Boys				Girls			
		15-16 (%)		17-18 (%)		15-16 (%)		17-18 (%)	
Andalusia	1148	272	23.69%	277	24.13%	313	27.18%	286	24.91%
Aragon	665	160	24.06%	217	32.63%	150	22.56%	138	20.75%
Principality of Asturias	744	218	29.17%	148	19.89%	228	30.65%	150	20.16%
Balearic Islands	1243	339	27.19%	285	22.93%	357	28.72%	262	21.08%
Canary Islands	914	222	24.29%	218	23.85%	229	25.05%	245	26.81%
Cantabria	639	201	31.30%	134	20.97%	210	32.86%	94	14.71%
Castile and León	644	166	25.62%	185	28.73%	164	25.47%	129	20.03%
Castile–La Mancha	1189	386	32.46%	222	18.67%	385	32.38%	196	16.48%
Catalonia	1812	534	29.47%	362	19.98%	503	27.76%	413	22.79%
Valencian Community	1372	379	27.62%	254	18.51%	410	29.88%	329	23.98%
Extremadura	982	300	30.55%	183	18.64%	318	32.38%	181	18.43%
Galicia	722	147	20.36%	179	24.79%	170	23.55%	226	31.30%
Community of Madrid	1626	471	28.91%	344	21.16%	477	29.34%	334	20.54%
Region of Murcia	778	199	25.58%	180	23.14%	235	30.21%	164	21.08%
Chartered Community of Navarre	1207	354	29.25%	261	21.62%	389	32.23%	203	16.82%
Basque Country	1141	361	31.64%	196	17.18%	400	35.06%	184	16.13%
La Rioja	536	105	19.59%	148	27.61%	111	20.71%	172	32.09%
Ceuta and Melilla	316	47	14.87%	87	27.53%	72	22.78%	110	34.81%
Total	17,678	4,861		3,880		5,121		3,816	

The gender identity of participants was identified using a variation of the two-step method, one of the most recommended approaches (Stats NZ, 2020b; The GenIUSS Group, 2014), combining the responses to the two questions regarding sex and self-perceived gender identity. Other studies have used slightly different versions of the two-step method (Eisenberg et al., 2017; Kaltiala-Heino & Lindberg, 2019; Tate et al., 2013), depending on the research needs or the sample characteristics.



After comparing the two variables regarding sex and gender identity and coding the responses, three categories were established. If the self-perceived gender was consistent with the sex indicated initially, we coded the participant as cisgender. If the perceived gender was not matched with the response on the sex item, the participant was classified as binary transgender (boys perceiving themselves as being a girl and girls perceiving themselves as being a boy). Those who marked the option “I identify neither as a boy nor a girl” or used the open-ended option to indicate another identity (such as agender or gender-fluid) were categorized as non-binary transgender (Table 4). A more extensive description of the process will be provided in the **Study 1**.

Table 4. Version of the two-step approach used in the 2018 HBSC study in Spain

		Self-perceived gender item: Identities of people are varied: some people identify themselves as boys, others as girls, and there are people who don't feel represented in this system. Please, choose the option that you feel more identified with:			
		I identify as a boy	I identify as a girl	I identify neither as a boy nor a girl	Other
Sex item:			(Binary)	Non-binary transgender	Additional coding is required
Are you a boy or a girl?	Boy	Cisgender boy	Transgender girl	adolescent	Additional coding is required
	Girl	(Binary) Transgender boy	Cisgender girl	Non-binary transgender	Additional coding is required
				adolescent	

Of the 17,678 participants, 303 were identified as transgender adolescents, amounting to 0.75% of the total HBSC sample and 1.71% of the sample that answered the two-step approach. Of the total subsample of transgender adolescents, 90 were identified as binary transgender adolescents (M = 16.34, SD = 0.94) and 213 as non-binary transgender adolescents (M = 16.42, SD = 1.10).

Matching and resampling

Given the imbalanced comparison ratio between groups (17,375 cisgender adolescents versus 303 transgender adolescents), resampling based on the matching method was used to facilitate sample equalization in Studies 2 to 6.

This technique, widely used in case-control studies (N. Pearce, 2016), facilitates the equalization of the sample in possible confounders (e.g., age or sex). Furthermore, this technique reduces the selection bias, minimizes the negative consequences in the comparability between groups in observational studies when the comparison ratio between groups is very



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unbalanced, and improves internal validity. Among the main disadvantages of this technique are the unequal precision in the estimation of the statistics and its influence on the statistical power (M. J. Campbell et al., 1995). Although matching is a technique with multiple benefits compared to with the use of samples with different sizes, it must be conducted according to certain criteria to avoid possible drawbacks on this process (Mansournia et al., 2018). This technique allows multiple adaptations, such as the matching of cases (in this case, transgender adolescents) to controls (cisgender adolescents) from a ratio different from 1:1 (in this case, ratio 1:3), which has been widely contrasted in specific matching studies (Ejigou, 1996; Julious & Campbell, 1998; Walter, 1980).

This process has also been applied in other research and clinical studies conducted with transgender adults, considering gender identity as a variable to match with the control sample (Witcomb et al., 2015) or other sociodemographic variables such as age (Auer et al., 2013; Davey et al., 2014).

A 1:3 ratio was used taking into consideration the variables of age, country of birth, socioeconomic status, type of school, and habitat (Table 5). The final *p*-value and the effect sizes for the comparisons between cisgender and transgender groups across sociodemographic control variables were enough evidence of equivalence considering the cut-off cited by Mervis and Klein-Tasman (2004), based on Frick (1995): *p*-values between .20 and .50 are ambiguous; *p*-values of .50 and above combined with a small effect are sufficient evidence of equivalence. All matched variables demonstrated equivalences between cisgender and transgender adolescents with high *p*-values and negligible effect sizes. Only the birth country showed an ambiguous *p*-value (but negligible effect size).

The final sample was comprised of 1,212 adolescents (*M* = 16.41, *SD* = 1.07), of which 303 were transgender adolescents (*M* = 16.40, *SD* = 1.05) and 909 were cisgender adolescents (*M* = 16.41, *SD* = 1.08) with a comparable profile.



Table 5. Sociodemographic characteristics of the final sample of study participants (n = 1212) by gender identity

	Cisgender adolescents			Binary transgender adolescents			Non-binary transgender adolescents			χ^2	p	V
	n	%	SRij	n	%	SRij	n	%	SRij			
Age												
15-16	495	54.46	0.2	50	55.56	0.3	113	53.05	0.4	0.20	.905	0.013
17-18	414	45.54	-0.2	40	44.44	-0.3	100	46.95	-0.4			
Socioeconomic status												
Low	288	31.68	0.0	25	35.71	0.8	47	29.75	-0.6	0.83	.935	0.019
Medium	408	44.88	0.0	29	41.43	-0.6	73	46.20	0.4			
High	213	23.43	-0.1	16	22.86	-0.1	38	24.05	0.2			
Born in Spain												
Yes	750	82.51	1.4	62	73.81	-1.9	157	80.93	-0.3	3.96	.138	0.058
No	159	17.49	-1.4	22	26.19	1.9	37	19.07	0.3			
Type of school												
Public	660	72.61	0.3	65	72.22	0.0	152	71.36	-0.4	0.14	.935	0.011
Private	249	27.39	-0.3	25	27.78	0.0	61	28.64	0.4			
Habitat												
Urban	458	50.39	-0.1	46	51.11	0.1	108	50.70	0.1	0.02	.989	0.004
Rural	451	49.61	0.1	44	48.89	-0.1	105	49.30	-0.1			

SRij = adjusted residuals; χ^2 = Chi-squared; V = Cramer's V.

Note. There is no statistically significant difference between both groups

5.3 Procedure

As HBSC is a cross-sectional study and a school-based survey, data were collected through self-completion questionnaires administered in the classroom (C. Roberts et al., 2009).

The procedure carried out in each member country of the network must be done in accordance to the methodological guidelines of the international study, which establish three basic requirements: the questionnaire must be completed voluntarily and anonymously by the school-children themselves, the confidentiality of the answers obtained must be guaranteed and scrupulously respected, and the survey must be completed at school during school hours (Currie et al., 2008; Inchley, Currie, Cosma, & Samdal, 2018).

A passive consent form was provided for parents or legal guardians of the participants before data collection. Participants were instructed about the study. It was emphasized that their participation was voluntary, and they were free to skip questions or cancel their participation at any time.

These international guidelines establish the schedule and deadline for data collection too. In the case of HBSC 2018 study in Spain, schools selected through the aforementioned



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sampling method were contacted at three different times by phone call: from May 2017 to June 2017 to present the project in the first instance, from September 2017 to October 2017 to remind those who showed interest in collaborating their expected participation and invite new schools to collaborate, and from February to May 2018 to collect the data (C. Moreno, Rivera, et al., 2019).

An email with information about the HBSC study was sent to those schools that showed interest in participating. The email contained instructions for their participation, and an example of the personalized report and infographics that would later on be sent to each participating school to thank them for their collaboration. The schools that wanted to collaborate received an individual identification code that would be used to identify the school in order to make the report and infographics. In addition, a staff member (preferably the principal/director, head of studies, or counsellor) was asked to complete a questionnaire on the characteristics of the school. If a school decided not to participate, a substitute school with the same sociodemographic characteristics (age of adolescents, geographic area, type of school and habitat) was contacted in order to guarantee sample representativeness.

Information and communications technologies (ICT) were employed in the data collection procedure. ICTs facilitated the participation of schools by allowing the anonymity and confidentiality of the students, as well as reducing the costs associated with printing and distributing the questionnaires at schools. A computer-assisted web interviewing (CAWI) system was used in data collection to allow subjects to fill out an online questionnaire through the SurveyMonkey platform on Internet. The use of the computerized procedure to complete the questionnaire helped to avoid possible mistakes associated with the process of data dump from paper to database. Likewise, the data were sent instantaneously to the research team as soon as students completed the survey, which made it possible to provide personalized advice to the schools while they were participating (C. Moreno, Rivera, et al., 2019).

The first page of the questionnaire on the platform detailed the purpose of the study, the specific instructions for completing the questionnaire, and how the anonymity of the responses was ensured. In addition, this information was also provided to the teachers that supervised the data collection at the school.

At the end of the data collection, each school received a certificate of participation, an infographic which summarized the outcomes of the main variables of the study, and a report with the results obtained in their school. Both data presented in the infographic and the report allowed the comparison with the national and the regional average score obtained in the



variables examined by the adolescents in the same age group. In order to warrant the anonymity of the participants, a minimum of 20 students per school were requested to participate in the survey.

Processing of special data: dataset cleaning and missing values

After data collection, the database was cleaned. In the first step, 53 participants were removed because they were older than 19 years of age. In addition, 159 participants were also eliminated due to inconsistency in their answers throughout the questionnaire. Moreover, 94 participants were discarded because they indicated a gap of two grades with respect to their reported age, which is highly improbable considering the promotion requirements in Spain. Another 156 participants were deleted because they wrote offensive answers in the open-ended questions, an aspect that indicates no predisposition to respond honestly to the questions. Likewise, 60 participants were also dropped from the database for indicating highly improbable professions of their fathers and/or mothers on the International Standardized System of Classification of Occupations (ISCO). Finally, 527 questionnaires were excluded for having a low response rate: less than 40% of the questionnaire (C. Moreno, Rivera, et al., 2019). Further details can be found on the Spanish Methodology Report of the HBSC 2018 study (C. Moreno, Rivera, et al., 2019).

As mentioned previously, participation in the questionnaire was voluntary and participants could choose which questions to answer. However, there were two types of mandatory questions: sociodemographic items necessary to prepare the reports (sex, date of birth and grade level) and questions following the skip logic (such as the ones referring to sexual intercourse or family structure), so participants would skip to a specific question on a later page based on their answer to these previous items.

The response rate was calculated taking into account the total number of adolescents who answered each question. Thus, the missing value rate refers to the subset of the sample who each question was presented but did not answer it. Not all the adolescents who make up the study sample completed the same questionnaire because there were different models depending on the age, the contents of each package that were randomly presented to a part of the study sample, and the subset of items which depended on the answer to specific skip logic questions (such as whether they have or have had a romantic partner). Thus, the missing value rate should be calculated with reference to the part of the sample that completed the corresponding question package and the questions used as filters according to age.



Another important aspect to take under consideration is that the estimated time to complete the questionnaire was approximately one hour, and the questions that were placed at the end of each type of questionnaire could present a greater number of missing values due to the effect of fatigue or because some participants did not reach the end of the questionnaire.

5.4 Measures

The international standard questionnaire for each survey cycle is made up of three sections that give rise to each national survey (C. Roberts et al., 2009). Firstly, the mandatory questions that each country is required to include to create the international common database. For example, items such as sex, age, physical activity, prevalence of bullying perpetration and victimization, or support from family and friends.

Second, thematic optional packages are proposed by experts who belong to focus groups that specialize on research topic areas within the international network. Each country can choose as many optional packages as it wants. For example, items such as the level of education of the parents, romantic attraction, illicit drug use in lifetime, or positive mental health through active engagement.

Third, national-specific questions proposed by each country according to specifically relevant issues, interests, and concerns. For example, the measure of self-perceived gender identity proposed by the Spanish team or the scale of partner support.

The study addresses a wide range of topics related to adolescent health, lifestyles, and developmental contexts. Specifically, the following topics were included in the HBSC Spain survey in the 2018 edition: 1. Demographic factors; 2. Eating habits; 3. Sleep habits; 4. Oral health; 5. Body image & BMI; 6. Physical activity; 7. Electronic media communication; 8. Risk behaviours, 9. Anti-social behaviour; 10. Sexual health; 11. Violence and injuries; 12. Family; 13. School; 14. Peer culture; 15. Romantic relationships; 16. Health and well-being; 17. Immigration; 18. Social inequalities; 19. Neighbourhood (C. Moreno, Ramos, et al., 2019).

Although the questionnaire was quite similar for all participants, there were three slightly different versions: the shortest version for 5th- and 6th-grade primary-school students (11-12 years old), a second one for 1st- and 2nd-grade secondary-school students (13-14 years), and the most extensive version for students from the 3rd grade of secondary school and



onwards (from 15 years old onwards). The three versions differed in the amount and kind of sensitive content included to facilitate the time needed to complete the questionnaire and adapt to the degree of understanding needed to respond adequately. This thesis used the version of the questionnaire administered to participants above 15 years old. This was the longest and most sophisticated version of the questionnaire due to the degree of understanding needed to respond adequately to questions with a sensitive or complex psychological content. Examples of this kind of questions include the sense of coherence scale or the substance use items.

Additionally, the structure itself of the 2018 Spanish HBSC questionnaire is intricate. Within each of the age-specific versions, four variations of the questionnaire were programmed to explore a greater number of variables during the available time for fulfilling the survey (one hour estimated in one session during school hours). Every questionnaire was composed by a package of common questions called the CORE package, presented to all the participants, plus one of three packages (A, B or C version) with a probability of being presented to the adolescents randomly set in the online platform. More detailed information is available in the Spanish Methodology Report of the HBSC 2018 study (C. Moreno, Rivera, et al., 2019).

Most of the contents were evaluated in the sample of 1,212 participants. However, for some variables the sample size is slightly smaller, either because some questions only appeared in specific combinations of packages, or because of the missing values themselves (due to lack of time, fatigue, or unwillingness to answer). Table 6 summarizes the instruments used in each of the studies and to which package they belong in the national survey². These variables are described below.

Sociodemographic variables

Sex: Participants were asked “Are you a boy or a girl?” (*¿Eres un chico o una chica?*). This question has been used without changes since the first wave of HBSC data collection in 1982. As it is a mandatory measure for all countries of the network, it was not possible to change either the wording of the question or the response options.

² Package 1 is available in versions A and B of the HBSC questionnaire; package 2 is available in versions B and C of the HBSC questionnaire; package 3 is available in versions A and C of the HBSC questionnaire. The distribution of the packages allows for the inclusion of a wide range of content in the total questionnaire, but implies that each version of the questionnaire loses one third of the sample.



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Self-perceived gender identity: The Spanish HBSC team designed a question for the participants to report on their self-perceived gender identity after consulting with experts and reviewing the literature: “Identities of people are varied: some people identify themselves as boys, others as girls, and there are people who don’t feel represented in this system. Please, choose the option that you feel more identified with” (*Las identidades de las personas son variadas: algunas personas se identifican como chicos, otras como chicas y otras no se sienten representadas por este sistema. Marca, por favor, la opción con la que te sientas más identificado/a*). Four response options were available: “I identify as a boy” (*Me identifico como chico*), “I identify as a girl” (*Me identifico como chica*), “I identify neither as a boy nor a girl” (*No me identifico ni como chico ni como chica*), and “Other” (*Otro/s*). This last response option was open-ended allowing the participants to explain in their own words how they perceive their identity. Text responses were coded manually.

Participant gender was identified using a variation of the two-step method—one of the most recommended approaches—(Stats NZ, 2020b; The GenIUSS Group, 2014), comparing the responses to the two questions regarding sex and gender identity. Other studies have used slightly different versions of the two-step method (Eisenberg et al., 2017; Kaltiala-Heino & Lindberg, 2019; Tate et al., 2013), depending on the research needs or the sample characteristics. If the self-perceived gender was consistent with the initially indicated sex, the participant was coded as cisgender. If the perceived gender did not match the response on the sex item, the participant was classified as binary transgender (boys perceiving themselves as being a girl and girls perceiving themselves as being a boy). Participants who expressed binary gender identities in the open-ended option and whose sex was the opposite of the gender they described, or even explicitly said they were binary transgender youth, were also identified as binary transgender. Those who marked the option “I identify neither as a boy nor a girl” or used the open-ended option to indicate another identity were categorized as non-binary transgender.

A more detailed process on how to analyse the two-step measure is explained in the **Study 1**. Also, a guide on how to code the responses of the two-step approach is presented in Appendix 1 (in Spanish) and Appendix 2 (in English).

Age: Two age groups were differentiated: 15-16 and 17-18 years old.

Country of birth: Participants were asked in which country they were born, and responses were divided into two categories: born in Spain or born in any other country.

Socioeconomic status: The Family Affluence Scale (FAS-III) is a 6-item measure of family material wealth, being a proxy indicator of socio-economic position. A global score was calculated as the



sum of the individual item scores (Currie et al., 2014): “Does your family own a car, van, or truck?” (0 = no; 1 = yes, one; 2 = yes, two or more); “Do you have your own bedroom for yourself?” (0 = no; 1 = yes); “How many computers does your family own (including laptops and tablets, not including game consoles and smartphones)?” (0 = none, 1 = one, 2 = two, 3 = more than two); “How many bathrooms (room with a bath/shower or both) are in your home?” (0 = none, 1 = one, 2 = two, 3 = more than two); “Does your family have a dishwasher at home?” (0 = no; 1 = yes); “How many times did you and your family travel out of Spain for a holiday/vacation last year?” (0 = not at all, 1 = once, 2 = twice, 3 = more than twice). The responses were recoded into low (0–6); medium (7–9) and high family wealth (10–13).

Type of school: Schools were divided into public (if the funding came from the regional or national government) or private (if the funding was mainly private).

Habitat: The place where schools were located was classified as urban or rural according to the number of inhabitants registered in the Spanish Statistical Office (*Instituto Nacional de Estadística*).

Lifestyles

Frequency of breakfast: The participants were asked: “How often do you have breakfast (something more than a glass of milk or fruit juice)?”. The responses were grouped according to the weekly frequency—infrequently (never or almost never), irregular (from 2 to 6 days a week), and daily (7 days a week)—as used in previous studies (Ramos et al., 2013).

Dietary habits: Food intake was addressed through a question on how many times a week the participants ate fruit, vegetables, salty snacks, and sweets. Drink consumption was evaluated by how many times a week they consumed energy drinks and sugary soft drinks. In the case of fruits and vegetables, the answers were coded as infrequently (never or less than once a week), irregularly (from 1 to 6 times a week), and daily (every day, and every day more than once a day). Regarding salty snacks, sweets, energy drinks, and soft drinks, the answers were classified inversely, with daily consumption being the least-healthy behavior. These categories were based on current scientific evidence (A. Marques, Demetriou, et al., 2019; Moreno-Maldonado et al., 2019).

Dieting: Participants were asked if they were currently dieting and were given four options: No; Yes, to gain weight/volume; Yes, to lose weight/volume; and Other. In the last option, the participants could indicate another kind of dieting, such as a gluten-free or vegetarian. Options



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were split to identify those who were dieting to modify weight/volume and those who were not, following a similar procedure as in previous research (Dzielska et al., 2020).

Physical activity: Two self-reported items on physical activity in the past 7 days were used. In regards to moderate to vigorous physical activity, participants could indicate the number of days they were physically active for at least 60 minutes a day, and responses were divided into three categories: infrequently (less than two days a week), irregularly (from 3 to 6 days a week), or daily (everyday). Vigorous physical activity was assessed through the frequency of physical activity outside of school hours that made them sweat or out of breath, and was categorized as infrequently (never), irregularly (less than 2-3 days a week), and regularly (more than 4 day a week). Current recommendations by the WHO (2020a) were reviewed to categorize the more- or less-healthy physical activity behaviour.

Hours of sleep: Sleep habits were calculated according to the number of hours a day that the participants typically slept, considering weekdays and weekends separately. The responses were coded according to The National Sleep Foundation’s guidelines (Hirshkowitz et al., 2015) for adolescent sleep time: insufficient (less than 7 hours), sufficient (7 hours), or optimal (minimum of 8 hours).

Tooth brushing: The students informed about the frequency of brushing their teeth, and their responses were classified as irregularly or never (less than once a day), daily (once a day), or optimal (more than once a day). At least twice a day is an indicator of acceptable healthy oral hygiene (Thornton-Evans et al., 2019).

Well-being and psychological adjustment:

Self-reported health: This was measured through a single question about how participants currently perceive their health, with four response options: *poor, passable, good, or excellent* (Idler & Benyamini, 1997). This single-item measure was validated for quantitative use (Silventoinen et al., 2007).

Life satisfaction: Using the Cantril ladder (Cantril, 1965) participants indicated on a scale from 0 (*the lowest score*) to 10 (*the highest score*) their current overall satisfaction with their life: “Here is a picture of a ladder. The top of the ladder ‘10’ is the best possible life for you and the bottom ‘0’ is the worst possible life for you. In general, where on the ladder do you feel you stand at the moment? Tick the box next to the number that best describes where you stand.” Previous research found strong correlations between single-item life satisfaction measures and the scales



of satisfaction with life, and demonstrated that the measure had similar correlations with indicators of personality, subjective health and well-being for adolescents and young adults (Cheung & Lucas, 2014; Ciria et al., 2018; Jovanović, 2016).

Health-related quality of life: KIDSCREEN-10 is an instrument designed to evaluate health-related quality of life in the 8-18-year-old population based on physical, psychological, and social indicators (The KIDSCREEN Group Europe, 2006). The participants were asked about different states over a period of one week: “feeling well and fit”, “full of energy”, “sad”, “lonely”, “having enough time for myself”, “doing things I want in my free time”, “receiving fair treatment from my parents”, “having a good time with friends”, “getting on well at school” and “being able to pay attention/concentrate”. Each of the 10 items was evaluated on a 5-point scale, ranging from *I totally disagree/not at all* to *I totally agree/always*. Cronbach’s alpha was .82 for the sample of transgender and cisgender adolescents in this thesis.

Psychosomatic complaints: The HBSC Symptom Checklist was used to evaluate physical (headache, stomachache, backache, and feeling dizzy) and psychological (feeling nervous, feeling low, irritability, and difficulty sleeping) complaints (Haugland & Wold, 2001). Participants were specifically asked about the frequency of experiencing these symptoms in the last six months: *about every day, more than once a week, about every week, about every month, and rarely or never*. Cronbach’s alpha was .79 and .71 for the two subscales, respectively, and .83 for the global scale for the total sample used in this thesis.

Sense of coherence: The SOC-13 is a semantic differential scale on a 7-point Likert scale that allowed for the evaluation of the adolescent’s sense of coherence. Participants were asked to indicate their level of agreement or disagreement with 13 items that assessed how they viewed their own lives, how they identified and controlled stressful events, and how they managed their resources, resulting in a global score (Antonovsky, 1993). Three dimensions were evaluated: *comprehensibility* (e.g., “Has it happened in the past that you were surprised by the behaviour of people whom you thought you knew well?”; “Do you have very mixed-up feelings and ideas?”), *manageability* (e.g., “Has it happened that people whom you counted on disappointed you?”; “Many people sometimes feel like sad sacks in certain situations. How often have you felt this way in the past?”), and *meaningfulness* (“Do you have the feeling that you don’t really care about what goes on around you?”; “Until now your life has had...”). Because of the close connection between the three components of the scale, the use of the overall score was recommended (Antonovsky, 1993). The scale has shown adequate psychometric properties in



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adolescents (Eriksson & Mittelmark, 2017; Rivera de los Santos, 2012). Cronbach's alpha was .81 in this study for the final sample in this thesis.

Social environment

The satisfaction of adolescents with their social contexts: Participants indicated on a scale from 0 (the lowest score) to 10 (the highest score on satisfaction), based on the Cantril Ladder (Cantril, 1965), their satisfaction with the relationship with their family, friends, classmates, and teachers in four separate questions.

Family support: The Multidimensional Scale of Perceived Social Support (Zimet et al., 1988) included a 4-item subscale of perceived social support from the family: "My family really tries to help me"; "I get the emotional help and support I need from my family"; "I can talk about my problems with my family"; and "My family is willing to help me make decisions". Participants rated how much they felt supported from 1 = *Strongly disagree* to 7 = *Strongly agree*. Higher scores indicated higher levels of perceived support from the family. The punctuations obtained in each item were summed and an average was estimated to obtain a global score. Cronbach's coefficient alpha was .87 for the original study (Zimet et al., 1988) and .90 for the total sample of transgender and cisgender adolescents included in this thesis.

Friend support: The Multidimensional Scale of Perceived Social Support (Zimet et al., 1988) includes a 4-item subscale of perceived social support from friends: "My friends really try to help me"; "I can count on my friends when things go wrong"; "I have friends with whom I can share my joys and sorrows"; and "I can talk about my problems with my friends". Adolescents rated how much they felt supported by their friends from 1 = *Strongly disagree* to 7 = *Strongly agree*. Higher scores indicated higher levels of perceived support from friends. The scores obtained in each item were summed and an average was estimated to obtain a global score. Cronbach's coefficient alpha was .85 for the original study (Zimet et al., 1988) and .93 for the sample of in this thesis.

Classmate support: On a Likert scale ranging from 1 = *Strongly disagree* to 5 = *Strongly agree*, participants indicated on the 3-item Classmate Support Scale (Torsheim et al., 2000) the extent to which they experienced their classmates as supportive: "The students in my class(es) enjoy being together"; "Most of the students in my class(es) are kind and helpful"; and "Other students accept me as I am". Higher scores indicated higher level of perceived support from classmates. The scores obtained in each item were summed and an average was estimated to obtain a global



score. In the original sample of 15-year-olds participants, Cronbach's alpha was .75 (Torsheim et al., 2000). Cronbach's alpha was .80 for the final sample of adolescents analysed in this thesis.

Teacher support: Participants rated in the 3-item Teacher Support Scale (Torsheim et al., 2000), from 1 = *Strongly disagree* to 5 = *Strongly agree*, the extent to which they experienced their teachers as supportive: "I feel that my teachers accept me as I am"; "I feel that my teachers care about me as a person"; and "I feel a lot of trust in my teacher". Higher scores indicated higher level of perceived support from teachers. The scores obtained in each item were summed and an average was estimated to obtain a global score. Cronbach's alpha for the scale was .77 in the sample of 15-year-olds participants in the original study (Torsheim et al., 2000), and Cronbach's alpha was .83 for the sample of transgender and cisgender adolescents included in this thesis.

Partner support: Participants who had previously indicated that they had a partner currently were asked to respond to the 3-item subscale of emotional support of the Network of Relationships Inventory (Furman & Buhrmester, 1985). Participants rated how much they felt supported by their most important romantic relationship in the last year using 5-point Likert scales from 1 = *Little or None* to 5 = *the Most*: "How often do you turn to your partner for support with personal problems?"; "How often do you depend on your partner for help, advice, or sympathy?"; "When you are feeling down or upset, how often do you depend on your partner to cheer things up?". The scores obtained in each item were summed and an average was estimated to obtain a global score. Cronbach's alpha was .91.

School victimization

Bullying perpetration and bullying victimization: This instrument, adapted from the Revised Olweus Bully/Victim Questionnaire (Olweus, 1996), consisted in two separate questions enabling the identification of bullying victims ("How often have you been bullied at school in the past couple of months?"), and bullying aggressors ("How often have you taken part in bullying another person(s) at school in the past couple of months?") at the school setting. The frequency of episodes was divided as follows: 1) *I have not been bullied at school in the past couple of months / I have not bullied another person(s) at school in the past couple of months*; 2) *It has happened once or twice*; 3) *2 or 3 times a month*; 4) *About once a week*; 5) *Several times a week*. According to the cut-off point proposed by Solberg and Olweus (2003), adolescents were considered victims when they reported a bullying victimization frequency of 2 or 3 times a month or higher in the last two months, and a bullying aggressor was anyone who had participated in episodes of bullying with the same frequency.



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Cyberbullying perpetration and cyberbullying victimization: Two new items on cyberbullying, based on the Revised Olweus Bully/Victim Questionnaire (Olweus, 1996), were introduced to the HBSC survey in 2017/2018 to reflect situations of online aggression and victimization (Inchley et al., 2020). As in the previous measure, participants were asked in two separate questions how often they have been cyberbullied and taken part in cyberbullying in the past couple of months. An extended definition of cyberbullying precedes the answer options (i.e.: sent mean instant messages, email, or text messages; wall postings; created a website making fun of someone; posted unflattering or inappropriate pictures online without permission or shared them with others)? The frequency of episodes was divided as follows: 1) *I have not been cyberbullied in the past couple of months / I have not cyberbullied another person in the past couple of months*; 2) *It has happened once or twice*; 3) *2 or 3 times a month*; 4) *About once a week*; and 5) *Several times a week*. According to the cut-off point proposed by Solberg and Olweus (2003), adolescents were considered cyberbullied when they reported a cyberbullying victimization frequency of 2 or 3 times a month or higher in the last two months, and a cyberbullying aggressor is anyone who had participated in episodes of cyberbullying with the same frequency.

Type of victimization: 5 types of specific victimization experiences were explored using the Revised Olweus Bully/Victim Questionnaire (Olweus, 1996). This scale measured the behaviour-based prevalence of being bullied in the past couple of months in five specific experiences of school victimization: 1) "I was called mean names, was made fun of, or teased in a hurtful way"; 2) "Other students left me out of things on purpose, excluded me from their group of friends, or completely ignored me"; 3) "I was hit, kicked, pushed, shoved around, or locked indoors"; 4) "Other students told lies or spread false rumours about me and tried to make others dislike me"; and 5) "Other students made sexual jokes or gestures to me." The frequency of episodes was divided as described in the previous measures. As has been done in other research studies to identify victims of bullying (García-Moya et al., 2014; Paniagua et al., 2020; Sánchez-Quejía et al., 2016), the measure is the result of calculating the maximum frequency function on the 5 items of bullying experiences; participants whose answers showed a frequency of at least 2 or 3 times a month in at least 1 of the 5 items were considered victims of bullying.



Table 6. Summary of instruments used in the doctoral dissertation

Measures/Instruments	Package	Study					
		1	2	3	4	5	6
<i>Gender identity</i>							
Two-step approach	Core	✓					
<i>Lifestyles</i>							
Frequency of breakfast	Package 3		✓				
Dietary habits	Package 3		✓				
Dieting	Package 3		✓				
Physical activity	Core		✓				
Hours of sleep	Package 3		✓				
Tooth brushing	Package 3		✓				
<i>Mental health</i>							
Self-reported health	Core			✓			
Life satisfaction	Core			✓			
Health-related quality of life	Core		✓		✓		✓
Psychosomatic complaints	Core			✓			
Sense of coherence	Package 1			✓			
<i>Social environment</i>							
Satisfaction with family context	Core				✓		
Family support	Core				✓		✓
Satisfaction with friends context	Core				✓		
Friends support	Core				✓		✓
Satisfaction with classmate context	Core				✓		
Classmate support	Core				✓		✓
Satisfaction with teacher context	Core				✓		
Teacher support	Core				✓		✓
Romantic partner support	Core				✓		
<i>School victimization</i>							
Reported having bullied others	Core					✓	
Reported having been bullied	Core					✓	✓
Reported having cyberbullied others	Core					✓	
Reported having been cyberbullied	Core					✓	✓
Types of bullying	Package 2						✓



5.5 Data analysis

Different statistical analyses were carried out in this dissertation using SPSS 26.0 (IBM Corp., Armonk, NY). PROCESS 3.4 macro for SPSS (Hayes, 2018) was used to perform analyses in the **Study 4** and the **Study 6**.

Tests for effect size were reported in every study in order to know the magnitude of the differences among variables between groups of participants (G. M. Sullivan & Feinn, 2012) and also to avoid committing Type I—that means rejecting the null hypothesis when it is actually true—due to the sample size (Shaughnessy et al., 2011; Tomczak & Tomczak, 2014). Effect sizes were calculated with SPSS and the Psychometrica website (Lenhard & Lenhard, 2014, 2016)³.

Lastly, R software (version 3.6.1; R Core Team (n.d.) and RStudio (version 1.2.5042) with packages interactions (version 1.1.5, Long, (2021) and tidyverse (version 1.3.1; Wickham et al., (2019) were used, following the tutorial provided by Nordmann et al. (2021) to represent interaction plots in the **Study 4** and boxplots in the **Study 6**.

The analyses performed in each of the studies are described below and summarized in Table 7.

Study 1: Two-step approach

Descriptive data was obtained from the sex and self-perceived gender identity items, using percentages to describe them. Adjusted standardized residuals (SR_{ij}) and chi-squared tests (χ^2) were used to compare cisgender and transgender adolescents by sociodemographic variables (sex, age, socioeconomic status, country of birth, type of school, and habitat). Adjusted residuals can be compared in the contingency table to see which categories have the greatest difference between the expected counts and the actual counts relative to sample size; an adjusted residual having absolute value that exceeds ± 1.96 indicates lack of fit of null hypothesis in that cell (Agresti, 2007; Field, 2017).

Phi coefficient and Cramer's V were estimated to test the magnitude of the effects, using the following thresholds: ≤ 0.09 = negligible; 0.10–0.29 = small; 0.30–0.49 = medium; and ≥ 0.50 = high (J. Cohen, 1988; Fritz et al., 2012). Phi coefficient was employed to examine the association between two categorical variables with two levels and Cramer's V was employed to

³ <http://www.psychometrica.de/correlation.html> and http://www.psychometrica.de/effect_size.html



examine the association between two categorical variables when there is more than a 2 X 2 contingency (Gingrich, 2020).

Study 2: Lifestyles

First, the sample was divided into cisgender and transgender adolescents. Then, transgender adolescents were grouped into binary transgender and non-binary transgender adolescents.

Descriptive analysis with adjusted standardized residuals (SRij) and chi-squared tests (χ^2) were employed to compare cisgender, binary transgender, and non-binary transgender adolescents. Phi coefficient and Cramer's V were calculated to measure the effects size, considering different cut-off points: 0–0.09 = negligible; 0.10–0.29 = small; 0.30–0.49 = medium; and ≥ 0.50 = high (J. Cohen, 1988; Fritz et al., 2012). Phi coefficient was employed to examine the association between two categorical variables with two levels, and Cramer's V was employed to examine the association between two categorical variables when there is more than a 2 X 2 contingency (Gingrich, 2020).

Study 3: Mental health and psychological adjustment

The sample was divided into cisgender and transgender adolescents. Then, transgender adolescents were disaggregated into binary transgender and non-binary transgender adolescents.

Descriptive analysis with mean (M), standard deviation (SD), adjusted residuals (SRij), chi-squared test (χ^2), Student's t-test, and analysis of variance (ANOVA), with the Bonferroni test for multiple comparisons, were used to compare cisgender, binary transgender, and non-binary transgender adolescents on health, adjustment, and well-being indicators. Cramer's V and Cohen's d were estimated to test the effect size, considering different cut-off points. For Cramer's V, 0–0.09 = negligible; 0.10–0.29 = small; 0.30–0.49 = medium; and ≥ 0.50 = high. For Cohen's d, 0–0.19 = negligible; 0.20–0.49 = small; 0.50–0.79 = medium; and ≥ 0.80 = high (J. Cohen, 1988; Fritz et al., 2012).



