NEW RESEARCH SEXUALITY & GENDER

Check for updates

The Role of Resilience and Support From Others in the Association Between Family Support and Internalizing Symptoms in Spanish-Speaking Trans and Nonbinary Youth

Aitor Jiménez-Granado[a,*], PhD, Sara Rodriguez-Gonzalez[a], MSc, Ángel Prieto-Fidalgo[a], PhD, Laura Molina[a], MSc, Esther Calvete[a], PhD

Objective: The family support of trans and nonbinary (TNB) youth is usually the lowest perceived source of support, which is associated with higher internalizing symptoms. In this study, we examined whether other sources of support and individual-level resilience might compensate for the lack of family support in the development of symptoms.

Method: A total of 225 Spanish-speaking (74.7% Spaniards) TNB youths (59.56% men, 13.78% women, and 26.67% nonbinary) between 12 and 25 years of age (mean age = 20.45 years, SD = 2.50 years) completed measures of family support, support from friends, support from a "special person," individual-level resilience, and internalizing symptoms. The relationships were assessed through path analysis.

Results: Family support was the lowest perceived source of support. The path analyses revealed that family support ($b = –0.16$, $p = .002$), support from friends ($b = –0.12$, $p = .016$), and individual-level resilience ($b = –0.25$, $p < .001$) were negatively related to internalizing symptoms. In particular, family support was associated with lower levels of internalizing symptoms when individual-level resilience was high ($b = –0.29$, $t = –4.54$, $p < .001$) and in younger individuals ($b = –0.24$, $t = –3.37$, $p = .001$).

Conclusion: Although family support is strongly related to lower internalizing symptoms among TNB youth, this study showed that individual-level resilience is a moderator of this relationship. Although a causal pathway cannot be established, interventions should strengthen both family support and individual-level resilience to help TNB youth improve their internalizing symptoms.

Plain language summary: This study evaluated how family support affects mental health issues in trans and nonbinary (TNB) youth, focusing on 225 Spanish-speaking individuals aged 12 to 25. Family support was the least-perceived source of support among participants. However, when present, family support was linked to lower mental health concerns. This relation was mediated by resilience. These findings suggest that boosting both family support and resilience could help TNB youth manage mental health challenges.

Key words: TNB; youth; internalizing symptoms; social support; resilience

JAACAP Open 2025;3(4):1098-1106.

Transgender, or trans, is the term to describe individuals who do not identify with the gender assigned to them at birth. Within the trans umbrella, people identify as either binary and nonbinary. On the one hand, binary individuals are individuals who undergo a gender transition from one specific gender to another, either male or female.[1] On the other hand, nonbinary individuals do not align with the traditional male or female categories. They may identify with both genders (as gender fluid individuals do), depending on the context, or with neither.[2] In addition, some nonbinary individuals may identify as trans, whereas others may not.[3] Although there is little information on the number of people who identify as trans or nonbinary (TNB),[4] some recent censuses have estimated that TNB people constitute about 0.33% to 0.8% of the population.[5,6] Among young people (<24 years of age), estimates reach as high as 1.4%.[4] As the numbers show, TNB people are a small minority in society.

As explained by Minority Stress Theory,[7] TNB youth, as a minority group, suffer from stress due to discrimination, stigma, and prejudice,[8,9] and this is associated with greater psychological problems.[10] Thus, in comparison to their cisgender peers, TNB youth exhibit higher levels of internalized symptoms, such as anxiety and depression,[11] as well as posttraumatic stress disorder symptoms.[12] Furthermore, a recent study found that younger TNB individuals experienced higher levels of internalizing symptoms than older individuals, making age a possible risk factor.[13]

Social support has been identified as one of the main protective factors against the development of internalizing

symptoms, especially in adolescents,[14] among TNB youth.[15] In particular, the literature has shown that social support is associated with less internalizing symptoms,[16] lower suicide risk,[17] and higher quality of life.[18] Social support comprises different social interaction contexts, such as peer or family support. Although TNB people are increasingly legally protected in Spanish-speaking countries, such as Spain and Argentina, they still face particularly high rates of family rejection.[19,20] This issue is especially problematic within this population, because recent studies indicated that family support is the form of support most closely associated with reduced internalizing symptoms in trans people.[21] Moreover, TNB children who are supported by their families exhibit mental health similar to that of their cisgender peers.[22] In fact, a lack of family support can limit access to gender-affirming care,[23] which is associated with poorer mental health.[24]

Given the relevance of family support and the difficulties often experienced by TNB youth in obtaining sufficient support from their families, it is important to identify other factors that may compensate in some way for deficits in family support. One such factor is support obtained from others outside the family environment (eg, friends, partner). For example, in a community sample of early adolescents, peer acceptance served to alleviate the detrimental effects of parental rejection on psychological adjustment.[25] Notwithstanding, this has not been yet tested with TNB youth. Regarding TNB youth, support from non–parent-specific forms of support has been shown to play a beneficial role in reducing internalizing symptoms, particularly, in adolescents.[26] In fact, one study found that whereas family support was associated with better psychological well-being, support from friends was significantly associated with all other domains of quality of life, including the social and environmental domains, and support from a special person was associated with better physical quality of life.[18] In addition, support from friends was found to mitigate the effect of victimization on internalizing symptoms,[15] and support from a special person mitigated the effect of discrimination on suicide attempts.[17]

