REVISTAPORTUGUESADE PSIQUIATRIA ESAÚDEMENTAL
2023; 9(4): 28-39; https://doi.org/10.51338/rppsm.555

ORIGINAL ARTICLE/ ARTIGO ORIGINAL

People with Gender Diversity in Portugal: A Brief Insight into Psychological Welfare and Family and Social Environments

Pessoas com Diversidade de Género em Portugal: Uma Breve Análise ao Bem-Estar Psicológico e aos Ambientes Familiar e Social

JOSÉ LUÍS DE MAGALHÃES GUIMARÃES[*1], CAROLINA LUÍSA CARDOSO LEMOS[2], ZÉLIA MARIA TEIXEIRA BRANDÃO FIGUEIREDO[3]

1. Psychiatry, Unidade Local de Saúde de Castelo Branco, Castelo Branco, Portugal.
2. Population study, School of Medicine and Biomedical Sciences of Porto University, Porto, Portugal.
3. Psychiatry, Magalhães Lemos Psychiatric Hospital, Porto, Portugal.

ABSTRACT

Introduction: Transgender people experience many life challenges, often by relatives or peers, which can lead to multiple mental health issues.

Methods: Given the described family and social challenges in people with gender diversity and their impact on mental welfare, the need for a brief description of these settings arose. Being so, an original questionnaire was constructed and, afterwards, provided to different healthcare professionals and organizations who contact with transgender people. Subsequently, these partners applied the questionnaire to people who met the following criteria: self-identifying as a transgender person, being 18 years old or older and residing in Portugal. This was done to try to encompass as many adult transgender people as possible who may contact Portuguese health services and have a broad notion of their family, social and psychological background. By having a general comprehension of these matters, we hope to inform the clinical community, impact clinical assessment and promote an empathic relationship with the patient.

Results: Regarding tolerance towards gender diversity, we found that it increased substantially from childhood and adolescence to current life; also, we ascertained that, when the trans person's household is not tolerant, neither are the peers, and vice-versa (p=0.023). As for the topics of gender and sexuality, we found a gap between the amount of trans youth who think about these topics and the amount of households, peers or schools who approach them. In regards to mental health, we found that anxiety, depression and suicidal issues remain significantly present among trans people; however, a non-binary gender identity may be a protective mental health factor.

Conclusion: Mental health challenges remain prevalent within trans people, whether they are feelings of anxiety, depression, suicidal issues, family or social struggles. This paper wishes to raise awareness of these struggles to promote a better healthcare professional–patient relationship. We also wish to impact clinical practice, namely to do an early distinction between a case of gender diversity or gender dysphoria, identify potential therapeutic targets and goals and to help formulate a therapeutic plan together with the patient.

Keywords: Gender Dysphoria; Gender Identity; Mental Health; Sexual and Gender Minorities; Transgender Persons

Recebido/Received: 2024-04-30
Aceite/Accepted: 2024-10-25
Publicado Online/Published Online: 2025-04-03
Publicado/Published: 2025-04-03

* Autor Correspondente/Corresponding Author: José Luís de Magalhães Guimarães | jlmguimaraes98@gmail.com | Santa Catarina Street, nº 1525, 6th floor, right apartment; zip code 4000-458 Porto

RESUMO

Introdução: Pessoas transgénero experienciam vários desafios de vida, frequentemente por familiares ou pares, que pode levar a múltiplos desafios à saúde mental.

Métodos: Dados os desafios familiares e sociais em pessoas com diversidade de género e o seu impacto na saúde mental, a necessidade por uma breve descrição destas condicionantes surgiu. Assim sendo, construiu-se um questionário original e, posteriormente, foi cedido a diferentes profissionais e organizações que contactam com pessoas transgénero. Subsequentemente, estes parceiros aplicaram o questionário a pessoas que cumpriam os seguintes critérios: autoidentificam-se como uma pessoa transgénero, têm 18 ou mais anos de idade e residem em Portugal. Isto foi feito para tentar englobar o maior número possível de pessoas transgénero adultas que pudessem contactar com os serviços de saúde portugueses e para ter uma noção geral sobre o seu fundo familiar, social e psicológico. Ao ter uma noção global sobre estes assuntos, esperamos informar a comunidade clínica, impactar a avaliação clínica e promover uma relação empática com o utente.