Study 4: Social support

First, the sample was separated into two groups: cisgender and transgender adolescents. Next, adolescents were divided into three categories: cisgender, binary transgender, and non-binary transgender adolescents.

To present descriptive statistics for all the variables, means (*M*) and standard deviations (*SD*) were calculated by gender identity (cisgender, binary transgender, and non-binary transgender adolescents). Then, all the variables of the social environment (perceived social support and satisfaction with the social contexts) were compared through Student's t-test and one-way variance of analysis (*ANOVA*) with the Bonferroni test for multiple comparisons. Cohen's *d* were calculated to test the effects size, considering different cut-off points: 0–0.19 = negligible; 0.20–0.49 = small; 0.50–0.79 = medium; and ≥ 0.80 = high (J. Cohen, 1988; P. D. Ellis, 2010).

Hierarchical multiple regression analyses based on the general linear model were conducted to test whether health-related quality of life could be predicted by perceived social support and gender identity, and to test the moderating role of gender identity in the relationship between sources of social support and health-related quality of life. For each hierarchical regression, gender identity was recoded as a dummy variable (cisgender adolescents coded as '1' and transgender adolescents coded as '0'), and it was entered in a stepwise manner in Step 1. Perceived social support for each context was entered in Step 2. At Step 3, the moderation effect was included. Five models were calculated in the last step. The level of explanation achieved by the model was assessed by the R^2 value, and the magnitude and direction of each variable effect was interpreted based on standardized beta (β) values and partial eta squared (η^2) correlations: 0-0.009 = negligible; 0.01-0.059 = small; 0.06-0.13 = medium; and ≥ 0.14 = high (J. Cohen, 1988; P. D. Ellis, 2010). The interaction effects were illustrated by graphing the regression equation at relevant beta values of the gender identity as the moderating variable. Moderation analyses were also performed using PROCESS Model 1 to ensure the correct interpretation of the models.

Study 5: School victimization

Descriptive analyses with adjusted standardized residuals (*SR_{ij}*) and chi-squared tests (χ^2) were calculated to study the presence or absence of the different roles and types of bullying and cyberbullying among cisgender, binary transgender, and non-binary transgender adolescents.



The Phi coefficient and Cramer's V were calculated to measure the effects size, considering the cut-off points: 0–0.09 = negligible; 0.10–0.29 = small; 0.30–0.49 = medium; and ≥ 0.50 = high (J. Cohen, 1988; Fritz et al., 2012). Phi coefficient was employed to examine the association between two categorical variables with two levels, and Cramer's V was employed to examine the association between two categorical variables when there is more than a 2 X 2 contingency (Gingrich, 1992). Being a victim of bullying and cyberbullying was recoded as a dichotomous variable ('0 = no victim' and '1 = victim') according to the criteria described by Solberg & Olweus (2003). For the Revised Olweus Bully/Victim Questionnaire, the total score was calculated through the maximum frequency function on the five items and was recoded as being or not being a victim of bullying. In addition, the prevalence of being a victim or not was compared for each of the items according to the criteria described by Solberg & Olweus (2003).

Study 6: The gender minority stress model

Gender identity was recoded as a dichotomous variable, where transgender adolescents were coded as '0' and cisgender adolescents were coded as '1'. Being a victim of bullying and cyberbullying was recoded as a dichotomous variable ('0 = no victim' and '1 = victim') according to the criteria described by Solberg & Olweus (2003).

A descriptive analysis of the relationships between bullying and cyberbullying victimization, perceived social support from family, friends, classmates, and teachers, and health-related quality of life was obtained using Pearson correlation coefficients for quantitative variables and Point-Biserial Correlation Coefficient for categorical dichotomous variables. Differences in correlations were compared between cisgender and transgender adolescents using the Fisher's Z-test (Clogg et al., 1995). Cut-off point was established in values above 2.33 (in absolute values), corresponding to a 99% unilateral confidence interval.

A multivariate analysis (multiple linear regression) was performed to study differences in models and explain the health-related quality of life considering the effect of being a victim of bullying and social support (Model 1) and being victim of cyberbullying and social support (Model 2) for cisgender and transgender adolescents. The level of explanation achieved by the model was assessed by the R^2 value, and the magnitude and direction of each variable effect was interpreted based on no standardized beta (B) values and partial eta squared (η^2) correlations: 0-0.009 = negligible; 0.01-0.059 = small; 0.06-0.13 = medium; and ≥ 0.14 = high (J. Cohen, 1988; P. D. Ellis, 2010).



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Tests of moderated mediation (model 59 in PROCESS) were performed to examine the conditional effect of the mediation model as a function of the gender identity. In this model, the effect of bullying and cyberbullying victimization on the health-related quality of life (direct effect) and on the support from family, friends, classmates, and teachers (mediators) were supposedly be moderated by the gender identity.

Bootstrapping is recognized as the optimal approach for testing indirect effects. It minimizes Type 1 error and lack of power issues, and does not require assumptions about the normality of the sampling distribution of the indirect effect (Hayes, 2009). In order to provide inferential tests for conditional indirect effects, indices of moderated mediation were estimated, based on 5,000 bootstrapped samples (Hayes, 2018). Confidence intervals that did not contain zero indicated a significant indirect effect via the specific mediator.

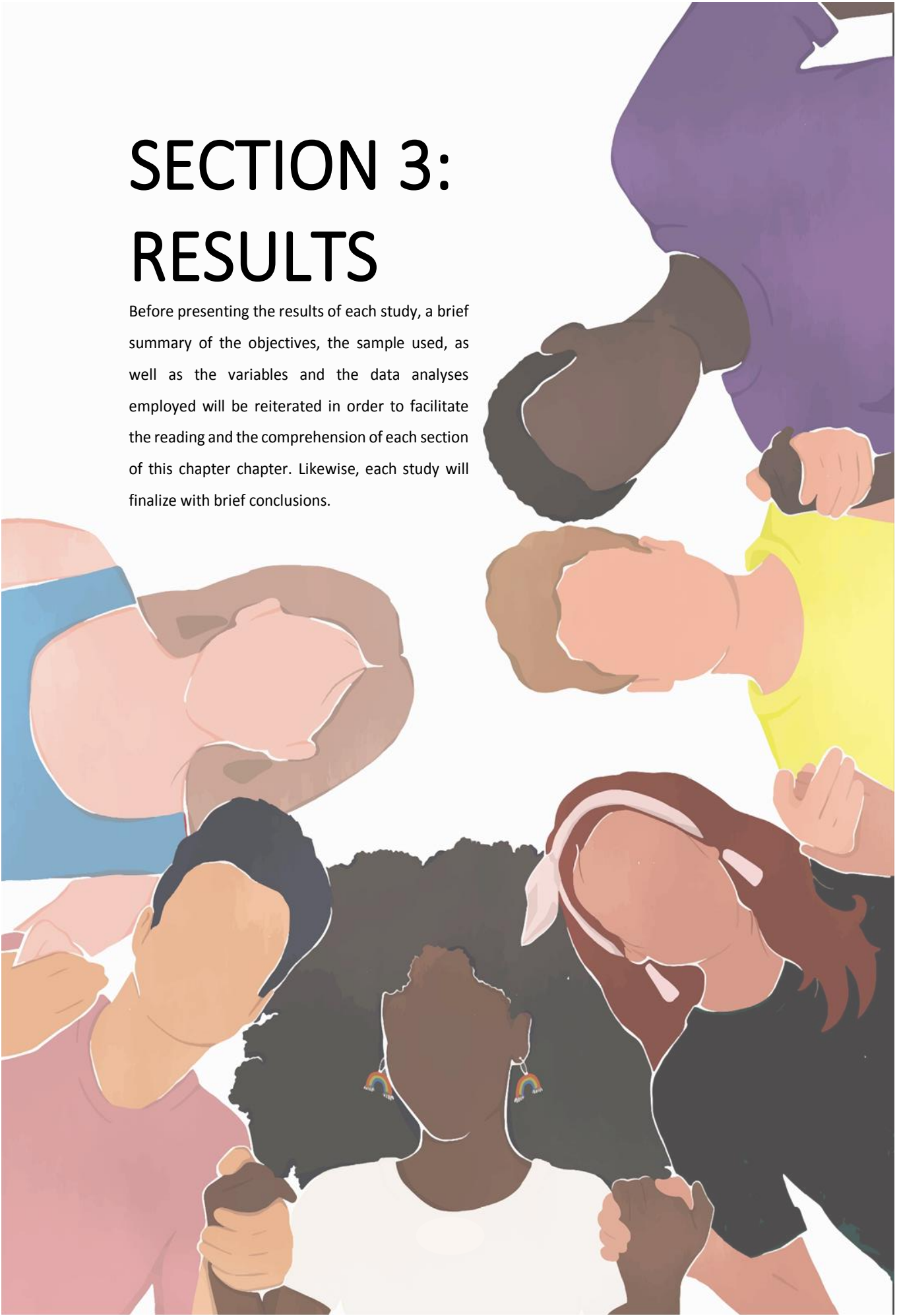
Table 7. Summary of analyses conducted in the doctoral thesis

Analysis	Study					
	1	2	3	4	5	6
<i>Resampling</i>						
Matching technique		✓	✓	✓	✓	✓
<i>Observed and expected results comparisons</i>						
Chi-Squared test	✓	✓	✓		✓	
<i>Mean comparisons</i>						
Student's t test			✓	✓		
ANOVA			✓	✓		
<i>Effect size</i>						
Phi coefficient / Cramer' V	✓	✓	✓		✓	
Cohen's d			✓	✓		
Partial eta squared				✓		✓
Z-Score						✓
<i>Regression analyses</i>						
Hierarchical multiple regression				✓		
Moderated mediation model						✓



SECTION 3: RESULTS

Before presenting the results of each study, a brief summary of the objectives, the sample used, as well as the variables and the data analyses employed will be reiterated in order to facilitate the reading and the comprehension of each section of this chapter chapter. Likewise, each study will finalize with brief conclusions.



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CHAPTER 6: STUDY 1 (TWO-STEP APPROACH)

Abstract:

During the last decade, a growing number of studies were carried out on transgender youth. Most of these studies used non-probabilistic sampling techniques and were mainly located in English-speaking countries. So far, no randomized and population-based studies exist in Spain that include a reliable measure to evaluate gender identity in adolescents. The aim of this study is to estimate the proportion of different gender identities (cisgender, binary transgender, non-binary, and other) among Spanish adolescents using a two-step process. Data of those 17,678 adolescents (M = 16.33, SD = 1.07, range: 15–18 years) who participated in the 2018 HBSC study in Spain were analyzed. Sex and self-perceived gender were asked. Participants could choose in the first question if they were a boy or a girl. In the second question, they could select if they identified themselves as a boy, as a girl, or neither; and an open-ended option was also provided for those who wanted to give another identity label. The open-ended responses were coded, and descriptive statistics were calculated. Responses on sex and self-perceived gender were cross-tabulated. Gender of the majority of participants (97.7%) was congruent with their sex assigned at birth (cisgender); 0.5% were binary transgender; 1.2% did not identify with the binary categories (non-binary transgender); 0.4% of responses were irrelevant or incoherent; and 0.2% did not answer the self-identity gender question. This is the first study to estimate gender identity proportions in a representative randomly selected sample of adolescent population-survey in Spain. Measuring sex and gender in an inclusive way and assess health outcomes across gender identities can help developing policies and planning health promotion activities that are more sensitive to the needs of the transgender community. The two-step approach (asking about sex assigned at birth and gender identity) seems to be an inclusive and feasible tool to ask gender identity in adolescent population health surveys.

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Based on:

- Participation in scientific conferences:

Ciria-Barreiro, E., Moreno, C., Rivera, F., & Moreno-Maldonado, C. (2021, August 11-13). How do Spanish adolescents answer to a two-step method to measure gender identity? [Poster presentation]. 4th EPATH conference, online.

Moreno-Maldonado, C., Ciria-Barreiro, E., Luna, S., & Rivera, F. (2020, December 3-5). Identifying sex and gender diversity in adolescents surveys: An analysis of the results from the Health Behaviour in School-Aged Children (HBSC) and the OPINA Barometer project in Spain. In J. Inchley (Chair), Sex, gender and gender identity: reflections and discussions in the Health Behaviour in School-Aged Children international network [Symposium]. 12th Excellence in Pediatrics Virtual Conference 2020, online.

Ciria-Barreiro, E. (2020, November 5). ¿Qué sabemos de la investigación sobre identidad de género en la adolescencia? Retos y soluciones [Paper presentation]. II Seminario Psicología, Investigación y Género, online.

Ciria-Barreiro, E., Moreno-Maldonado, C., Moreno, C., Rivera, F., Költő, A., & Nic Gabhainn, S. (2020, June 11-12). Which is the best way to measure gender identity? Good practices in adolescent research. In A. Költő (Chair), Sex & gender in HBSC: What's next? [Symposium]. HBSC Spring Meeting, online.

Ciria-Barreiro, E., Moreno-Maldonado, C., Moreno, C., & Rivera, F. (2019, June 18-20). How to classify gender identity on adolescence? Exploring the functioning of a single-item measure in Spanish school-aged adolescents [Poster presentation]. HBSC Spring Meeting, Reykjavik, Iceland.

Ciria-Barreiro, E., Moreno-Maldonado, C., Rivera, F., Moreno, C., & Andrés-Villas, M. (2019, May 9-11). Explorando características sociodemográficas de los adolescentes españoles: diferencias en función de la identidad de género [Poster presentation]. V Congresso Ibero Americano e Luso Brasileiro de Psicologia da Saúde and I Congresso Promoção da Saúde e do Bem-Estar, Faro, Portugal.

Moreno-Maldonado, C. & Ciria-Barreiro, E. (2019, February 13-15). Un análisis exploratorio sobre la identidad de sexo, género y la orientación sexual en adolescentes españoles [Paper presentation]. I Congreso Internacional de Diversidad Sexual y Género en la Educación, la Filología y las Artes, Seville, Spain.

- Article:

Ciria-Barreiro, E., Moreno-Maldonado, C., Rivera, F., & Moreno, C. Using a two-step approach to measure gender identity in Spanish youth [Manuscript submitted for publication]. Departamento de Psicología Evolutiva y de la Educación, Universidad de Sevilla.



RESULTS
CHAPTER 6: STUDY 1

Objective:

This study tests whether the two-step approach is a reliable and valid way to estimate the proportion of transgender adolescents in Spain. Specifically, the proportion of adolescents is counted based on their responses to a first item of sex, a second item of their self-perceived gender identity, and the result of combining the answers of these two measures.

Method:

The 2018 HBSC study in Spain included 40,495 adolescents between 11-18 years old enrolled in Spanish schools. The combination of the questions about sex and self-perceived gender identity was administered to participants aged 15 or older who were enrolled in grades equal or higher than 3rd of secondary school. In sum, 17,678 participants responded to both of these two items (M = 16.33, SD = 1.07).

Participants were asked about their sex and self-perceived gender identity, and we have cross-tabulated the two questions to know gender identity. Descriptive data, adjusted residuals and chi-squared tests were used to compare expected proportions of cisgender and transgender adolescents in every sociodemographic variable.

Results:

The distribution of responses on the sex and self-perceived gender items is presented in Table 8. A small proportion of the total sample, 0.2% of the participants (n = 31) skipped to answer the self-perceived gender identity question.

Table 8. Sex and self-perceived gender identity's frequency

		n	%
Sex	Boy	8741	49.45
	Girl	8937	50.55
Self-perceived gender	Boy	8596	48.62
	Girl	8745	49.44
	Neither	192	1.10
	Other	114	0.64
	Missing	31	0.20

When sex and self-perceived gender were cross-tabulated, 97.9% of boys and 97.6% of girls were found to identify themselves with the gender in line with their sex. A small fraction of the participants (0.6% of the boys and 0.4% of the girls) identified themselves as belonging to



the opposite gender. Around 0.8% of the boys and 1.4% of the girls identified as neither, and 0.9% and 0.4% as other, respectively (Table 9).

Table 9. Cross-table with sex and gender self-perceived gender identity's data before coding the Other option

	I identify myself as boy		I identify myself as girl		Neither		Other	
	n	% row	n	% row	n	% row	n	% row
Boys	8543	97.91	37	0.42	67	0.77	78	0.89
Girls	53	0.59	8708	97.60	125	1.40	36	0.40

The content of the answers written in the “Other” open-ended option was reviewed in order to complete the analysis of the two-step process. Of the 114 responses, 10.53% of the participants described gender experiences from a binary perspective and 18.42% from a non-binary perspective (Table 10). Considering the answer given in the question on sex item and the description of the self-perceived gender in the open-ended option, some participants were identified as cisgender boys and girls (if self-perceived gender was consistent with the initially indicated sex); others as transgender boys or girls (if perceived gender was the opposite of the initially indicated sex), and others as non-binary transgender adolescents (if they indicated other gender identities).

There were some participants who used the “other” option and gave responses that could not be categorized as gender identity: 4.39% of the participants misunderstood the instructions and talked about their sexual orientation. One participant explained they were intersex. Four participants marked the “other” option but did not give a text response. Finally, 7.89% of the answers could not be analyzed because of the ambiguity or lack of information. Nevertheless, most of the “other” answers (54.39%) were random comments, others were jokes, and others indicated that the participants did not take the question seriously (Table 10).



RESULTS
CHAPTER 6: STUDY 1

Table 10. Examples of “Other” answers

Type of answer	Categories	n	%	Examples
Answers categorized as gender identity	Binary gender answers	12	10.53	I identify myself as a homosexual boy; I’m a boy and it’s enough; I identify myself as a girl, just like everybody; My name is Laura
	Non-binary gender answers	21	18.42	I identify myself as a person because I don't like labels; I am sometimes like a boy and sometimes like a girl; I am a non-binary person; Thanks to the ‘Queer theory’, I identify myself as ‘I’ without having to specify either sex or gender; Gender Fluid;
Answers not categorized as gender identity	Random answers, jokes, offensive comments or strong language	62	54.39	I am an immaterial creature; I’m a non-binary orange traffic cone; I am an Attack Helicopter ⁴ ; I am Batman; I am a unicorn; I am not sick; Identifying doesn’t change the reality
	Question is not understood, or answer is ambiguous	9	7.89	It is early to know it; I am confused
	Sexual orientation	5	4.39	I am gay; I am bisexual; Asexual as far as humans are concerned
	Differences in sex development	1	0.88	I am intersexual (Androgen insensitivity syndrome)
	Blank space	4	3.51	

Finally, we used the two-step approach (cross-tabulating the answers of the two items and coding the open-ended options). In the total sample, 97.6% of the participants could be identified as cisgender and 1.7% could be identified as transgender (Table 11). Under the transgender umbrella, 0.5% considered themselves as the opposite gender and 1.2% used tags that do not belong to the binary system, as queer, agender or gender fluid.

⁴ The “I Sexually Identify as an Attack Helicopter” cypypasta or meme went viral in 2014 as a parody of non-binary gender identities. It is used by conservative right-wing ideologists or transphobic trolls on Internet in order to taunt the gender identity discussion (Blake et al., 2020; Jaroszewski et al., 2018).



Table 11. Results of the two-step approach

	n	%
Cisgender		
Cisgender boy	8548	48.35
Cisgender girl	8713	49.28
Transgender		
Binary transgender		
Transgender binary boy	53	0.30
Transgender binary girl	37	0.21
Non-binary transgender		
Agender	192	1.09
Queer, gender fluid	23	0.13
Other	77	0.44
Missing	35	0.20

In sum, 303 participants were classified as binary or non-binary transgender (Table 12). This proportion was higher among participants who defined their sex as a girl (64.03%) than who identified themselves as a boy (35.97%) in the sex question compared with cisgender adolescents (50.48% marked the girl option and 49.52% selected the boy option). The proportion of transgender participants compared to the proportion of cisgender participants according to the age, socioeconomic status, and country of birth was significantly different: transgender participants were more likely to belong to the low socioeconomic category, not being born in Spain, and to attend to public schools than their cisgender counterparts. Age and area of residence were not associated with gender identity status.

Figure 10 represents the geographic distribution of the 303 transgender participants identified in this study. The region where the most of them lived was Catalonia (36 of 303), Balearic Island (29 of 303), and Community of Madrid (26 of 303), and the regions where the least they were located were Ceuta (3 of 303), Melilla (4 of 303), and Asturias (8 of 303).

Conclusion:

This study aimed to identify transgender adolescents in a nationally representative school-based survey in Spain. Results showed that the proportion of transgender youth is coherent with the proportions reported in studies conducted in other countries with adolescents and adults. The variation of the two-step approach to assess sex assigned at birth and gender identity showed to be useful for the HBSC study, scholars, and policy-makers in order to identify transgender and other gender minority youth. In addition, estimating accurately the prevalence of transgender population and identifying them might help to understand their health disparities, design interventions that meet their needs, and help them to experience their gender identity in a positive way.



CHAPTER 7: STUDY 2 (LIFESTYLES)

Abstract:

There is little information available regarding lifestyles among gender non-conforming or transgender adolescents, especially in non-English-speaking countries. The present study investigates the lifestyles behaviors of adolescents in Spain according to their gender identity using a nationally representative sample. The study included 1,212 adolescents (M = 16.41 years old; SD = 1.07) who participated in the 2018 HBSC survey in Spain. Participants were identified as binary transgender (n = 90), non-binary transgender (n = 203), and cisgender adolescents (n = 909). Food and drink consumption, physical activity, hours of sleep, and tooth brushing were explored among the different groups through comparisons of frequencies (chi-square statistic, Phi, and Cramer's V). No significant differences were found between cisgender and transgender adolescents in the consumption of fruits, vegetables, salty snacks, sweets, sugar-drinks, and energy drinks. However, differences were detected for the other variables. Both binary and non-binary transgender adolescents were more likely than cisgender adolescents to diet to modify their weight or volume. Binary transgender participants were less likely than the other groups to have breakfast daily and to brush their teeth more than once a day. Non-binary transgender students reported less hours of sleep and physical activity and more skipping breakfast compared with the other groups. Nevertheless, effect sizes of the differences were negligible or small. Transgender adolescents reported more negative lifestyle outcomes than cisgender youth in some indicators, whereas in others there were no differences. Interventions should concentrate on the positive aspects of transgender adolescents' lifestyles, as well as the disparities in behaviors between gender identity subgroups, in order to best meet their needs.

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Based on:

- Participation in scientific conferences:

Ciria-Barreiro, E., Moreno-Maldonado, C., Moreno, C., & Rivera, F. (2019, October 23-26). Adolescent lifestyles from a gender identity perspective: preliminary outcomes of the Spanish HBSC Study [Paper presentation]. 23rd ILGA-Europe Annual Conference, Prague, Czech Republic.

- Article:

Ciria-Barreiro, E., Moreno-Maldonado, C., Rivera, F., and Moreno, C. (2021). Transgender adolescent health: A study of diet, physical activity, sleep habits, and oral-care in adolescents according to their gender identity [Manuscript submitted for publication]. Departamento de Psicología Evolutiva y de la Educación, Universidad de Sevilla

Objective:

This study evaluates patterns of diet, physical activity, sleep habits, and oral-care in adolescents according to their gender identity. First, these variables are studied by comparing the results between cisgender and transgender adolescents. Next, the group of transgender adolescents is disaggregated into binary and non-binary categories to explore the characteristics inside the group.

Method:

The sample of participants of the HBSC Study 2018 in Spain who answered the two-step approach consisted of 90 binary transgender adolescents, 213 non-binary transgender adolescents, and 17,375 cisgender adolescents between the ages of 15-18. A cisgender adolescents subsample was selected through a matching process in terms of age, country of birth, socioeconomic level, type of school, and habitat, in order to ensure the comparability with the transgender group. The resulting sample consisted of 303 transgender adolescents and 909 cisgender adolescents. The final sample comprised 303 transgender adolescents and 909 cisgender adolescents with a comparable profile

Descriptive data, adjusted residuals ($>\pm 1.96$) (SR_{ij}), and chi-square (χ^2) tests were employed to compare cisgender, binary transgender and non-binary transgender adolescents in frequency of breakfast, dietary habits, physical activity, hours of sleep, and tooth brushing. Phi (ϕ) and Cramer's V were calculated to measure the effects sizes.



RESULTS
CHAPTER 7: STUDY 2

Results:

Information about the frequency of breakfast, dieting, and frequency of consumption of fruits, vegetables, salty snacks, sweets, sugar drinks, and energy drink in cisgender and transgender adolescents, as well as the differences among them, is provided in Table 13. Patterns of fruit, vegetables, salty snacks, sweets, energy drinks, and sugar drinks consumption were similar among cisgender and transgender adolescents, as no statistically significant differences were found. About one-third of the adolescents (both cisgender and transgender) consumed fruit or vegetables every day. With respect to sweets and salty snacks, infrequent consumption was 20.62% for sweets and 30.32% for salty snacks in the transgender sample, and 17.33% for sweets and 24.42% for salty snacks in the cisgender sample. Regarding beverages, about a third of participants drank sugary drinks infrequently (33.83% of cisgender adolescents and 35.62% of transgender adolescents) and more than three quarters of them (80.00% of cisgender adolescents and 76.17% of transgender adolescents) drank energy drinks infrequently.

Statistically significant differences, albeit negligible, were observed in the frequencies of having breakfast and dieting to modify weight or volume. Having breakfast daily was more frequent in the cisgender group, whereas dieting to modify weight or volume was more frequent in the transgender group.

After dividing the transgender group into binary transgender and non-binary transgender adolescents (Table 14), the same indicators (having breakfast and current diet) reached statistical significance, however the effect size was negligible. Cisgender adolescents showed the highest frequency of having breakfast every day. On the contrary, non-binary transgender adolescents showed the highest percentage of infrequent breakfast. Similarly, non-binary transgender adolescents reported a higher frequency of dieting to modify weight/volume with respect to cisgender adolescents, although similar to binary transgender adolescents.

Examining sleep habits and tooth brushing (Table 15), the differences between cisgender and transgender adolescents were statistically significant. The effect size revealed that these differences were small. Transgender adolescents fell short of the recommended minimum 8-hours sleep on weekdays more than cisgender adolescents (28.12% vs. 36.80%), as well as on weekends (75.68% vs. 85.76%). Moreover, differences were significant in insufficient sleep: almost half of transgender adolescents slept an insufficient number of hours on weekdays, and almost three times as many transgender adolescent compared to cisgender adolescent slept insufficient hours on weekends. Likewise, fewer transgender adolescents than cisgender adolescents reported brushing their teeth more than once a day (57.01% vs 68.21%).



Regarding physical activity (Table 15), roughly 13% of adolescents did moderate to vigorous physical activity every day, and a quarter of the participants met the recommended standards for vigorous physical activity. Statistical differences were found between cisgender and transgender adolescents, however the effect size was negligible in both measures: the probability of infrequent physical activity was higher for transgender adolescents.

Further analyses were performed among cisgender, binary transgender and non-binary transgender adolescents (Table 16). Non-binary transgender adolescents reported the least-healthy profile, that is, the lowest optimal hours of sleep, both on weekdays and at weekends, and the highest probability of not doing physical activity, both moderate to vigorous physical activity and vigorous physical activity. Finally, binary transgender adolescents showed the lowest percentage of optimal tooth brushing. Although these differences were statistically significant, the effects sizes between groups were negligible for all the measures, and small for weekend sleep.



RESULTS
CHAPTER 7: STUDY 2

Table 13. Differences amongst cisgender and transgender adolescents in eating and dieting behaviors

	Cisgender adolescents			Transgender adolescents			χ^2	<i>p</i>	<i>V</i> / ϕ
	<i>n</i>	%	<i>SRij</i>	<i>n</i>	%	<i>SRij</i>			
Having breakfast									
Infrequently	72	11.92%	-1.8	37	16.82%	1.8	7.18	.028*	0.093
Irregularly	237	39.24%	-1.3	97	44.09%	1.3			
Daily	295	48.84%	2.5	86	39.09%	-2.5			
Fruit consumption									
Infrequently	86	14.19%	-1.4	40	18.10%	1.4	2.90	.234	0.059
Irregularly	360	59.41%	1.5	118	53.39%	-1.5			
Daily	160	26.40%	-0.6	63	28.51%	0.6			
Vegetable consumption									
Infrequently	58	9.73%	1.1	16	7.31%	-1.1	2.64	.267	0.057
Irregularly	380	63.76%	0.7	134	61.18%	-0.7			
Daily	158	26.51%	-1.4	69	31.51%	1.4			
Salty snacks consumption									
Daily	32	5.33%	-1.2	15	7.73%	1.2	2.92	.232	0.061
Irregularly	464	77.33%	1.6	139	71.65%	-1.6			
Infrequently	104	17.33%	-1.0	40	20.62%	1.0			
Sweets consumption									
Daily	85	14.11%	-1.1	38	17.19%	1.1	5.39	.068	0.081
Irregularly	370	61.46%	2.3	116	52.49%	-2.3			
Infrequently	147	24.42%	-1.7	67	30.32%	1.7			
Energy drink consumption									
Daily	20	3.31%	0.5	5	2.59%	-0.5	2.21	.331	0.053
Irregularly	101	16.69%	-1.4	41	21.24%	1.4			
Infrequently	484	80.00%	1.1	147	76.17%	-1.1			
Sugar-drink consumption									
Daily	91	15.02%	-0.3	35	15.98%	0.3	0.49	.783	0.024
Irregularly	310	51.15%	0.7	106	48.40%	-0.7			
Infrequently	205	33.83%	-0.5	78	35.62%	0.5			
Current diet to modify weight/volume									
No	521	86.54%	2.5	177	79.37%	-2.5	6.43	.011*	-0.088
Yes	81	13.46%	-2.5	46	20.63%	2.5			

SRij = adjusted residuals; χ^2 = Chi-squared; *V* = Cramer's *V*; ϕ Phi

**p* < .05

Bold font indicates in which categories the differences in eating and dieting behaviors were found significant between cisgender and transgender adolescents



**CONTEXTUALIZING THE WELL-BEING
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Table 14. Differences amongst cisgender, binary transgender, and non-binary transgender adolescents in eating and dieting behaviors

	Cisgender adolescents			Binary transgender adolescents			Non-binary transgender adolescents			χ^2	<i>p</i>	<i>V</i>
	<i>n</i>	%	<i>SRij</i>	<i>n</i>	%	<i>SRij</i>	<i>n</i>	%	<i>SRij</i>			
Having breakfast												
Infrequently	72	11.92%	-1.8	8	12.31%	-0.2	29	18.71%	2.2	9.70	.046*	0.077
Irregularly	237	39.24%	-1.3	33	50.77%	1.8	64	41.29%	0.2			
Daily	295	48.84%	2.5	24	36.92%	-1.6	62	40.00%	-1.7			
Fruit consumption												
Infrequently	86	14.19%	-1.4	15	23.08%	1.8	25	16.02%	0.3	4.70	.320	0.053
Irregularly	360	59.41%	1.5	32	49.23%	-1.5	86	55.13%	-0.7			
Daily	160	26.40%	-0.6	18	27.69%	0.1	45	28.85%	0.6			
Vegetable consumption												
Infrequently	58	9.73%	1.1	5	8.06%	-0.3	11	7.00%	-1.0	4.95	.293	0.055
Irregularly	380	63.76%	0.7	42	67.74%	0.8	92	58.60%	-1.3			
Daily	158	26.51%	-1.4	15	24.20%	-0.7	54	34.40%	2.0			
Salty snacks consumption												
Daily	32	5.33%	-1.2	4	7.02%	0.4	11	8.03%	1.2	3.23	.521	0.045
Irregularly	464	77.33%	1.6	40	70.18%	-1.1	99	72.26%	-1.1			
Infrequently	104	17.33%	-1.0	13	22.81%	0.9	27	19.71%	0.5			
Sweets consumption												
Daily	85	14.11%	-1.1	11	16.92%	0.5	27	17.31%	0.9	5.47	.243	0.058
Irregularly	370	61.46%	2.3	35	53.85%	-0.9	81	51.92%	-2.0			
Infrequently	147	24.42%	-1.7	19	29.23%	0.6	48	30.77%	1.5			
Energy drink consumption												
Daily	20	3.31%	0.5	2	3.57%	0.2	3	2.19%	-0.7	2.57	.632	0.040
Irregularly	101	16.69%	-1.4	11	19.64%	0.4	30	21.90%	1.4			
Infrequently	484	80.00%	1.1	43	76.79%	-0.4	104	75.91%	-1.0			
Sugar-drink consumption												
Daily	91	15.02%	-0.3	7	10.77%	-1.1	28	18.18%	1.1	4.62	.328	0.053
Irregularly	310	51.15%	0.7	38	58.46%	1.4	68	44.16%	-1.7			
Infrequently	205	33.83%	-0.5	20	30.77%	-0.6	58	37.66%	1.0			
Current diet to modify weight/volume												
No	521	86.54%	2.5	52	80.00%	-1.1	125	79.11%	-2.1	6.46	.040*	0.088
Yes	81	13.46%	-2.5	13	20.00%	1.1	33	20.87%	2.1			

SRij = adjusted residuals; χ^2 = Chi-squared; *V* = Cramer's *V*

**p* < .05

Bold font indicates in which categories the differences in eating and dieting behaviors were found significant among cisgender, binary transgender and non-binary transgender adolescents.



RESULTS
CHAPTER 7: STUDY 2

Table 15. Differences amongst cisgender and transgender adolescents in physical activity, sleeping, and tooth brushing

	Cisgender adolescents			Transgender adolescents			χ^2	<i>p</i>	<i>V</i>
	<i>n</i>	%	<i>SRij</i>	<i>n</i>	%	<i>SRij</i>			
Moderate to vigorous physical activity									
Infrequently	280	30.94%	-3.0	122	40.26%	3.0			
Irregular	506	55.91%	2.8	141	46.53%	-2.8	9.66	.008**	0.089
Daily	119	13.15%	0.0	40	13.20%	0.0			
Vigorous physical activity									
Never	102	11.26%	-2.9	49	17.82%	2.9			
Less than 2-3 days a week	563	62.14%	1.2	160	58.18%	-1.2	8.19	.017*	0.083
More than 4 day a week	241	26.60%	0.9	66	24.00%	-0.9			
Hours of sleep on weekdays									
Insufficient	181	29.87%	-3.5	96	42.86%	3.5			
Sufficient	202	33.33%	1.2	65	29.02%	-1.2	12.78	.002**	0.124
Optimal	223	36.80%	2.3	63	28.12%	-2.3			
Hours of sleep at weekend									
Insufficient	40	6.62%	-4.6	38	17.11%	4.6			
Sufficient	46	7.62%	0.2	16	7.21%	-0.2	20.96	<.001***	0.159
Optimal	518	85.76%	3.4	168	75.68%	-3.4			
Tooth brushing									
Irregularly	49	8.11%	-2.4	30	13.57%	2.4			
Daily	143	23.68%	-1.7	65	29.41%	1.7	10.26	.006**	0.112
Optimal	412	68.21%	3.0	126	57.01%	-3.0			

SRij = adjusted residuals; χ^2 = Chi-squared; *V* = Cramer's *V*

p* < .05, *p* < .01, ****p* < .001

Bold font indicates in which categories the differences in physical activity, sleeping, and tooth brushing were found significant between cisgender and transgender adolescents



**CONTEXTUALIZING THE WELL-BEING
OF TRANSGENDER YOUTH IN SPAIN**

Table 16. Differences amongst cisgender, binary transgender, and non-binary transgender adolescents in physical activity, sleeping, and tooth brushing

	Cisgender adolescents			Binary transgender adolescents			Non-binary transgender adolescents			χ^2	<i>p</i>	<i>V</i>
	<i>n</i>	%	<i>SRij</i>	<i>n</i>	%	<i>SRij</i>	<i>n</i>	%	<i>SRij</i>			
Moderate to vigorous physical activity												
Infrequently	280	30.94%	-3.0	33	36.66%	0.7	89	41.78%	2.9	13.41	.009**	0.074
Irregular	506	55.91%	2.8	40	44.44%	-1.8	101	47.42%	-2.0			
Daily	119	13.15%	0.0	17	18.90%	1.7	23	10.80%	-1.1			
Vigorous physical activity												
Never	102	11.26%	-2.9	11	13.41%	0.2	38	19.69%	3.1	11.22	.024*	0.069
Less than 2-3 days a week	563	62.14%	1.2	47	57.32%	-0.8	113	58.55%	-0.8			
More than 4 day a week	241	26.60%	0.9	24	29.27%	0.7	42	21.76%	-1.5			
Hours of sleep on weekdays												
Insufficient	181	29.87%	-3.5	23	35.38%	0.4	73	45.91%	3.7	15.09	.005**	0.095
Sufficient	202	33.33%	1.2	21	32.31%	0.0	44	27.67%	-1.3			
Optimal	223	36.80%	2.3	21	32.31%	-0.4	42	26.42%	-2.4			
Hours of sleep at weekend												
Insufficient	40	6.62%	-4.6	7	10.94%	0.4	31	19.62%	4.9	24.98	<.001***	0.123
Sufficient	46	7.62%	0.2	5	7.81%	0.1	11	6.96%	-0.3			
Optimal	518	85.76%	3.4	52	81.25%	-0.4	116	73.42%	-3.6			
Tooth brushing												
Irregularly	49	8.11%	-2.4	13	20.0%	3.0	17	10.90%	0.6	14.76	.005**	0.095
Daily	143	23.68%	-1.7	17	26.15%	0.2	48	30.77%	1.8			
Optimal	412	68.21%	3.0	35	53.84%	-2.0	91	58.33%	-2.0			

SRij = adjusted residuals; χ^2 = Chi-squared; *V* = Cramer's *V*

p* < .05, *p* < .01, ****p* < .001

Bold font indicates in which categories the differences in physical activity, sleeping, and tooth brushing were found significant among cisgender, binary transgender and non-binary transgender adolescents.