Social support, from both family and other sources, has been considered a resilience factor, as it can contribute to an individual's adaptation in the face of adversity.[27] In general terms, resilience is a multilevel factor,[28] influenced by different systems surrounding the person and affecting them with different intensity.[29] In this sense, apart from the micro-system and meso-system factors, resilience encompasses many other aspects besides.[30] One such factor is the individual's personal ability to overcome adversity.[31] This type of individual-level resilience includes adaptive coping strategies, self-worth or pride, optimism, and self-efficacy beliefs.[32,33] Individual-level resilience has been shown to be an important factor offering protection against many hardships, and it may buffer the negative health implications of minority-related stress.[7] In this sense, identity pride[34] and self-competence[35] have been associated with lower levels of distress in TNB individuals. Moreover, a recent study showed that individual-level resilience might mitigate the effect of poor parent–child relationships on children's self-esteem and their exposure to peer victimization.[36] Therefore, when contextual-level resilience factors are lacking, individual-level resilience may help to actively promote TNB individuals' growth and psychological well-being.[37]

Current Study

TNB youth have high rates of mental health issues, particularly internalizing symptoms.[38] Although family support is among the most well-established factors associated with lowering of such symptoms in TNB youth, it is also the lowest commonly perceived source of support.[21] Other sources of support[15,17] and individual-level resilience[31,32] can also associate with lower internalizing symptoms in TNB individuals. Based on the results of previous studies, the objective of this study was to examine whether other sources of social support beyond the family, such as support from friends and/or a "special person," and resilience as a personal competence moderate the effect of family support on internalizing symptoms. In addition, we aimed to examine the moderating role of age in the relationship between family support and internalizing symptoms. We hypothesized that both sources of social support and individual-level resilience would mitigate the negative association between family support and internalizing symptoms, and that being younger would make family support more relevant. A secondary objective was to provide data about the perceived social support from several sources among TNB youth.

METHOD

Procedure

The Research Ethics Committee of the University of Deusto approved the project (REF: ETK-32/20-21). To carry out this study, 41 trans and LGBTIQ+ Spanish-speaking associations, mainly Spanish associations, were contacted. In addition, 67 influencers and LGBTIQ+ activists were contacted, 32 of whom helped by sharing the study through social media platforms and networks. All participants received information about the main objective and ethical aspects of the study. Confidentiality, voluntariness, and data anonymization were assured. Informed

consent was required before responding to the questionnaires. The questionnaires were completed online through Qualtrics and required between 15 and 20 minutes to complete. For minors interested in participating in the study, parental permission was requested. In particular, parents were required to email the researchers, who subsequently forwarded to them the informed consent form. Once the consent form had been completed, the link to the questionnaire was made available for the minors to access. Before responding to the questionnaires, the minors were also provided with the details of the study, and they had to agree and indicate their willingness to participate. Twelve 20-euro Amazon vouchers were raffled off to the study participants.

Participants

Table 1 presents the characteristics of the participants. Of 450 entries, 253 participants completed the online survey. Only TNB individuals under 25 years of age were selected (92.89% of the total completers), to maintain sample homogeneity. Of those 235, ten did not have answer the variable to be explained and therefore were eliminated. Thus, the final sample consisted of 225 participants. Of these, 134 (59.6%) were identified as trans boys/men, 31 (13.8%) as trans girls/women, 49 (21.8%) as nonbinary, and 11 (4.9%) as gender fluid (which fall under the nonbinary umbrella). The mean age of the sample was 20.45 (SD = 2.50) years and ranged from 12 to 25 years. Regarding countries of residence, 168 (74.7%) participants resided in Spain, 32 (14.2%) in Argentina, 10 (4.4%) in Mexico, 10 (4.4%) in Peru, and 5 (2.2%) in other countries. No differences were found between gender identification and mean age ($F_{3,221} = 0.91$, $p = .44$). In terms of achieved educational level, 11 participants had completed elementary school, 41 had completed middle school, 62 had completed high school, 38 had completed vocational training, 65 had a bachelor's degree, 6 had a master's degree, and 1 participant did not report.

TABLE 1 Sociodemographic Characteristics of the Sample

	n (%)
Gender identity	
Boys/men	134 (59.6)
Girls/women	31 (13.8)
Non-binary	49 (21.8)
Gender fluid	11 (4.9)
Country of residence	
Spain	168 (74.7)
Argentina	32 (14.2)
Mexico	10 (4.4)
Peru	10 (4.4)
Other countries	5 (2.2)
Highest educational level	
Elementary school	11 (4.8)
Middle school	41 (18.2)
High school	62 (27.6)
Vocational training	38 (16.9)
Bachelor's degree	65 (28.9)
Master's degree	6 (2.7)

Note: *Percentages do not sum to 100% because of rounding or missing data (one participant did not report information on educational level).*

Measures

The Spanish version[39] of the Depression, Anxiety, and Stress scale (DASS-21) was administrated to assess internalizing symptoms.[40] This self-report questionnaire consists of 21 items that assess depression (7 items; eg, "I have felt discouraged and sad"), anxiety (7 items; eg, "I have had tremors"), and stress (7 items; eg, "I have tended to overreact to situations") symptoms during the last month. A unidimensional factor was used for this study. The responses were given on a Likert-type scale, with 4 options ranging from 1 ("has not happened to me") to 4 ("has happened to me a lot or most of the time"). The Cronbach alpha coefficient for the unidimensional factor in this study was excellent ($\alpha = 0.96$).