Resultados: Relativamente à tolerância para a diversidade de género, verificou-se que aumentou substancialmente da infância e adolescência para a vida atual; também se constatou que, quando o agregado familiar da pessoa trans não é tolerante, os pares também não são, e vice-versa (p=0,023). Quanto aos tópicos de género e sexualidade, há uma diferença importante entre quantos jovens trans pensam sobre estes tópicos e quantos dos seus agregados, pares e escolas falaram sobre os mesmos. Em relação à saúde mental, constatou-se que a ansiedade, depressão e questões suicidas permanecem significativamente presentes entre pessoas trans; contudo, uma identidade de género não-binária pode ser um fator protetor.

Conclusão: Desafios à saúde mental mantém-se prevalentes entre pessoas trans, sejam sentimentos de ansiedade, depressão, questões suicidárias ou dificuldades familiares ou sociais. Este artigo pretende consciencializar para estes desafios e promover uma melhor relação entre profissional de saúde e utente. Também pretendemos impactar a prática clínica, nomeadamente para fazer uma distinção precoce entre um caso de diversidade de género ou disforia de género, identificar potenciais alvos e objetivos terapêuticos, e formular um plano terapêutico juntamente com o utente.

Palavras-chave: Disforia de Género; Identidade de Género; Minorias Sexuais e de Género; Pessoas Transgénero; Saúde Mental

INTRODUCTION

The terms "transgender" or "trans" refer to people whose gender identity does not match their birth-assigned sex. These terms differ from the term "gender dysphoria", which is a clinical term referring to the psychosocial distress associated with an incongruence between one's gender identity and birth-assigned sex (usually based on external genitalia or chromosomes).[1–3] It is important to use clear and consensual definitions regarding the involved concepts,[4] which can be found in Table 1.[4–6] The population of study for this paper is people with gender diversity (PwGD), and not specifically those struggling with gender dysphoria.

There is a scarcity of studies[4,7] and great difficulty in properly estimating the prevalence of PwGD and gender dysphoria. One major challenge is the lack of standardized terminology[4]: some studies defined a PwGD as someone with a diagnostic record of gender dysphoria or that had been submitted to gender-affirming interventions (estimating a prevalence of 7-9/100 000); however, other studies defined them as someone who self-identifies as "transgender" or as "belonging to a different gender" (estimating a prevalence of 871/100 000).[8] More recent population-based studies estimate to a 0.5%-1.8%, without detecting a significant difference between sexes.[4,9,10]

Many Western cultures view gender as binary (masculine or feminine), implying that one should conform to either one category or the other, which might encourage a pathologic view of gender diversity. However, gender becomes increasingly understood as a spectrum between masculine and feminine, comprehending the existence of multiple genders. Societies that understand gender this way may be more receptive to PwGD.[4] One can find examples of a community's cultural perspective in their laws – in Portugal's case, an important example is found in law nº 38/2018, titled "Right to self-determination of gender identity and expression and the protection of one's sexual characteristics", which makes explicit gender identity and expression as self-determined, granting each citizen the right to self-define, and forbidding gender identity or expression-related discrimination (*Lei No 38-2018*, 2018). This is an important step in trans health, since the World Professional Association for Transgender Health (WPATH) acknowledges that "health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship."[7]

It is also known that PwGD have an increased risk for multiple adversities, whether they are in the family, social or intimate environment, leading to a significant impact on one's functioning and quality of life.[4,12] One study demonstrated this – it concluded that trans students presented academic-affecting discrimination levels and more verbal threats significantly higher, compared to cis women.[13] Furthermore, a 2021 Gay & Lesbian Alliance Against Defamation (GLAAD) report states that 59% of Lesbian, Gay, Bisexual, Trans and Queer (LGBTQ) people was discriminated based on their sexual orientation or gender identity.[14] In Portugal's case, ILGA Portugal issued a similar report,

stating that 16% of LGBTQ discrimination victims were trans men, trans women, or intersex people, being their parents or schoolmates an important part of the reported aggressors. This discrimination was usually in the form of verbal threats (46%) or bullying (14%) and domestic violence occurred in 6% of cases. Regarding the aggression's impact on the victim, although the most common response in terms of physical impact was "Did not affect me" (42%), the highest level of impact defined by the inquiry ("Affected me a lot") was the most common response when it came to psychologic (43%) and social impact (28%).[15] A different Portuguese study states that half of its trans sample has suffered discrimination by a health professional.[16] Being so, it is understandable how PwGD faces an increased risk for numerous obstacles to their quality of life, such as diminished well-being and self-esteem and symptoms of anxiety or depression.[4] One study on trans youth reports suicidal ideation in almost half of its sample and 25% of them had already attempted suicide. It also points out body-related low self-esteem and thoughts about the assessment others make regarding their bodies, among other factors, as important markers related to these attempts.[17]