RESULTS
CHAPTER 7: STUDY 2

Conclusion:

Transgender students have a higher likelihood of inadequate habits, such as skipping breakfast, low physical activity, sleeping insufficient time, or neglecting oral care. However, dietary habits were sufficient and therefore presuming the pathologization of transgender health could be a gargantuan bias. Binary transgender and non-binary transgender adolescents can have particular needs, however everyone has the right to achieve a balanced lifestyle, which in turn impacts their health and well-being. Consequently, policy makers and professionals related to public health and education should commit to fostering strategies and programs that meet current and future concerns.

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CHAPTER 8: STUDY 3 (MENTAL HEALTH AND PSYCHOLOGICAL ADJUSTMENT)

Abstract:

Research indicates that transgender adolescents face a higher risk of suffering from anxiety problems, psychosomatic complaints, or mood disorders than their cisgender peers. However, this information comes almost exclusively from English-speaking countries in Europe and North America, therefore an analysis of the health of transgender adolescents in other geo-political contexts is needed. The aim of this study was to describe the well-being and mental health of Spanish adolescents by gender identity using a nationally representative sample. The sample comprised 1,212 15-18-year-old adolescents (M = 16.41 years old; SD = 1.07) who participated in the 2018 HBSC study in Spain. Out of the total sample, 90 were identified as binary transgender adolescents, 213 as non-binary transgender adolescents, and 909 as cisgender adolescents (selected through a matching process from an original sample of 17,375 cisgender adolescents). Comparisons of frequencies and means (chi-square, t-test, and analysis of variance) were used to analyze self-reported health, life satisfaction, health-related quality of life, psychosomatic complaints, and sense of coherence. Non-binary transgender adolescents reported the lowest levels of perceived excellent health ($p < .001$), the highest frequency of psychological complaints ($p < .001$) and physical complaints ($p < .05$), and a lower sense of coherence ($p < .05$) compared with both cisgender and binary transgender adolescents. Likewise, non-binary transgender adolescents reported lower levels of life satisfaction ($p < .001$) and health-related quality of life ($p < .001$) than cisgender adolescents. The differences found between binary and non-binary transgender youth highlight the diversity within the transgender community. Both research and intervention programs should consider the unique experiences within the transgender community in order to adapt sensitively to their needs.

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Based on:

- Participation in scientific conferences:

Ciria-Barreiro, E., Rivera, F., Leal-Lopez, E., & Moreno-Maldonado, C. (2019, August 29-31). Beyond the differences: Analysis of the physical and psychological health of Spanish adolescents according to their gender identity [Poster presentation]. 19th European Conference on Developmental Psychology, Athens, Greece.

- Article:

Ciria-Barreiro, E., Moreno-Maldonado, C., Rivera, F., & Moreno, C. (2021). A Comparative Study of Health and Well-being Among Cisgender and Binary and Nonbinary Transgender Adolescents in Spain. *LGBT Health*, 8(8), 536–544. <https://doi.org/10.1089/lgbt.2020.0477>

Objective:

This study examines the mental health and well-being according to their gender identity, based on self-reported health, life satisfaction, health-related quality of life, psychosomatic complaints, and sense of coherence. Results are first compared between cisgender and transgender adolescents, and then these variables are examined between binary and non-binary transgender adolescents.

Method:

Of the 17,678 participants in the HBSC Study 2018 in Spain, 90 were binary transgender adolescents and 213 were non-binary transgender adolescents. Given the imbalanced comparison ratio between groups, resampling based on matching was used to facilitate sample equalization. The final sample comprised 303 transgender adolescents and 909 cisgender adolescents with a comparable profile.

Mean (M), standard deviation (SD), adjusted residuals (SRij), chi-squared test (χ^2), Student's t-test, and analysis of variance, with the Bonferroni test for multiple comparisons, were used to compare cisgender, binary transgender, and non-binary transgender adolescents on health indicators. Cramer's V and Cohen's d were estimated to test the effect size.

Results:

Regarding perceived health (Table 17), statistically significant differences, albeit small, were observed between cisgender and transgender adolescents. The self-reported perception of



RESULTS
CHAPTER 8: STUDY 3

health as excellent was more frequent in the cisgender group, whereas poor or passable health was more frequent in the transgender group.

Table 17. Differences between cisgender and transgender adolescents in self-reported perception of health

Self-reported health	Cisgender adolescents			Transgender adolescents			χ^2	<i>p</i>	<i>V</i>
	<i>n</i>	%	<i>SRij</i>	<i>n</i>	%	<i>SRij</i>			
Poor	17	1.87	-1.85	11	3.75	1.85	12.42	.006**	0.102
Passable	135	14.87	-2.79	64	21.85	2.79			
Good	520	57.27	1.31	155	52.90	-1.31			
Excellent	236	25.99	1.54	63	21.50	-1.54			

SRij = adjusted residuals; χ^2 = Chi-squared; *V* = Cramer's *V*

***p* < .01

Bold font indicates in which categories the differences in self-reported health were found significant among cisgender and transgender adolescents

After dividing the transgender group into binary and non-binary adolescents (Table 18) the differences among groups became clearer, with non-binary transgender adolescents showing the lowest levels of excellent health. Likewise, the percentage of adolescents with only passable health was higher for non-binary transgender adolescents than for cisgender adolescents. The differences among groups were statistically significant, but the effect size was small.

Table 18. Differences among cisgender, binary transgender, and non-binary transgender adolescents in self-reported perception of health

Self-reported health	Cisgender adolescents			Binary transgender adolescents			Non-binary transgender adolescents			χ^2	<i>p</i>	<i>V</i>
	<i>n</i>	%	<i>SRij</i>	<i>n</i>	%	<i>SRij</i>	<i>n</i>	%	<i>SRij</i>			
Poor	17	1.87	-1.9	5	5.75	2.2	6	2.91	0.6	25.48	<.001***	0.103
Passable	135	14.87	-2.8	11	12.64	-1.0	53	25.72	3.9			
Good	520	57.27	1.3	44	50.57	-1.1	111	53.88	-0.7			
Excellent	236	25.99	1.5	27	31.03	1.4	36	17.48	-2.7			

SRij = adjusted residuals; χ^2 = Chi-squared; *V* = Cramer's *V*

****p* < .001

Bold font indicates in which categories the differences in self-reported health were found significant among cisgender, binary transgender and non-binary transgender adolescents.

Differences were also found in the remaining health measures (Table 19). Transgender adolescents scored lower in life satisfaction, health-related quality of life, and sense of coherence. In addition, they reported more psychological and physical complaints than



cisgender adolescents. The effect sizes were small for all items except for sense of coherence, which was medium.

Table 19. Differences between cisgender and transgender adolescents in various health indicators

	Cisgender adolescents		Transgender adolescents		<i>t</i>	<i>p</i>	<i>d</i>
	<i>n</i>	<i>M (SD)</i>	<i>n</i>	<i>M (SD)</i>			
Life satisfaction	907	7.46 (1.33)	291	6.78 (1.65)	4.83	<.001***	-0.36
Health related quality of life	855	3.54 (0.67)	271	3.26 (0.67)	5.97	<.001***	-0.42
Psychological complaints	906	3.10 (1.40)	284	3.56 (1.40)	-4.88	<.001***	0.33
Physical complaints	908	2.68 (1.40)	285	2.93 (1.42)	-2.61	.009**	0.18
Sense of coherence	556	4.25 (1.01)	138	3.69 (1.00)	5.94	<.001***	-0.56

M = mean; *SD* = standard deviation; *t* = Student's *t*; *d* = Cohen's *d*

p* < .01, *p* < .001

After disaggregating the transgender group (Table 20), non-binary transgender adolescents reported the lowest levels of life satisfaction, health-related quality of life, and sense of coherence compared with cisgender and binary transgender adolescents. Although the differences between non-binary transgender and cisgender adolescents were statistically significant, the effect sizes of the differences were considered small for life satisfaction, and medium for health-related quality of life and sense of coherence. Similarly, significant differences, with a negligible effect size, were found in sense of coherence score between binary transgender and non-binary transgender adolescents.

Regarding psychosomatic complaints, non-binary transgender adolescents showed the highest frequency of psychological symptoms, with these differences being statistically significant and with a medium effect size. Likewise, non-binary transgender adolescents reported the highest frequency of physical complaints compared with cisgender and binary transgender adolescents. Although these differences were statistically significant, the effect sizes were small.



RESULTS
CHAPTER 8: STUDY 3

Table 20. Differences among cisgender, binary transgender, and non-binary transgender adolescents in various health indicators

	Cisgender adolescents		Binary transgender adolescents		Non-binary transgender adolescents		<i>F</i>	<i>p</i>	<i>Post hoc</i>	<i>p</i>	<i>d</i>
	<i>n</i>	<i>M (SD)</i>	<i>n</i>	<i>M (SD)</i>	<i>n</i>	<i>M (SD)</i>					
Life satisfaction	907	7.46 (1.33)	87	7.03 (1.93)	204	6.68 (2.25)	15.54	<.001***	Cis-Bin	.129	-0.24
									Cis-NoB	<.001***	-0.42
									Bin-NoB	.129	-0.18
Health-related quality life	855	3.54 (0.67)	80	3.41 (0.63)	191	3.20 (0.69)	20.74	<.001***	Cis-Bin	.293	-0.20
									Cis-NoB	<.001***	-0.51
									Bin-NoB	.053	-0.32
Psychological complaints	906	3.10 (1.40)	87	3.05 (1.56)	197	3.79 (1.26)	20.61	<.001***	Cis-Bin	1.000	-0.04
									Cis-NoB	<.001***	0.50
									Bin-NoB	<.001***	0.55
Physical complaints	908	2.68 (1.40)	87	2.57 (1.43)	198	3.08 (1.39)	7.393	<.001***	Cis-Bin	1.000	-0.07
									Cis-NoB	.001**	0.29
									Bin-NoB	.015*	0.36
Sense of coherence	556	4.25 (1.01)	37	4.03 (0.99)	101	3.56 (0.97)	20.72	<.001***	Cis-Bin	.559	-0.22
									Cis-NoB	<.001***	-0.69
									Bin-NoB	.046*	-0.05

M = mean; *SD* = standard deviation; *F* = ANOVA; *Post hoc* = Bonferroni test; *d* = Cohen's *d*; Cis = cisgender adolescents; Bin = binary transgender adolescents; NonB = non-binary transgender adolescents.

p* < .05, *p* < .01, ****p* < .001

Conclusion:

Transgender adolescents –especially non-binary– showed a higher frequency of adjustment problems. These results offer information about the estimate proportion of transgender adolescents in Spain, elucidate their experiences, and characterize their health status. We hope to encourage further research with the goal of designing policies that meet the needs of the transgender community, especially in the currently turbulent times in which the rights of transgender people are in jeopardy.



CHAPTER 9: STUDY 4 (SOCIAL SUPPORT)

Abstract:

Transgender adolescents usually report low rates of perceived support from their nearest social contexts, such as family or friends. This is a matter of great concern taking into consideration the impact of social contexts for well-being, as long as these spaces can be sources of risks or protective factors for adjustment. Data came from the 2018 HBSC study, using information of binary transgender (n = 90), non-binary transgender (n = 213), and cisgender adolescents (n = 909) 15-18 year-old adolescents (M = 16.41 years old; SD = 1.07). Analysis of variance between groups was calculated to compare scores of health-related quality of life, perceived social support from family, friends, classmates, teachers, and romantic partner, and satisfaction with these social contexts. Hierarchical linear regression analyses were conducted to examine main effects and interactions effects of gender identity on the relationship between social support and well-being. Non-binary transgender adolescents showed the lowest scores on perceived support and satisfaction with family, friends and classmates, as well the lowest scores on health-related quality of life. Simultaneous multiple regressions showed that family, friends, classmate or teacher support are more predictive of health-related quality of life than gender identity. Moreover, the interaction model indicated that the association between classmate support and well-being was moderated by the gender identity, such that health-related quality of life was higher for cisgender adolescents who had high social support from their classmates in comparison to transgender adolescents. Findings highlight the importance of social support during adolescence. To promote better mental health and adjustment is important to achieve a deep understanding of social contexts to offer the most sensitive actions to meet the needs of transgender adolescents.

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Based on:

- Participation in scientific conferences:

Ciria-Barreiro, E., Moreno-Maldonado, C., Rivera, F., and Moreno, C. (2021, November 10-12). "How much does my partner care about me?" Effects of partner support on life satisfaction cisgender and transgender adolescents. In A. van der Star (Chair), Sexual and gender minority health [Symposium]. 14th European Public Health Conference 2021, online.

Ciria-Barreiro, E., Villafuerte-Díaz, A., Leal-López, E., Moreno-Maldonado, C. (2021, June 14-18). Percepciones del apoyo y la satisfacción con los/as/es compañeros/as/es, profesorado y familia en función de la identidad de género [Paper presentation]. X International Congress of Psychology and Education, online en línea

Ciria-Barreiro, E., Jiménez-Iglesias, A., Sánchez-Queija, I., Leal-López, E., Rivera, F. (2020, December 3-5). Developmental contexts and gender identity: why do perceived support and satisfaction with family and friends matter? In J. Inchley (Chair), Sex, gender and gender identity: reflections and discussions in the Health Behaviour in School-Aged Children international network [Symposium]. 12th Excellence in Pediatrics Virtual Conference 2020, online.

- Article:

Ciria-Barreiro, E., Moreno-Maldonado, C., Rivera, F., and Moreno, C. (2021). When Perceived Social Support Matters for Well-being in Transgender Youth [Manuscript in preparation]. Departamento de Psicología Evolutiva y de la Educación, Universidad de Sevilla.

Objective:

This study analysed perceive support and satisfaction with family, friends, classmates, teachers and romantic partners according to gender identity. Firstly, the differences between the group of cisgender and transgender adolescents in relation to their satisfaction with, and perceived support from, the different developmental contexts were analysed. Secondly, the differences in relation to the mentioned variables within the group of transgender adolescents, thus between binary and non-binary transgender adolescents, were analysed too. Thirdly, how perceived support from the different developmental context influences health-related quality of life among adolescents according to their gender identity was evaluated.

Method:

The global sample of adolescents who answered the two-step measure consisted of 90 binary transgender, 213 non-binary transgender, and 17,375 cisgender adolescents, of which 909 cisgender adolescents were taken as a subsample with a sociodemographic profile similar to



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CHAPTER 9: STUDY 4

that of transgender adolescents through a matching process to control that results and their interpretation are not due to the large size of the original sample. Thus, resulting in a final simple of 1,212 15-18-year-old adolescents ($M = 16.41$ years old; $SD = 1.07$).

Means (M) and standard deviations (SD) were provided by gender identity for all examined variables. Then, groups conformed by gender identity were compared across all of them by Student's t test and one-way variance of analysis ($ANOVA$) with the Bonferroni test for multiple comparisons. Cohen's d for were calculate to test the effects size. Hierarchical multiple regression analyses were conducted to test the moderating role of gender identity in the relationship between sources of social support and health-related quality of life. For each hierarchical regression, gender identity recoded as a dummy variable (cisgender adolescents as "1" and transgender adolescents as "0") was entered in a stepwise manner in Step 1. Perceived social support for each context was entered in Step 2. At Step 3, moderation effect was included. In total, five models were calculated.

Results:

In regards to perceived social support and satisfaction with the different social context (Table 21), statistically significant differences, albeit small, were observed between cisgender and transgender adolescents. Transgender adolescents scored lower in perceived support from family, friends, and classmates. In addition, they reported lower satisfaction with their family, friends, and classmates than cisgender adolescents.



Table 21. Differences amongst cisgender and transgender adolescents in perceived social support and satisfaction with social context

	Cisgender adolescents		Transgender adolescents		<i>t</i>	<i>p</i>	<i>d</i>
	<i>n</i>	<i>M (SD)</i>	<i>n</i>	<i>M (SD)</i>			
Family support	908	5.78 (1.33)	301	5.20 (1.65)	5.59	<.001***	-0.41
Family satisfaction	908	8.04 (1.95)	302	7.27 (2.36)	5.09	<.001***	-0.37
Friends support	909	5.96 (1.37)	296	5.57 (1.60)	3.78	<.001***	-0.27
Friends satisfaction	909	8.59 (1.41)	295	8.17 (1.82)	3.58	<.001***	-0.28
Classmates support	899	3.83 (0.84)	271	3.52 (0.93)	4.99	<.001***	-0.37
Classmates satisfaction	897	7.70 (1.96)	266	6.86 (2.34)	5.32	<.001***	-0.41
Teacher support	901	3.41 (0.93)	271	3.40 (1.05)	0.06	.954	-0.00
Teachers satisfaction	900	6.74 (2.09)	81	6.56 (2.35)	1.06	.290	-0.08
Partner support	520	10.72 (3.67)	165	10.69 (3.80)	-0.10	.923	-0.01

M = mean; *SD* = standard deviation; *t* = Student's *t*; *d* = Cohen's *d*

****p* < .001

Table 22 provides the descriptive information for all studied variables and the results from the comparison among cisgender, binary transgender, and non-binary transgender adolescents. Differences were statistically significant for all the variables, except for teacher support, teacher's satisfaction, and partner support. Overall, cisgender adolescents reported the highest scores on perceived support and satisfaction with all the social contexts. The non-binary transgender group reported the lowest scores on perceived support and satisfaction with family, friends, and classmates. The effect sizes of the comparisons between non-binary transgender and cisgender adolescents were small for satisfaction with family and friends, and perceived support from friends and classmates. Furthermore, effect sizes were small for satisfaction with family between binary transgender and non-binary transgender adolescents. In addition, medium effect sizes were found between non-binary transgender and cisgender adolescents for perceived support from family and satisfaction with classmates.



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CHAPTER 9: STUDY 4

Table 22. Differences amongst cisgender, binary transgender and non-binary transgender adolescents in perceived social support and satisfaction with social context and health-related quality of life

	Cisgender adolescents		Binary transgender adolescents		Non-binary transgender adolescents		<i>F</i>	<i>p</i>	<i>Post hoc</i>	<i>p</i>	<i>d</i>
	<i>n</i>	<i>M (SD)</i>	<i>n</i>	<i>M (SD)</i>	<i>n</i>	<i>M (SD)</i>					
Family support	908	5.78 (1.33)	90	5.45 (1.65)	211	5.08 (1.65)	21.54	<.001***	Cis-Bin	.111	-0.24
									Cis-NoB	<.001***	-0.50
									Bin-NoB	.114	-0.22
Family satisfaction	908	8.04 (1.95)	90	7.71 (2.18)	212	7.09 (2.42)	18.62	<.001***	Cis-Bin	.441	-0.17
									Cis-NoB	<.001***	-0.46
									Bin-NoB	.049*	-0.26
Friends support	909	5.96 (1.37)	87	5.59 (1.47)	209	5.56 (1.66)	8.38	<.001***	Cis-Bin	.065	-0.27
									Cis-NoB	<.001***	-0.28
									Bin-NoB	1.000	-0.02
Friends satisfaction	909	8.59 (1.41)	87	8.26 (1.78)	208	8.13 (1.83)	8.49	<.001***	Cis-Bin	.177	-0.23
									Cis-NoB	<.001***	-0.31
									Bin-NoB	1.000	-0.07
Classmates support	899	3.83 (0.84)	83	3.60 (0.89)	188	3.48 (0.95)	14.45	<.001***	Cis-Bin	.055	-0.28
									Cis-NoB	<.001***	-0.41
									Bin-NoB	.898	-0.13
Classmates satisfaction	897	7.70 (1.96)	81	7.35 (2.06)	185	6.65 (2.43)	20.50	<.001***	Cis-Bin	.408	-0.18
									Cis-NoB	<.001***	-0.51
									Bin-NoB	.032*	-0.30
Teacher support	901	3.41 (0.93)	82	3.33 (1.05)	189	3.43 (1.05)	0.29	.745	Cis-Bin	>.999	-0.08
									Cis-NoB	>.999	0.02
									Bin-NoB	>.999	0.09
Teachers satisfaction	900	6.74 (2.09)	81	6.56 (2.35)	185	6.58 (2.28)	0.62	.536	Cis-Bin	>.999	-0.09
									Cis-NoB	>.999	-0.08
									Bin-NoB	>.999	0.00
Partner support	520	10.72 (3.67)	52	10.50 (3.92)	113	10.78 (3.76)	0.11	.900	Cis-Bin	>.999	-0.06
									Cis-NoB	>.999	0.01
									Bin-NoB	>.999	0.07

M = mean; *SD* = standard deviation; *F* = ANOVA; *Post hoc* = Bonferroni test; *d* = Cohen's *d*; Cis = cisgender adolescents; Bin = binary transgender adolescents; NoB = non-binary transgender adolescents.

p* < .05, **p* < .001



Hierarchical multiple regressions were run to assess whether the social support and gender identity could predict the health-related quality of life, and to analyze if the effect of social support on health varied according to the gender identity. Hence, five separate moderation models, one for each developmental context, were calculated: gender identity was added to the first step, followed by social support, and then the interaction term. As shown in Table 23, gender identity was significantly associated with health-related quality of life in all models (although effect size evaluated with partial eta squared was small). Being cisgender was associated with having between 1.58 and 1.75 more points on health-related quality of life compared to transgender counterparts.

In the second step, perceived social support from family, friends, classmates, teachers, and romantic partners were added, respectively, to each model, showing to be significantly associated with health-related quality of life in all models, except that from partner support. Each unit of support was positively associated with well-being. Moreover, family support was the context with the greater capacity to explain adolescents' health-related quality of life when compared to the other sources of social support (family: $\beta = .473, p < .001$; friends: $\beta = 0.245, p < .001$; classmates; $\beta = .298, p < .001$; teachers: $\beta = .276, p < .001$). The effect sizes showed that differences were medium for friends, classmates, and teacher support, and high for family support. Gender identity stills contributed significantly to the explanation of the variance in health-related quality of life in this step for each model, although effect size was negligible in the model of family support and small in the rest of models.

After adding the moderation effect between the perceived support and the gender identity on health-related quality of life in the third step for all the models, the presence of support from family, friends, classmates, and teachers was significantly associated with health-related quality of life. Moreover, gender identity was no longer a significant factor explaining well-being when interactions are included in the model of family, friends, romantic partner, and teacher support. A significant interaction between gender identity and social support was found only for classmate support ($\beta = .305, p < .05$), albeit effect size was negligible.



RESULTS
CHAPTER 9: STUDY 4

Table 23. Results from hierarchical regression analyses showing moderation effect of gender identity on the relationship between perceived support and health-related quality of life

		<i>n</i>	<i>R</i> ²	ΔF	<i>p</i>	β	<i>t</i>	<i>p</i>	ηp^2
Model 1	Step 1 GI	1123	.031	35.525	<.001***	.175	5.96	<.001***	.031
	Step 2 GI Family		.247	321.227	<.001***	.084 .473	3.19 17.92	.001*** <.001***	.009 .223
	Step 3 GI Family GI x Family		.247	1.273	0.259	-.015 .431 .119	-0.16 9.35 1.13	0.870 <.001*** 0.259	.000 .195 .001
Model 2	Step 1 GI	1125	.031	35.663	<.001***	.175	5.97	<.001***	.031
	Step 2 GI Friends		.089	72.403	<.001***	.142 .245	4.96 8.51	<.001*** <.001***	.021 .061
	Step 3 GI Friends GI x Friends		.089	0.008	0.928	.152 .248 .011	1.40 4.79 -0.09	0.163 <.001*** 0.928	.002 .052 .000
Model 3	Step 1 GI	643	.025	16.395	<.001***	.158	4.05	<.001***	.031
	Step 2 GI Partner		.029	2.909	0.089	.157 .066	4.04 1.71	<.001*** 0.089	.025 .005
	Step 3 GI Partner GI x Partner		.029	0.002	0.963	.162 .069 -0.006	1.39 0.90 -0.05	0.166 0.367 0.963	.003 .004 .000
Model 4	Step 1 GI	1099	.026	29.792	<.001***	.163	5.49	<.001***	.031
	Step 2 GI Classmates		.113	107.346	<.001***	.115 .298	3.99 10.36	<.001*** <.001***	.014 .089
	Step 3 GI Classmates GI x Classmates		.117	5.241	0.022**	-.145 .189 .305	-1.24 3.40 2.29	0.215 .001*** 0.022*	.001 .057 .005
Model 5	Step 1 GI	1100	.025	28.634	<.001***	.159	5.35	<.001***	.031
	Step 2 GI Teacher		.101	92.821	<.001***	.155 .276	5.40 9.63	<.001*** <.001***	.026 .078
	Step 3 GI Teacher GI x Teacher		.103	2.213	0.137	.014 .208 .163	0.14 3.86 1.49	0.888 <.001*** 0.137	.000 .056 .002

p* < .05, **p* < .001

*R*²: coefficient of determination (not adjusted); ΔF : ANOVA change; *p* = significance level; β = standardized beta; *t* = Student's *t*; ηp^2 = partial eta squared; GI = Gender Identity; Family = Family support; Friends = Friends support; Partner = Partner support; Classmates = Classmates support; Teacher = Teacher support.



Plotting of the relationship between social support and health-related quality of life showed that those adolescents who perceived a higher support from family, friends, romantic partner, classmates, and teachers had higher health-related quality of life (Figure 11). A simple slope analysis following the procedure suggested by Aiken & West (1991) revealed that only one interaction effect was found: when classmate support was low, cisgender adolescents had lower levels of health-related quality of life than transgender adolescents. However, cisgender adolescents who perceived high classmate support had the highest health-related quality of life. Consequently, more classmate support predicted higher levels of psychological well-being for cisgender youth ($\beta = .305, p = .022$). All other interaction effects between social support and gender identity were not significant.

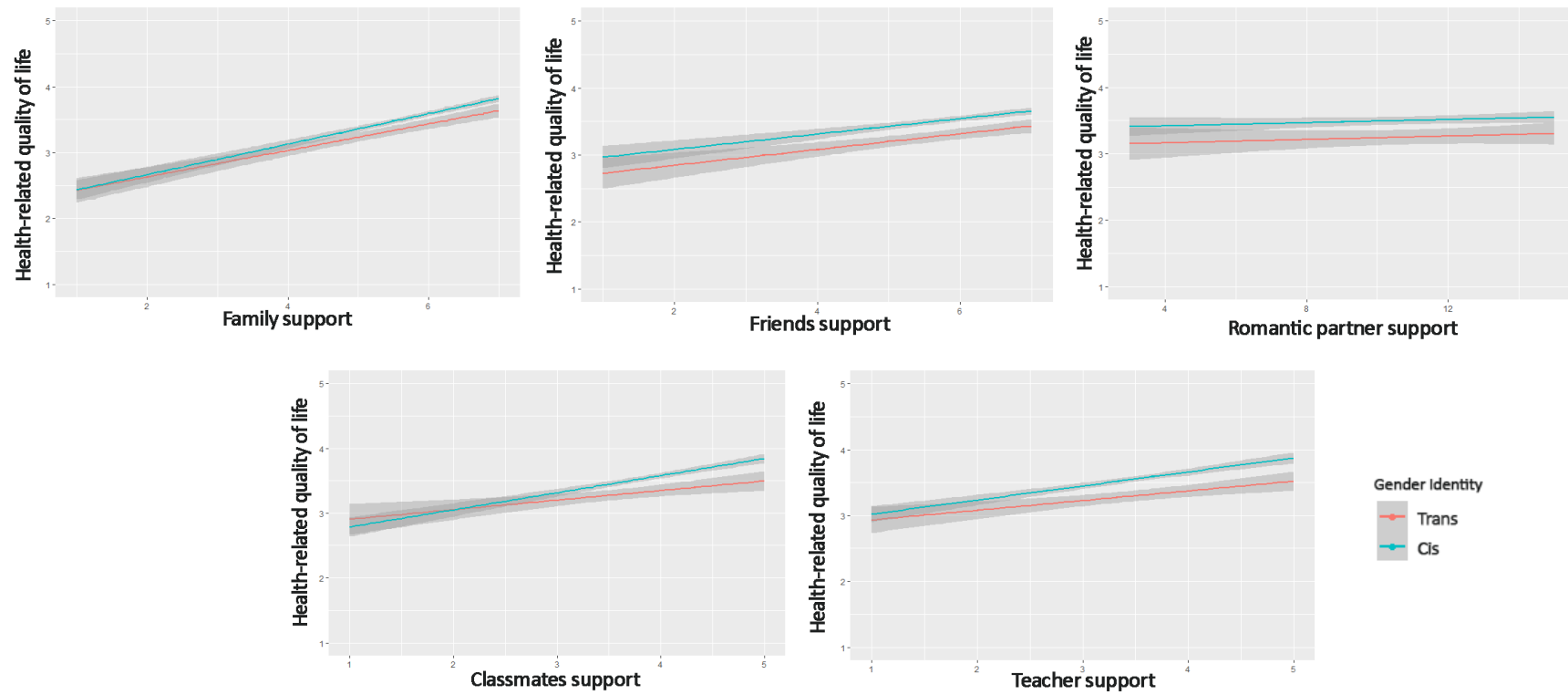
Conclusions:

From ecological models, such as the minority stress model, it is understood that well-being and adjustment are highly related to social environments. This study advances the knowledge about sources of social support and their relation to psychosocial adjustment for cisgender and transgender youth. Transgender adolescents –especially non-binary– reported lower levels of health-related quality of life, as well as less satisfaction and perceived support from family, friends, and classmates than cisgender adolescents. The different models showed that there were differences between cisgender and transgender adolescents in their health-related quality of life. In addition, the effect of family, friends, and classmates support and satisfaction in adolescents well-being was also found to be significant.

Finally, interaction effects were also observed, showing that cisgender adolescents health could be more sensitive to low classmate support than that of their transgender peers. Social connectedness and support are critical protective factors for youth, hence interventions with families, peers, teachers or advisors related to transgender adolescents are needed too to address social isolation. Interventions focusing on communication, understanding of gender identity, or training skills for advocacy may be initial steps in helping people become more supportive.



Figure 11. Moderation effect of gender identity and perceived social support on health-related quality of life



[196]



CHAPTER 10: STUDY 5 (SCHOOL VICTIMIZATION)

Abstract:

Young people belonging to gender minority groups experience high rates of violence in the different contexts where they live. Unfortunately, transgender adolescents face elevated rates of violence at school through physical, verbal, or relational abuses in comparison to cisgender adolescents. Considering the lack of support they usually perceive from their environment (such as family and peers), the effects of bullying can be especially serious for them, having a direct impact on their school performance or their mental health. Although international research data are available to know this reality, few studies have been conducted with probabilistic methodologies in Spain to evaluate the prevalence of experiences of bullying suffered by transgender adolescents. Data from 303 transgender adolescents and 909 cisgender adolescents between 15 and 18 years ($M = 16.41$; $SD = 1.07$) who participated in the 2018 edition of the HBSC study in Spain were analyzed. To identify episodes of bullying and the type of abuse, the Olweus Scale and two questions about the frequency of participating in episodes of school violence—being bully or cyberbully and being bullied or cyberbullied—in the last two months were asked. Transgender adolescents have suffered from violence in the school environment more frequently than cisgender adolescents who have also been victims of bullying, and are also more likely to be victims. The prevalence of transgender adolescents who have been abused physically, verbally, or relationally (for example, being excluded by the peer group or having been the victim of sexual jokes) is higher than their cisgender peers. Based on these results, the importance of creating a safe school climate and environment for the transgender community is discussed.



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Based on:

- Participation in scientific conferences:

Ciria-Barreiro, E., Moreno-Maldonado, C., Moreno, C. (2020, September, 29-30). Safe Schools? Profiles and experiences of bullying suffered by transgender adolescents in Spain [Paper presentation]. I Congreso Internacional de Atención a la Diversidad Afectivo-Sexual, Corporal y de Género, online.

- Article:

Ciria-Barreiro, E., Moreno-Maldonado, C., Rivera, F., and Moreno, C. The role of developmental contexts as mediators between bullying victimization and well-being for adolescents: An analysis from the Gender Minority Stress model [Manuscript in preparation]. Departamento de Psicología Evolutiva y de la Educación, Universidad de Sevilla

Objective:

This study estimated the prevalence of school victimization experienced by adolescents according to their gender identity. For this, it was proposed to examine the prevalence of being a bully or a victim of bullying (in school setting) and/or being a cyberbully or a victim of cyberbullying among cisgender and transgender adolescents. Moreover, differences in the types of victimization experiences suffered were studied. In addition, for these analyses, the group of transgender adolescents is divided into binary and non-binary transgender youth to explore possible differences in the experience of being bullied at school.

Method:

The sample of adolescents who answered the two-step measure were 90 binary transgender, 213 non-binary transgender, and 17,375 cisgender adolescents. Through a matching process, a subsample of 909 cisgender adolescents with a sociodemographic profile similar to that of transgender adolescents was taken. Thus, final sample consisted of 1,212 15-18-year-old adolescents (M = 16.41 years old; SD = 1.07).

Descriptive analysis was calculated to examine the frequency of the different roles and types of bullying and cyberbullying among cisgender, binary transgender, and non-binary transgender adolescents. Adjusted standardized residuals (SR_{ij}) and chi-squared tests (χ^2) were used to assess differences among the three groups according to their gender identity. Phi coefficient and Cramer's V were calculated to measure the effects size of the differences. Being victim of bullying and cyberbullying were recoded as a dichotomous variable ('0 = no victim' and '1 = victim').



RESULTS
CHAPTER 10: STUDY 5

Results:

Table 24 provides comparison data for transgender and cisgender adolescents in roles of school victimization. Transgender adolescents were about more than three times more frequent of being victim of bullying and eleven times more frequent of being victim of cyberbullying. However, the role of being an aggressor at school was more frequent in the transgender group too (more than twice as likely). No differences were observed for cyberbullying others. Statistically significant differences, albeit negligible effect size, of being victim of bullying, and small effect size for being bully and being victim of cyberbullying, were observed between cisgender and transgender adolescents.

Table 24. Frequency of cisgender and transgender adolescents reporting having experienced bullying and cyberbullying as bully or victim

	Cisgender adolescents			Transgender adolescents			χ^2	<i>p</i>	ϕ
	<i>n</i>	%	<i>SRij</i>	<i>n</i>	%	<i>SRij</i>			
Bullied others									
No, less than 2 times	886	98.12	2.4	287	95.67	-2.4	19.08	<.001***	0.126
Yes, more than 2 o 3 times	17	1.88	-2.4	13	4.33	2.4			
Been bullied									
No, less than 2 times	878	97.56	4.4	274	91.95	-4.4	5.56	.018*	0.068
Yes, more than 2 o 3 times	22	2.44	-4.4	24	8.05	4.4			
Cyberbullied others									
No, less than 2 times	902	99.45	1.9	289	98.30	-1.9	3.55	.059	0.054
Yes, more than 2 o 3 times	5	0.55	-1.9	5	1.70	1.9			
Been cyberbullied									
No, less than 2 times	900	99.67	4.7	285	96.28	-4.7	22.12	<.001***	0.136
Yes, more than 2 o 3 times	3	0.33	-4.7	11	3.72	4.7			

SRij = adjusted residuals; χ^2 = Chi-squared; ϕ = Phi

p* < .05, **p* < .001

Bold font indicates in which categories the differences in frequency of perceived school victimization were found between cisgender and transgender adolescents

After dividing the transgender group into binary and non-binary adolescents (Table 25), all the comparisons showed statistically significant differences, but the effect size was negligible for perpetration of bullying at school, and small for the rest of variables. The data shows the highest percentage of victims of cyberbullying among the non-binary transgender adolescents. Frequency of being victim of bullying was similar for binary and non-binary transgender



adolescents and higher compared with cisgender adolescents. The results also showed that non-binary transgender adolescents were more involved in bullying aggression and binary transgender adolescents in cyberbullying aggression than cisgender peers.