Social support was assessed using the Spanish version[41] of the Multidimensional Scale of Perceived Social Support (MSPSS).[42] This self-report questionnaire consists of 12 items that measure family support (4 items; eg, "my family really tries to help me"), support from friends (4 items; eg, "my friends really try to help me"), and support from a special person (4 items; eg, "there is a special person with whom I can share sorrows and joys"). Responses are given on 7-point Likert-type scale ranging from 0 ("strongly disagree") to 6 ("totally agree"). The items of the 3 subscales are parallel and differ only in terms of the source of support. Cronbach alpha coefficients for family support ($\alpha = 0.91$), support from friends ($\alpha = 0.94$), and support from a special person ($\alpha = 0.95$) were excellent in this study.

The Spanish version[31] of the Brief Resilience Scale (BRS)[43] was used for the assessment of individual-level resilience. This questionnaire includes 6 items that assess the respondent's capacity to face and pull through adverse and stressful circumstances (eg, "I tend to recover quickly after a bad experience"). Responses are given on a 4-point Likert-type scale ranging from 0 ("strongly disagree") to 4 ("strongly agree"). The Cronbach alpha coefficient for the scale in this study was good ($\alpha = 0.83$).

Data analysis

Although results of the Little test of missing completely at random (MCAR) was not statistically significant

($\chi^2[5] = 5.60$, $p = .344$), multiple imputation (N = 100 samples) was used for the analysis. The study variables showed adequate ranges in terms of kurtosis and symmetry. The regression model was estimated with MPLUS-8.11 using the maximum likelihood method. The model included the total score for symptoms (anxiety, depression, and stress) as the outcome and scores for family support, support from friends, support from a special person, individual-level resilience, and age as explanatory variables. The model also included the interaction terms between family support and each of the other variables (support from friends, support from a special person, individual-level resilience, and age). To create the interaction terms, the variables were converted into Z scores. A post hoc power analysis for the model was conducted, resulting in 91.61%, 99.99%, and 100% to find small (0.05), medium (0.15), and large (0.35) effect sizes of correlation, respectively.[44]

RESULTS

Table 2 displays the correlation coefficients between the study variables and their main descriptive statistics. All variables except support from a special person and age were significantly associated with lower levels of internalizing symptoms. The correlation between support from friends and support from a special person was high ($r = 0.52$), suggesting some overlap between the two.

Table 2 also shows the mean scores for the study variables. In particular, the lower scores for family support compared to the other 2 sources of support stand out. A post hoc analysis of variance for related variables showed that the score for family support was significantly lower than the score for support from friends ($F_{1,224} = 149$, $p < .001$) and score for support from a special person ($F_{1,224} = 135$, $p < .001$). There was no statistically significant difference between support from friends and support from a special person ($F_{1,224} = 0.57$, $p = .450$).

The study hypotheses were then tested. The results of the regressive model are displayed in Table 3 and depicted in Figure 1. The model exhibited excellent fit indices: χ^2 (9, 225) = 10.64, $p = .301$; root mean square error of approximation (RMSEA) = 0.028 (90% CI = 0.00; 0.08), comparative fit index (CFI) = 0.98, Tucker–Lewis index (TLI) = 0.98, standardized root mean square residual (SRMR) = 0.031. Family support, support from friends, individual-level resilience, and age were significantly associated with lower levels of internalizing symptoms. However, support from a special person was not associated with internalizing symptoms. Moreover, the family support × individual-level resilience interaction was statistically significant, and the family support × age interaction was marginally significant. Figure 2 displays the form of the interaction for individuals high (+1 SD) and low (–1 SD) in family support and individual resilience. As can be observed, when resilience was high, family support was negatively associated with internalizing symptoms ($b = –0.29$, $t = –4.54$, $p < .001$). In contrast, when resilience was low, family support was not statistically associated with internalizing symptoms ($b = –0.03$, $t = –0.39$, $p = .695$). Similarly, in Figure 3, it can be observed that in younger participants family support was negatively associated with internalizing symptoms ($b = –0.24$, $t = –3.37$, $p = .001$), but this relationship was not significant for older participants ($b = –0.07$, $t = –1.02$, $p = .310$).

Because of the absence of a significant association of support from a special person and internalizing symptoms and the high correlation between this variable and support from friends, we conducted a sensitivity analysis in which

TABLE 2 Correlation Coefficients and Descriptive Statistics of the Study Variables

	1	2	3	4	5	6
1. Internalizing symptoms	1					
2. Family support	−0.31**	1				
3. Support from friends	−0.20*	0.22**	1			
4. Support from a special person	−0.11	0.26**	0.52**	1		
5. Individual-level resilience	−0.40**	0.19*	0.10	0.01	1	
6. Age	−0.12	0.02	0.01	0.06	0.05	1
Mean	2.59	2.75	4.47	4.39	1.28	20.45
SD	0.79	1.85	1.49	1.61	0.60	2.50
Median	2.67	2.75	5.00	4.75	1.50	20.00
Interquartile range	1.88-3.26	1.00-4.50	3.75-5.75	3.5-5.75	1.00-2.17	19.00-22.00
Range	1-4	0.6	0.6	0-6	0-3.25	12-25
Missing data	0	0	0	0	4	0

Note: *p < .05; **p < .001.

TABLE 3 Regressive Coefficients for Family Support, Other Sources of Social Support, and Individual-Level Resilience as Explanatory Variables of Internalizing Symptoms

	b	SE	*t*	*p*	95% CI	
Family support	−0.16	0.05	−3.17	.002	−0.26	−0.06
Support from friends	−0.12	0.05	−2.40	.016	−0.22	−0.02
Support from a special person	0.01	0.05	0.09	.929	−0.09	0.11
Individual-level resilience	−0.25	0.05	−5.55	< .001	−0.35	−0.15
Age	−0.11	0.05	−2.27	.023	−0.21	−0.01
Family support × support from friends	−0.05	0.05	−1.02	.306	−0.15	0.05
Family support × support from a special person	−0.04	0.06	−0.77	.439	−0.16	0.08
Family support × individual-level resilience	−0.13	0.05	−2.83	.005	−0.23	−0.03
Family support × age	−0.08	0.04	−1.92	.055	−0.16	0.00

Note: *Nonstandardized beta coefficients are shown.*

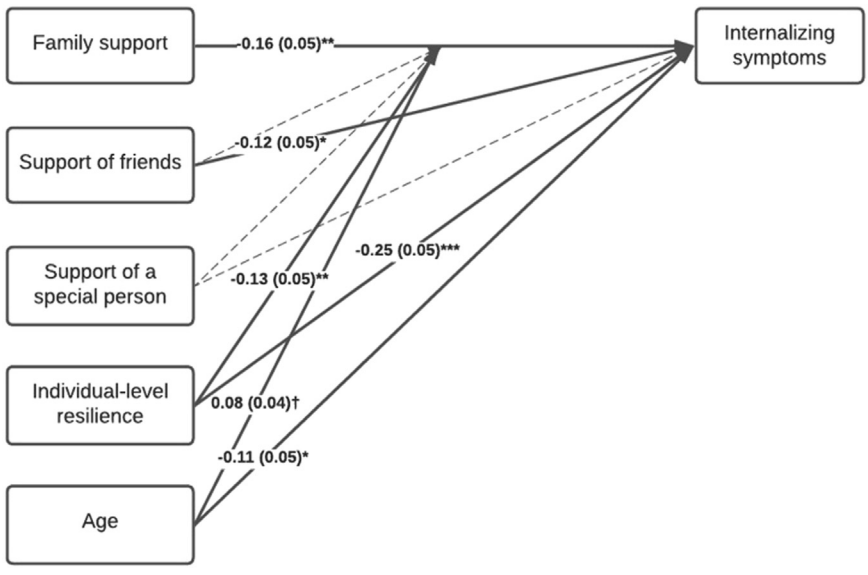
we removed "special person" from the model. The results remained very similar (Table S1, available online).

DISCUSSION

Family support is strongly associated with lower internalizing symptoms among TNB youth, but this kind of support is often perceived as the lowest one.[21] The main objective of the present study was to examine whether additional sources of contextual support beyond the family and individual-level resilience attenuated the association between low family support and internalizing symptoms. In addition, we aimed to address the role of age in the relationship between family support and internalizing symptoms.

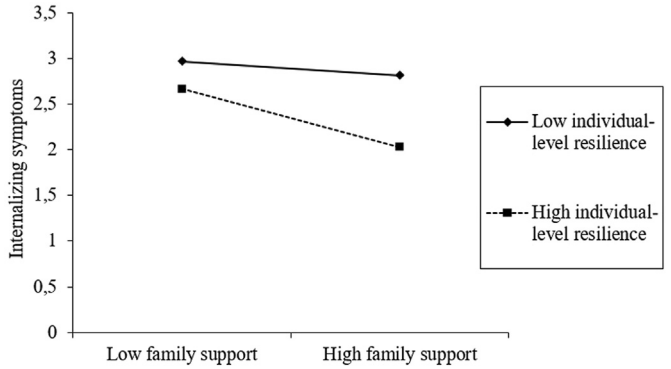
Based on the results, only the individual-level resilience moderated the association between family support and internalizing symptoms. The form of this interaction was somewhat unexpected. Specifically, the relationship between family support and internalizing symptoms was negative only when individual-level resilience was high. In contrast, when levels of individual resilience were low, the participants tended to report high levels of internalizing symptoms, regardless of the level of family support. These results suggest that individual-level resilience is key in dealing with the difficulties that TNB youth experience. In the absence of such resilience, family support might not be as impactful as it should when the youth are coping with internal distress or external difficulties, although other unmeasured factors might be contributing to or confounding this relationship. This would be consistent with findings from studies in which family support failed to buffer the relationship between enacted stigma and psychological distress[30] and between discrimination and internalizing symptoms.[13] Conversely, a previous study reported that family support did buffer the relationship between discrimination and anxiety, but it failed to moderate the

FIGURE 1 Path Analysis Model Among the Study Variables



Note: †p < .10; *p < .05; **p < .01; ***p < .001.