Table 25. Frequency of cisgender, binary transgender and non-binary transgender adolescents reporting types of roles of bully or victim

	Cisgender adolescents			Binary transgender adolescents			Non-binary transgender adolescents			χ^2	<i>p</i>	<i>V</i>
	<i>n</i>	%	<i>SRij</i>	<i>n</i>	%	<i>SRij</i>	<i>n</i>	%	<i>SRij</i>			
Bullied others												
No, less than 2 times	886	98.12	2.4	87	97.75	0.2	200	94.8	-2.8	7.83	.020*	0.081
Yes, more than 2 o 3 times	17	1.88	-2.4	2	2.25	-0.2	11	5.2	2.8			
Been bullied												
No, less than 2 times	878	97.56	4.4	80	91.95	-2.1	194	91.94	-3.5	19.08	<.001***	0.126
Yes, more than 2 o 3 times	22	2.44	-4.4	7	8.05	2.1	17	8.06	3.5			
Cyberbullied others												
No, less than 2 times	902	99.45	1.9	82	95.35	-4.0	207	99.52	0.6	16.37	<.001***	0.117
Yes, more than 2 o 3 times	5	0.55	-1.9	4	4.65	4.0	1	0.48	-0.6			
Been cyberbullied												
No, less than 2 times	900	99.67	4.7	85	97.70	-1.0	200	95.69	-4.6	24.27	<.001***	0.142
Yes, more than 2 o 3 times	3	0.33	-4.7	2	2.30	1.0	9	4.31	4.6			

SRij = adjusted residuals; χ^2 = Chi-squared; *V* = Cramer's *V*

p* < .05, *p* < .01, ****p* < .001

Bold font indicates in which categories the differences in frequency and roles of perceived school victimization were found among cisgender, binary transgender and non-binary transgender adolescents

In regard to the types of victimization at school setting, statistically significant differences, albeit negligible, were observed (Table 26). Transgender adolescents were more at risk of being a victim of social exclusion, rumours, and sexual jokes, as well the overall score in comparison to cisgender adolescents.



RESULTS
CHAPTER 10: STUDY 5

Table 26. Frequencies of types of bullying between cisgender and transgender adolescents

	Cisgender adolescents			Transgender adolescents			χ^2	p	ϕ
	<i>n</i>	%	<i>SRij</i>	<i>n</i>	%	<i>SRij</i>			
Total score of types of victimization									
No, less than 2 times	503	83.00	2.4	164	75.57	-2.4	5.738	.017*	0.083
Yes, more than 2 o 3 times	103	17.00	-2.4	53	24.42	2.4			
I was called mean names...									
No, less than 2 times	564	93.53	1.6	196	90.32	-1.6	2.42	.119	0.054
Yes, more than 2 o 3 times	39	6.47	-1.6	21	9.68	1.6			
Other students excluded me									
No, less than 2 times	576	95.36	2.2	198	91.24	-2.2	5.02	.025*	0.078
Yes, more than 2 o 3 times	28	4.64	-2.2	19	8.76	2.2			
I was hit									
No, less than 2 times	592	98.18	0.8	210	97.22	-0.8	0.71	.399	0.029
Yes, more than 2 o 3 times	11	1.82	-0.8	6	2.78	0.8			
Other students spread false rumors									
No, less than 2 times	560	92.87	2.0	192	88.48	-2.0	4.04	.044*	0.070
Yes, more than 2 o 3 times	43	7.13	-2.0	25	11.52	2.0			
Other students made sexual jokes									
No, less than 2 times	568	93.73	2.9	190	87.56	-2.9	8.37	.004**	0.101
Yes, more than 2 o 3 times	38	6.27	-2.9	27	12.44	2.9			

SRij = adjusted residuals; χ^2 = Chi-squared; ϕ = Phi

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

Bold font indicates in which categories there are differences in types of victimization between cisgender and transgender adolescents.

After disaggregating the transgender group into binary transgender and non-binary transgender adolescents, the total score and every item of the measure of types of bullying were explored (Table 27). Differences in frequencies between the groups shown in the previous table were due to the scores of the non-binary transgender adolescent: non-binary transgender adolescents showed the highest percentage of being victim of bullying, specifically in sexual jokes, lies, rumours, and exclusion (with a small effect size).



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Table 27. Frequencies of types of bullying among cisgender, binary transgender, and non-binary transgender adolescents

	Cisgender adolescents			Binary Transgender adolescents			Non-binary transgender adolescents			χ^2	<i>p</i>	<i>V</i>
	<i>n</i>	%	<i>SRij</i>	<i>n</i>	%	<i>SRij</i>	<i>n</i>	%	<i>SRij</i>			
Total score of types of victimization												
No, less than 2 times	503	83.00	2.4	55	82.09	0.2	109	72.67	-2.9	8.41	.015*	0.101
Yes, more than 2 o 3 times	103	17.00	-2.4	12	17.91	-0.2	41	27.33	2.9			
I was called mean names...												
No, less than 2 times	564	93.53	1.6	63	94.03	0.4	133	88.67	-2.1	4.39	.111	0.073
Yes, more than 2 o 3 times	39	6.47	-1.6	4	5.98	-0.4	17	11.33	2.1			
Other students excluded me												
No, less than 2 times	576	95.36	2.2	66	98.51	1.6	132	88.00	-3.7	14.50	.001***	0.133
Yes, more than 2 o 3 times	28	4.64	-2.2	1	1.49	-1.6	18	12.00	3.7			
I was hit												
No, less than 2 times	592	98.18	0.8	64	95.52	-1.4	146	97.99	0.1	2.09	.351	0.051
Yes, more than 2 o 3 times	11	1.82	-0.8	3	4.48	1.4	3	2.01	-0.1			
Other students spread false rumors												
No, less than 2 times	560	92.87	2.0	64	95.52	1.2	128	85.33	-3.1	10.37	.006**	0.112
Yes, more than 2 o 3 times	43	7.13	-2.0	3	4.48	-1.2	22	14.67	3.1			
Other students made sexual jokes												
No, less than 2 times	568	93.73	2.9	62	92.54	0.1	128	85.33	-3.4	11.67	.003**	0.119
Yes, more than 2 o 3 times	38	6.27	-2.9	5	7.46	-0.1	22	14.67	3.4			

SRij = adjusted residuals; χ^2 = Chi-squared; *V* = Cramer's *V*

p* < .05, *p* < .01, ****p* < .001

Bold font indicates in which categories there are differences in types of victimization between cisgender, binary transgender and non-binary transgender adolescents.



RESULTS
CHAPTER 10: STUDY 5

Conclusion:

The probability of being involved in bullying situations is higher for transgender adolescents in the roles of victim and bully in bullying at school and cyberbullying. Likewise, non-binary transgender adolescents seem to be more involved in bullying situations. The results of this study highlight the high levels of bullying that transgender adolescents are subjected. Interventions must be design to address this issue and protect the well-being of transgender adolescents in the school environment. Moreover, transphobic bullying must be studied specifically.



CHAPTER 11: STUDY 6 (THE GENDER MINORITY STRESS MODEL)

Abstract:

Transgender adolescents are more likely to be victims of bullying in the school setting. Moreover, the effects of bullying can be especially severe for them, given the lack of support they usually perceive from their closest developmental contexts. Based on the gender minority stress model, the aim of this research was to explore the relationships among the perceived social support, bullying victimization, and well-being in transgender youth in Spain. The sample was comprised of 303 transgender adolescents and 909 cisgender adolescents between 15-18 years' old (M = 16.41 years old; SD = 1.07) who participated in the 2018 HBSC study in Spain. Health-related quality of life was measured using the Kidscreen-10 scale. The Multidimensional Scale of Perceived Social Support was employed to examine adolescents' perceived support from their family and friends. Perceived support from school setting was evaluated using the Classmate Support Scale and Teacher Support Scale. To identify episodes of bullying, two questions about the frequency of being bullied and cyberbullied in the last two months were employed. For the analysis, a moderated mediation model (model 59 in the PROCESS macro for SPSS) was performed. Overall, transgender adolescents scored lower in health-related quality of life, showed to perceive less support from their families, friends, and schoolmates, and experienced higher rates of bullying and cyberbullying when compared with cisgender adolescents. Gender identity was found to moderate the effect of perceived social support of classmates on health-related quality of life, both in bullying and cyberbullying victimization. Creating a safe school climate and space for transgender people is an urgent need, therefore experts should design strategies and policies to foster a more tolerant attitude to gender diversity among adolescents.



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Based on:

- Participation in scientific conferences:

Ciria-Barreiro, E., Moreno-Maldonado, C., Rivera, F., Moreno, C. (2021, August 11-13). The role of developmental contexts as mediators between bullying victimization and well-being for adolescents: An analysis from the Gender Minority Stress model [Paper presentation]. 4th EPATH conference, online.

- Article:

Ciria-Barreiro, E., Moreno-Maldonado, C., Rivera, F., and Moreno, C. The role of developmental contexts as mediators between bullying victimization and well-being for adolescents: An analysis from the Gender Minority Stress model [Manuscript in preparation]. Departamento de Psicología Evolutiva y de la Educación, Universidad de Sevilla.

Objective:

The last objective of this thesis is to explore the connection among school victimization, well-being, perceived social support, and gender identity. First, the mediation effect of social support from family, friends, classmates, and teachers on health-related quality of life when adolescents are exposed to episodes of bullying and cyberbullying victimization is explored. Then, the moderation effect of gender identity (coded into the two categories of cisgender and transgender adolescents) on these mediation models is explored.

Method:

Gender identity ('0 = transgender' and '1 = cisgender'), being victim of bullying ('0 = no victim' and '1 = victim'), and being victim of cyberbullying ('0 = no victim' and '1 = victim') were recoded as a dichotomous variable. A descriptive analysis of the relationships between bullying and cyberbullying victimization, perceived social support from family, friends, classmates, and teachers, and health-related quality of life was obtained using Pearson correlation coefficients for quantitative variables and Point-Biserial Correlation Coefficient for categorical dichotomous variables. Differences in correlations were compared between cisgender and transgender adolescents using the Fisher's Z-test.

A multivariate analysis (multiple linear regression) was performed to study differences in models which explains health-related quality of life considering the effect of being victim of bullying and social support (Model 1) and being victim of cyberbullying and social support (Model 2). Tests of moderated mediation (model 59 in PROCESS) were performed to examine the conditional effect of the mediation model as a function of the gender identity. In this model, the



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CHAPTER 11: STUDY 6

effect of bullying and cyberbullying victimization on health-related quality of life (direct effect), and on family, friends, classmates, and teacher support (mediators), were supposed to be moderated by the gender identity.

Results:

According to the Pearson correlation analysis (Table 28), correlations between health-related quality of life and perceived support from family, friends, classmates, and teachers support were significant ($p < .01$) and positive, both for cisgender and transgender adolescents. Also, being victim of bullying and being victim of cyberbullying was significant ($p < .01$) and positive correlated for cisgender ($r = .116$) and transgender adolescents ($r = .276$). Delving deeper the correlations of being victim of bullying and cyberbullying, negative significant correlation ($p < .01$) were found between bullying and classmate support for both cisgender ($r = -.154$) and transgender adolescents ($r = -.158$). Victim of cyberbullying was negative correlated ($p < .01$) with health-related quality of life for transgender adolescents ($r = -.227$) and was negative correlated ($p < .01$) with classmate support for cisgender adolescents ($r = -.111$).

Table 28. Bivariate Pearson’s Correlations between sources of support, health-related quality of life, and bullying/cyberbullying victimization for cisgender and transgender adolescents

	Health related-quality of life		Family Support		Friends Support		Classmates Support		Teacher Support		Victim of bullying	
	Cis	Trans	Cis	Trans	Cis	Trans	Cis	Trans	Cis	Trans	Cis	Trans
Family Support	.464**	.500**	1	1								
	Z = 0.669											
Friends Support	.234**	.282**	.205**	.280**	1	1						
	Z = 0.734		Z = 1.196									
Classmates Support	.329**	.205**	.225**	.198**	.235**	.242**	1	1				
	Z = 1.858*		Z = 0.405		Z = 0.107							
Teacher Support	.295**	.235**	.325**	.222**	.180**	.198**	.381**	.336**	1	1		
	Z = 0.897		Z = 1.599		Z = 0.268		Z = 0.741					
Victim of bullying	-.045	-.106	.003	-.083	-.042	.006	-.154**	-.158**	-.035	-.056	1	1
	Z = 0.059											
Victim of cyberbullying	.008	-.227**	-.027	-.062	-.002	.006	-.111**	.028	-.032	-.059	.116**	.276**
	Z = 3.173***						Z = 1.194		Z = 2.472**			

** $p < .01$, *** $p < .001$

Bold font indicates Fisher’s Z equal or greater to 2.33.



To further explore the relation between health-related quality of life, social support, and school victimization, two multiple linear regression models were performed in two steps for cisgender and transgender adolescents, respectively (see Table 29). In the first model and first step, being victim of bullying was not statistically significant neither for transgender (Model 1.1) nor cisgender adolescents (Model 2.1) on health-related quality of life. When the effect of perceived social support is added in the next step, it is observed that the model explained 27.6% of health-related quality of life for transgender adolescents and 27.9% for cisgender adolescents. Family support is the variable that most explains health-related quality of life for both cisgender and transgender (with high effect). However, for transgender adolescents only friends contribute somewhat in the model (with high effect size), but for cisgender adolescents the classmate support has more relevance in the model (effect size medium) than friends support. Being a victim of bullying still does not have an explanatory effect on health-related quality of life.



RESULTS
CHAPTER 11: STUDY 6

Table 29. Results from multiple linear regression

	Variable	<i>n</i>	<i>R</i>	<i>R</i> ²	ΔF	<i>p</i>	<i>B</i>	<i>SE</i>	<i>p</i>	ηp^2	
Transgender adolescents	Model 1.1	Step 1	248	.103	.011	2.660			.104		
		Bullying					-0.264	.162	.104	.011	
		Step 2		.525	.276	22.239	<.001***				
		Bullying victim					-0.164	.141	.249	.009	
		Family					0.167	.024	<.001***	.245	
		Friends					0.056	.024	.020*	.162	
		Classmates					0.036	.043	.407	.043	
		Teacher					0.057	.037	.124	.067	
		Model 2.1	Step 1	248	.191	.036	9.345			.002	
		Cyberbullying					-0.770	.252	.002**	.710	
		Step 2		.540	.292	21.906	<.001***				
		Cyberbullying					-0.645	.219	.003**	.019	
		Family					0.163	.024	<.001***	.223	
		Friends					0.055	.024	.022*	.154	
	Classmates					0.053	.043	.218	.044		
	Teacher					0.052	.037	.158	.052		
Cisgender adolescents	Model 1.2	Step 1	836	.045	.002	1.707			.192		
		Bullying					-0.198	-1.307	.192	.002	
		Step 2		.528	.279	79.799	<.001***				
		Bullying					-0.040	.131	.761	.001	
		Family					0.185	.016	<.001***	.178	
		Friends					0.046	.015	.003**	.034	
		Classmates					0.148	.027	<.001***	.066	
		Teacher					0.063	.024	.009**	.026	
		Model 2.2	Step 1	840	.009	.000	.061			.805	
		Cyberbullying					0.096	.389	.805	.000	
		Step 2		.533	.284	82.605	<.001***				
		Cyberbullying					0.496	.332	.136	.001	
		Family					0.185	.016	<.001***	.179	
		Friends					0.046	.015	.003**	.035	
	Classmates					0.154	.026	<.001***	.067		
	Teacher					0.062	.024	.010**	.025		

R = coefficient of determination; *R*² = coefficient of determination (not adjusted); ΔF = ANOVA change; *p* = significance level; *B* = not standardized beta; *SE* = Standard error; ηp^2 = partial eta squared Bullying = being victim of bullying at school; Cyberbullying = being victim of cyberbullying; Family = Family support; Friends = Friends support; Classmates = Classmates support; Teacher = Teacher support.

p* < .05, *p* < .01, ****p* < .001



Regarding the second model (Model 2.1 for transgender adolescents and Model 2.2 for cisgender adolescents), in the first step, being victim of cyberbullying was statistically significant for both transgender –binary and non-binary– adolescents ($\beta = .770$; high effect size), but not for cisgender adolescents. When social support is included in the models, the model was statistically significant and explained 29.2% of health-related quality of life for transgender adolescents and 28.4% for cisgender adolescents. In the case of the second step for transgender adolescents in the second model, being a victim of cyberbullying continues to have an explanatory effect (small effect size) on health-related quality of life, but family support and peer support have greater importance in the model (with high effect size). In the case of cisgender adolescents, different developmental contexts have a relevant effect in explaining health-related quality of life, with family being the dimension with the greater capacity to explain health-related quality of life (with high effect size), followed by classmates support (with medium effect size).

Two separate process models were run for bullying and cyberbullying victimization to identify the role of gender identity on the relationship between school victimization and well-being. Gender identity was tested as moderator of the mediation effect of social support from family, friends, classmates, and teachers between school victimization and health-related quality of life.

Overall model tests of being victim of bullying and gender identity with every source of social support as the criterion variable were significant, but not for teacher support (Table 30). Simple effect of gender identity as the moderator variable on social support were statistically significant, but not main effect of being victim of bullying nor interaction effect.

In the final model, where health-related quality of life was the dependent variable (Table 30), two main positive statistically significant effects, social support from family and friends, were detected. Also, the only significant interaction effect found was between classmates' support and gender identity on health-related quality of life (Figure 12). An examination of indirect effects indicated that cisgender adolescents had higher health-related quality of life when they felt higher social support, but not for transgender adolescents (Figure 13).



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CHAPTER 11: STUDY 6

Table 30. Model summary for the moderated mediation model between being victim of bullying and health-related quality of life through social support by gender identity (n = 1,086)

	R	R ²	F	β	t	LLCI-ULCI
DV = Family support	.18	.03	11.50***			
Bullying victim				-0.36	-1.04	-1.04 / 0.32
IG				0.56	5.32***	0.35 / .077
Bullying X IG				0.46	0.99	-0.46 / 1.40
DV = Friends support	.14	.02	77.63***			
Bullying victim				-0.16	-0.46	-0.83 / 0.52
IG				0.46	4.37***	0.25 / 0.66
Bullying X IG				-0.32	-0.68	-1.24 / 0.60
DV = Classmates support	.23	.05	20.05***			
Bullying				-0.58	-2.83	-0.99 / -0.18
IG				0.30	4.77***	0.18 / 0.42
Bullying X IG				-0.36	-1.30	-0.92 / 0.19
DV = Teacher support	.05	.00	0.81			
Bullying				-0.18	-0.76	-0.64 / 0.28
IG				0.04	0.56	-0.10 / 0.18
Bullying X IG				-0.08	-0.24	-0.70 / 0.55
DV = HRQOL	.55	.30	41.44**			
Bullying				-0.16	-1.15	-0.44 / 0.11
Family				0.17	7.01***	0.12 / 0.21
Friends				0.06	2.33*	0.01 / 0.10
Classmates				0.03	0.83	-0.05 / 0.12
Teacher				0.06	1.54	-0.02 / 0.13
IG				-0.38	-1.61	-0.84 / 0.08
Bullying x IG				0.12	0.64	-0.26 / 0.50
Family X IG				0.02	0.63	-0.04 / 0.07
Friends x IG				-0.01	-0.34	-0.07 / 0.05
Classmate x IG				0.11	2.19*	0.01 / 0.21
Teacher x IG				0.01	0.13	-0.08 / 0.92

R = coefficient of determination; *R*² = coefficient of determination (not adjusted); *F* = ANOVA; *β* = standardized beta; *t* = Student's *t*; LLCI-ULCI = lower limit and upper limit confident interval; DV = dependent variable; Bullying= being victim of bullying; HRQOL = health-related quality of life; Family = Family support; Friends = Friends support; Classmates = Classmates support; Teacher = Teacher support

p* < .05, **p* < .001

Bold font indicates in which categories the effect of the variable was significant.



Figure 12. Interaction of being victim of bullying, classmate support and gender identity predicting health-related quality of life

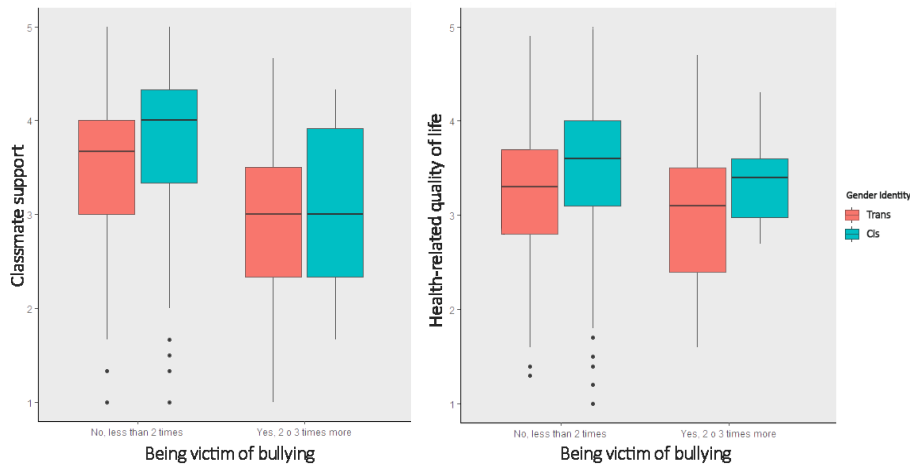
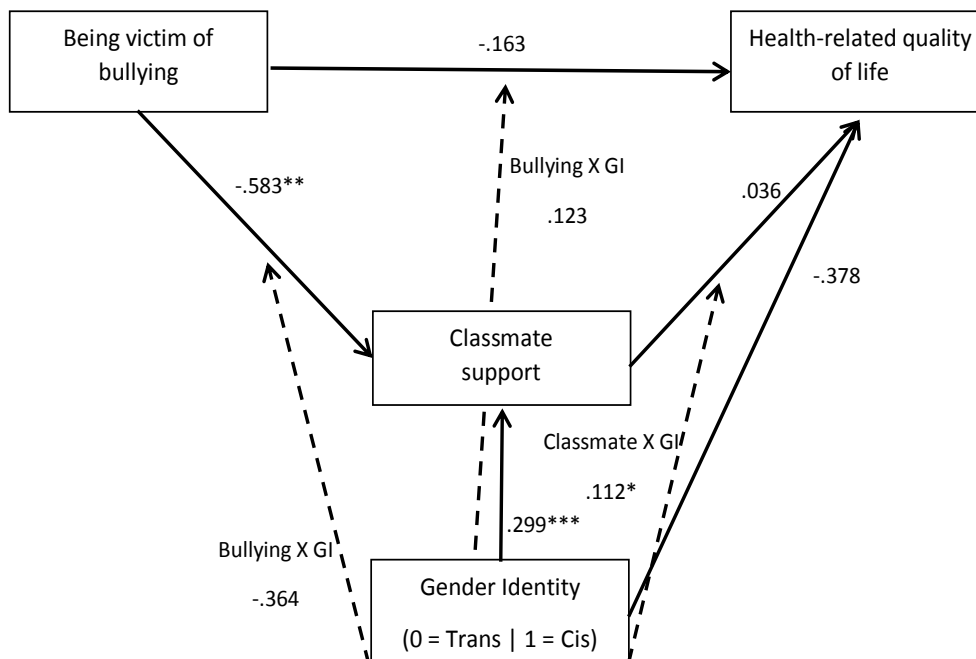


Figure 13. Path diagram for the moderated mediation model between being victim of bullying and health-related quality of life through classmate support by gender identity (n = 1,086)



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Next, we studied the buffering effect of gender identity in the mediation effect of social support between cyberbullying victimization and health-related quality of life (Table 31). Model tests of being victim of cyberbullying and gender identity with every source of social support as the dependent variable were significant, but not for teacher support. There no were direct effects of being victim of cyberbullying to sources of social support when gender identity was included in the model. Only simple effect of gender identity as the moderator variable on social support was statistically significant, and only one interaction effect was detected: when cisgender adolescents were victims of cyberbullying, they felt less support from their classmates

Going one step further, in the final model, no conditional indirect effects of being victim of cyberbullying onto health-related quality of life through sources of social support were observed (only support from friends was positive significant). Additionally, we found two interaction effects of gender identity on health-related quality of life. First, in regard to cyberbullying victimization, cisgender adolescent who were victim of cyberbullying showed higher health-related quality of life than transgender adolescents. Second, cisgender adolescents have higher health-related quality of life when they feel higher social support, but not for transgender adolescents (Figures 14 and 15).



**CONTEXTUALIZING THE WELL-BEING
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Table 31. Model summary for the moderated mediation model between being victim of cyberbullying and health-related quality of life through social support by gender identity (n = 1,090)

	R	R ²	F	β	t	LLCI-ULCI
DV = Family support	.18	.03	11.58***			
Cyberbullying				-0.54	-0.99	-1.60 / 0.53
IG				0.58	5.57***	0.37 / 0.78
Cyberbullying X IG				-0.08	-0.08	-2.00 / 1.85
DV = Friends support	.14	.02	6.94**			
Cyberbullying				-0.54	-0.99	-1.60 / 0.53
IG				0.44	4.26***	0.24 / 0.64
Cyberbullying X IG				0.48	0.49	-1.45 / 2.40
DV = Classmates support	.19	.03	12.95***			
Cyberbullying				0.30	0.91	-0.34 / 0.94
IG				0.33	5.37***	0.21 / 0.46
Cyberbullying X IG				-1.92	-3.26**	-3.08 / -0.76
DV = Teacher support	.04	.00	0.70			
Cyberbullying				-0.27	-0.75	-0.99 / 0.44
IG				0.05	0.70	-0.09 / 0.19
Cyberbullying g X IG				-0.26	-0.39	-1.55 / 1.04
DV = HRQOL	.55	.30	42.82***			
Cyberbullying				-0.65	-2.97	-1.08 / -0.22
Family				0.16	6.85	0.11 / 0.21
Friends				0.06	2.30*	0.01 / 0.10
Classmates				0.05	1.23	-0.03 / 0.13
Teacher				0.05	1.41	-0.02 / 0.12
IG				-0.40	-1.72	-0.85 / 0.06
Cyberbullying x IG				1.15	2.89**	0.37 / 1.93
Family X IG				0.02	0.79	-0.03 / 0.08
Friends x IG				-0.01	-0.32	-0.06 / 0.05
Classmates x IG				0.10	2.00*	0.00 / 0.20
Teacher x IG				0.01	0.23	-0.08 / 0.10

R = coefficient of determination; *R*² = coefficient of determination (not adjusted); *F* = ANOVA; β = standardized beta; *t* = Student's *t*; LLCI-ULCI = lower limit and upper limit confident interval; DV = dependent variable; Bullying= being victim of bullying; HRQOL = health-related quality of life; Family = Family support; Friends = Friends support; Classmates = Classmates support; Teacher = Teacher support

p* < .05, *p* < .01, ****p* < .001



RESULTS
CHAPTER 11: STUDY 6

Figure 14. Interaction of being victim of cyberbullying, classmate support and gender identity predicting health-related quality of life

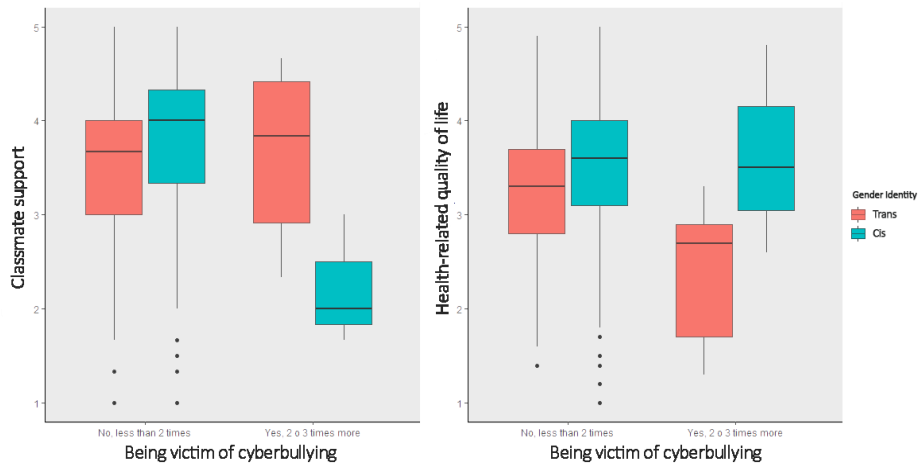
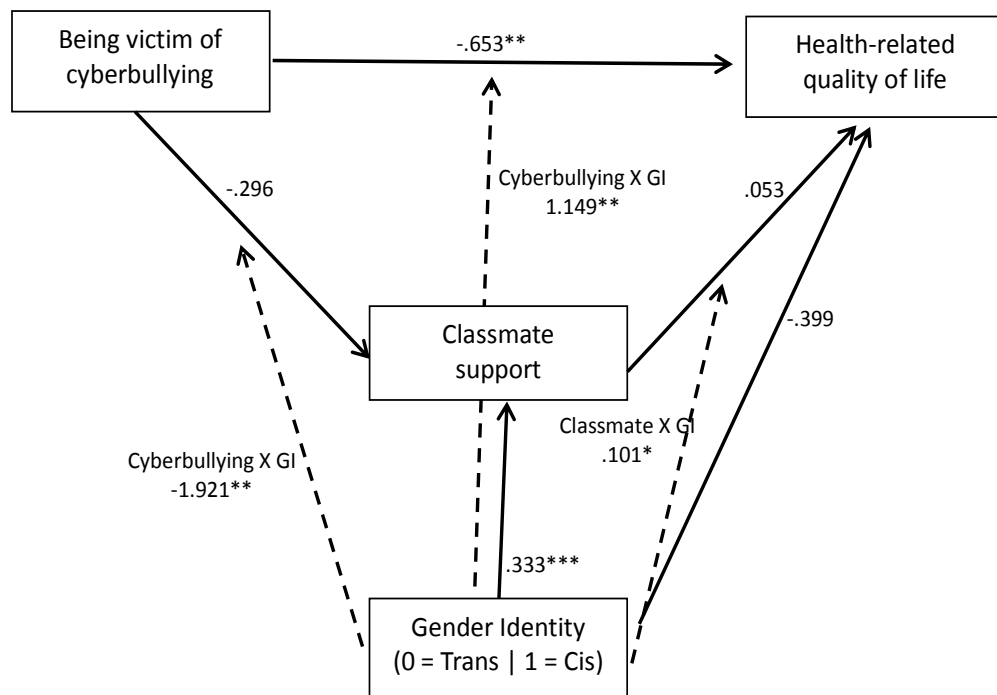


Figure 15. Path diagram for the moderated mediation model between being victim of cyberbullying and health-related quality of life through classmate support by gender identity (n = 1,090)



Conclusions:

Transgender adolescents are more in risk or in danger because they perceived less support, they feel less healthy, they are extremely expose to school victimization, and they don't access to the benefit of classmate support against bullying as cisgender adolescents did. Therefore, understanding the health and well-being of transgender adolescents requires an understanding of the different contexts in which they are involved, as they are often sources of stress rather than sources of support (as the minority stress model stipulates). Intervention should not focus only on counselling at school or therapy at clinical setting for transgender adolescents.

It is not only about supporting transgender people, but helping the different agents, systems, or people linked to this phenomenon. Different levels must be taken into account to promote inclusive schools, as students, school staff, and families. Some of the action we can made to address the student's needs and to create safe spaces for them are: offering information on sexual and gender diversity to break or bust myths and misconceptions about the hegemony of the gender binary system or the cis-hetero-normative system; helping all the students to identify any kind of physical, psychological or social violence to prevent them; or establishing programs or alliances for students, as school Mediation Programs.



ÁMBITO- PREFIJO

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SECTION 4: DISCUSSION

The main results included in this doctoral dissertation are explained in this chapter. It is divided into three sections. First, results from each of the studies are discussed in relation to the literature review presented in the introduction. Second, the strengths and limitations of the research are examined as a whole, and future lines of research are proposed. Lastly, closing thoughts, implications for practice and research, and final conclusions are shared.



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CHAPTER 12: GENERAL DISCUSSION

The purpose of this thesis was to bring to light an overview of the health and well-being of transgender adolescents in Spain. First, the utility of the two-step approach as a measure of gender identity in adolescence was assessed (**Study 1**). Second, with the aim of offering a normative view of adolescent development which also considered the characteristics of transgender adolescents, different dimensions of health were studied, covering lifestyles (**Study 2**), mental health (**Study 3**), and developmental contexts (**Study 4**). Third, from the minority stress framework, the prevalence of involvement in bullying and cyberbullying episodes was estimated (**Study 5**). Then, an integrative model of the influence of perceived social support on the quality of life when victimization at school is experienced according to gender identity was proposed (**Study 6**).

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12.1 The utility of the two-step approach

Study 1: What is the most appropriate measure to ask about gender identity in adolescence?

The aim of the **Study 1** was to test whether a two-step measure was adequate to get know the gender identity of Spanish adolescents. We used a variation of the two-step approach to measure sex (step 1) and self-perceived gender (step 2) in a nationally representative sample of adolescents in Spain.

The proportion of transgender youth estimated in this study (1.7%) was similar to previous research conducted with adolescents in other Western countries (M. D. Connolly et al., 2016; Goodman et al., 2019; Zhang et al., 2020). For example, Clark et al. (2014) found in the Youth'12 study from New Zealand that 1.2% of the adolescents reported being transgender, 2.5% reported being not sure about their gender, and 1.7% did not understand the question. Eisenberg et al. (2017) reported in the Minnesota Student Survey that 2.7% of the responders identified as transgender nonconforming. In the Youth Risk Behaviour Survey, Shield et al. (2013), found that 1.3% of the adolescents from San Francisco were transgender. In the Growing Up Today Survey, a prospective cohort study of United States, Reisner et al., (2014) found that 0.3% of the cohort 2010 participants were gender minority. Kaltiala-Heino & Lindberg (2019) in the School Health Promotion Survey 2017 in Finland saw that 0.7% of the adolescents reported perceived gender opposite to reported sex, 4.2% reported other or non-binary gender identity, and 1.5% had not responded to the question on perceived gender. However, all those studies are from different countries and used different measures to assess gender identity.

According to the international standards and recommendations (Broussard et al., 2018; Cameron & Stinson, 2019; T. Jones, 2019; The GenIUSS Group, 2014), our version of the two-step approach combined different elements of good practices for asking about gender identity in adolescence. It provided simple instructions to understand what gender identity is. It used a sensitive and inclusive language. It offers both binary and non-binary values. It included an open-ended option that allows the respondent to fully describe their gender identity. It was brief and easy to put in the sociodemographic section in any questionnaire. Finally, it was relatively easy to code. Moreover, there were few missing data for the self-perceived gender identity question, as happens in other studies which included the two-step approach (Kaltiala-Heino & Lindberg, 2019; Tate et al., 2013).



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However, not all participants understood the instructions. Some students wrote in the open-ended question about their sexual orientation, their sex, or random comments. These responses have been very uncommon (less than 1% of the total), but were expected considering previous experiences of using the two-step approach with an open-ended option (Reisner, Biello, et al., 2014) .

Thus, the procedure employed to identify transgender adolescents—our modified version of the two step approach—seems to be a useful tool for research with adolescents and the group identified seems to adequately represent the global adolescent transgender population in Spain.

As mentioned above, one of the first questions that researchers must keep in mind is the dimension they want to evaluate, because this may have an impact on the estimates of the evaluated groups (G. R. Bauer et al., 2017; Geary et al., 2018). It is not the same to ask if the adolescents consider themselves transgender, which reflects their perceived gender identity, as if they are diagnosed with “gender dysphoria”, or to ask what gender pronouns do they prefer (Collin et al., 2016).

Also, another relevant condition in the research is the type of sampling. Qualitative research with transgender adolescents provides rich and specific indicators to understand their realities from their perspective (e.g., Eisenberg et al., 2018; J. Taylor et al., 2019). More and more studies are gradually being conducted in large-surveys, school-based surveys, or community health centres, although most base their conclusions on samples obtained through non-probabilistic strategies (such as the snowball method or convenience sampling) from social media, health clinics, or LGBTQ+ associations (Veale, Watson, et al., 2017; Wheldon et al., 2019). In the case of samples obtained on social media (e.g., Facebook, Twitter, Instagram, or Tik Tok), even though there are efficient spaces for recruiting hard-to-reach populations (such as transgender adolescents), the design of the posts and advertisement affects the quality of the data (Stern et al., 2022). Overall, the conclusions that are drawn become generalized, when there may be contextual conditions that are not considered.