FIGURE 2 Interaction Between Family Support and Individual-Level Resilience for Internalizing Symptoms

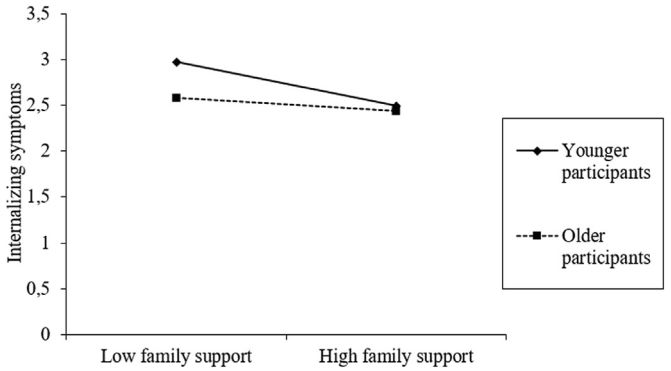


relationship between discrimination and depression or suicidal ideation (individual-level resilience did buffer those relationships).[33] Resilience is a multilevel complex construct, and our results reinforce previous conceptualizations that family support should help in building individual-level resilience because, in its absence, its beneficial role might be reduced.

Moreover, the negative association between individual-level resilience and internalizing symptoms is consistent with the results of previous studies.[29,30] Resilience, as an individual-level competence, has already been shown to be associated with lower internalizing symptoms among cisgender youth[45] and TNB youth.[26] Youth with higher levels of individual-level resilience tend to cope better with internal and external stressors, leading to less rumination and a greater sense of emotional mastery, helping to prevent the development of internalizing psychopathology.[34,35]

In this study, we also expected that other sources of social support (ie, support from friends and support from a special person) could interact with family support and thus compensate for the negative effects of the lack of support

FIGURE 3 Interaction Between Family Support and Age for Internalizing Symptoms



from family members. However, the results did not support our hypothesis. This is contrary to previous findings,[25,46] which showed that support from friends buffered the negative impact of family rejection on psychological adjustment. However, these studies were conducted with a sample of cisgender individuals, who are not always representative of TNB individuals, particularly early adolescents. Adolescence is a crucial period in the individuation process of a person's life, in which the social group exerts great influence; however, this influence tends to change over time.[14] In this sense, our sample might not be represented by the same assumptions regarding the relevance of support from friends in the relationship of family support or rejection and internalizing symptoms. The mean age of our sample (20.45 years) compared to the above-mentioned studies, and the underrepresentation of TNB adolescents (only 11 participants), could explain the absence of an interaction. In fact, as in previous studies,[13] we found that younger TNB individuals benefited to a greater extent from family support. In younger TNB people, 2 crucial realities to understand this finding collide. First, younger TNB people tend to have higher internalizing symptoms.[13] Second, they tend to rely further on their families when seeking support.[21] Therefore, as they grow older, the protective effect of family support on the development of internalizing symptoms tends to diminish.

A secondary objective of this study was to assess perceived social support from several sources among TNB youth. As in previous studies, the participants scored lower on family support than on other sources of social support.[19,20] Both support from family and friends, but not from a special person, were found to be associated with lower levels of internalizing symptoms. This aligns with previous studies, which have consistently shown that support from both family and friends is linked to lower internalizing symptoms.[20,23] Notably, family support appeared to be more strongly associated with internalizing symptoms than friend support among TNB youth, as found in previous studies, although both were relevant.[18,23] Our finding that family support and support from friends were each related to lower levels of internalizing symptoms, whereas the interaction between them was not, suggested that these 2 sources of support operate independently in this sample. As previously discussed, age may be a crucial factor in understanding this phenomenon. The importance and overlap of family support and support from friends tend to collide during adolescence but diverge in early adulthood, when individuation processes are better stablished.[14] In addition, the presence of a special person was not associated with internalizing symptoms. Previous results were inconclusive regarding this source of support. On the one hand, when

speaking of quality of life, support from a special person was related only to better physical quality of life, such as activities of daily living or mobility, but was not associated with better psychological, social, and environmental quality of life.[16] On the other hand, a study found that support from a special person was related to less depressive symptoms and suicide attempts.[15] Our results are more consistent with the findings of the study with negative results.[16] In both studies, the measurement tool (MSPSS) was the same. The term "special person" may be interpreted in a variety of ways, potentially leading to confusion. Some individuals may understand it to refer to a romantic partner, whereas others may perceive it as a member of an association, a friend, or someone else. Moreover, TNB youth often engage in TNB communities exclusively and tend to limit their relationships to those networks because of the discrimination that they experience in other contexts.[19] This may result in them perceiving the support of a "special person" as equivalent to the support of friends.

This study had certain limitations that should be considered in future research. First, the cross-sectional nature of the study makes it impossible to establish predictive associations between the variables. Thus, for example, perception of family and social support could be influenced by levels of internalizing symptoms. Similarly, individual-level resilience could rely, at least partially, on social support. Future longitudinal research is needed to evaluate whether family support, support from friends, and individual-level resilience predict levels of internalizing symptoms.

Second, the sample was very heterogeneous in terms of origin. Although the majority of the participants (74.7%) were from Spain, participants from other Spanish-speaking countries were also included. This may have affected the results because of cultural differences, differences in legislation regarding TNB matters,[47] and differences in family support.[48] In this vein, the definition of "special person" in the MSPSS tool was not specified and could be confusing, particularly in different cultures. Future researches should further specify who could be understood as a "special person" to capture the relevance of the roles of different persons surrounding TNB youth.

Third, the partial use of a "snowballing" method as a sample recruiting technique (via TNB associations) might bias the results. Therefore, in future research, the sample should be balanced to control for variables such as country of residence and age and the sample recruited completely randomly. Also, the sample was skewed toward older participants rather than adolescence and, given that our results pointed to the fact that younger TNB individuals could benefit from family support to a major extent when compared to older ones, future research should try to recruit a younger sample of TNB adolescents. Finally, also regarding the sample, future studies should examine whether the identified relationships and the resulting conclusions are replicated in other samples, such as those comprising cisgender youth, other minority groups, or youth residing in countries with cultural contexts disparate from those in this study. In this way, a more expansive scope than the one pursued in this study could be explored.

The results of this study show that family support for TNB youth is an important area for improvement. Consistent with previous studies, the participants in this study had lower levels of family support than other types of social support,[19–21] although family support was shown to be more relevant to their psychological well-being.[18,21] The results also highlight the importance of support from friends, as well as individual-level resilience, conceptualized as the ability to overcome difficulties, for psychological well-being. Although it was expected that high levels of other sources of support and individual-level resilience could compensate for the negative effect of deficiencies in family support, the results indicate that, in general, these are relatively independent factors. Only individual-level resilience interacted with family support in explaining internalizing symptoms. Specifically, when TNB youth have low levels of individual resilience, they tend to exhibit elevated levels of internalizing symptoms, regardless of family support. In contrast, the protective effect of the family emerged only when the level of individual resilience was high. In addition, our results show that family support was more relevant to well-being in younger participants than it was in older ones.

These results have valuable implications for interventions. A review concluded that individual-level coping interventions are essential for TNB individuals to deal with the negative outcomes of stigmatization.[9] In this sense, our results suggest that working with the families of TNB youth to provide gender affirmation is very important, particularly in younger TNB youth, but is not enough. It is also crucial to work with these youth individually to help them develop appropriate coping skills that will enable them to adapt to the discrimination, stigma, and prejudice that they often experience. In this sense, they could benefit from gender-affirming care in different ways. For instance, group interventions could help them reinforce their individual skills, while providing them with effective support from new peers in nonpathologizing contexts.[49]

CRediT authorship contribution statement

Aitor Jiménez-Granado: Writing – review & editing, Writing – original draft, Methodology, Data curation, Conceptualization. **Sara Rodriguez-Gonzalez:** Writing –

review & editing, Writing – original draft, Resources. **Ángel Prieto-Fidalgo:** Writing – review & editing, Writing – original draft. **Laura Molina:** Writing – review & editing, Writing – original draft. **Esther Calvete:** Writing – review & editing, Writing – original draft, Funding acquisition, Formal analysis, Conceptualization.

This article is part of a special series devoted to the mental health of sexual and gender minority youth, with a focus on the domains of epidemiology (including phenomenology, co-occurring conditions and features as well as bio-psychosocial influences), basic and translational neuroscience, including genetics and neuroimaging, the prevention and treatment of mental health concerns, measurement, service design and implementation, and mental health policy. This special series was edited by Guest Editors Stewart L. Adelson, MD, David S. Hong, MD, Meng-Chuan Lai, MD, PhD, and Jack L. Turban, MD; Consulting Editor Tonya White, MD, PhD; Associate Editor Robert R. Althoff, MD, PhD; Editor Manpreet K. Singh, MD, MS; and Editor-in-Chief Douglas K. Novins, MD.

Accepted April 25, 2025.

This article was reviewed under and accepted by Tonya White, MD, PhD.

[a]University of Deusto, Bilbao, Spain

This project was funded by a grant from the Basque Country Government (Ref. IT1532-22) and by the RED2022-134247-T Network for the PROmotion of EMOtional Health and Wellbeing of Adolescents (PROEMO), MCIN/AEI/10.13039/501100011033.

Data Sharing: Deidentified participant data will be made available upon publication at https://osf.io/z6exf/?view_only=c3758291261249b8bcbbfc563fa33ee1

Aitor Jiménez-Granado, Ángel Prieto-Fidalgo, and Esther Calvete served as the statistical experts for this research.

The authors thank the children, families, participants, and associations who shared and participated in the study for their invaluable collaboration.

Disclosure: Aitor Jiménez-Granado, Sara Rodriguez Gonzalez, Ángel Prieto-Fidalgo, Laura Molina, and Esther Calvete have reported no biomedical financial interests or potential conflicts of interest.

*Correspondence to Aitor Jiménez-Granado, PhD, Avenida de las Universidades, 24, 48007, Bilbao, Spain; e-mail: aitor.jimenez@deusto.es