It is not only about the sampling techniques or the methodology; it is also about the cultural context or language in which this data is obtained. Most research on the health of transgender people using random sampling is conducted in English-speaking countries such as the United States, Canada, the United Kingdom, or New Zealand. Hence, publications of international studies conducted outside these countries are scarce (Wanta & Unger, 2017; Zhang et al., 2020). Moreover, studies performed with non-English-speaking samples take place



in countries with inclusive and protective policies for the LGBTI community, such as the Netherlands or Finland (ILGA-Europe, 2020). Therefore, in countries without explicit laws to protect transgender adolescents or where their demands are not attended in public institutions, prevalence is difficult to identify: transgender adolescents could prefer to hide their identity to avoid the rejection of society, family, or peers, or they might not have the chance to explore their gender identity (M. D. Connolly et al., 2016). As a result, the image of the transgender community is based on data from very specific cultural and legal environments.

It is not an easy task to gather information on the exact proportion of LGBTQ+ citizens in a country. Very few countries, including Australia, Canada, Denmark or the Netherlands, have incorporated specific and systematic measures to get to know the proportion of sexual orientation or gender identity minorities in their census (Schönpflug et al., 2018; United Nations Economic Commission for Europe, 2019). In addition, hate speech against the LGBTI community is rising both in official government sources and in the media (ILGA-Europe, 2021a). For example, hate speech on social media and the trend of politicians attacking LGBTI people have grown in countries such as Bulgaria, Hungary, Italy, Poland, Russia, Turkey, or Ukraine, among others. Another example of a situation that jeopardizes the safety of transgender people is society's rejection of self-determination laws and legal gender recognition. In many countries, such as Germany, Finland, the United Kingdom, or Spain, there are opposition forces that consider that this right for transgender people would harm the rights of women or minors (ILGA-Europe, 2021a; Transgender Europe, 2021b).

The openness of LGBTQ+ people regarding their status varies around the world, and this complex phenomenon can be observed in different surveys. A census-representative survey conducted by Dalia Research on 11,754 people across the European Union found that 5.9% of Europeans identify as LGBT when asked directly (Lam, 2016). Country-specific results included 7.4% in Germany, 6.9% in Spain, 6.5% in the UK, 6.4% in the Netherlands, 5.4% in France, 4.9% in Poland, 4.8% in Italy, and 1.5% in Hungary. A survey conducted by Ipsos (2021) among more than 19,000 individuals on 27 countries showed, on average, that the participants who identify as transgender, non-binary, or non-conforming were 2%; countries such as Germany or Chile reached 4%, and countries such as Italy, Poland, or South Africa made up 1%. A global average of 51% of participants supported LGBT+ being open about their sexual orientation or gender identity with everyone; the highest support could be found in Spain (73%), Argentina (69%), and Chile (68%), and the lowest in Russia (12%) and Malaysia (14%). Likewise, there is a majority support for LGBT+ anti-discrimination laws in 21 countries, mostly in Sweden (71%), Spain, and Chile (70%); and support was the lowest in Russia (24%), Malaysia (27%), and Hungary (31%).



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The experiences of LGBTQ+ persons in various areas of life, including with regard to their safety, health, education, and employment, have been assessed in a number of countries (e.g., Belgium, France, the Netherlands, Norway, or Spain) (Human Rights Council of the United Nations, 2019; Organisation for Economic Cooperation and Development, 2020). However, there are many countries in which LGBTQ+ people would rather not participate in this kind of surveys so as to not compromise their safety. This means that the countries in which one can obtain real information on the estimated proportion of the LGBTQ+ population are very few, and this highly depends on national policies that ensure the safety and well-being of LGBTQ+ people.

Another social issue to consider when collecting information on gender identity is language. Sex can be defined as a person’s biological status and it is typically categorized as male, female, or intersex. Gender, on the other hand, refers to the attitudes, feelings, and behaviours that a given culture associates with a person’s biological sex (American Psychological Association, 2012). It is important to point out that in some languages including German (*Geschlecht*), Dutch (*geslacht*), or Hungarian (*nem*), there are no different words for sex and gender. However, in languages such as English or Spanish, there are two independent but related words for sex (*sexo*) and gender (*género*). Nevertheless, language differences must be considered for they can lead to subtle variations in how these concepts are interpreted. For example, sexual identity can be understood in English as an individual feature that is assigned on the basis of the most salient sexual aspects of life—such as sexual attractions, desires, or behaviours (Savin-Williams, 2011)—but in Spanish it refers to the conviction of belonging to one sex category or another (Hernández et al., 2010; López Sánchez, 2020).

These differences are also observed in clinical diagnosis and intervention. For example, the translation of the gender dysphoria category in the DSM-V was conflicting, since the original version stipulates that it is “a marked incongruence between one’s experienced/expressed gender and assigned gender”; however, in the Spanish version gender was translated as sex (*Una marcada incongruencia entre el sexo que uno siente o expresa y el que se le asigna*). The reason for this change in the translation is unknown, but one possible explanation is that the translators of the Spanish version prioritized the ‘biological sex’ status over the social construction of gender (Grau, 2020). Consequently, different languages might require a nuanced approach to translations (United Nations Economic Commission for Europe, 2019). In this sense, concepts such as “gender/sex” (Fausto-Sterling, 2019; van Anders, 2015) may help to understand how the biological and cultural levels of our identity are interwoven. As van Anders (2015, p. 1181)



describes, the “whole people/identities and/or aspects of women, men and people that relate to identity and/or [cannot really be sourced specifically to sex or gender”.

These challenges of translation can also be seen in key concepts such as “queer”. It is not only the problem of etymology, but also the resignifications that may be given to the concept in the historical moment, in the geographical area, in each language or even its purpose (Palekar, 2017). Historically, the term queer has carried a pejorative meaning (S. J. Ellis et al., 2019, Chapter 11), being related to terms such as “strange” or “odd” (Sierra, 2008) and it could be translated in Spanish as “*torcido*” or “*raro*” (Sabuco, 2009). “Queer” has been a stigmatizing term and it has been used as an insult in order to refer to what is “abnormal” or was not normative from the hetero-cis-normativity (Sierra, 2008), but currently it has been re-signified as new forms of dissident gender and sexuality (S. J. Ellis et al., 2019, Chapter 7; Sierra, 2008). Moreover, experiences that are “queer” from the Western American culture and the colonial/postcolonial perspectives are not necessarily “queer” in other anthropological or ethnic frameworks, which makes more difficult the cross-cultural translation (Baldo et al., 2018; Palekar, 2017). For example, in the Spanish case, beyond the “copycat” translation, we also find differences in the use of “queer” as term from the activist or the academic settings (Sabuco, 2009).

Hence, language is yet another of the many indicators of cultures. Many languages reflect the binary system from which we understand society, reality, embodiment, and performativity. The binary discourse artificially divides acceptable expression of gender into masculine or feminine, one or another, no more options (Diamond, 2020; Fausto-Sterling, 2019; Rider et al., 2018; Wiseman & Davidson, 2012). As a result, people feel the pressure (through the family, peers, culture, etc.) to adjust themselves to roles, expressions, and expectations according to the sex assigned to them at birth.

A binary discourse of reality limits the experience of fluidity, especially for the young people who do not conform to the strict gender patrons or who consider their gender as different from the sex assigned to them at birth. Again, this polarization forces people to conform rigidly to extreme masculine or feminine roles according to the binary standard about what it means to be a man or a woman, without considering alternative forms of gender expression.

Beyond the cultural or structural analysis on gender, the development of the gender identity is also an individual experience. In this sense, developmental psychology has studied identity as a complex process which happens in parallel with physical, cognitive, and social



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development (Steensma, Kreukels, et al., 2013). Most of the children become aware of the first signs of gender identity between 18 and 24 months of age, manifested in behaviour such as playing with gender-typed toys. Taking into account the classical models of developmental psychology, the stability of gender constancy will vary from childhood to adolescence (Martin et al., 2002). Dynamic models are also necessary to understand how gender and gender identity development are constructed, changed, stabilized, and reconstructed over time and shaped by endogenous factors and social dynamics (Diamond et al., 2011; Fausto-Sterling, 2021).

Concerns about the ability to understand the meaning of concepts such as “gender identity”, “transsexualism”, or “transgender” are common. Nonetheless, cognitive testing is a valuable technique to assess measurement performance. Research based on this methodology to study the understanding of the meaning of concepts related to gender identity find that adolescents and young adults, both who do and do not belong to the LGBTQ+ community, can differentiate between the meanings of sex and gender (Conron et al., 2008; Glick et al., 2018; Michaels et al., 2017; Reisner, Conron, et al., 2014).

Despite social pressure to fit into a gender model according to the sex assigned at birth, results such as the ones included in the present study indicate that other identities are gradually occupying public space. In this research, the proportion of non-binary transgender adolescents was higher than those who identified as opposite to their sex. Similar results were found in previous studies (Price-Feeney et al., 2020; Rider et al., 2018). Many adolescents may feel bewildered trying to understand their own feelings, processes, and experiences. At the same time, they can be uncomfortable or disagree with the limitations of gender roles imposed by the pressure of hetero-cis-normativity to fit into the binary categories (Ansara & Hegarty, 2012; Worthen, 2016).

In the past, words such as “queer” could be self-deprecating or pejorative, so using them to label “baby boomers” could be unpolite, unrespectful, or inadequate in surveys aimed at older people (Reisner, Biello, et al., 2014). Nowadays, terms as “non-binary”, “agender”, “gender neutral”, “neutrois”, “gender fluid”, or “pangender” are becoming popular among younger generations, such as Gen Y and Gen Z (Glick et al., 2018; Porta et al., 2020; Twist & de Graaf, 2019). Access to the Internet and to social media allows young people to realize the possibilities existing outside the strict categories woman/man or to consider them as a spectrum within which identity flows. Hence, receiving information about other experiences and realities has led today’s young people to adopt non-binary, rather than binary, gender identities to a much larger extent than older generations (Diamond, 2020).



At this point, it is important to highlight three issues that can make the methodology used to ask about gender identity in large-surveys more sensitive. First, even if these concepts are socially accepted in Western societies, they cannot be used in all contexts. Genderqueer or transgender are umbrella terms to describe gender identity or gender expression that does not conform to the assigned birth sex or the dominant societal norms. In spite of that, many cultures understand gender in terms differing from the gender binary without sharing the nuances that these Western constructs could imply, such as the Native American *Two-Spirit People*, the *Hijra* people from India, or the *Kathoey* people from Thailand (B. Vincent & Manzano, 2017).

Second, although including a broad list of labels in the item to get to know the gender identity is an ethical and good practice, items should also be clean-cut. Having too many gender categories in a survey item could limit analytic power and force researches to recode into larger categories, missing the original aim of sensitivity (Glick et al., 2018). Also, Broussard et al. (2018) included an item based on the 58 gender identity categories available on Facebook and found that it was the less preferred format to obtain information on the gender identity, given that it was too complex to understand. Therefore, using umbrella terms such as “non-binary” could be an efficient label, at least in Western societies.

Third, survey response categories that accurately reflect the LGBTQ+ status of respondents may change over time and may differ across generational cohorts. Likewise, introducing new categories to the general population can create confusion. Statements should allow participants to clearly distinguish among sex, gender, or gender identity, avoiding misinterpretations with other terms such as “intersexuality”, especially across languages; an example of this is to explain that “transgender” or “non-binary” are not sexual orientations (G. R. Bauer et al., 2017; Frohard-Dourlent et al., 2017; Watson et al., 2020).

Although studies using cognitive testing methodology allow researchers to conclude that populations can comprehend the meaning of concepts related to the LGBTQ+ community, there is also the concern that cisgender respondents will be offended or confused by the question and will exit the survey or answer incorrectly (Fraser, 2018; Glick et al., 2018).

Considering the binary perspective that provides the foundation for sex and gender in our society and the possible misunderstandings from people who do not belong to the LGBTQ+ community, it is reasonable to question whether society is ready to foster a positive development of transgender adolescents, especially in Spain.

Spain is reportedly one of the safest countries for the transgender community, ranking among the highest on the Rainbow Map (ILGA-Europe, 2021b). The approval of same-sex



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marriage in 2005 was a turning point for the acceptance of the LGBTI community in Spain (González, 2009; Monte et al., 2016). It may also have helped Spanish adolescents become inclusive and tolerant, although homo-, bi- and transphobic behaviours among adolescents and young adults remain frequent (Instituto de la Juventud, 2021).

Other changes currently underway in the country include the public discussion of a proposed reform, the draft on Full and Effective Equality for transgender people and for guaranteeing LGBTI rights (Gobierno de España, 2021). After the rejection of the previous legislative proposal (Proposición de Ley 122/000133), the new law will recognize the right to gender self-determination without any psychiatric report, but non-binary people are not eligible for recognition of identity.

Although Spain is a safe country for transgender people, each region of the country has its own legal environment regarding transgender rights, so inclusive laws and policies have not been implemented nationally. For example, legal gender recognition for minors based on self-determination is recognized only in some regions (Andalusia, Aragon, Canary Islands, Community of Madrid, and Valencian Community) (Ávila, 2018; Chiam et al., 2020; López, 2020). FELGTBI+ (2020) launched a report comparing levels of protection for transgender children and youth in the education system in the 17 Spanish regions, and the report found that Aragon, Navarre, and Valencian Community have the highest levels of protection (ILGA-Europe, 2021a). Nevertheless, other regions of the country do not even have a current law focus on protecting transgender or LGBTI rights in any sense (Asturias, Castile La Mancha, Castile and León, La Rioja, Ceuta, and Melilla) (López, 2020). This causes inequality among transgender adolescents in the country, and the absence of a national law leaves these adolescents helpless. In fact, as observed in this study, a lower proportion of transgender adolescents was detected in regions without LGBTI laws or policies.

Moreover, some of the laws aimed to protect LGBTQ+ adolescents are at risk of being banned in some regions (e.g., Andalusia or Region of Murcia). Far-right parties argue that parents have the right to educate their children as they consider fit in order to fight against what they call “indoctrination in the classrooms” by feminist and LGB groups. They justify the use of parental veto in order to prevent their children from participating in discussions and workshops on sex education, misogynistic violence, gender equality or LGBTQ+ diversity (Corp, 2021). However, this censure goes against to the best interests of children and their right to receive accurate, objective, and scientific information about those topics, which can help them develop an autonomous approach and critical thinking (Climent, 2020).



Similar regional inequalities exist in other countries too, and this can also have an impact on the estimate of the real transgender population. The Williams Institute provided an estimate of the percentage of youth (13 to 17) that identifies as transgender in USA. The largest populations of transgender youth were found in California, Texas, New York, and Florida, and the smallest populations of transgender youth were found in North Dakota, Vermont, and Wyoming (Herman et al., 2017). In states such as California, Connecticut, or New York it is possible to have a new birth certificate and change one's gender marker without having to undergo sex reassignment surgery or present a court order. States such as Florida, North Dakota, or Wisconsin require proof of sex reassignment surgery to change the birth certificate (Chiam et al., 2020; Movement Advancement Project, 2020).

Such inequalities demonstrate that regional and state policies must be harmonized in order to guarantee access to full rights for the transgender community. Geographical differences and other intersecting individual features like one's ethnic or racial status (Crenshaw, 1991) can lead to specific discrimination in an environment that is assumed to be globally safe. We found that the distribution of transgender participants is different from cisgender adolescents in some sociodemographic variables; this may lead to a "multiple jeopardy", i.e., the discrimination against transgender youth based not only on their gender minority status but on other characteristics too (D. K. King, 1988). For instance, transgender adolescents of low socioeconomic status or born in other countries (who may carry a personal background of a hetero-cis-normativity mindset) may have an elevated risk of experiencing violence (Shelton, 2015; Spizzirri et al., 2021), especially if they are living in regions where laws are not supportive enough.

It seems that transgender adolescents in Spain, like in many other countries, face discrimination and isolation. The last report launched by the Spanish Ministry of Home Affairs (Ministerio del Interior, 2021) points out that there was an 8.6% increase in hate crimes based on sexual orientation or gender identity of the victim from 2018 to 2019 (the rate stabilized from 2019 to 2020). In most cases, both the perpetrators and sufferers of the hate crimes were adolescents and young adults (up to the age of 25).

In school-based research carried out in some regions of Spain, we observed that even the young population still displays homophobic or transphobic attitudes. For example, according to COGAM (2019), 12% of sexual minority students have suffered insults because they are or look like homosexual, bisexual or trans. The percentage of those who have suffered such attacks doubles to 24% for transgender adolescents. Also, many young people find it difficult to



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distinguish concepts. A study found that 48% of adolescents did not understand the difference between “transsexual” and “transgender” (Observatorio Andaluz contra la Homofobia Bifobia y Transfobia, 2019). Another recent study revealed that, although adolescents supported equal rights and opportunities, exclusive (hetero-centrism, cis-centrism, and sex-binarism) and discriminatory (homophobia, transphobia, and interphobia) conceptions were still widely present (Granero Andújar, 2019).

Some of the “random” or funny answers participants provided are in line with the above findings. Some participants thought that they were asked about their sexual orientation (*I’m a bisexual*); others used the open-ended option to make jokes (*I’m a gamer*). But the most worrying answers were the insults against the transgender community, especially those aiming to parody or to mock gender classifications as happens with the term “attack helicopter”, a meme from the Internet that ridicules non-binary gender identifications (Blake et al., 2020; Jaroszewski et al., 2018): *This is shameful; The only possibilities are being a man or woman; Damn gender ideology; I identify myself as an Attack Helicopter... Just kidding, as a boy.*

Despite the social changes which led younger generations to deconstruct the meanings of gender, the rejection of a non-binary vision persists. Although there has been increasing recognition of sexual and gender diversity in recent decades, there is still a great lack of knowledge that endangers the healthy development of transgender and other gender-minority adolescents. Their non-conformity with the binary system of identity, the lack of resources in health services, or the legal challenges involved in identity recognition pose specific burdens to non-binary and genderqueer youth (Lefevor et al., 2019; Price-Feeney et al., 2020; Reisner & Hughto, 2019; Rimes et al., 2017). These results point to a clear need to reduce the stigma and discrimination attached to being transgender and to improve support for the groups that work with transgender youth (e.g., families, schools, peers, policies).

In short, with the data analysed in the **Study 1** we can provide information that validates the use of a two-step measure to ask adolescents about their gender identity in Spanish.



12.2 The health of transgender adolescents: an overview

Study 2: How are the lifestyles of transgender adolescents?

The aim of the **Study 2** of this doctoral dissertation was to further understand adolescent lifestyles according to their gender identity. Findings reveal that 1) a small proportion of adolescents met the standard recommendations for every health indicator used in the study; 2) transgender adolescents are more likely to fall short of the recommended standards for having breakfast, doing physical activity, sleep time, and toothbrushing than their cisgender peers; 3) the effects sizes of the differences between groups were negligible regarding the frequency of breakfast, dieting, and physical activity, and small for sleep time and toothbrushing; and (4) no significant differences were found between cisgender and transgender adolescents in dieting intake.

Prior research has shown mixed findings about the behaviour of gender minority youths regarding nutrition. Some studies have pointed out that transgender and gender nonconforming adolescents reported a low daily intake frequency of vegetables and fruit, and a high daily intake frequency of fast food, and soft drinks compared with the cisgender subgroup (Bishop et al., 2020). However, in a sample of sexual and gender-minority youth there were no differences in fruit and vegetable, but they were more likely to frequently consume fast food and takeaways (Lucassen et al., 2019). Furthermore, in a sample of college students there were no significant differences between transgender and cisgender participants for fruit and vegetable, breakfast, soda, diet soda, and fast food consumption (Vankim et al., 2014).

Transgender adolescents (especially binary transgender adolescents) were more likely to skip daily breakfast and to diet to modify their weight or volume. These findings are supported by other studies that report that transgender adolescents are more likely to engage in unhealthy dieting practices, disordered eating behaviors, or harmful weight-control strategies than cisgender adolescents (Himmelstein et al., 2019; Lucassen et al., 2019), including binge eating, fasting, vomiting, or using diet pills and laxatives (Guss et al., 2017; S. R. Roberts et al., 2021; Watson et al., 2017).

Research studies carried out with transgender adolescents indicate that this population is less likely to participate in regular physical activity, physical education class, school sports teams, or extracurricular activities at school than their cisgender peers (Aparicio-García et al., 2018; Bishop et al., 2020; Lucassen et al., 2019). The present study shows partially similar findings: non-binary transgender adolescents were more likely to avoid moderate to vigorous physical activity than cisgender teens, but binary transgender adolescents were the group that



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participated in daily moderate and vigorous physical activity the most. Very few research studies found no differences in engagement in sports among cisgender and transgender students, or that transgender students are more likely to play sports than cisgender adolescents females, but not cisgender males (Kulick et al., 2019). However, most research showing transgender adolescents to be less engaged in physical activity than their cisgender peers coincides in a possible explanation: this population usually feels unsafe in physical activity settings or in gender-segregated spaces (bathrooms or locker rooms) (Greenspan et al., 2019; Kosciw et al., 2020; Kulick et al., 2019).

The results found in the present study regarding sleep patterns—transgender adolescents showing less optimal sleep time compared to their cisgender peers—were expected based on previous results from a narrative literature review (E. S. Butler et al., 2020). Gender minority groups could face a greater risk of sleep disparities and problems (too much/too little time, poor quality, or inadequate sleep) compared to cisgender individuals and other sexual minority subgroups (Levenson et al., 2021).

Results related to oral care showed that barely half of the transgender adolescents met the recommendation of brushing their teeth more than once a day. This result is consistent with a previous qualitative study finding transgender youth to be more likely to abandon oral care because they are unaware of its importance for their overall health (Macdonald et al., 2022).

There are some reasons to why gender minority groups may be less likely to engage in healthy behaviors. It is widely documented that experiencing acute or chronic stressful situations has an impact on overall self-care and health on adolescence (e.g., sleep patterns, engagement in physical activity, weight control behaviors, etc.) (Pingitore et al., 2019). According to the Minority Stress Model (Hendricks & Testa, 2012; I. Meyer, 2003), transgender and gender non-conforming individuals suffer from social stress in the form of prejudice, social rejection, or isolation due to their minority position, which affects their health and adjustment. One setting in which gender-identity victimization is best appreciated is the school environment and the physical education classes, due to the high prevalence of discrimination against many transgender youth (Day et al., 2018; Gill et al., 2010; Greenspan et al., 2019; Mackie et al., 2021). It is not only the normative gender expectations of sports activities, enforced by teachers and peers, but also the use of gender-segregated spaces such as locker rooms or bathrooms (Hargie et al., 2017; B. Jones et al., 2017).

Although gender minority youths are often motivated to enrol in physical activity settings such as sport teams or physical activity classes (Kulick et al., 2019), they might prefer to



avoid these spaces because they feel unsafe (Bishop et al., 2020; Gill et al., 2010; Greenspan et al., 2019). Sport backgrounds are frequently an unwelcoming context for reinforcing homophobia and transphobia due to Western cultural expectations linked to athleticism and gender norms (Lucassen et al., 2019). This feeling of being unsafe or excluded is based on the lack of public acceptance and the rejection they experience because of their gender identity or expression (which challenge the cis-hetero-normative culture and norms), which reinforces the idea that they deserve the hostility and disapproval from their peers (Hargie et al., 2017). As a result, gender-minority youth (especially non-binary transgender adolescents) may engage in less physical activity than their cisgender peers.

Nevertheless, the relations between the contexts of development, the stress suffered from them and the acquisition of lifestyles is more complex (Puhl et al., 2019). Research suggests that sexual and gender-minority youth who experience weight-based victimization from family members and at school have poorer weight-related health. Furthermore, weight-based victimization at school was also associated with higher physical activity levels, probably to change their weight and reduce future discrimination from peers.

Furthermore, transgender people sometimes feel unsafe when they use healthcare services (primary care, dental medicine, endocrinology, etc.), which may diminish their interest in their overall health (Reisner et al., 2016; Rider et al., 2018; White Hughto et al., 2015). Barriers causing transgender adolescents to avoid health services can include the refusal of treatment by practitioners or negative staff attitudes and insensitivity towards transgender people (e.g., verbal harassment, using their original or birth name, one which they themselves no longer use) (McCann & Sharek, 2016). This increased stress, prejudice, and fear can lead patients to delay routine medical care.

Thus, there are contextual factors determining the opportunities to develop healthy lifestyles that can jeopardize the chance to achieve the physical, cognitive, and emotional benefits that are linked to a healthy lifestyle (Himmelstein et al., 2019). However, the minority stress model is not enough to explain how gender minority adolescents are at a greater risk for unhealthy lifestyles compared with their cisgender peers.

Gender-identity development occurs within a system based on hetero-cis-normativity and cisgenderism: sex and gender are treated as binary and exclusive experiences, and anything going against this convention is banned (Worthen, 2016). However, gender experiences are more complex than the assumed binary categories (Diamond, 2020; Hyde et al., 2019). Non-binary identities and gender expressions are not a “trend” for youth, as long as experiences that



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can be considered as “non-binary” in Western societies are common in other cultures (B. Vincent & Manzano, 2017). Thus, it could be hypothesized that there are different mechanisms behind the kind of victimization and, therefore, different strategies to manage the minority-related stress according to the heterogeneity of the gender minority group. Then, the stress experienced by the non-binary transgender youth (e.g., the anxiety of identifying as transgender, self-consciousness regarding their physical body, or gender dysphoria) could explain the difficulties in reaching the optimal hours of sleep in this study, as occurred in other research studies (Harry-Hernandez et al., 2020).

Cisgender and transgender adolescents are exposed to these messages and are vulnerable to social pressure to reach the standards of masculinity and femineity (Aparicio-García, 2017). Gender, diet, sport, and physical appearance are intricately connected and have different meanings depending on the gender identity. In cis-hetero-normative cultures, sport and appearance for men is linked to masculinity, muscularity, and power, but sport for women can disrupt the social construct of femininity (Gill et al., 2010; Mereish & Poteat, 2015). For instance, eating disorders and body dissatisfaction affect gender minority adolescents and young adults (Goldhammer et al., 2019), possibly due to experiencing feelings of gender dysphoria (B. Jones et al., 2017) or as a result of beauty stereotypes (Guss et al., 2017). Also, desire for thinness (as a beauty ideal) can be similar for cisgender girls and transgender adolescents (Guss et al., 2017), as a matched control study found that body dissatisfaction was associated with being assigned female at birth, regardless of gender identity (Witcomb et al., 2015).

It may be very important or useful for binary transgender adolescents to fit into the binary idea of what society understands as a ‘boy’ or a ‘girl’. *Passing* is a complex construct which refers to the degree to which a transgender individual is socially perceived as the gender with which they identify, and can be crucial for many transgender people as it provides a better sense of self, and it also reduces their risk of facing transphobic violence (Tortajada et al., 2021). Passing helps to manage the stress involved in the process of gender attribution, but it also reinforces an inflexible logic of gender as binary fixed positions instead of a spectrum (García Fernández, 2017). However, at the same time, *passing* has been used against transgender people as a discrimination mechanism to insinuate that transgender people *pass* in order to deceive others regarding their gender and/or sex, which denies the respect that transgender people deserve (Anderson et al., 2020; Parr & Howe, 2021).



Results of the present study show that binary transgender adolescents have the highest frequency of physical activity (compared to cisgender and non-binary transgender adolescents), indicating that binary transgender adolescents may engage in behaviors which help them achieve their ideal body image according to gender stereotypes. Passing leads to the problem that transgender people who do not identify with any of the two available genders are not treated as people who deserve recognition and respect (Parr & Howe, 2021). By extension, when non-binary transgender people defy gender roles and stereotypes they may be exposed to distinct forms of rejection against their identity which can impact their general health (Fiani & Han, 2019; Pulice-Farrow et al., 2020). In fact, different studies have pointed out that non-binary transgender people have a higher probability of finding themselves in risk and victimization situations (Chew et al., 2020; Durbeej et al., 2021; Price-Feeney et al., 2020). Thus, the stress experienced by non-binary transgender adolescents could explain their difficulty in reaching the optimal hours of sleep, as found in this and other studies (Harry-Hernandez et al., 2020).

Some transgender or gender-nonconforming people can experience gender dysphoria, understood as intense distress caused by the discrepancy between gender identity and sex assigned at birth (Fisk, 1974). Many—but not all—adolescents who experience gender dysphoria have a strong desire for hormones and surgery, hence some transgender adolescents begin treatments to alleviate their gender dysphoria (Wiepjes et al., 2018).

Treatment options include changes in gender expression and role, hormone therapy, or surgery to change sex characteristics (Coleman et al., 2012; Hembree et al., 2017). Despite the common preconception that hormone treatments present an elevated risk of side-effects, studies conducted with transgender adults indicate that the administration of hormones carries a low risk for side-effects and adverse events, such as loss of bone mineral density and muscle (related to osteoporosis), elevated blood pressure and hypertension (related to cardiovascular disease), or fasting insulin (related to diabetes) (Dekker et al., 2016; Shumer et al., 2016). At the same time, many transgender adolescents are unaware that an unhealthy lifestyle has a negative influence on their treatment, particularly on surgery (A. L. C. de Vries & Cohen-Kettenis, 2012).

Therefore, from the moment that an adolescent might be eligible for puberty-suppressing hormones—as soon as pubertal changes have begun, at least Tanner Stage 2 (Salas-Humara et al., 2019)—families, practitioners and users must take into account how important it is to have a healthy lifestyle to reduce the side-effects of the treatment (Hembree et al., 2017; World Professional Association for Transgender Health, 2012).



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Finally, a common factor for all adolescents that underlies the acquisition of lifestyle habits is socioeconomic status. Adolescents from more affluent families have healthier eating habits; they are more likely to eat breakfast daily, eat fruit and vegetables every day, and brush their teeth twice a day, and they are less likely to be overweight or obese (Inchley et al., 2020). Not only the household income, but also the educational level of the parents (especially the mother) and their occupational status are associated to both adolescent health and lifestyles (Moreno-Maldonado et al., 2019; Scaglioni et al., 2018). That was observed in the study of Bishop et al. (2020), who identified that transgender students assigned male at birth were more likely to report skipping meals for financial reasons and participating in free or reduced-price school lunches. The high risk of LGBTQ+ youth to experience homelessness or financial issues (Shelton, 2015)—which are also highly stressful situations—is a reminder that socioeconomic status must be considered when explaining the difficulties to access resources or supportive spaces to develop healthy lifestyle habits.

Acknowledging the adversities facing transgender adolescents—especially from the Minority Stress Model—should not lead researchers to pathologizing their identity or ignore other factors involved in their health. Transgender health research becomes insensitive when ‘cisgender identity’ is assumed as the ‘normal’ or ‘typical’ reference (Adams et al., 2017; Ansara & Hegarty, 2012). Furthermore, the heterogeneity of the transgender and gender-diverse community should be accurately reflected, although this can be a complicated challenge in the cis-hetero-normative framework where what is “normal” is to be both cisgender and heterosexual (Worthen, 2016).

It is also important to note that, although it may seem that only transgender adolescents do not meet lifestyle standards, international research indicates that adolescents in general are neglecting their health habits. Despite the documented importance of eating fruits and vegetables daily, regularly engaging in physical activity, or sleeping sufficiently, only half of adolescents who participated in the international HBSC study eat fruit or vegetables daily, and 16% of adolescents consumed soft-drinks every day (Inchley et al., 2020). Moreover, less than 20% of adolescents achieve the recommended 60 minutes of moderate to vigorous physical activity daily (Guthold et al., 2020; Inchley et al., 2020). Likewise, the prevalence of adolescents with a perfectly healthy lifestyle—based on a composite score of daily physical activity, daily fruit and vegetable consumption, daily on screen-based behaviors, and abstinence from drugs—was less than 5% (A. Marques et al., 2020).



Taking into account ecological models such as Bronfenbrenner's ecological systems theory (Bronfenbrenner & Morris, 2006), it is important to consider the influence from microsystem to macrosystem levels to understand adolescent development. Spain is rated as one of the safest countries for the LGBTI community (ILGA-Europe, 2021a, 2021b) by virtue of its civil and institutional support for LGBTI rights, and especially the attempts to approve a law facilitating the self-determination of gender. It is possible that more concerning results might be found in countries where the rights of the LGBTI community are not as respected, given that feelings of safety or support from social contexts may influence the development of healthy lifestyles or overall well-being (Delozier et al., 2020; García et al., 2020).

Skipping breakfast, physical inactivity, insufficient sleep, or bad oral hygiene indicate that not enough progress has been made in the implementation of policies in general. Increasing the availability and affordability of intervention services must be addressed through an early and multi-level approach among relevant sectors at national and local levels. Moreover, programs should be tailored to gender-identity subgroups among transgender youth according to their needs. Parents, teachers, health care providers, advocacy organizations, and policy makers should focus on creating safe spaces for these youth to develop a sense of competence and to help them make better and healthier choices. People outside the transgender community are often not adequately prepared to understand the reality and perception of transgender adolescents about their bodies, their health, and how inaccessible and unwelcoming the environment can be for them. For that reason, policies must explicitly ban transphobic harassment, discrimination, and bullying.

Study 3: What is the mental health status of transgender adolescents?

The aim of the **Study 3** of this thesis was to examine the adjustment and well-being of adolescents in Spain by gender identity. Transgender adolescents, especially non-binary transgender adolescents, had lower scores for perceived health, life satisfaction, health-related quality of life, and sense of coherence, as well as a higher frequency of psychosomatic symptoms than cisgender adolescents. These findings are consistent with previously published results for populations of both transgender youth and adults (T. C. Clark et al., 2014; M. D. Connolly et al., 2016; Reisner et al., 2016; Veale, Watson, et al., 2017). Similar results were also found in the study conducted by Aparicio-García and colleagues (2018) with a sample of 250 14–25-year-old Spanish transgender youth, with larger proportions of non-binary youth reporting feeling



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isolated, contemplating suicide, and describing psychological health problems than cisgender youth.

Adolescence involves physical, psychological, social, cognitive, and biological changes that lay the foundation for adolescents to understand who they are and how they perceive themselves (Pingitore et al., 2019). These changes may be viewed either as opportunities for growth or as stressful challenges. For example, girls could perceive their pubertal changes as more stressful than boys due to physical changes (such as menstruation) or the connotations associated with beauty standards (Ramos et al., 2019). In addition, both cisgender and transgender adolescents may experience their physical changes negatively if they do not receive the necessary support from their social environments (e.g., family or healthcare professional) to help them understand their pubertal and identity development (Diamond, 2013, 2020; Gülgöz et al., 2019).

As researchers in developmental psychology or cognitive development have argued (such as Erikson, Marcia, or Kohlberg), adolescence is a period of healthy experimentation in different areas, including identity (Steensma, Kreukels, et al., 2013). Thus, adolescence is also an important period of exploration and discovery in relation to gender identity and sexual orientation, including strengthening or questioning gender roles or using different types of labels to define their gender identity or sexual orientation (Watson et al., 2020). However, due to the progressive visibility of non-binary gender identities and experiences, this self-discovery may currently be more complex than ever. Furthermore, society could simultaneously penalize these youth if they are considered to have overstepped the traditional binary view of gender (Diamond, 2013). The pressure of hetero-cis-normativity and the binary view of sex and gender hinder social and institutional recognition of gender diversity, and people do not always validate transgender experiences, especially non-binary identities (e.g., rejection of gender-neutral pronouns), resulting in the occurrence of more stressful events and, consequently, more mental health problems (Schilt & Lagos, 2017). These increased difficulties in formulating gender identity and in social acceptance could explain the source of mental health problems and the lower emotional well-being that these adolescents experience.

Based on the minority stress model, it was expected (and confirmed by the results) that transgender participants (especially non-binary adolescents) would show worse scores than their cisgender peers in health and adjustment. Previous research has showed similar results (Delozier et al., 2020; Lefevor, Boyd-Rogers, et al., 2019; Price-Feeney et al., 2020). Although the present study identified different profiles of adjustment and well-being by gender identity, most



of the comparisons between groups showed small effect sizes. If we take a closer look at the effect sizes of the three groups of adolescents, the highest statistically significant differences were found when comparing the scores of cisgender and non-binary transgender adolescents on sense of coherence, health-related quality of life, and psychological complaints. Moreover, the scores of binary transgender and cisgender adolescents on physical and psychological complaints were similar, and certainly differences were observed when comparing both groups with non-binary adolescents, as previous studies reported (Lagos, 2018).