https://doi.org/10.1016/j.jaacop.2025.04.005

REFERENCES

1. Richards C, Bouman WP, Seal L, *et al*. Non-binary or genderqueer genders. Int Rev Psychiatry. 2016;28(1):95-102. https://doi.org/10.3109/09540261.2015.1106446
2. Matsuno E, Budge SL. Non-binary/genderqueer identities: a critical review of the literature. Curr Sex Health Rep. 2017;9(3):116-120. https://doi.org/10.1007/s11930-017-0111-8
3. Darwin H. Doing gender beyond the binary: a virtual ethnography. Symb Interact. 2017;40(3):317-334. https://doi.org/10.1002/symb.316
4. Collin L, Reisner SL, Tangpricha V, *et al*. Prevalence of transgender depends on the "case" definition: a systematic review. J Sex Med. 2016;13(4):613-626. https://doi.org/10.1016/j.jsxm.2016.02.001
5. Lavagna M, Lines PI, Tettamanti S, *et al*. Censo nacional de población, hogares y viviendas 2022; 2023. Instituto Nacional de Estadística y Censos (INDEC): resultados definitivos de identidad de género. Accessed February 20, 2024. https://www.indec.gob.ar/indec/web/Nivel4-Tema-2-41-165
6. Office for National Statistics, United Kingdom. Sexual orientation and gender identity: census 2021 in England and Wales 2023. 2021. Accessed February 20, 2024. https://www.ons.gov.uk/releases/sexualorientationandgenderidentitycensus2021inenglandandwales
7. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychol Bull. 2003;129(5):674-697. https://doi.org/10.1037/0033-2909.129.5.674
8. Hu T, Jin F, Deng H. Association between gender nonconformity and victimization: a meta-analysis. Curr Psychol. 2024;43:281-299. https://doi.org/10.1007/s12144-023-04269-x
9. White-Hughto JM, Reisner SL, Pachankis JE. Transgender stigma and health: a critical review of stigma determinants, mechanisms, and interventions. Soc Sci Med. 2015;147:222-231. https://doi.org/10.1016/j.socscimed.2015.11.010
10. Valentine SE, Shipherd JC. A systematic review of social stress and mental health among transgender and gender non-conforming people in the United States. Clin Psychol Rev. 2018;66:24-38. https://doi.org/10.1016/j.cpr.2018.03.003
11. Borgogna NC, McDermott RC, Aita SL, *et al*. Anxiety and depression across gender and sexual minorities: implications for transgender, gender nonconforming, pansexual, demisexual, asexual, queer, and questioning individuals. Psychol Sex Orient Gender Divers. 2019;6(1):54-63. https://doi.org/10.1037/sgd0000306
12. Marchi M, Travascio A, Uberti D, *et al*. Post-traumatic stress disorder among LGBTQ people: a systematic review and meta-analysis. Epidemiol Psychiatr Sci. 2023;32:e44. https://doi.org/10.1017/S2045796023000586
13. Elmer EM, van Tilburg T, Fokkema T. Minority stress and loneliness in a global sample of sexual minority adults: the roles of social anxiety, social inhibition, and community involvement. Arch Sex Behav. 2022;51(4):2269-2298. https://doi.org/10.1007/s10508-021-02132-3
14. Wrzus C, Neyer FJ. Co-development of personality and friendships across the lifespan: an empirical review on selection and socialization. Eur Psychol. 2016;21(4):254-273. https://doi.org/10.1027/1016-9040/a000277
15. Durwood L, Eisner L, Fladeboe K, *et al*. Social support and internalizing psychopathology in transgender youth. J Youth and Adolesc. 2021;50:841-854. https://doi.org/10.1007/s10964-020-01391-y
16. Rotondi NK, Bauer GR, Scanlon K, *et al*. Prevalence of and risk and protective factors for depression in female-to-male transgender Ontarians: Trans PULSE Project. Can J Community Ment Health. 2012;30(2):135-155. https://doi.org/10.7870/cjcmh-2011-0021
17. Trujillo MA, Perrin PB, Sutter M, *et al*. The buffering role of social support on the associations among discrimination, mental health, and suicidality in a transgender sample. Int J Transgend. 2017;18(1):39-52. https://doi.org/10.1080/15532739.2016.1247405
18. Başar K, Öz G, Karakaya J. Perceived discrimination, social support, and quality of life in gender dysphoria. J Sex Med. 2016;13(7):1133-1141. https://doi.org/10.1016/j.jsxm.2016.04.071
19. Bradford J, Reisner SL, Honnold JA, *et al*. Experiences of transgender-related discrimination and implications for health: results from the Virginia Transgender Health Initiative Study. Am J Public Health. 2013;103(10):1820-1829. https://doi.org/10.2105/AJPH.2012.300796
20. Turban JL, Beckwith N, Reisner SL, *et al*. Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults. JAMA Psychiatry. 2020;77(1):68-76. https://doi.org/10.1001/jamapsychiatry.2019.2285
21. Puckett JA, Matsuno E, Dyar C, *et al*. Mental health and resilience in transgender individuals: what type of support makes a difference? J Fam Psychol. 2019;33(8):954-964. https://doi.org/10.1037/fam0000561
22. Olson KR, Durwood L, DeMeules M, *et al*. Mental health of transgender children who are supported in their identities. Pediatrics. 2016;137(3):e20153223. https://doi.org/10.1542/peds.2015-3223
23. Wren B. 'I can accept my child is transsexual but if I ever see him in a dress, I'll hit him': dilemmas in parenting a transgendered adolescent. Clin Child Psychol Psychiatry. 2002;7(3):377-397. https://doi.org/10.1177/1359104502007003006
24. Gómez-Gil E, Zubiaurre-Elorza L, Esteva de Antonio I, *et al*. Determinants of quality of life in Spanish transsexuals attending a gender unit before genital sex reassignment surgery. Qual Life Res. 2014;23:669-676. https://doi.org/10.1007/s11136-013-0497-3
25. Sentse M, Lindenberg S, Omvlee A, *et al*. Rejection and acceptance across contexts: parents and peers as risks and buffers for early adolescent psychopathology. The TRAILS study. J Abnorm Child Psychol. 2010;38(1):119-130. https://doi.org/10.1007/s10802-009-9351-z

26. Tankersley AP, Grafsky EL, Dike J, *et al*. Risk and resilience factors for mental health among transgender and gender nonconforming (TGNC) youth: a systematic review. Clin Child Fam Psych. 2021;24(2):183-206. https://doi.org/10.1007/s10567-021-00344-6
27. Fergus S, Zimmerman MA. Adolescent resilience: a framework for understanding healthy development in the face of risk. Annu Rev Public Health. 2005;26:399-419. https://doi.org/10.1146/annurev.publhealth.26.021304.144357
28. Ungar M, Theron L. Resilience and mental health: how multisystemic processes contribute to positive outcomes. Lancet Psychiatry. 2020;7(5):441-448. https://doi.org/10.1016/S2215-0366(19)30434-1
29. Ungar M, Ghazinour M, Richter J. Annual research review: what is resilience within the social ecology of human development? J Child Psychol Psychiatry. 2013;54(4):348-366. https://doi.org/10.1111/jcpp.12025
30. Matsuno E, Israel T. Psychological interventions promoting resilience among transgender individuals: Transgender Resilience Intervention Model (TRIM). Couns Psychol. 2018;46(5):632-655. https://doi.org/10.1177/0011000018787261
31. Smith BW, Dalen J, Wiggins K, *et al*. The Brief Resilience Scale: assessing the ability to bounce back. Int J Behav Med. 2008;15:194-200. https://doi.org/10.1080/10705500802222972
32. Kleiman EM, Chiara AM, Liu RT, *et al*. Optimism and well-being: a prospective multi-method and multi-dimensional examination of optimism as a resilience factor following the occurrence of stressful life events. Cogn Emot. 2017;31(2):269-283. https://doi.org/10.1080/02699931.2015.1108284
33. Tebbe EA, Bell HL, Cassidy K, *et al*. "It's loving yourself for you": happiness in trans and nonbinary adults. Psychol Sex Orient Gender Divers. 2022;11(3):397-412. https://doi.org/10.1037/sgd0000613
34. Bockting WO, Miner MH, Swinburne RE, *et al*. Stigma, mental health, and resilience in an online sample of the US transgender population. Am J Public Health. 2013;103(5):943-951. https://doi.org/10.2105/AJPH.2013.301241
35. Gonzalez CA, Bockting WO, Beckman LJ, *et al*. Agentic and communal personality traits: their associations with depression and resilience among transgender women. Sex Roles. 2012;67:528-543. https://doi.org/10.1007/s11199-012-0202-y
36. Zhou P, Dong J, Liu J, *et al*. Relationship between parent-child relationships and peer victimization: a moderated mediation model of self-esteem and resilience. J Child Fam Stud. 2023;32(3):641-651. https://doi.org/10.1007/s10826-022-02457-0
37. Scandurra C, Amodeo AL, Valerio P, *et al*. Minority stress, resilience, and mental health: a study of Italian transgender people. J Soc Issues. 2017;73(3):563-585. https://doi.org/10.1111/josi.12232
38. Wittlin NM, Kuper LE, Olson KR. Mental health of transgender and gender diverse youth. Annu Rev Clin Psychol. 2023;19(1):207-232. https://doi.org/10.1146/annurev-clinpsy-072220-020326
39. Bados A, Solanas A, Andrés R. Psychometric properties of the Spanish version of Depression, Anxiety and Stress Scales (DASS). Psicothema. 2005;17(4):679-683; https://reunido.uniovi.es/index.php/PST/article/view/8331/8195
40. Lovibond PF, Lovibond SH. Manual for the Depression Anxiety Stress Scales. Psychology Foundation of Australia; 1995.
41. Landeta O, Calvete E. Adaptation and validation of the Multidimensional Scale of Perceived Social Support. Anxiety Stress. 2002;8(2-3):173-182; https://www.ansiedadyestres.es/sites/default/files/rev/ucm/2002/anyes2002a13.pdf
42. Zimet GD, Dahlem NW, Zimet SG, *et al*. The Multidimensional Scale of Perceived Social Support. J Pers Assess. 1988;52(1):30-41. https://doi.org/10.1207/s15327752jpa5201_2
43. Rodríguez-Rey R, Alonso-tapia J, Hernansaiz-Garrido H. Reliability and validity of the Brief Resilience Scale (BRS) Spanish version. Psychol Assess. 2016;28(5):e101-e110. https://doi.org/10.1037/pas0000191
44. Cohen J. Statistical Power Analysis for the Behavioral Sciences. Academic Press; 2013.
45. Mesman E, Vreeker A, Hillegers M. Resilience and mental health in children and adolescents: an update of the recent literature and future directions. Curr Opin Psychiatry. 2021;34(6):586-592. https://doi.org/10.1097/YCO.0000000000000741
46. Dugan T, Coles M, eds. The Child in Our Times: Studies in the Development of Resilience. New York: Brunner Mazel; 1989.
47. Williamson M. A global analysis of transgender rights: introducing the Trans Rights Indicator Project (TRIP). Perspect Politics; 2023:1-20. https://doi.org/10.1017/S1537592723002827
48. Katz-Wise SL, Godwin EG, Parsa N, *et al*. Using family and ecological systems approaches to conceptualize family- and community-based experiences of transgender and/or nonbinary youth from the Trans Teen and Family Narratives Project. Psychol Sex Orient Gend Divers. 2022;9(1):21-36. https://doi.org/10.1037/sgd0000442
49. McCann E, Donohue G, Brown M. Experiences and perceptions of trans and gender non-binary people regarding their psychosocial support needs: a systematic review of the qualitative research evidence. Int J Environ Res Public Health. 2021;18(7):3403. https://doi.org/10.3390/ijerph18073403