Along these lines, different studies have found that non-binary transgender people have a higher probability of reporting health risks (e.g., higher rates of depression, anxiety, drug abuse, or suicidal attempts), or experiencing victimization (Chew et al., 2020), such as experiencing harassing (Lefevor, Boyd-Rogers, et al., 2019), being physically threatened or abused (Price-Feeney et al., 2020), being homeless/unstably housed (Reisner & Hughto, 2019), or having problematic alcohol use (Reisner & Hughto, 2019). This may be caused by specific challenges and stigma, such as nonconformity with the binary system of identity, lack of resources in health services, difficulties to access hormone therapy or legal challenges surrounding identity recognition (B. A. Clark et al., 2018; Scheim et al., 2020; J. Taylor et al., 2019).

The conceptualization of the mental health of people pertaining to minority gender identities stems from classic models which mainly consider indicators such as anxiety disorders, emotional distress, substance use, or suicidal ideation (M. D. Connolly et al., 2016; McCann & Brown, 2018; Reisner et al., 2016). Measures such as life-satisfaction, health-related quality of life, or sense of coherence have very seldom been used to research the health of this community (e.g., Anderssen et al., 2020; Röder et al., 2018; Zou et al., 2018). For this reason, the use of measures of psychological adjustment and well-being for adolescent health within theoretical frameworks based on health promotion, such as the salutogenic model (Antonovsky, 1993) or the assets model (Morgan & Ziglio, 2007; Pérez-Wilson et al., 2021), allows for a reconceptualization of the pathological approach.

In relation to the results of the other studies in this thesis, and looking at the HBSC questionnaire as a whole, the information provided on mental health in this study is one of many indicators of the general well-being of transgender adolescents. The results discussed in the chapter dedicated to lifestyles, and the role of support and school violence that we will examine in the following chapters, placed us in a thorough landscape where we observed that differences in mental health among adolescents go beyond individual variables. By employing systemic and



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ecological frameworks, we can understand that everyday life (e.g., social relationships with families and in schools) affects their well-being. Facing adverse situations of isolation, rejection, or loss of opportunities to get healthcare resources, it is not surprising that transgender adolescents end up developing health problems and even serious psychopathologies. Recognizing, measuring, and rendering individuals and social indicators that can promote health throughout adolescence is crucial to informing appropriate and engaging sensitive and accurate health policies (Gahagan & Colpitts, 2017).

Study 4: How do transgender adolescents perceive support and satisfaction in their developmental contexts?

The aim of the **Study 4** presented in this doctoral dissertation was to assess the quality of developmental contexts and their contribution to health for adolescents according to their gender identity. First, scores of perceived support from different developmental contexts (family, friends, classmates, teachers, and romantic partner) and satisfaction with these social environments among cisgender, binary transgender and non-binary transgender adolescents were explored. After that, the effect of the perceived social support from different developmental contexts (family, friends, classmates, teachers, and romantic partner) on health-related quality of life was tested by identifying patterns of association between those sources of support and the measure of well-being through the interaction effect of gender identity.

The results showed that transgender adolescents reported significantly less perceived support and less satisfaction with family, friends, and classmates, albeit small effect sizes in the means comparisons were found. After splitting the group of transgender adolescents into binary and non-binary adolescents, it became obvious that non-binary adolescents perceived the lowest support and satisfaction with these developmental contexts. Comparing the scores of cisgender and non-binary adolescents on perceived family support and satisfaction with classmates revealed medium effect sizes. However, most of the mean comparison revealed small effect sizes. No statistically significant differences were found for perceived support and satisfaction with teachers and romantic partners between cisgender and transgender adolescents.

Consistent with previous research, transgender adolescents struggle with isolation and its health consequences due to a generally perceived lack of support. Transgender youth may be less likely to have strong family relationship and may experience lower average levels of



family support compared to their cisgender peers (C. Brown et al., 2020; T. C. Clark et al., 2014; Eisenberg et al., 2017; Lefevor, Sprague, et al., 2019). Moreover, transgender adolescents sometimes turn to their friends for care and assistance as a strategy to compensate for the lack of acceptance in their family (Bower-Brown et al., 2021; Bry et al., 2018; Weinhardt et al., 2019). However, transgender youth often face microaggressions based on their identity even in chosen groups of friends where support and sympathy are expected and required (Galupo, Henise, et al., 2014; Pulice-Farrow, Clements, et al., 2017). Therefore, it is not surprising that transgender adolescents rated in this study their perception of support and satisfaction with their relationships with family and friends lower than cisgender peers did, especially non-binary adolescents, as other research also found (Aparicio-García et al., 2018; Chew et al., 2020)

No differences were found between cisgender and transgender adolescents in their perception of romantic partner support, unlike other studies which pointed to the role of the partner as a source of support for transgender youth (Araya et al., 2021; Galupo et al., 2019; Pulice-Farrow et al., 2019).

Studies focused on the prevalence of bullying and on the perception of isolation and lack of connectedness with social agents at school lead us to expect that transgender adolescents would perceive teachers and classmates as unsupportive (Colvin et al., 2019; Johns et al., 2021; Mackie et al., 2021; Martín-Castillo et al., 2020; D. H. Russell et al., 2020). That was partially confirmed by our results: transgender adolescents had lower scores for perception of support and satisfaction with classmates than cisgender adolescents, but no differences were found in the perception of support and satisfaction with teachers.

Previous research concludes that transgender adolescents who want to be treated as their gender identity by their classmates are more likely to suffer exclusion and lack of support than those who hid their gender identity (Domínguez-Martínez et al., 2020). This is especially notable for non-binary transgender adolescents, who are more likely to suffer bullying because they do not fit into masculine or feminine roles as cisnormativity dictates (K. C. Johnson, LeBlanc, Deardorff, et al., 2020; Rimes et al., 2017). Regarding the quality of the relationships with teachers, dimensions of this relationships, satisfaction and support, the results were quite surprising, considering that many studies show that teachers often do not defend their rights at school, do not protect them against bullying, and even behave against their gender identity and gender expression through negative reactions (Bower-Brown et al., 2021; K. C. Johnson, LeBlanc, Deardorff, et al., 2020; D. H. Russell et al., 2020). However, these differences in the results and their interpretation may be explained by how the variables have been assessed in each study.



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Low perception of support and satisfaction with social environments are factors that must be considered to better understand the health of transgender adolescents. Previous research clearly indicates that the absence of support or protective social networks leads to a range of negative health consequences. For instance, high levels of family rejection or peer victimization are associated with higher odds of substance abuse (Hatchel & Marx, 2018; Klein & Golub, 2016). Besides, some of the most serious consequences of low family support are social isolation, rejection, and economic vulnerability (James et al., 2016). Thus, transgender youth experience homelessness disproportionately compared to cisgender youth (Jin et al., 2020; Shelton, 2015). In addition, transgender youth who do not have access to supportive networks report elevated rates of emotional distress and mood disorders (T. C. Clark et al., 2014; M. D. Connolly et al., 2016; Eisenberg et al., 2017), school maladjustment (Day et al., 2018; Ullman, 2017; Wernick et al., 2014), as well as suicidal ideation and suicidal and non-suicidal self-injury (Perez-Brumer et al., 2017; Trujillo et al., 2017; Veale, Watson, et al., 2017).

The estimated hierarchical models suggest that gender identity is a key factor in understanding health-related quality of life (as we discussed in the **Study 3**). Moreover, when the effect of the different developmental contexts was introduced in every model (except in the case of perceived support from romantic partner), family support revealed being the most relevant predictor of health-related quality of life, as can be seen in previous research (Gower, Rider, Brown, et al., 2018).

Countless studies demonstrate that family support is one of the most paramount factors in fostering the well-being and adjustment of transgender adolescents. Strong and positive family relationships may buffer and mitigate the effects of stigma and general discrimination on psychological distress for transgender youth (B. A. Clark et al., 2020; Fuller & Riggs, 2018) and protect from emotional distress, depression and anxiety, substance use, isolation, self-harm, and suicide risk (Gower, Rider, Brown, et al., 2018; Katz-Wise et al., 2018; McDonald, 2018). Furthermore, having high parental and family support is associated with improving abilities to make decisions and engaging in other social communities (K. C. Johnson, LeBlanc, Sterzing, et al., 2020), as well as living in one's affirmed gender identity and enjoying a higher quality of life (Weinhardt et al., 2019).

In addition, research conducted with prepubescent children or adolescents who attended gender clinics or chose transitioning have shown that acceptance and high support from family was significantly associated with better psychological functioning (Olson et al., 2016), higher quality of life, fewer depressive symptoms, and lower perceived burden of being



gender-diverse (L. Simons et al., 2013). There are even studies that emphasize that family social support can predict psychological adjustment of children better than social transition (Sievert et al., 2021). Transgender people recognize too the need of having social support in their transition process (Magalhães et al., 2020).

The data from this study also show that support from other developmental contexts (except romantic partners) has a positive impact on the health of transgender adolescents. This is the case of support from friends. As can be seen in this study, the support of friends might have a positive effect on health-related quality of life for adolescents overall and for transgender adolescents specifically. Some studies provide similar data that show us how important is friends support for the positive development of adolescents in general (Bukowski et al., 2010; Marion et al., 2013; Salado et al., 2022; Sánchez-Queija & Sánchez-Jiménez, 2015). and for transgender adolescents. In regards to transgender youth, poor quality of peer relationships affects psychological distress (A. L. C. de Vries et al., 2016; Lefevor, Sprague, et al., 2019) and health-related quality of life through internalizing problems (Munroe et al., 2020; Röder et al., 2018).

Furthermore, having high teacher support in the school setting predicts a wide range of positive health outcomes for transgender adolescents, as revealed by the data in this study, as a perceived high teacher support was positively associated to health-related quality of life. Connectedness to teachers has been linked to positive school outcomes, such as increasing courage to report bullying episodes, feelings of safety, better academic performance, and avoiding truancy (T. Jones et al., 2016; McGuire et al., 2010; V. P. Poteat et al., 2021). At the same time, high support from teachers has been associated with better mental health and social adjustment, including lower prevalence of depressive symptoms, non-suicidal self-injury, and dating violence (Pössel et al., 2018; Ross-Reed et al., 2019).

Referring now to the positive effect of high classmate support, an interaction effect of gender identity was found between perceived classmate support and health-related quality of life: when classmate support was low, cisgender adolescents had lower levels of health-related quality of life than transgender adolescents. However, cisgender adolescents who perceived high classmate support had the highest health-related quality of life. The more support the adolescent perceived, the higher the health-related quality of life. Considering the interaction effect of gender identity, it was found that transgender adolescents benefit less from the positive effect of classmate support than cisgender adolescents. Other research showed similar results with perceived family and school support. Even though family and school support may



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be protective against violence victimization and self-harm among high-school students, these positive effects were less robust for transgender youth, who also had lowest levels of support than their cisgender peers (Ross-Reed et al., 2019).

These results raise three concerns. First, transgender adolescents may need additional support in certain settings or in regard to specific social agents. Considering the strong relationship between being victim of bullying, experiencing less feeling of school belonging, and suffering more times the pressure of hetero-cis-normativity, it is not surprising that transgender adolescents may require such additional emotional support to reduce the risk of victimization and attend to their mental health and social adjustment (Ross-Reed et al., 2019).

Second, it may be that each developmental context serves to enhance different dimensions of health. Perhaps if other health outcomes or health-related behaviors had been studied, such as life satisfaction, meaning in life, or risky behaviors such as substance use or self-harm, other interaction effects with friends or families might have occurred (Johns et al., 2018; Ross-Reed et al., 2019; Weinhardt et al., 2019). At the same time, the way in which support was assessed also affects the interpretation of the model. For example, family, friends or romantic partners often exhibit simultaneous supportive and rejecting behaviors toward transgender youth (Galupo, Henise, et al., 2014; K. C. Johnson, LeBlanc, Sterzing, et al., 2020; Pulice-Farrow, Brown, et al., 2017; Sterzing et al., 2019). This nuance of the simultaneous effect of rejecting and supporting behaviors on mental health has not been caught in this study.

Third, no interaction effects with gender identity were observed for the support of family, friends, and teachers. This may indicate that social support was equally predictive of health-related quality of life for cisgender and transgender adolescents, as other research studies report (Lefevor, Sprague, et al., 2019). Transgender adolescents rated the quality of their contexts in terms of perceived support and satisfaction lower than cisgender adolescents. In addition, we can also assume that transgender adolescents have specific needs related to identity development, gender expression, making decisions about transition... Nonetheless, this is still adolescents we are talking about, people in a process of changing, learning, experimenting, growing up, and who have common basic psychological needs such as autonomy, competence and relatedness (Deci & Ryan, 2008; R. Ryan & Deci, 2000). Undoubtedly, this may show us that it is equally important to consider the specific needs or the health inequities of transgender adolescents, especially from a strengths-based approach (T. C. Poteat et al., 2021), and to acknowledge that, as adolescents, they also need to be cared for, nurtured, and loved. This is probably why the family was the context where adolescents showed



to perceive the higher support, being more satisfied with, and having a stronger influence on their Health related quality of life for both, cisgender and transgender adolescents.

According to the minority stress model (Hendricks & Testa, 2012; I. Meyer, 2003), stigma, prejudice and discrimination against transgender people are based on assumptions about what sexual orientation and gender identity are considered legitimate. Thus, the rejection or lack of support might be underpinned by cisnormativity and heteropatriarchy (Ansara & Hegarty, 2014; S. Miller, 2016).

Cultural beliefs and conceptual understanding of gender identity and expression may influence interactions between parents and children. Heteronormative and gender-normative cultures are reproduced first at the family environment to teach children how they should be and behave according to their sex and gender (Ericsson, 2018; Kane, 2006). Gender stereotypes permeate society and that includes peer socialization and the school setting, where classmates and teachers can reproduce expectations of heterosexuality and gender-binary roles, and then 'force' people to fit into them (Jewell & Brown, 2014; Persinger et al., 2020). Transgender adolescents who transgress these social norms and expectations about gender are more likely to experience marginalization and health risks (Tyler et al., 2020).

In order to provide support for transgender adolescents, the first step is to be aware of the social pressures we are under regarding sex and gender and to accept the identity of the transgender adolescent (Le et al., 2016). From an ecological approach, support should be offered simultaneously from the microsystem (e.g., family and school) to the macro level (e.g., by designing policies that uphold the rights of transgender people). Thus, some behaviours that support transgender youth include identity affirmation and acceptance (e.g., by using their pronouns and chosen names); self-education (e.g., learning about transgender health topics); advocacy (e.g., encouraging school staff to apply gender-affirming policies); and assistance obtaining gender-affirming medical care (K. C. Johnson, LeBlanc, Sterzing, et al., 2020).

In conclusion, the findings presented in this study offer a more comprehensive understanding of how social support plays a central role in the well-being of transgender adolescents. Generally speaking, transgender adolescents perceive developmental contexts as less supportive than their cisgender counterparts. Family is the most relevant social environment for transgender adolescents, although it seems that each developmental context may offer different assets for a healthy development during adolescence. The developmental contexts, with the exception of classmates, seem to contribute similarly to health-related quality



of life for cisgender and transgender adolescents, while classmate support has a milder effect on health-related quality of life for transgender adolescents.

12.3 The gender minority stress model: violence at school against transgender youth

Study 5: Are transgender adolescents involved in bullying and cyberbullying episodes?

The aim of the **Study 5** was to estimate the prevalence of involvement in bullying and cyberbullying according to gender identity. To this end, different roles in school bullying and cyberbullying—i.e., bully and victim—as well as different types of violence suffered in the school environment were compared among cisgender, binary transgender and non-binary transgender adolescents.

With respect to being a victim of bullying and cyberbullying, the initial hypothesis was confirmed: transgender adolescents were more likely to suffer both episodes of violence at school and in online environments than their cisgender peers. In this study, it was found that transgender adolescents had over three times greater odds of being a victim of bullying and eleven times greater odds of being a victim of cyberbullying. However, effect size of the differences between the groups was negligible for being a victim of bullying and small for being a victim of online violence. This finding is in line with previous international research: different observational studies and literature reviews showed that experiences of being bullied are extremely common among transgender youth (Abreu & Kenny, 2018; T. C. Clark et al., 2014; Day et al., 2018; Hatchel, Valido, et al., 2019; Johns et al., 2019; Kosciw et al., 2020; McBride, 2021). For instance, a scoping review on the mental health of transgender youth in secondary schools outlined that between 32% and 44% of transgender adolescents reported being victimized at school, while between 17% and 80% of transgender adolescents self-identified as victims of bullying (Mackie et al., 2021).

After examining the heterogeneity of the transgender adolescent group, non-binary transgender adolescents had the highest frequency of involvement in bullying and cyberbullying episodes as victims, although effect sizes of the differences were small. As pointed out in previous research, non-binary transgender adolescents might experience higher levels of



discrimination and violence at school than binary transgender peers (Aparicio-García et al., 2018; Bower-Brown et al., 2021; Heino et al., 2021).

It also must be pointed out that transgender adolescents are not only victims of discrimination in an abstract sense, but they can also identify the aspects of their lives in which they experience violence. In this study it has been observed that transgender adolescents were more at risk of being a victim of social exclusion, rumours, and sexual jokes than cisgender adolescents. The diversity of experiences became once again evident after disaggregating the group of transgender adolescents. The effect sizes of the differences for these forms of violence at the school setting were negligible when transgender adolescents were compared to cisgender adolescents as a single group. When the group of transgender adolescents was split, it was detected that non-binary transgender adolescents were the group that suffered the most from social exclusion, rumours, and sexual jokes, despite of the fact that the effect sizes of the comparisons were small.

These findings are consistent with previous research indicating that transgender youth are often victims of multiple forms of violence simultaneously, such as being the target of rumours or jokes, physically attacked, excluded or isolated, and threatened, not to mention being sexually assaulted (Atteberry-Ash et al., 2019; Johns et al., 2019; Norris & Orchowksi, 2020; Sterzing et al., 2017).

Particularly noteworthy is the high frequency with which transgender adolescents are victims of sexual jokes, as it may be the key to understanding the prevalence of school violence. Transgender youth experience sexual harassment in multiples ways. This includes verbal harassment such as sexual jokes, unwanted comments, or homophobic name-calling (Låftman et al., 2021). Many studies suggest that the reasons for this abuse can be found in the adolescents' gender identity or expression. Transgender adolescents report experiences of physical and verbal abuse, including negative gender-based comments, within the schooling environment on the basis of their gender or gender expression (T. Jones et al., 2016; Kosciw et al., 2020; McGuire et al., 2010). Similar data are also found in the research carried out by COGAM in Spain, where high-school students, especially transgender adolescents, suffered insults because they were or looked like homosexual, bisexual or transgender (Martín Vela et al., 2019).

As posited on the basis of the gender minority stress model (Hendricks & Testa, 2012; Toomey, 2021), the hetero-cis-normativity imposed by society constrains people to conform to social norms and expectations according to a binary view of sex and gender. Therefore, any expression, role or behaviour that disrupts hetero-cis-normativity is socially sanctioned through



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rejection, isolation and violence, which, in turn, has other severe consequences on health and well-being.

Children and adolescents are exposed to the modelling of gender roles by the expectations of the immediate environment (e.g., parents, peers, teachers) and distal referents (e.g., Internet, social media). All of these influences contribute to the development of a specific notion of what gender and identity are, what being a “man” or a “woman” means, or how you have to fit into social norms according to your gender. Behaviours, cognitions, and expressions that do not conform to these specific expectations are heavily punished by society. Consequently, these sanctions are self-integrated and self-regulated during childhood and adolescence, which motivates alignment with social standards at the expense of personal choices across the life span (Bussey, 2011).

Daily interactions with peers contribute to learning and enacting traditional gender roles and highlight the differences between the genders, which modulate the development of gender identity (Bussey, 2011). Given that children and adolescents can be very susceptible to the rigidity of gender roles and expectations during their cognitive, social and personal development, it is not surprising that they could force their peers to conform to gender roles and expectations (Egan & Perry, 2001; Pichardo & de Stéfano, 2015; Stockard, 2006). Therefore, transgender adolescents, especially those who challenge or transgress binary gender norms, may be heavily sanctioned in interactions with their peers (Blondeel et al., 2018; Chew et al., 2020), including being the victim of bullying and cyberbullying through social isolation or sexual jokes when they claim to be treated according to their gender identity (Domínguez-Martínez et al., 2020; Norris & Orchowski, 2020).

Cisnormative microaggressions or homophobic bullying are harmful forms of peer influence that censor any non-conforming gender expression and enforce rigid binary gender norms in daily interactions through peer pressure and shaming (DeLay et al., 2018; McBride, 2021). For example, homophobic name calling—that is, mocking an individual’s presumed sexual minority status and non-conforming gender expression through disrespectful language—might reshape an early adolescent’s gender identity by minimizing or hiding non-conforming feelings or expressions of gender identity (DeLay et al., 2018).

The social pressure exerted against binary transgender adolescents to fit into the gender norms plays a relevant role in the formation of their identity (Parr & Howe, 2021). However, the situation is more problematic for non-binary adolescents. Non-binary transgender adolescents face specific challenges for having an identity that is not normative: process of navigating the



identity and self-presentation, lack of referents and role models, lack of information and resources, misconceptions about non-binary identities, pressure for transitioning from one binary gender to the other, scepticism and social delegitimization, etc. (Fiani & Han, 2019; Matsuno, 2019). Having an identity that does not fit into either masculine or feminine roles may make them especially vulnerable to being rejected, misgendered, and bullied (Chew et al., 2020), as can also be deduced from the results presented in the **Study 5** of this thesis.

Overall, these aggressions directly targeted at gender identity during an essential period of development have negative consequences on the health of transgender adolescents, affecting their emotional well-being and their feelings of safety at school (Gower, Rider, Brown, et al., 2018; McBride, 2021). In a hostile environment, transgender adolescents might feel ostracized by other students and miss opportunities to participate in social events (Henderson et al., 2022) and avoid to discuss their gender identity or even come out (Bower-Brown et al., 2021; Cederved et al., 2021). For this reason, it is no wonder that transgender adolescents prefer to hide their identity at school (European Union Agency for Fundamental Rights, 2020c).

Given this situation of violence perpetrated constantly in the school environment, one way out for transgender adolescents is to use social media in order to engage in supportive communities, limit isolation, navigate and develop identities, get information, and access resources (Austin et al., 2020; Selkie et al., 2020). However, social media can be an unsafe space where transgender adolescents can be the target of bullying as well as discrimination, as can be gathered from the results of this study and others (Abreu & Kenny, 2018; Atteberry-Ash et al., 2019; Ybarra et al., 2015). Anonymity and lack of face-to-face interaction make it easier for transgender adolescents to be humiliated, insulted, mocked or threatened on social media platforms such as Facebook, Instagram, Twitter, Tumblr, or Snapchat (Henderson et al., 2022; Kosciw et al., 2020; Selkie et al., 2020). Being the target of hurtful comments does not only happen on public platforms on the Internet; there are experiences of victimization within transgender online communities too, which can be directly or indirectly distressing for transgender adolescents (Selkie et al., 2020). This is especially so for people who are non-binary, gender non-conforming, or queer, who could feel that they are not transgender 'enough' for some online communities, leading to explicit rejection, invalidation, and exclusion (Selkie et al., 2020).

So far, we have discussed the reasons why transgender adolescents are more often the victims of bullying and cyberbullying. The role of the aggressor was also explored in this study. In this regard, binary transgender adolescents were found to be the group that bullied others



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the most and that non-binary adolescents were the group that cyberbullied others the most. The role of the bully within the transgender community has barely been investigated. One of the very few studies examining the different roles of transgender adolescents in episodes of violence showed that both being bullied and perpetrating bullying can be more common among gender minorities (Heino et al., 2021).

Although these data are worrying, this phenomenon can also be understandable. Transgender adolescents may also react aggressively and use violence to take revenge as compensation for the victimization they experience, or to defend themselves as a coping mechanism in situations of aggressions or cyberaggressions, as other research conducted with adolescents has noted (del Moral et al., 2014; Guo et al., 2021; Quintana-Orts et al., 2020).

The data presented in this study reminds us of the widespread agreement in the literature on the disproportionately high rates of school victimization for transgender adolescents and the pernicious impact on their health and well-being (Mackie et al., 2021; McBride, 2021). These data should be used to look at this situation, address policies to promote the acceptance of gender diversity, and design interventions to improve school climate in order to make transgender adolescents feel safe in their schools (Day et al., 2020). The agents related to this social environment, including family, teachers and, above all, peers, should take on this commitment, as we further explore in the **Study 6** of this thesis.

Study 6: Can developmental contexts act as positive assets or resources to protect adolescents from the effects of bullying and cyberbullying on well-being?

In the previous studies, mental health (**Study 3**), the quality of developmental contexts (**Study 4**), and involvement in bullying and cyberbullying (**Study 5**) were explored individually. The aim of the last study was to provide an integrative model of the mediating effect of social support on the relationship between being a victim of bullying and cyberbullying on health-related quality of life, considering at the same time the buffering role of gender identity on the complete model. Due to the complexity of the models analysed, it may be appropriate to briefly summarize the results found.

In this study, social support was found to play an essential role in explaining adolescent health-related quality of life. Regarding models conducted with transgender adolescents, it was observed that being a victim of bullying did not influence health-related quality of life, although



support from family and friends predicted health-related quality of life. On the other hand, being a victim of cyberbullying negatively predicted health-related quality of life for transgender adolescents. When measures of social support were also included in the model, family support was found to be the measure that most predicted health-related quality of life, but being a victim of cyberbullying still contributed negatively to the explanatory model of health-related quality of life, followed by the positive effect of friends' support.

In the case of cisgender adolescents, neither being a victim of bullying nor being a victim of cyberbullying explained the health-related quality of life. In their case, support from family, classmates, friends, and teachers were the variables that predicted health-related quality of life.

Two moderated mediation models were tested. In relation to the model built for bullying victimization, being a victim of bullying was not related to health-related quality of life, although support from family and friends were positively related to health-related quality of life. Moreover, an interaction effect was detected among classmate support and gender identity, as previously mentioned in the **Study 4**: when classmate support was low, cisgender adolescents had lower levels of health-related quality of life than transgender adolescents. However, cisgender adolescents who perceived high classmate support had the highest health-related quality of life. By looking at the graphs plotted with results about being victim of bullying, it was seen that both cisgender and transgender adolescents perceived less classmate support when they were victims of bullying, although there were no interaction effects. Moreover, cisgender adolescents, whether or not they had been victims of bullying, scored higher on health-related quality of life than transgender adolescents.

Regarding the model built for cyberbullying, health-related quality of life was explained by friend support and by the interactions between being a victim of cyberbullying and gender identity, and classmate support and gender identity. Cisgender youth who were not cyberbullied was the group that most perceived support from classmates. We would expect to find that adolescents who were victims of cyberbullying perceived less support from their classmates, as was the case for cisgender adolescents and can be seen in the graphs. However, in the case of transgender adolescents, those who were cyberbullied perceived more support from their classmates than transgender adolescents who were not cyberbullied.

Finally, being cyberbullied impacted on health differently among adolescents depending on their gender identity. Transgender adolescents who were cyberbullied had the lowest scores on health-related quality of life than cisgender adolescents. The scores on health-related quality of life scores for transgender adolescents who were victims of cyberbullying were significantly



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lower for those who were not victims of cyberbullying. However, there were no differences in health-related quality of life scores between cisgender adolescents who were or were not victims of cyberbullying. Moreover, even transgender adolescents who were not victims of cyberbullying had lower health-related quality of life than cisgender adolescents who were cyberbullying victims.

All in all, results suggest that cisgender adolescents were more sensitive to the absence or presence of classmate support. This partially confirmed the starting hypothesis. The health-related quality of life of both, cisgender and transgender adolescents is related to the perception of support from their developmental contexts. For transgender adolescents, health-related quality of life also was associated with online victimization.

Depending on the type of school violence studied, it could be seen that family, friends or classmates had a positive influence on the health of adolescents, but a moderating effect of gender identity was only observed in the mediating effect of classmate support on health when adolescents were victims of cyberbullying. Furthermore, being a victim of cyberbullying had a greater negative impact on the perception of social support from their classmates for cisgender adolescents compared with transgender adolescents. In spite of this, cisgender adolescents, whether or not they were victims of school violence, had a higher health-related quality of life than transgender adolescents.

Overall, the results presented in the **Study 5** and this study pointed out that transgender adolescents are defenceless and unprotected in the school setting, and they do not always take advantage of the protective effects of the support from their developmental contexts when their well-being is threatened.

According to previous research, a positive climate fosters feelings of belonging, safety, and acceptance by others at school for adolescents in general, which has a range of positive effects on academic, interpersonal and health outcomes (Aldridge & McChesney, 2018; A. M. Ryan & Shin, 2018; Song et al., 2015). Factors such as safety and the quality of the relationships are relevant in defining and assessing school climate (Thapa et al., 2013). Therefore, supportive relationships are necessary in order to ensure a stimulating environment for positive development.

Findings of this study showed that cisgender adolescents could be especially vulnerable to the lack of classmate support. In fact, classmates might be a supportive network which can reduce internalizing symptoms and protect adolescents from the negative effects of peer



victimization on externalizing behaviours (Attar-Schwartz et al., 2019; Coyle & Malecki, 2018; Wit et al., 2011).

At the same time, classmate support was not a significant factor in the quality of life of transgender adolescents. In this regard, previous research has pointed to the importance of social support and relationships with families, teachers, and peers as essential elements in overcoming situations of discrimination and violence for transgender adolescents (Lewis et al., 2021; Martín-Castillo et al., 2020; Tankersley et al., 2021). According to the literature, peer support might have been expected to be an essential asset (Martín-Castillo et al., 2020), but this has not been the case in this study. While social support is an important element in explaining the health of transgender adolescents, other factors, such as prevalence of cyberbullying victimization, appear to be more relevant in understanding transgender adolescent health in this study.

Many studies have found that transgender adolescents experience difficulties in the educational environment, mainly related to the lack of acceptance of their identity (Gower, Rider, Coleman, et al., 2018; Kosciw et al., 2020; Peter et al., 2016) and the lack of safety and of belonging at school (Day et al., 2018, 2019; Hatchel, Valido, et al., 2019). It is not surprising, therefore, that transgender adolescents feel lonely or are usually involved in episodes of school violence (McBride, 2021).

Regarding the importance of supportive relationships at school, higher connectedness with supportive adults is associated with improved mental health outcomes. In this sense, teachers could have a role to play here. It was seen in this study that support from teachers can have a positive impact on health-related quality of life for cisgender adolescents. Similar results were found in other research in regards to the protective role of teacher support for social exclusion or emotional regulation (Arslan, 2018; Duru & Balkis, 2018; Spilt et al., 2012).

In the case of transgender adolescents, teachers did not show a significant impact on their health-related quality of life. It is true that teachers are not usually the most influent developmental contexts on adolescent well-being in general (Hombrados-Mendieta et al., 2012). In fact, transgender adolescents often consider that teachers do not support them enough on issues related to gender identity and gender expression, and teachers would not defend them against bullying and harassment at school (Dessel et al., 2017; Wernick et al., 2014). What is more, there is also research pointing out that even some teachers might discriminate transgender adolescents and participate in episodes of school violence through negative reactions that deny their gender identity (Bower-Brown et al., 2021; Gallardo Nieto &



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Espinosa Spínola, 2021; K. C. Johnson, LeBlanc, Dearthorff, et al., 2020; D. H. Russell et al., 2020). However, different research points out that supportive adults at school could be a key factor for their safety (Evans & Rawlings, 2021; McGuire et al., 2010). For example, teachers have the potential to be the first adult to ask for help in the school (L. R. Allen et al., 2020) or can encourage transgender adolescents to express their gender in their own way (Ullman, 2017).

When considered together, the findings of this study show that the school environment might not be a safe space for transgender adolescents. Similar conclusions can be drawn from the existing literature, which suggests that school environments are hostile against transgender adolescents and make them feel rejected and unwelcomed (Colvin et al., 2019; Gallardo-Nieto et al., 2021; Johns et al., 2021; Kosciw et al., 2018). In addition, even if school belonging would be a protective factor for transgender adolescents in situations of peer victimization (Hatchel, Valido, et al., 2019), discrimination faced by transgender adolescents may decrease the possible positive effects of their social relationships in the school environment. This situation leads to transgender adolescents being more often victims of bullying (Heino et al., 2021; Kosciw et al., 2020), suffering more health and school issues (e.g., Day et al., 2018; Gower, Rider, Coleman, et al., 2018; Price-Feeney et al., 2018; Reisner, Greytak, et al., 2015; Witcomb et al., 2019), missing the positive and protective effects of social support (Ross-Reed et al., 2019), and being forced to develop alternative resilience strategies to cope with discrimination, such as advocating for themselves within the school system (Johns et al., 2021).

Based on the results from this study, perhaps it is important to contemplate how to involve classmates and teachers in the process of prevention, detection, and intervention on bullying episodes. It could be reasonable to think that in many cases classmates may not be aware of the consequences of their actions and feel that violence is legitimized against those who do not comfort cis-hetero-normative standards. This can also happen to teachers who may allow the students to attack or isolate their transgender peers. Maybe the reason why transgender adolescents do not consider teacher support as important for them is because teachers do not know how to meet their needs.

In this regard, Domínguez-Martínez and Robles (2019) made a thorough review of international interventions focused on reducing bullying and promoting inclusive educational environments for transgender youths. An extensive list of recommendations was provided in this review. Suggestions for students included providing tools to identify transphobic bullying and report aggressions to families or teachers; giving information on sexual and gender diversity in order to change negative attitudes against the transgender community; or promoting gender



equality values. Similarly, teachers also need to deconstruct their previous knowledge about sexuality; learn how to detect and address transphobic bullying; and upgrade their skills to manage conflicts, encourage students to respect each other, be prepared to intervene in cases of violence, and offer support to victims of bullying.

In addition to the most obvious agents present in the school context—that is, classmates and teachers—other social stakeholders may have an influence on the school climate and culture. Families, school staff, and friends who attend the same school can help transgender adolescents feel safe and belonging in this context and may even play a relevant role in situations of victimization.

An example of the importance of fostering these synergies between different agents is the relationship between teachers and families. Sometimes the families of transgender adolescents need to feel that the school will respect the gender-affirming process (Birnkrant & Przeworski, 2017). Likewise, teachers can assist families in the process of acceptance and educate parents and youth about bullying (Domínguez-Martínez & Robles, 2019).

Another significant relationship established in the school environment is between teachers and school counsellors. On many occasions, school staff consider that they do not have sufficient training on topics related to gender diversity (E. J. Meyer & Leonardi, 2018). School counsellors play a key role in improving interventions in the school environment aimed at transgender adolescents, insofar as they can be a source of education for teachers, school personnel, or families (Abreu et al., 2020; Luecke, 2018); at the same time, they can be a reference figure to advocate for transgender students (J. D. Simons et al., 2018).

Family support may not always minimize the effects of bullying on the health of transgender adolescents (Ross-Reed et al., 2019) or may not always foster school belonging when peer victimization occurs (Hatchel, Merrin, et al., 2019). This could be partly due to the fact that transgender adolescents generally perceive low levels of support from their families, as seen in the **Study 4** and previous research (C. Brown et al., 2020; Lefevor, Sprague, et al., 2019). Hence, low levels of family support could be an additional important predictor of psychological distress (Domínguez-Martínez et al., 2020; E. A. McConnell et al., 2016), especially when transgender adolescents are also victims of bullying (Fox et al., 2020). Nevertheless, engagement of families at school also plays an essential role in advocating for transgender youth's rights to self-determination. For example, parents can request the change of their children's personal data (e.g., name, pronouns, and gender), or can ask for arrangements to



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address their children’s needs (e.g., allowing them to use a bathroom consistent with their gender identity) (Birnkrant & Przeworski, 2017).

Friends might not go to the same classroom or group as classmates or teachers do. Friends may also be an important factor for adjustment and well-being because they participate in the everyday life of transgender adolescents and help them to overcome stressful events, tough (Bower-Brown et al., 2021; Galupo, Bauerband, et al., 2014). Therefore, it would also be helpful to explore how the friendships of transgender adolescents can be a source of support and resilience in the face of discrimination (Johns et al., 2018), such as isolation at school or bullying. For example, it might be worth knowing whether they keep friendships on Internet and online networks (Krueger & Young, 2015; Selkie et al., 2020; Ybarra et al., 2015), if their friends also belong to the transgender community (L. R. Allen et al., 2020; Stone et al., 2020), and how these friendships affect their well-being in the school environment (Domínguez-Martínez et al., 2020).

The results of this study highlight that the quality of life of transgender adolescents depends on how supportive their developmental contexts are. It is therefore interesting to consider and elucidate the most effective strategies to promote a sense of school belonging and engagement with school that could potentially mitigate the harmful effects of bullying on transgender adolescent health.

There is broad consensus on how schools can improve safety, provide positive environment, and empower transgender adolescents, particularly in dealing with distal stressors such as bullying and cyberbullying (Burgess et al., 2021; McGuire et al., 2010; J. D. Simons et al., 2018; E. Smith et al., 2014). Best practices for preventing violence in school settings include the presence of supportive people, setting up support groups for LGBTQ+ students, the design and teaching of an inclusive curriculum and the implementation of programs and policies that explicitly protect students from transphobic violence and harassment.

In regard to support and acceptance from adults at school, teachers are able to create a sense of community in the school in a variety of ways, and have the opportunity to influence students at different stages of their development through modelling (Theodore & Stoker, 2021). Thus, if teachers participate in microaggressions they may perpetuate bullying among students against transgender adolescents because they are legitimizing the violence (Bower-Brown et al., 2021). On the other hand, when teachers intervene to stop harassment against transgender adolescents, the likelihood that students would intervene in bullying victimization increase (Burgess et al., 2021). One of the most effective practices is to respect and use the adolescent’s



chosen name and pronouns correctly in order to avoid misgendering and thus reduce internalizing symptoms (S. T. Russell et al., 2018). Other strategies to promote a safe environment include the use of inclusive language and respect for confidentiality, which proves to transgender adolescents that they can trust and receive support from key adults at school when sharing personal information (Evans & Rawlings, 2021).

Moreover, in addition to interventions to the victims of bullying and cyberbullying, educational and preventive interventions should be conducted in order to mitigate the occurrence of the episodes. Along these lines, creating support groups within the school environment can be accomplished through different programmes and structures to protect transgender adolescent. One of the most well-known strategies are Gay-Straight Alliances or Gender-Sexuality Alliances (Fish, 2020).

The aim of these school-based clubs is to bring together youth across sexual orientations and gender identities to offer support, socialization, and protection at school (V. P. Poteat et al., 2020). It has been documented that these alliances contribute to reduce levels of at-school victimization and increase the sense of peer validation for youth who participate in these programs, with positive consequences for the physical, emotional, social, and academic well-being of LGBTQ+ students (Day et al., 2020; Gower, Forster, et al., 2018; Marx & Kettrey, 2016; V. P. Poteat et al., 2020).

However, mixed results are found offered when evaluating the impact of this type of programs. The success of this project lies in the ease with which LGBTQ+ adolescents can connect with supportive adults and LGBTQ+ schoolmates (Day et al., 2020). Nevertheless, the presence of these alliances at school alone does not contribute to improving the school climate for all LGBTQ+ students at school (Burgess et al., 2021), and they may help to address some of the problems of safety at school rather than fix the underlying causes of discrimination (Harris et al., 2022). Thus, having a support group is not the same as having an affirming school environment (Harris et al., 2022). Therefore, these programmes work if the school implements other activities and interventions to protect transgender adolescents at the same time.

Such alliances might not be very common in Spanish schools, but building partnerships with LGBTI+ associations can also be a good strategy to provide safe spaces and references for transgender adolescents. Establishing alliances with LGBTI+ associations can also be a valuable strategy to provide safe spaces and positive referents for transgender adolescents (Pichardo & de Stéfano, 2015, 2020).



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Another essential pillar in preventing transphobia and promoting a safe school environment for transgender adolescents is to change the school curriculum towards a LGBTQ-inclusive curriculum. The implementation of LGBTQ-inclusive curriculum encompasses different topics.

First, all curricula must refer to current struggles that transgender people face and the latest evidence on key terms and concepts to overcome myths and stereotypes (Domínguez-Martínez & Robles, 2019; A. L. Sullivan & Urraro, 2019). This also leads to the discussion of the social construct of sexuality, and how these constructs (e.g. cisnormativity or the imposition of the gender binary) contribute to attitudes that reject and discriminate transgender people (Domínguez-Martínez & Robles, 2019). For example, comprehensive sexual health education should incorporate information on sexual and gender diversity to make it visible (Domínguez-Martínez & Robles, 2019), going beyond the mere prevention of the risk of unplanned pregnancy and sexually transmitted diseases. Another way to render the transgender community visible is by teaching positive representations of transgender people and LGBTQ+ history at school by inviting transgender guest speakers to dispel myths, and by including transgender students in leadership activities (Burgess et al., 2021; Domínguez-Martínez & Robles, 2019; A. L. Sullivan & Urraro, 2019).

Finally, evidence in the literature shows that another key element to prevent bullying against transgender adolescents is the implementation of comprehensive policies in schools. Not all policies aimed at reducing bullying rates are equally effective, but what is clear is that the unavailability of school plans or policies to protect transgender adolescents at school contribute to exposing them to discrimination (Persinger et al., 2020). In this sense, policies can address different needs of transgender adolescents at school. For example, policies can be specifically designed to combat bullying through discipline approaches based on restorative justice programs and positive behaviour interventions instead of punitive policies that rely on suspension and expulsion (Orr & Baum, 2015). These interventions must penalize any form of violence based on gender identity and, at the same time, provide an educational process to raise awareness about transphobia from a human rights perspective in order to raise awareness of the harmful effects of aggression (Domínguez-Martínez & Robles, 2019).

Other practices that schools can implement are sex and gender non-discrimination policies to ensure that transgender adolescents do not feel discriminated or uncomfortable in their use of school spaces (e.g. bathrooms) or the expression of their identity (e.g., clothing or pronouns) (Kosciw et al., 2018).



In sum, research supports that the implementation of these policies reduces the frequency of victimization and enhances the feeling of safety at school (Burgess et al., 2021; Ioverno et al., 2022). Policies implemented in schools, as well as regional and national laws and legislation, need to prioritize the protection of the welfare and rights of transgender adolescents in the face of discrimination and harassment.

As a final thought on approaches to bullying prevention and intervention, this study and previous research point out that developmental contexts should be studied individually in order to delve into their features, but also in an interconnected way because social environments are related between them and are establishing complex interactions. Therefore, the suggestions of intervention described in this discussion should simultaneously involve different stakeholders (e.g., teachers, administrators, counsellors, health educators, social workers, community members, parents, and students) in different levels (e.g., individual, interpersonal, organizational, and community) in a process of searching for solutions to improve the experiences of adolescents in the educational system (Jarpe-Ratner et al., 2021; E. J. Meyer & Leonardi, 2018; Shattuck et al., 2021).

The minority stress model is useful for understanding stigma and its effects on the well-being of transgender youth (Johns et al., 2021). Thus, based upon the gender minority stress model, we analysed bullying and cyberbullying as distal stressors that exclude transgender youth from school life and can explain health disparities between cisgender and transgender adolescents. Minority stress also evaluates the role of social support in moderating and mediating the impact of stress on well-being. (I. Meyer, 2020). Therefore, social support was included in this minority stress model as a mediator factor. However, the complete model should also include proximal stressors (e.g., expectations of rejections or internalized transphobia) and other aspects rather than social support from the social networks in order to offer the broadest perspective of how educational systems and social structures create barriers against the well-being of transgender youth (Johns et al., 2021).

This study undoubtedly contributes to the wide body of evidence available in the literature on the high vulnerability of transgender adolescents when they are victims of violence in the school environment. Theoretical frameworks based on socioecological theories, such as Bronfenbrenner's ecological system model or the minority stress model, should be the conceptual basis for designing policies and interventions, beginning with the needs of transgender adolescents to encompass the most immediate systems and larger cultural world surrounding youth. Interventions can be aimed at training on conflict resolution strategies for



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transgender youth, implementing bullying prevention and intervention programs aimed for schoolmates, teaching LGBTQ+ inclusive curricula, promoting awareness-raising and training campaigns for professionals and families, and the design of laws that protect the rights and well-being of transgender adolescents. We hope this research will be useful in promoting safe, inclusive, and empowering spaces for transgender adolescents.

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CHAPTER 13: STRENGTHS, LIMITATIONS AND FUTURE LINES OF RESEARCH

In this section, towards the end of the manuscript, the strengths, shortcomings, and future lines of the research will be discussed.

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This study has several strengths that are worth noting. The most published research with the transgender community is based on large surveys conducted in Western, English-speaking contexts (Wanta & Unger, 2017); for example, the National LGBT Survey in the UK (Government Equalities Office, 2018), the National School Climate Survey in the USA (Kosciw et al., 2020), or the Canadian Trans and Non-binary Youth Health Survey in Canada (A. Taylor et al., 2020). Very few studies using random sampling for data collection in large samples (especially with an adolescent target group) include sociodemographic indicators to assess the gender identity or sexual orientation of participants (T. Jones, 2019).

Hidden or hard-to-reach populations present special challenges for the sample process, including sampling, recruitment, identification, data collection, and representativeness (Bacher et al., 2019). Studies on gender-minority youth have usually utilized non-probability samplings as a way of gathering information from hidden groups, making it difficult to reach out to them through probability sampling techniques (Schrager et al., 2019). Non-probability methods (e.g., convenience sampling on community organizations or clinical settings) presents pragmatic advantages for sampling large numbers of this kind of hard-to-reach or socially disadvantaged groups (Bonevski et al., 2014). However, participants recruited through non-probability methods are not necessarily fully representative of the whole population. Therefore, this study stands out both for using random multistage stratified cluster sampling—thus being representative of the adolescent transgender community enrolled in Spanish schools—and for adding a new cultural context to the existing literature on transgender identity.

In order to recruit a larger sample size, lesbian, gay, bisexual, and transgender populations are often collected and conflated under the same community (Glick et al., 2018; B. W. Vincent, 2018). As a result, sexual and gender minority youth are often seen as a homogenous group, both in the scientific literature and in the use of acronyms (e.g., SGM, SOGI, LGBT, etc.) (Bosse et al., 2018). The transgender population might be more marginalized than others groups within the LGBTQ+ community, and their experiences are frequently hidden by a focus on sexual orientation rather than on gender identities in health research (Gahagan & Colpitts, 2017). With this study we can overcome the scarce literature on the health of transgender and other gender minority youth, and we can provide specific data on the transgender adolescent community in Spain

The sample size reached through probability sampling in this thesis was large enough to perform robust statistical analyses, filling gaps in the literature that qualitative research cannot overcome (T. C. Poteat et al., 2021).



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Besides, we cannot ignore the heterogeneity of the transgender community. As a result of the traditional understandings of gender and sex as binary categories, the existence and unique experiences of non-binary people have been largely absent from the academic literature as well as from access to health care (B. A. Clark et al., 2018). Most of the research on transgender health tends to consider transgender individuals as belonging to a homogenous population, although non-binary youth are increasingly visible in the transgender communities and in research as the specific population they are, with specific health needs (Scandurra et al., 2019).

Thus, the two-step version used in this research project led us to obtain specific information on the proportion of binary and non-binary transgender adolescents in Spain. Furthermore, it is not only a matter of finding out the proportion of the transgender community in the adolescent population, but also of exploring transgender adolescent health from a holistic approach and of reflecting the diversity of the transgender and gender-diverse community.

Another of this study's contributions is the wide range of objectives and instruments used to fill gaps detected in the scientific literature. For example, examining lifestyles, including unusual indicators such as energy drink or salty snack consumption, provides information that is rarely available in the literature. Previous research on the lifestyles and health habits of transgender people is scarce and has been conducted with qualitative methodology or convenience samples recruited from LGBTQ+ associations, clinical settings, social media, or through snowball sampling (Levenson et al., 2021; López-Cañada et al., 2020; Macdonald et al., 2022). Furthermore, most of the studies have been conducted with young adults (B. Jones et al., 2017) or mixing the gender minority groups with the sexual minority groups (Himmelstein et al., 2019).

In addition, the mental health of gender-minority people is often conceptualized based on classic models that mainly consider indicators such as anxiety disorders, emotional distress, substance use, or suicidal ideation (M. D. Connolly et al., 2016; McCann & Brown, 2018). Measures such as life satisfaction or sense of coherence have very seldomly been employed to research the health of this community (Anderssen et al., 2020; Zou et al., 2018). In this sense, the use of instruments based on health promotion and positive development, such as the salutogenic model or the assets model (Pérez-Wilson et al., 2021), reconceptualizes the pathological approach and helps us move forward in a more positive approach to the study of transgender adolescents. This project includes key measures of adolescent psychological adjustment and well-being.



Another strength of this work is the use of multiple statistical techniques to analyse the data and cover each of the study objectives, as well as carefully interpret statistical tests with the sizes of effect estimates (Greenland et al., 2016).

However, the findings of this study must be seen under the light of some limitations too. To start with, this research was based on a variation of the two-step approach. Given that the question on sex—following the international HBSC protocol—asked whether the participant was a boy or a girl and did not include the wording “assigned at birth”, this could lead to the underestimation of the percentage of transgender adolescents. Neither does it allow a third response option for the intersex population.

Some binary transgender adolescents may have interpreted this question as referring to their gender identity instead of their sex assigned at birth. Previous research has highlighted the importance of offering a clear statement/question in order for participants to know what they are being asked (Rider et al., 2018). Moreover, we did not have the opportunity to cross-check the answers (e.g., by conducting interviews) (Grasso, Goldhammer, et al., 2019). Therefore, the proportion of binary transgender adolescents could be higher than indicated by our data.

The preferred approaches to examine sex and gender vary over time. Although the two-step approach is the most popular and adequate method, in one of the New Zealand’s most recent public consultations about sex and gender-identity statistical standards, it was reported that some people consider asking about sex assigned at birth to be particularly sensitive and intrusive. Others felt this question and concept might be offensive or invalidating and not respectful of self-determination (Stats NZ, 2020b).

However, our version of the two-step measure seems to have led us to estimate a similar proportion of transgender adolescents as has been observed in studies where variations of the two-step approach were also employed.

The research conducted by Tate, Ledbetter and Youssef (2013) was one of the most important studies to offer a two-step method. However, participants were asked about gender assigned at birth rather than sex. Moreover, “transgender” and “intersex” categories were offered as response options in the measure of gender assigned at birth, although, as Gloria Fraser (Fraser, 2018) points out, “transgender” and “intersex” are not gender categories.

Eisenberg and colleagues (2017) explained that the two-item approach they used was based on GenIUSS group guidelines, employing a birth-assigned sex measure such as biological sex (male/female), followed by the question “Do you consider yourself transgender,



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genderqueer, genderfluid, or unsure about your gender identity?” with “yes” or “no” response options. Grasso et al. (2019) asked the sex assigned at birth (male/female) and the current gender identity (male/female/transgender male/transgender female/other/not to disclosure). Although both sex assigned at birth and current gender identity were asked in these studies, participants often misunderstood the first measure. Although there is explicit reference to the fact that the question refers to sex assigned or registered at birth, some participants still answer the question in regard to their gender identity (G. R. Bauer et al., 2017). Lastly, one of the first studies conducted in Europe was led by Kaltiala-Heino and Lindberg (2019). The respondents were first asked “What is your sex?” (boy/girl), referring to the sex reported on identity documents, and were later asked about their perceived gender: “Do you perceive yourself to be...”, with options “a boy / a girl/ both / none / my perception varies”. The authors recognized that, due to the wording of the questions, some respondents may have possibly indicated perceived gender identity in the sex question of their two-step approach.

Adapting the statements or response options for the sex and gender items (as in the aforementioned study, where the sex item did not include “assigned or registered at birth”) can lead to imprecise data, especially if the youth do not clearly understand the wording of the item.

In short, although researchers may adapt the wording of the two-step method to fit their specific research aims and conditions (Cameron & Stinson, 2019; Fraser, 2018), the specific measure employed for sex and gender should be carefully considered when comparing and interpreting data in order to correctly interpret differences in prevalence.

Secondly, it is systematically pointed out that increasing the sample size can be a solution to perform more complex analyses, such as structural equation modelling (SEM) or the study of invariance. However, this position requires prior consideration. The SEM analysis is a multivariate statistical technique used to examine complex associations, test the direct and indirect effects on causal relation between various types of variables (e.g., categorical, ordinal, or continuous variables), and evaluate comparisons across alternative models (Fan et al., 2016; Ruiz et al., 2010; Wolf et al., 2013). Invariance testing within the SEM literature is used to estimate whether the model (measurement and structural) or the measures are invariant or have the same meanings across groups (F. F. Chen, 2007; Sass, 2011). Therefore, researchers are encouraged to conduct this type of analysis to explore different models with the transgender community and in cross-cultural research (e.g., Bauerband et al., 2019; Hatchel, Valido, et al., 2019; Iliadis et al., 2020).



Thus, sample size is one of the key elements to be considered in statistical power, along with the chosen alpha level and the magnitude of the effect of interest. The SEM analyses are sensitive to sample size in a number of ways, such as biases that can lead to under- or overestimating the standard error, which increases the risk of Type I and II errors respectively (Wolf et al., 2013). Then, the estimation of sample size is an important issue when conducting SEM analysis. One of the classic sample size rules-of-thumb indicate that groups of 100 members ensure low power and sample sizes of 200 per group are the minimum recommended for SEM (Meade, 2005; Ruiz et al., 2010). However, this kind of guideline is not model-specific and may lead to over- or underestimated sample size requirement; at the same time, models have to consider other factors that affect the accuracy of the statistical power, the parameter estimates, and the model fit statistics (Fan et al., 2016; Wolf et al., 2013).

Even though a large sample size is not necessarily a warranty of robustness, the sample size of the transgender adolescent group was large enough to perform variable-centred analyses (Howard & Hoffman, 2018). However, the sample size of the binary and non-binary transgender adolescents was too small to examine their characteristics independently in studies 4 and 6. In fact, the conflation of non-binary and binary transgender experiences under umbrella categories may not be at all adequate if there are cases of non-binary adolescents who do not identify as transgender (Darwin, 2020). Also, between-group comparisons would be lost after collapsing the experiences of transgender adolescents under the same label (Glick et al., 2018). Perhaps a larger sample of binary and non-binary transgender adolescents as independent groups could have led us to perform more sophisticated analyses to gain a deeper insight into the diversity and individuality of each identity (e.g., transgender girls, transgender boys, queer youth, third-gender individuals, or agender adolescents, among other identities), especially the non-binary and “dissident” identities in our country (López Gómez & Platero, 2018).

Next, with respect to the study design, the causation hypothesis or the directionality of the effects and relationships between variables could not be tested due to the cross-sectional nature of the design of the HBSC Study (L. L. Wang et al., 2013). Furthermore, the HBSC collects data through online questionnaires that allow us to explore a large number of contents and variables. As we explained in the method chapter, the final Spanish version of the questionnaire is divided into three packages. Some measures are common to the different versions of the packages, but other variables correspond to specific packages. This makes it problematic to analyse some models, either because the measures did not coincide between packages or because of insufficient sample size. Consequently, models such as the relationships between



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developmental contexts and lifestyles, or the effects of specific types of bullying on mental health, have not been analysed.

The instruments used for each study have been previously validated in international studies. Even so, the use of self-reported measures to assess health-related behaviours—instead of objective instruments (e.g., accelerometer for physical activity or polysomnography for sleep quality)—could introduce bias or inaccuracy in the answers of participants (Chaput et al., 2016; Lang et al., 2016; Sevil-Serrano et al., 2019).

The matching process eventually made it possible to obtain comparable profiles between cisgender and transgender adolescents to reduce bias and increase control for confounding in observational studies (D. B. Rubin, 2006), as previous research also did (e.g., Davey et al., 2014; Reisner, Veters, et al., 2015). By contrast, matching process hindered the possibility of employing an intersectional perspective which would have allowed differences by socioeconomic status or ethnicity to be explored (T. C. Poteat et al., 2021; Van Schuylenbergh et al., 2018).

Regarding future lines of research, the first proposal is to continue collecting data within the framework of the HBSC study, both in the national team and in the international network, because of the versatility of the project. As research in this field moves forward, it is important to reach a consensus regarding critical elements of gender assessments, such as clearly specifying “assigned at birth” in the sex item. More accurate measures of sex registered or assigned at birth (e.g., what sex was on your original birth certificate?) and self-perceived gender must be used in future research.

A challenge to be considered is the complexity in defining these constructs. In the last 10 years there has been a shift towards greater awareness of one's own experience of sexual orientation and gender identity, especially among young people, which is reflected in a broader and more flexible use of alternative labels as opposed to hegemonic categories (J. M. Jones, 2021; Porta et al., 2020; Watson et al., 2020). The HBSC study is a cohort cross-sectional study that allows for the identification of trends and changes between generations of adolescents. Currently in 2022 a new edition is being conducted—the 2021/2022 HBSC survey. Therefore, it is worthwhile to continue using a two-step measure with an open-ended option to learn how adolescents of Generation Z—that is, those born from the mid-to-late 1990s to the early 2010s—and Generation Alpha—those born between 2010 and 2025—define themselves (J. M. Jones, 2021).



Best practices encourage the use of sexual orientation and gender identity indicators in regional, national, and international studies and censuses (T. Jones, 2019; Meerwijk & Sevelius, 2017; United Nations Economic Commission for Europe, 2019; Westbrook & Saperstein, 2015). In this sense, the HBSC study is a perfect venue to investigate adolescent health and development from the gender identity perspective. In the past few years, the sexual health working group of the international HBSC Network has developed different measures related to the sexual orientation and sexual behaviours of adolescents (Költő et al., 2018; Young et al., 2016). Introducing a new, inclusive two-step measure in the international HBSC network that enables investigation of sex assigned at birth and gender identity would open up many possibilities to compare the health of cisgender and transgender youth across various countries and cultures. To this end, a pilot study is currently ongoing, led by some countries belonging to the Sexual Health Focus Group (including Spain), to analyse the best strategies for asking adolescents about sexual orientation and gender identity (Költő, Ciria-Barreiro, et al., 2021).

Further research regarding the minority stress model can explore transgender-specific processes and health issues, including proximal (e.g., internalized transphobia, vicarious stress exposure) and distal (e.g., gender-related discrimination) stressors, in order to address minority stress domains that may be unique to transgender adolescents (Puckett et al., 2021; Testa et al., 2015).

It is absolutely crucial that future lines of research depathologize the experiences and health of gender-diverse adolescents and shift towards strengths-based research models and interventions to successfully overcome health disparities (Suess Schwend et al., 2014). It is fully compatible to conduct studies on difficulties such as drug abuse or mental health problems and promote research on resilience, thriving, and human diversity (Henrickson et al., 2020; Schragger et al., 2019). Thus, individual and community resilience and how social movement build health could be examined (T. C. Poteat et al., 2021). For instance, individuals assets such as sociopolitical engagement, connectedness, social self-efficacy, self-worth, or self-acceptance can be included (Delozier et al., 2020; Frost et al., 2019; Költő, Gavin, et al., 2021; Matsuno & Israel, 2018). At the structural level, in addition to the contexts considered in this research, it would be desirable to analyse how LGBTQ+ community support or laws and policies can mitigate stigma or promote the protection and well-being of transgender adolescents (Delozier et al., 2020; Garcia et al., 2020; Matsuno & Israel, 2018; Shelton et al., 2018).



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In brief, it is important that the predominant “victim” narrative be balanced towards a more positive approach (Költő, Vaughan, et al., 2021), so the strengths and developmental assets of transgender and other gender minority youth can be explored.

Promising analyses and study designs may emerge from this doctoral thesis. The literature on the development of gender identity in late childhood and early adolescence is scarce. It would be interesting to compare which projective methodologies (Olson et al., 2015) or survey methodologies (Potter et al., 2021) work the best to explore young people’s gender identity (Zhang et al., 2020). Indeed, due to the dynamic experience of the gender identity, future research should consider follow-up and longitudinal studies in order to evaluate the stability and fluidity of the gender identity along the lifespan. At the same time, cognitive studies (performed with qualitative and quantitative methodologies) are recommended to explore the meanings of the labels and terms of gender identity (Conron et al., 2008).

In the case of being able to conduct qualitative research in other cultural contexts, an inspiring epistemological framework might be feminist anthropology, from which spaces for discussion can be developed beyond the biases of Western andocentric and ethnocentric thought (Gregorio, 2019; Gregorio & Alcázar, 2014) One of the most interesting points of feminist ethnography is the way in which gender identity is understood in the research process. This framework proposes the deconstruction of the fixed and immutable categories that define gender identity. Rather than this, feminist ethnography offers a view of the person as one who changes in the relationships with others. This facilitates the replacement of the dual and binary view of gender by an interactive and multiple process, both for the external identities and for the researcher's own identity (Gregorio, 2006).

Intersectional effects of membership in multiple social groups (e.g., gender identity, sexual orientation, socio-economic status, age, etc.) could be measured with multi-level analyses, which are recommended to explore the complex interaction structures between a large number of social groups memberships (Kern et al., 2020). Moreover, longitudinal and multi-level designs are also recommended to evaluate the stability not only of the gender identity but of the overall health of transgender adolescents.



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Once the results have been reported and the most significant findings have been discussed, it is pertinent to highlight the most meaningful implications of this thesis for both research and intervention.

The main purpose of this research has been to shed light on the daily life and development of adolescents according to their gender identity. We have tried to offer a positive outlook beyond pathology, without, however, losing sight of the stigmas that transgender adolescents may face and that impact their health and adjustment. One of the first themes we can expose here is our intention to recognize, respect, and validate the identities of the participants who contributed to this dissertation. We would like to stress that we have not addressed in depth issues related to gender dysphoria, gender self-determination, or gender affirmative models. However, we believe that the results of this dissertation are linked to these topics, so we will briefly discuss a few points.

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14.1 The controversy over transgender adolescents

Over the last decade, at the same time as there has been a growing awareness of the reality of transgender children and adolescents, a lot of criticism and debate has emerged to question their capacity to know their gender identity or whether they should be allowed to access gender-affirming interventions (Pullen Sansfaçon et al., 2020; Teich, 2012). Indeed, some critics point out that gender care is a kind of “child abuse” (Leibowitz et al., 2020).

Concerns regarding the decision-making process, diagnoses and medical treatments, and school-related issues of minors, as well as the safety of transgender, gender-diverse, or gender non-conforming children and adolescents are common (Dubin et al., 2020; Lev & Wolf-Gould, 2018)

The term ‘rapid-onset gender dysphoria’ was formulated to describe an ‘alleged’ emerging phenomenon of minors coming out as transgender due to social contagion and mental illness (Ashley, 2020). In the original paper, Lisa Littman (2018) indicated that many parents and clinicians reported that children who had not shown indication of gender dysphoria seemed to abruptly experience gender dysphoria during puberty because of being in contact with friends who came out as transgender during the same time. Shortly afterwards, the author of this theory recognized the methodological pitfalls of the research and claimed that the term should not be used to explain the experiences of all gender dysphoric youth (Littman, 2019). However, despite its lack of validity and methodological rigor, this term is still used to dismiss empirical evidence of the importance of gender affirmation and transition (Ashley, 2020).

The competence of prepubescent children or pubertal gender non-conforming adolescents to assess the short and long-term implications, risks, and benefits of suppression treatments or gender-affirming surgical interventions arises as another major controversy due to their cognitive development (D. Chen et al., 2018). For example, the term Trans-Exclusionary Radical Feminist (TERFs) emerged to designate the discrimination against transgender people led by a certain minority within radical feminism (Osborne, 2017). One of the most frequent statements made by TERFs is that minors are not ready to access gender-medical care because of their inability to understand the consequences of the process (R. Pearce et al., 2020).

Another argument against transgender adolescents arises over young people's ability to discern between what is gender identity and gender expression, and whether they can understand that having a gender expression which differs from societal norms is not the same as expressing a deep, essential gender identity that is different from the sex assigned at birth (Ehrensaft et al., 2018).



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Another major controversy revolves around the use of diagnostic classification systems related to gender diversity. At present, Gender Dysphoria and Gender Incongruence are the two diagnostic labels used in the Diagnostic and Statistical Manual of Mental Disorders (the most recent version is DSM-5) of the American Psychiatric Association and the International Classification of Diseases of the World Health Organization (the most recent version is ICD-11), respectively. Since the inception of these systems, there has been a long history of reconceptualizing and depathologizing gender diversity (World Professional Association for Transgender Health, 2021). In order to currently access different types of care and treatment in gender clinics, a diagnosis with these labels is required. However, users and activists claim that gender diversity should not be considered a "mental illness" and should be removed from diagnostic systems because it is discriminatory and stigmatizing (Castro-Peraza et al., 2019; Moleiro & Pinto, 2015). Given this scenario, a paradox arises: many gender non-conforming, transgender or gender-diverse people do not want their reality to be pathologized because this equates to having a mental disorder, but without these diagnoses they cannot access gender affirmative interventions (Baetens & Dhondt, 2021).

In childhood, the pathways of how one feels and experiences one's own gender are diverse. Some gender-nonconforming children may express their gender in more traditional ways as part of their natural development; others may continue to behave and express their gender non-conformity and might even experience anatomical discomfort at the onset of puberty. Some gender-nonconforming children may experience gender dysphoria, whereas others might not (Lev, 2016). Gender diversity or gender dysphoria cannot be consistent for all prepubescent children as they grow up. There is a possibility that children who meet the criteria for gender dysphoria or express a gender that differs from their sex assigned at birth will no longer do so in adolescence (e.g., Drummond et al., 2008; Steensma, McGuire, et al., 2013). Hence the difficulty to predict the development of gender expressions, trajectories, and identities from childhood into adolescence (Suess Schwend et al., 2018). Indeed, one of the risks of having such a diagnostic category, mainly for children, is that it assumes that any gender expression that is diverse or different from social expectations can be a psychiatric disorder (Baetens & Dhondt, 2021; Keo-meier & Ehrensaft, 2018).

Beyond diagnostic labels, another major controversy refers to the appropriate timing for medical and social gender transitions. Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People includes the international guidelines published by the World Professional Association for Transgender Health (WPATH) to guide policies and clinical treatment for the transgender community (Lev, 2016). The SOC7, the current



version (Coleman et al., 2012)—although WPATH is going to launch the 8th version in 2022 (World Professional Association for Transgender Health, 2022)—provides clinical guidance for health professionals so that they can assist transsexual, transgender, and gender nonconforming people with evidence-based clinical treatments and interventions.

Although many voices claim that affirmative therapy is abusive and involves putting children and adolescents through hormone and surgical treatments without scientific evidence, the reality is far from these worries.

First, adolescents who ask for gender-affirming treatments must satisfy certain criteria before proceeding (World Professional Association for Transgender Health, 2012). For example, adolescents may be eligible for puberty-suppressing hormones as soon as they experience the onset of puberty to at least Tanner Stage 2 or display an intense and pervasive pattern of gender non-conforming or gender dysphoria, among other criteria. Adolescents who seek sex hormone treatment must prove the persistence of gender dysphoria or gender incongruence and having sufficient maturity to consent, which most adolescents have by the age of 16 (Agana et al., 2019; Fernández Rodríguez et al., 2014; World Professional Association for Transgender Health, 2012). Therefore, children do not need hormone treatment until puberty but social support to explore their gender identity (Castro-Peraza et al., 2019). Moreover, follow-up studies and cross-sectional research indicate that many adolescents who access gender clinics have exhaustively thought about the gender affirming treatments, and are able to understand what puberty suppression and/or gender affirming hormones treatment involve, as well as consent to receiving them (Carmichael et al., 2021; A. L. C. De Vries et al., 2014; Vrouenraets et al., 2021).

Second, decades of research support the quality and safety of the treatments, although the existence of side effects is also recognized (Agana et al., 2019; S. Giordano & Holm, 2020; World Professional Association for Transgender Health, 2021). What is more, studies focused on gender affirming treatments observe that treatments are heterogeneous, according to the needs of the users: some participants have socially transitioned; others use puberty blockers and suppressors (fully reversible intervention); others have started gender-affirming hormone treatments (partially reversible intervention) or have even had gender affirming surgeries (irreversible interventions) when the patient is at least 18 years old or legal age of majority in the corresponding country (World Professional Association for Transgender Health, 2012). Adolescents who access affirmative therapy have the right to receive comprehensive information about pubertal blockers and cross-sex hormones and to know that surgical interventions are optional and not a mandatory action (Suess Schwend, 2020).



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A comprehensive biopsychosocial assessment for gender diversity in adolescence is a complex process in which quality and safety can only be guaranteed thanks to multidisciplinary teams and approaches (Gómez-Gil et al., 2020).

Third, public objection to facilitate social transition or to allow hormonal therapy can have serious consequences for transgender adolescents, their families, and their healthcare providers (A. L. C. de Vries et al., 2021; Leibowitz et al., 2020). Not being allowed to begin a hormone treatment is linked to discomfort, depression, anxiety, low self-esteem, social phobia, eating disorders, and even suicide attempts, self-harm, or the use of hormones without medical control (Agana et al., 2019; Baetens & Dhondt, 2021; A. L. C. De Vries et al., 2014; Guerrero-Fernández et al., 2015; López de Lara et al., 2020).

Despite the heterogeneity of the data on individual trajectories, which makes the definition of a singular and unique golden standard intervention to attend all cases complicated, it is clearly important to accept and respect the complexity of gender identity pathways. Gender self-determination is a 'tailored suit' (Tortajada et al., 2021), a process in which transgender people themselves have the right to define their identity and to be legally recognized (Mulió, 2020).

In short, when we work with transgender adolescents, we will inevitably deal with a number of debates and controversies that may go against their own identity and their own needs. The results deployed in this document have not addressed these issues, but we believe this thesis can serve to reinforce the importance of asking about the needs of transgender adolescents, both in terms of the lifespan moment and the experience of their identity, and of seeking the most appropriate ways in which to fully support them and recognize, validate, and respect their identities.

14.2 Addressing policies and interventions

Regarding intervention and considering the ecological approach that permeates this dissertation, different levels and systems are involved in the lives of transgender adolescents.

Pursuing the depathologization of the realities of transgender adolescents does not mean we must not address their well-being. In addition to treating the specific needs they may have, it should not be forgotten that we are talking about a specific developmental moment in their lifespan, characterized by the search, construction, and experimentation of identity in all



its areas. We hope that, in this sense, the data of this thesis will serve to detect specific areas of intervention, such as paying attention to their lifestyles, their social relationships, their mental health, or the protection of their rights and dignity in the face of stigma and violence.

Any work conducted with adolescents on any area of their lives must take place within an inclusive and safe space to make it easier for them to express themselves without constrictions. For example, connectedness to transgender-specific support groups could be beneficial because it is a safe space to meet people with the same needs and experiences, to speak out about political concerns, to get information, or to learn from positive role models (Garcia et al., 2020; Jackson Levin et al., 2020).

However, it is important to keep in mind the community or political dimensions of society. Thus, interventions with families, peers, teachers, advisors, and primary medical and mental health providers are also needed to address health problems and social issues. The results of this research indicate that it is crucial that the people closest to adolescents show them support and affection, so that both the needs they may have because of their adolescence and the specific needs they may have as transgender people can be addressed in order to foster the healthiest and optimal development. The results of this research show that transgender adolescents may feel less supported and more isolated, missing the opportunity to take advantage of the positive effect of the support of their developmental contexts.

Family support is a crucial aspect of the well-being of adolescents. Whether or not transgender adolescents decide to initiate any type of gender-affirmative intervention, they will undeniably need the support of their families to cope successfully with the challenges of this stage. Affection and support from the family enable resilient trajectories (N. Parra, 2021). Transgender youth require multidimensional support from their families: emotional support (e.g., acceptance, care, understanding and respect of their identity; advocacy when they are mistreated); instrumental support (e.g., helping youth find providers and attend medicals appointments, or buying items for social transition such as clothes or makeup); appraisal support (e.g., affirmations, motivations, and encouragement; use of their chosen name and pronouns as validating their gender identity), or informational support (e.g., tips for problem solving) (Andrzejewski et al., 2021; C. Ryan et al., 2010).

Transgender adolescents may need their families more than cisgender adolescents. For this reason, joining support groups and group care for parents can help families learn to address the needs of transgender adolescents. These support groups, supervised by care professionals, serve as resilience spaces where they can share their experiences accompanying their



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transgender children, including shock, fear, hope, joy, empowerment, dilemmas, solutions, and mutual support (Boivin et al., 2020; Malpas et al., 2018). It would be convenient to identify families that may need more specific help in order to offer them these resources, thus avoiding that they seek help from professionals who do not have specific training in transgender topics.

Another finding in this dissertation has been the importance of the role of peers in the quality of life of transgender adolescents, either friends or classmates. The present research shows the vulnerability that transgender adolescents suffer because of isolation and victimization in the school environment, and how they miss out on opportunities benefit from the positive effects of peer support in situations of adversity.

Despite the extremely high and severe prevalence of violence against transgender adolescents in the school environment, this space can also provide an opportunity to work on two main areas of intervention: the design of inclusive curricula and the implementation of strategies to prevent bullying in the school environment.

At present, when sexuality education policies are designed, the prevention of teenage pregnancy or of sexually transmitted diseases are emphasized over healthy sexuality, pleasure, and diversity (Ballester-Arnal, 2020), although great effort is being put in incorporating sex and gender equality policies incorporating intersectionality (Venegas et al., 2020). However, it is not enough. A LGBTQ-inclusive curricula should include topics such as newest evidence-based practices to teach key terminology; information on diversity and different forms of sexual orientation and gender identities; strategies to embed LGBTQ+ identities in general curricula; and discussions on the specific stigma and discrimination that LGBTQ+ adolescents face and how that impacts on their health (Domínguez-Martínez & Robles, 2019).

We must commit to incorporating tools to change attitudes and speak out openly about emotional education, sexuality, embodiment, sexual orientations, gender identities, and the deconstruction of gender roles and stereotypes. There are now excellent guides and tools for incorporating these questions into the curriculum to help make transgender adolescents visible and, above all, to teach their peers to respect and validate their experiences. To cite but a few examples of good materials to help incorporate transgender identities: the guidelines *Somos Diversidad* (Pichardo & de Stéfano, 2020), and *Sexualidad. Cuerpos, identidades y orientaciones* (N. Parra, 2018), and the books *How to Understand Your Gender: A Practical Guide for Exploring Who You Are* (M.-J. Barker & Iantaffi, 2017) and *Trans*exualidades: Acompañamiento, factores de salud y recursos educativos* (Platero, 2014).



One of the immediate implications of implementing these changes to affective-sexual, bodily, and gender diversity plans is the prevention of homophobic and transphobic bullying. Nevertheless, the results of this dissertation revealed the urgent need to undertake intervention programmes in the school context to combat the problem of bullying. Perhaps some of the first strategies we could consider would be to provide resources for victims to cope with bullying, such as spaces to report the aggression. Another measure might be punishing all forms of violence and bullying based on sexual orientation or gender identity (Domínguez-Martínez & Robles, 2019; Shattuck et al., 2021), for example through restorative justice programs (Orr & Baum, 2015).

Nevertheless, to prevent bullying episodes and uphold a safe school environment we must bear in mind the systemic approach. That is, teachers, counsellors, school principals, and administrative staff should be trained to deal appropriately with the needs of transgender students, to intervene in cases of aggression, and to change the school culture. This consists of reviewing the curricula and teaching the diversity of gender and sexuality, promoting the use of non-sexist language, or building bonds with others agents present in the lives of transgender students, such as their families or community and health services (Abreu et al., 2020; Birnkrant & Przeworski, 2017; Shattuck et al., 2021; J. D. Simons et al., 2018).

Emphasising the importance of training for professionals who work with transgender adolescents cannot be limited to the school context. Lack of knowledge about transgender people and their demands and attitudes of rejection or indifference can be observed in undergraduate students (Ozamiz-Etxebarria et al., 2020) and teaching staff (Fernández Hawrylak et al., 2020) from different knowledge areas. There is still a lack of specific training on sexual and gender diversity in the university system in Spain, which subsequently has an impact on the quality of the job that future professionals will perform (Pichardo & Stéfano, 2019). Then, an important task would be to increase knowledge and awareness of gender diversity and transgender people among future professionals, especially in sectors that are closely related to the lives of transgender people, such as health, in order to avoid transphobic attitudes or errors in professional practice against the dignity and well-being of transgender people.

In the case of health professionals, if they do not first deconstruct their gender bias based on the binary and cis-hetero-normative system, they might use terms and repeat clinical practices that are pathologizing and contrary to human rights (Gasch-Gallén et al., 2021). What is more, over the last decade, protocols and diagnostic labels have changed, and health professionals must know that new protocols to address the needs of transgender people provide



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comprehensive information about the risks of treatments and interventions, the opportunity to ask questions, and respect for autonomy in decision-making (Suess Schwend, 2020). Hence the need for the public health system to include compulsory formation for health professionals on terms, concepts, and health needs related to transgender topics, and on how to approach LGBTI people in an inclusive way (Organisation for Economic Cooperation and Development, 2020).

Health, education, and legal professionals can play an important role in building a society based on human rights and depathologization that acknowledges and respects diversity (Suess Schwend, 2020). From these arguments, one could conclude that we should commit to reducing prejudice and discrimination against transgender adolescents in their social environments and to enhancing the support from and for families, schools, and health care providers (Veale, Watson, et al., 2017).

14.3 Transgender laws

From the macrolevel ecological system, individual's development is also influenced by factors such as the economy, politics and laws. Especially regarding factors at this level, the design of laws that directly protect the rights of transgender people in Spain are an essential dimension affecting their experiences. In this respect, we will describe some national and regional laws, as well as laws designed for the protection of the LGBTQ+ community and laws specifically aimed at the transgender community.

Until 2021, 17 regional laws have been approved in Spain to provide protection for the rights of LGBTI people or transgender people specifically. These are the laws of 13 Autonomous Communities: Basque Country, Galicia, Andalusia, Catalonia, the Canary Islands, Extremadura, Madrid, Murcia, the Balearic Islands, the Valencian Community, Navarre, Aragon, and Cantabria. Of these 17 laws, 11 are for the LGBTI community and 6 are transgender laws. In Andalusia, Aragon, Valencia, and Madrid there are both LGBTI laws and transgender laws (López, 2020; Platero, 2020). FELGTBI+ (2020) launched a report comparing levels of protection for transgender children and youth in the education system in the 17 Spanish regions. The report found that Navarre, Valencian Community, and Aragon had the highest level of protection, and that in Cantabria, Castile La Mancha, Castile and y Leon, La Rioja, Asturias, and Ceuta and Melilla, transgender minors have no legal protection against transgender discrimination (ILGA-Europe,



2021a). Another relevant fact is that only 10 out of 17 regions have prohibited conversion therapy (Transgender Europe, 2021a).

The current national transgender legislation 3/2007 (Ley 3/2007) establishes restrictive conditions in order to change one's name and sex on identification cards and official documents: transgender people are not required to undergo genital surgery to legally change their gender status, but they must gain the diagnosis of gender dysphoria disorder and must receive at least two years of hormone treatment (Fernández-Rouco et al., 2018; Platero, 2020).

In the last five years we have witnessed a public debate on the development and passage of a national transgender legislative proposal that would have allowed legal gender recognition based on self-determination. The proposed reform 122/000133 would have eliminated the requirement for medical or psychological evidence to modify one's legal gender identity, and would have also allowed non-binary and blank gender markers on identity documents, upheld children's self-determination by allowing children and adolescents access to legal gender recognition. However, the proposal was rejected by the Spanish Congress of Deputies on May 2021 (Human Rights Watch, 2021).

It is striking that one of the reasons for the rejection of this proposal by both left- and right-wing parties was the consideration of gender self-determination (López, 2021), when 11 regional laws use the term gender self-determination and 12 regional law stipulate there is no need to pass medical examinations or undergo treatment—the 2014 Andalusia law was the first to introduce the right to self-determination, and to remove the requirement for psychological treatment or medical procedures in the gender recognition process (Fernández-Rouco et al., 2018; López, 2020).

A new draft on Full and Effective Equality for transgender people and for the guarantee of LGBTI rights, prepared by the Ministries for Equality and Justice, is under development after the rejection of the previous proposal (Gobierno de España, 2021). The aims of the future law are: 1) to guarantee real and effective equality of LGBTI people; 2) to prevent and eliminate all types of discrimination against the LGBTI community; 3) to establish the registry rectification of the sex and name of individuals (Council of Ministers, 2021). Regarding the third objective, the future law will recognize the right to gender self-determination. For this purpose, transgender people will be recognised by the authorities without any psychiatric report being required. The change of legal sex will be contemplated from the age of 12, with different procedures for minors to change sex in the registry according to the maturity and stability of the applicants (Council of Ministers, 2021). Although this draft preserves the spirit of the previous proposed



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reform, certain groups, such as non-binary people, are not eligible for recognition of their identity. That is, non-binary people will be helpless because they will not be offered a blank space on their official documents, and the Government withdrew its commitment to prepare a report on how the Spanish legal system would be amended to recognise non-binary gender identities (FELGTBI+, 2021; López, 2021).

From this overview of the state of laws in Spain, some conclusions can be drawn. The heterogeneity of legislation across the regions of the country contributes to strong inequalities. Some adolescents may have access to laws that recognize gender self-determination in the regions they live, while others do not. Likewise, some adolescents are protected by anti-discrimination policies, but others are exposed to government-approved mechanisms that compromise their safety (such as the use of the parental veto).

Law-making in our country needs to be consistent with other international guiding principles that protect the rights and welfare of transgender adolescents. For example, the principles of Yogyakarta (International Commission of Jurists, 2007, 2017) are not legally binding but are an outstanding international tool to identify, respect, and protect human rights referring to sexual orientation and gender identity. Principle 3 defines that gender identity is one of the most important aspects of self-determination, so people must not undergo medical procedures against their will as a requirement for legal recognition. Principle 16 defends that everyone has the right to education, and laws must protect students against all forms of social exclusion and violence, including bullying. Moreover, Principle 31 posits that everyone has the right to legal recognition.

Another notable regulatory standard is the LGBTIQ Equality Strategy 2020-2025 (European Commission, 2020), which advocates that Member States must tackle discrimination against LGBTIQ people, ensure LGBTIQ people's safety, build LGBTIQ inclusive societies, and lead the call for LGBTIQ equality around the world. Some of the objectives of this European commitment are to improve legal protection against discrimination; fighting inequality in education, health, culture, and sport; reinforcing legal protection for LGBTIQ people against hate crimes, hate speech and violence; promoting LGBTIQ people's physical and mental health; ensuring rights for LGBTIQ people in cross-border situations; and improving the recognition of trans and non-binary identities, and intersex people.

Despite the good intentions behind documents such as those described in the previous paragraph, there is still much to fight for. According to data from Transgender Europe, of the 39 countries where legal gender recognition is available, 28 countries in Europe and Central Asia



still require a mental health diagnosis for the legal gender recognition of transgender people, as occurs in Spain (Transgender Europe, 2021d). Other data show that transgender people remain unprotected: out of 39 countries, 28 countries protect transgender people against discrimination in accessing goods and services; 27 of the reviewed countries protect against discrimination in education based on gender identity; 24 countries prohibit discrimination in health on grounds of gender identity; 20 countries have laws that prohibit hate crimes against transgender people; and 15 countries provide protection on the grounds of gender expression (Transgender Europe, 2021c).

In hopes of being a fair and equal society now and in the future, we expect the results provided by this thesis will serve to develop policies and laws that come together in one common framework for action with the ultimate aim of protecting the rights and ensuring the well-being of transgender adolescents in this country.

14.4 2030 Agenda

The 2030 Agenda sets out a wide range of economic, social, and environmental objectives to foster more inclusive societies, more sustainable development, and a better future for all people (UN General Assembly, 2015). In this regard, this doctoral thesis provides information to address some of the Sustainable Development Goals (SDG) in order to promote the health and safety of transgender adolescents.

As discussed throughout the thesis, transgender people are exposed to situations of violence, stigma, and discrimination that have a negative impact on their health and adjustment. This calls for action to analyse how we can ensure and enhance access to the healthcare and justice system in a sensitive and appropriate way that can meet their needs.

SDG 3 focuses on ensuring healthy lives and promoting well-being for all at all ages. First, one of the recommendations that all member states must apply is to collect data disaggregating by sexual orientation, gender identity and expression, and sex characteristics (The Global Forum on MSM & HIV & OutRight Action International, 2017). Second, the findings presented in this thesis underpin the importance of developing policies and strategies to prevent and treat non-communicable diseases (e.g., mental health conditions), as well as promote well-being, corresponding to target 3.4. Third, as we also emphasize in this section, access to healthcare services of any kind must be ensured for transgender adolescents to address any of their needs,



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from primary care to gender-affirmation services—considered essential services for transgender people. The achievement of universal health coverage is covered by target 3.8 (The Global Forum on MSM & HIV & OutRight Action International, 2017; Theron, 2020).

SDG 10, dedicated to reducing inequality within and among countries, and SDG 16, linked to the promotion of inclusive societies for sustainable development, are key goals which summarize the urgent need to fight against social discrimination and inequalities through access to justice for all. We hope that the findings presented in this dissertation will reinforce the claim to empower social inclusion and promote equal opportunities for transgender adolescents, through equal access to justice for all, the design of policies, or the elimination of discriminatory laws, as outlined in target 10.2, 10.3, and 16.3 (Colina-Martín, 2021).

Although the spirit of the agenda is “to respect, protect, and promote human rights and fundamental freedoms for all, without distinction of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, disability, or other status” (UN General Assembly, 2015, p. 6), we feel it is necessary to draw particular attention to SDG 5. This objective presents the commitment to achieve gender equality and empower all women and girls. Achieving gender equality and recognising the discrimination to which women are subjected must be a paradigm present in the design of any policy or intervention. Although more progress has been made in gender equality over the last decades, many barriers remain, such as the under-representation of women in power and leadership positions, or the experience of physical or sexual violence (United Nations, 2021b). Showing our greatest respect and agreement with this goal, it might possibly be interpreting gender equality through the lenses of cisnormativity and heteronormativity (Matthyse, 2020). We hope that any gender policy that advocates for real and effective equality will also take into account transgender adolescents.



14.5 Conclusions

At a time when there is a simultaneous rise in social awareness of the reality of transgender people and a questioning of their rights and existence, this thesis offers a global picture of the health of transgender youth in Spain. After positioning ourselves in the minority stress model but trying to adopt a positive approach, the results of this dissertation contribute by highlighting the diversity and heterogeneity among binary and non-binary transgender identities. We hope that this new contribution can serve to validate the experiences of transgender adolescents, encourage new research lines from a sensitive, positive and strength-based approach to analyse and understand the health of transgender adolescents, and we also hope that this work will serve to detect areas of vulnerability and strength in order to develop evidence-based interventions and policies aimed to enhance their well-being.



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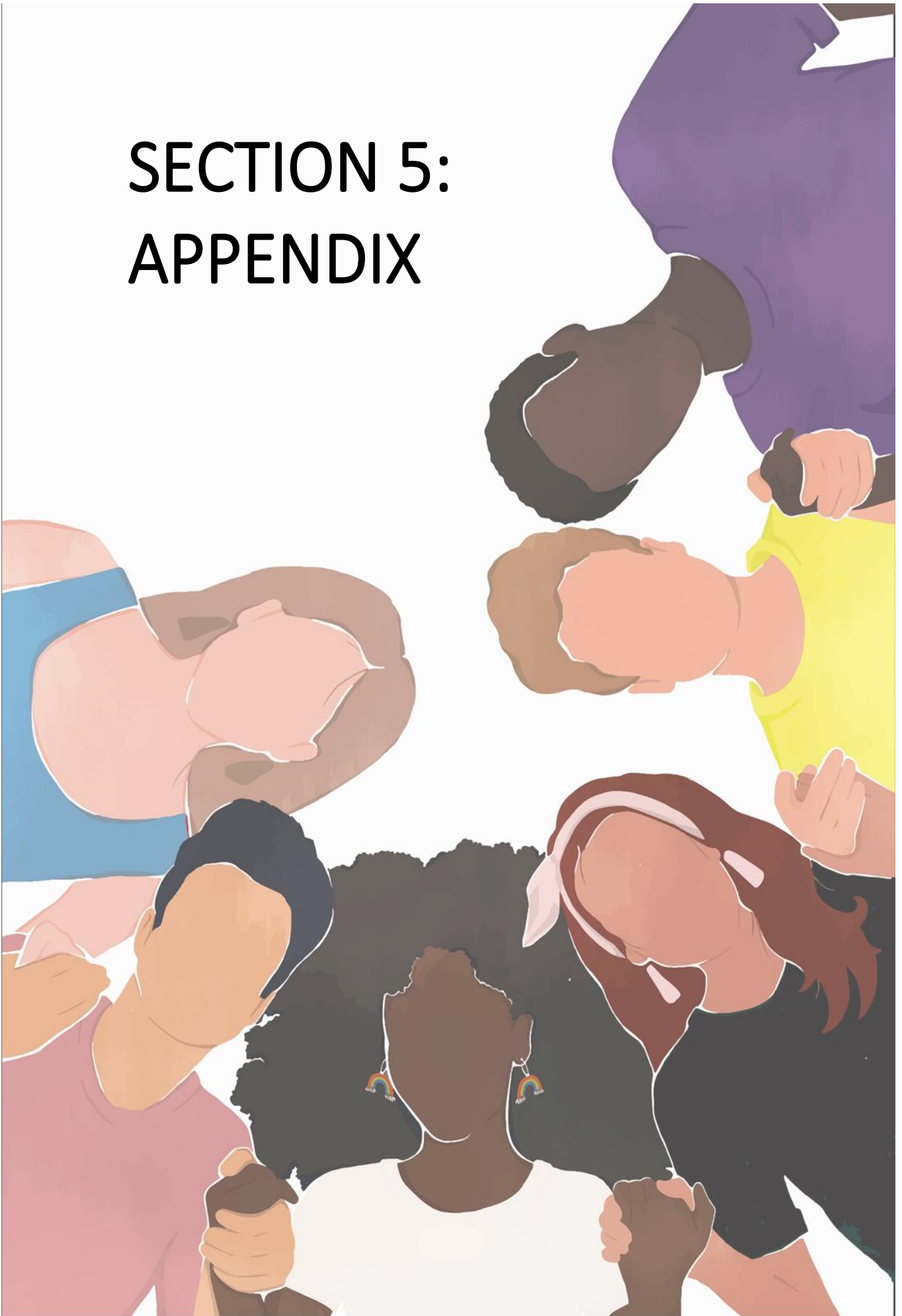
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SECTION 5: APPENDIX



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Appendix 1. Recomendaciones para codificar la identidad de género

Algunas cuestiones sobre las estrategias de codificación:

Cuando un participante no ha notificado su identidad percibida (pero sí su sexo), se ha dejado en blanco la respuesta (perdido).

Yo intento revisar las respuestas abiertas y compararlas con la forma en la que han contestado el cuestionario por si existiese la posibilidad de rescatar la pregunta. Es decir, si ya se ha procedido a una limpieza de sujetos que han contestado de forma jocosa o errónea y este participante ha pasado la criba, entiendo que posiblemente su respuesta a la pregunta de identidad percibida es honesta (por ejemplo, si selecciona una de las opciones cerradas o en la de opción abierta responde cosas como su nombre o su orientación sexual). Otro caso es el de los que responden burradas, pero esos directamente se codifican como perdidos porque se percibe claramente que no han contestado correctamente con conocimiento.

Pero hay estudios que intentan rescatar muestra y dan por sentado que si solo se notifica el sexo se puede entender que es cisgénero (yo no lo haría). También hay contenidos de la pregunta abierta que puede permitir identificar la identidad de género. A veces lo dicen de forma clara, pero otras veces se puede deducir por lo ofensivo o conservador que es su comentario. Yo he codificado la pregunta y rescatado el contenido cuando de forma educada indican su identidad (por ejemplo, cuando hacen una broma simpática o dicen sus nombres), pero cuando insultan sin dar más datos (por ejemplo, critican la ideología de género, insultan al colectivo trans...) lo he dejado como valor perdido. Es decir, en este segundo caso es una suposición (y creo que no me equivocaría), pero es "reinterpretar" el contenido sin un dato claro.

En la literatura hay cientos de términos. Nosotras apelamos a un criterio conservador (otra vez) en el que usamos categorías muy globales. Trans(género) es el "término paraguas", donde se recogen identidades binarias (chico que se identifica como chica) y no binarias (no me identifico, no estoy seguro, soy queer...) Hablamos de género no binario, pero puede haber investigadores que digan que lo queer, lo agénero o lo "no conforme" son categorías independientes. De todas maneras, desde lecturas de la APA, manuales sobre género y colectivo LGBTQ+..., está justificado hablar de identidades binarias y no binarias dentro de lo trans

Al final yo analizo los datos de las personas que informan correctamente de su identidad, pero hay investigaciones muy interesantes sobre las razones por las que hay valores perdidos (no entienden la pregunta, no quieren contestar...).

Propongo en la tabla una serie de etiquetas que van desde lo más específico (por ejemplo, chica transgénero) a lo más global (transgénero). Como verás, en los casos de "transgénero no binario" intento no usar los sustantivo binarios "chico/chica" porque no representan del todo a este colectivo.



APPENDIX 1

Sexo	Identidad percibida	Propuesta codificación
Chica	Me identifico como chica	Chica cisgénero Cisgénero
Chica	Me identifico como chico	Chico transgénero Transgénero binario Transgénero
Chica	No me identifico ni como chico ni como chica	Agénero Transgénero no binario Transgénero
Chica	Otros: comentarios o bromas de los que se puede extraer información coherente <ul style="list-style-type: none"> • Bromas: Como la diva que no es valorada • Comentarios: identificome como chica pero como todas; me identifico como chica pero me comporto como un chico • Nombres: maria de los ángeles, me identifico como Laura 	Chica cisgénero Cisgénero
Chico	Me identifico como chico	Chico cisgénero Cisgénero
Chico	Me identifico como chica	Chica transgénero Transgénero binario Transgénero
Chico	No me identifico ni como chico ni como chica	Agénero Transgénero no binario Transgénero
Chico	Otros: comentarios o bromas de los que se puede extraer información coherente <ul style="list-style-type: none"> • Bromas: me siento un helicoptero de combate nahh un chico • Comentarios: <ul style="list-style-type: none"> ○ me identifico como persona, a parte de chico. ○ un chico que se siente chico y es homosexual, osea que le gustan otros chicos. ○ Me identifico como chico homosexual ○ soy chico y ya está o eres chico o chica ni identificarse ni nada se es como se nace. ○ Me identifico como hombre. • Nombres: soy arturo rodriguez 	Chico cisgénero Cisgénero
Chico/Chica	Otros: respuestas extrañas <ul style="list-style-type: none"> • Formas despectivas de travestismo y orientación sexual: <ul style="list-style-type: none"> ○ Travelo, travesti, me identifico como marica mala. • Animales: <ul style="list-style-type: none"> ○ perro, león, rana, pez, marmota, mariposa, unicornio, velociraptor. • Personajes famosos (ficción o reales): <ul style="list-style-type: none"> ○ Chewbacca, Pikachu, Cardi B., Saiyan, Goku, Dios, Jesucristo, Donkey Kong, Naruto, Ironman, Batman • Vehículos: <ul style="list-style-type: none"> ○ helicóptero de combate, submarino, vehículo de guerra, buque de guerra, tanque, panzer, tractor. • Aleatorios, bromas: <ul style="list-style-type: none"> ○ republicano, reptiliano, porrero, extraterrestre, alien, entrenador Pokemon, gamer, hombre pelo en pecho arraigado en España, híbrida, el puto amo, un 	Incoherente (insultos, aleatorio,...) Valor perdido



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	<p>macho alfa, desgracia humana, cono de tráfico naranja no binario, soy un ser inmaterial</p> <ul style="list-style-type: none"> • No entiende la pregunta o da respuesta demasiado ambigua: <ul style="list-style-type: none"> ○ Respecto a este tema no tengo una opinión concreta ○ Confusa ○ Es pronto para saberlo ○ Abierto a todo, se aceptan propuestas... ○ Soy un ser vivo ○ A mi bola • Críticas a la pregunta: <ul style="list-style-type: none"> ○ identificarse no cambia la realidad ○ QUE OS IMPORTA A VOSOTROS PAYASOS ○ No estoy enfermo ○ Esto me parece vegonzoso, solo existe la posibilidad de ser hombre o mujer, la ideología de género ○ Otros? omegaLUL igual con esa pregunta soy una persona superior ○ Creo que no se debería clasificar de esta forma 	
Chico/Chica	<p>Otros: confunden con orientación sexual</p> <ul style="list-style-type: none"> • Heterosexual • Gay/Lesbiana • Soy bisexual • Asexual en cuanto a humanos se refiere 	<p>Orientación sexual Valor perdido</p>
Chico/Chica	<p>Otros: confunden con intersexualidad</p> <ul style="list-style-type: none"> • Soy intersexual (Síndrome de insensibilidad a andrógenos) 	<p>Intersexualidad Valor perdido</p>
Chico/Chica	<p>Otros: etiquetas sobre género</p> <ul style="list-style-type: none"> • Ausencia de etiquetas: <ul style="list-style-type: none"> ○ Indefinido ○ Soy quien yo quiero ser ○ Me identifico como persona ○ Me identifico como una persona porque no me gustan las etiquetas ○ Me identifico/siento como chica y chico; me identifico en parte chico y en parte chica; como chico a veces y otras como chica ○ Me siento chica en mayor parte pero tengo otra parte de otro genero que no es ni chico ni chica ○ Ambos; me identifico como ambos sexos/géneros ○ Mi género fluye entre las distintas identidades ○ Ni como chico ni como chica, me identifico como persona. • Etiquetas no binarias: <ul style="list-style-type: none"> ○ Género fluido ○ Queer ○ Gracias a la teoría "Queer" me identifico como "yo" sin tener que especificar ni sexo ni género ○ Soy una persona no binaria, soy una identidad no binaria 	<p>Transgénero no binario Transgénero</p>



Appendix 2. Guidelines to code gender identity

Some details and issues for coding the gender identity's open-ended question

When a participant did not report her/his/their perceived identity (but their gender), the data has been left blank (missing value).

If I have doubts about the answer (e.g., it might be a joke), I review all the open-ended items in the survey. Francisco Rivera always performs an exhaustive protocol to withdraw (spoil, delete?) the subjects that did not answer properly the survey. So, if we are coding the answer of the gender identity question after the data cleaning I can guess that we can (almost) trust the subject (e. g., if the subject write his/her/their name or sexual orientation).

There are also contents in the open-ended question that may allow identifying the gender identity of the adolescents. Sometimes they say something clearly (e. g., "I'm queer"), but other times it can be deduced by how offensive or conservative their comment is. I have coded the answer when they politely indicated their identity (for example, when they make a nice joke or say their names).

Answers like rude jokes or transphobic comments show that the subject did not answer properly to the item, so is coded as missing value (for example, they criticize the "gender ideology" or they insult the Trans community).

There are hundreds of concepts, tags or labels. We prefer to keep a conservative approach using general or global categories. Trans(gender) is the "umbrella term", where binary identities (boy who identifies as a girl) and non-binary identities (I do not identify myself, I am not sure, I am queer...) are included... We talk about "non-binary gender", but it could be queergender or "nonconforming". Anyways, different handbooks and guidelines let us talk about binary and non-binary identities within the trans community.

I offer in the next table a way to code the two-steps approach gender identity's question, from the most specific label (for example, "transgender girl") to the most global one ("transgender"). As you will see, in the cases of "non-binary transgender" I try not to use the binary nouns "boy/girl" because they do not fully represent this group.

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Sex	Perceived gender identity	Coding
Girl	I identify myself as a girl	Cisgender girl Cisgender
Girl	I identify myself as a boy	Transgender boy Binary transgender Transgender
Girl	Other: comments or jokes from where you can get some coherent information <ul style="list-style-type: none"> Jokes: "Like the dive who is underrated" Comments: "I identify myself as a girl, just like everybody"; "I identify myself as a girl, but I behave like a boy" Names: "María de los Ángeles"; "Laura" 	Cisgender girl Cisgender
Boy	I identify myself as a boy	Cisgender boy Cisgender
Boy	I identify myself as a girl	Transgender girl Binary transgender Transgender
Boy	Other: comments or jokes from where you can get some coherent information <ul style="list-style-type: none"> Jokes: "I identify as an Attack Helicopter... just kidding, as a boy" Comments: <ul style="list-style-type: none"> I identify myself as a person, in addition to as a boy A boy who feels like a boy and is homosexual, that is, he likes other boys I identify myself as a homosexual boy I'm a boy and it's enough. You are a boy or a girl, you don't identify, you are how you born I identify myself as a man Name: "I'm Arturo Rodríguez" 	Cisgender boy Cisgender
Girl/Boy	I identify myself neither boy nor girl	Agender Non-binary transgender Transgender
Girl/Boy	Otros: uncategorized answers <ul style="list-style-type: none"> Derogative ways to talk about sexual orientation or transvestism, drag or sexual orientation: <ul style="list-style-type: none"> Tranny, transvestite, fag, gaylord... Animals: <ul style="list-style-type: none"> dog, lion, frog, fish, groundhog, butterfly, unicorn, velociraptor, dinosaur... Famous people, personalities, celebrities (fictional or real): Chewbacca, Pikachu, Cardi B., Saiyan, Goku, God, Jesus Christ, Donkey Kong, Naruto, Ironman, Batman Vehicules: <ul style="list-style-type: none"> Attack helicopter, submarine, war vehicle, warship, tank, panzer, tractor... Jokes: <ul style="list-style-type: none"> Republican, Reptilian, joint smoker, Extraterrestrial, Alien, Pokémon Trainer, Gamer, "Macho Man in Spain", Hybrid, "The Fucking Master", Alpha Male, "non-binary orange traffic cone", "I am an immaterial creature" 	Incoherence (strong language, insults, random answers...) Missing value



APPENDIX 2

	<ul style="list-style-type: none"> • They do not understand the question, or the answer is too ambiguous: <ul style="list-style-type: none"> ○ “Regarding this topic, I don't have a specific opinion” ○ “Confused” ○ “It is early to know” ○ “I'm open to everything, proposals are accepted...” ○ “I'm a living being” ○ “I'm doing my own thing” • Criticism to the question: <ul style="list-style-type: none"> ○ “Identifying doesn't change the reality” ○ “What matters to you, moron” ○ “I'm not sick” ○ “To me, this question is shameful: there is only the possibility of being a man or a woman, gender ideology” ○ “Others? omegaLUL, with this question I might be a superior person” ○ “I think it should not be classified in this way” 	
Girl/Boy	Other: confusing with sexual orientation <ul style="list-style-type: none"> • Heterosexual • Gay/Lesbian • Bisexual • Asexual 	Sexual orientation Missing value
Girl/Boy	Other: confusing with intersexuality <ul style="list-style-type: none"> • “I'm intersexual (Androgen insensitivity syndrome)” 	Intersexuality Missing value
Girl/Boy	Otros: gender tag/label/category <ul style="list-style-type: none"> • Absence of labels: <ul style="list-style-type: none"> ○ “Undefined” ○ “I am who I want to be” ○ “I identify myself as a person” ○ “I identify myself as a person because I don't like labels” ○ I identify / feel like a girl and a boy; I identify myself partly boy and partly girl; sometimes as a boy and sometimes as a girl ○ “I feel like a girl the most of the time, but I have another part of myself, another gender, that is neither boy nor girl” ○ Both; I identify myself as both sexes/genders ○ My gender flows between different identities ○ “Neither as a boy nor as a girl, I identify myself as a person” • Non-binary labels: <ul style="list-style-type: none"> ○ “Gender Fluid” ○ “Queer” ○ Thanks to the “Queer theory” I identify myself as “I” without having to specify either sex or gender ○ “I am a non-binary person”; “I am a non-binary identity” 	Non-binary transgender Transgender



Appendix 3. Other paper and poster presentations

This appendix lists other publications done by the doctoral candidate which have been produced during the doctoral thesis time although are not relate to the topic of the doctoral dissertation.

Gender and inequality in the University of Seville

Majón-Valpuesta, D., Luna, S., Moreno-Maldonado, C., & **Ciria-Barreiro, E.** (2021, September 15-17). Is the university a real egalitarian space? Experiences of gender discrimination in the university community from a transgenerational and interprofessional perspective [Paper presentation]. XI European Conference of Gender Equality in the Higher education, online.

Moreno-Maldonado, C., Majón-Valpuesta, D., Luna, S., & **Ciria-Barreiro, E.** (2021, July 9-11). Propuestas de medidas de intervención para prevenir y reducir la discriminación por razón de género en el contexto universitario: Una reflexión conjunta con los agentes implicados. [Poster presentation]. V Congreso Nacional de Psicología and International Symposium on Public Health Psychology, online.

Luna, S., **Ciria-Barreiro, E.**, Majón-Valpuesta, D., & Moreno-Maldonado, C. (2021, May 26-29). "Detecta y reacciona": reflexiones de la comunidad de la Universidad de Sevilla sobre los mecanismos subyacentes a la discriminación por razón de género. [Paper presentation]. II Congreso Internacional de Diversidad Sexual y Género en la Educación, la Filología y las Artes, online.

HBSC Study

Moreno, C., Rivera, F., Ramos, P., Sánchez-Queija, I., Jiménez-Iglesias, A., García-Moya, I., Moreno-Maldonado, C., Paniagua, C., **Ciria-Barreiro, E.**, Villafuerte-Díaz, A. & Leal-López, E. (2019, June 18-20). The process of knowledge transfer in the Spanish HBSC Study: A challenge to transmit information to society [Poster presentation]. HBSC Spring Meeting, Reykjavik, Iceland.

Opinion Barometer of Childhood and Adolescence (UNICEF project)

Ciria-Barreiro, E., Moreno-Maldonado, C., Rivera, F., and Moreno, C. (2021, November 10-12). Health assets in transgender adolescents: The role of socio-political engagement and competence. In A. Költő (Chair), Developmental assets and resilience in gender minority youth: Towards a balanced research agenda network [Symposium]. 14th European Public Health Conference 2021, online.

Ciria-Barreiro, E., Moreno-Maldonado, C., Luna, S., & Majón-Valpuesta, D. (2021, September 15-17). Gender gap in adolescents expectations of future occupations and sociopolitical participation: The contribution of personal wellbeing, concerns with social issues, and social efficacy to reproducing inequalities [Paper presentation]. XI European Conference of Gender Equality in the Higher education, online.

Ciria-Barreiro, E., Moreno-Maldonado, C., Luna, S., & Rivera, F. (2021, August 11-13). Gender Identity and civic behaviours: direct and indirect effects on health-related quality of life of the transgender adolescents in Spain [Paper presentation]. 4th EPATH conference, online.

Moreno-Maldonado, C., **Ciria-Barreiro, E.**, Luna, S., & Rivera, F. (2020, December 3-5). Identifying sex and gender diversity in adolescents surveys: An analysis of the results from the Health Behaviour in School-Aged Children (HBSC) and the OPINA Barometer project in Spain. In J. Inchley (Chair), Sex, gender and gender identity: reflections and



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discussions in the Health Behaviour in School-Aged Children international network [Symposium]. 12th Excellence in Pediatrics Virtual Conference 2020, online.

Moreno, C., Luna, S., Ramos, P., Moreno-Maldonado, C., **Ciria, E.**, Salado, V. y Rivera, F. (2019, May 9-11). El Barómetro de Opinión de la Infancia y Adolescencia (OPINA): una iniciativa para la valoración de sus preocupaciones y opiniones sociales y políticas [Poster presentation]. V Congresso Ibero Americano e Luso Brasileiro de Psicologia da Saúde and I Congresso Promoção da Saúde e do Bem-Estar, Faro, Portugal.

Moreno-Maldonado, C., Abate, M., García-Moya, I., **Ciria-Barreiro, E.**, Villafuerte-Díaz, A., Rivera, F. & Moreno, C. (2018, June 22-23). Development of Spanish Children's Opinion Barometer: an instrument to explore adolescents' perspectives as citizens [Poster presentation]. HBSC Spring Meeting, Warsaw, Poland.

Abate, M., García-Moya, I., Sánchez-Queija, I., Moreno-Maldonado C., **Ciria-Barreiro, E.**, Moreno, C., & Ramos, P. (2018, September 12-15). Main factors contributing to well-being in adolescence. A qualitative study [Poster presentation]. XVI Biennial EARA Conference, Ghent, Belgium.

Other topics

Ciria, E., Andrés-Villas, M., Moreno-Maldonado, C., Ramos, P., Salado, V., & Rivera, F. (2018, November 7-9). ¿Cómo medir la satisfacción vital? Comparación de cuatro escalas diferentes de satisfacción vital en población universitaria [Poster presentation]. I Congreso de Universidades Promotoras de Salud. Modelos y entornos para capacitar y transferir en salud, Palma de Mallorca, Spain.

Ciria-Barreiro, E., Jiménez-Iglesias, A., Paniagua, C., Villafuerte, A., Leal-López, E., Moreno, C. & Rivera, F. (2018, September 12-15). Association between stressful life events and life satisfaction: the positive moderating effect of sense of coherence on adolescent's health [Poster presentation]. XVI Biennial EARA Conference, Ghent, Belgium.

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ÁMBITO- PREFIJO

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Trato de salir de mi mente

Me esfuerzo por desaprender

Recorro el camino inverso

Busco el origen

Busco algo ahí fuera

Dorian – Los amigos que perdí (La velocidad del vacío, 2013)



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