Table 1. Concepts and Definitions

Concept	Definition
Sex	Group of biological characteristics that define someone as male or female.[5]
Gender	Group of socially constructed characteristics that define masculinity or femininity: it includes gender norms, roles and behaviors traditionally associated with being a man or a woman, as well as interpersonal relationships.[6]
Gender identity	One's innate ability to feel masculine, feminine, neither or a combination of both.[4]
Gender expression	How one presents gender to the outer world.[4]
Gender diversity	Umbrella term for all gender identities, expressions and roles that differ from cultural norms.[4]
Trans or Transgender person	Someone who's gender identity does not match their birth-assigned sex and gender, regardless of having done any gender-affirming interventions. People should be addressed according to their gender identity; therefore and, as an example, a trans man is someone who identifies as a man regardless of his birth-assigned sex and gender, and a trans woman is someone who identifies as a woman regardless of her birth-assigned sex and gender.[4]
Cis or Cisgender person	Someone who's gender identity matches their birth-assigned sex and gender.

MATERIAL AND METHODS

We aim to do a brief description of the socio-psycho-cultural environment, where we include sociodemographic characteristics, family and social settings, experienced discrimination, and the presence of anxious, depressive, or suicidal elements. With this psychological welfare characterization, we do not intend to assess the presence or prevalence of mental health diagnosis, but rather perform an exploratory study that allows us to briefly describe and inform others about PwGD's life experience.

For this purpose, an original questionnaire was created and, afterward, provided to different professionals and organizations who contact PwGD. These partners then applied the questionnaire to PwGD who met the following admission criteria simultaneously: gender identity different from birth-assigned sex, age ≥ 18 years and residing in Portugal. This study received institutional approval by its ethics committee, was conducted according to the 1964 Helsinki Declaration and its later amendments or comparable ethical standards and all data was processed anonymously. Informed consent was provided and given by every participant. This article will only review the results of the questionnaire's sections 1-3 (Annex 1).

For statistical analysis, Microsoft Office Excel (version 2203) and SPSS (version 27) were used. Categoric variables were described through percentages, while continuous variables, such as age, through their means and standard deviation. To infer associations between variables, Pearson's chi-squared and Fisher's tests were used as necessary. We used a significance level of α=0.05.

RESULTS

We admitted 120 responses for analysis collected between December/2021, and February/2022.

Sociodemographic variables are displayed in Fig. 1 and Tables 2-10. Participant's age ranged from 18 to 66 years old (mean ± standard deviation: 26.59 ± 9.29). Regarding birth-assigned sex, we verified a 2:1 ratio (female:male). As for the environment they grew up in, we also verified a 2:1 ratio (urban:rural) and showed no association with the tolerance displayed by the household or peers (p=1 and p=0.330, respectively) and discrimination (p=0.824).

As for childhood and adolescence and current life characterization (Figs. 2 and 3), despite the low tolerance reported by the household and peers during childhood and adolescence, a visible increase was substantiated in current life; however, this did not clearly reflected statistically (p=0.052 and p=0.425, respectively). However, we verified that when the household is not tolerant, neither are the peers, and vice-versa (p=0.023).

During childhood and adolescence, despite the gap between the amount of PwGD who thought a lot about gender and sexuality and how often their households, peers and schools discussed these topics, no statistically significant difference was found (p=1, p=0.220 and p=0.659, respectively). Additionally, no association was found between

reports of bullying and school discussion of gender and sexuality or the rural/urban environment (p=0.622 and p=1, respectively).

In terms of discrimination by healthcare professionals (Fig. 4) for trans people who had done at least one gender-affirming intervention (n=115), no statistically significant difference was found between the different areas of residency of continental Portugal (p=0.567).

Regarding the psychological characterization (Fig. 5), a deeper investigation was done between trans men, trans women, and non-binary people. Between these, non-binary people reported less anxiety (Table 11), depressed humour (Table 12) and suicidal ideation (Table 13). We were able to validate this statistically for suicidal ideation (p=0.039); however, the same was not true for anxiety or depressed humor, due to a sample scarcity (specifically, of those who did not report these symptoms). For suicide attempts, the same result was encountered, but it was only possible to validate statistically between non-binary people and trans men (p=0.022); trans men and trans women present very similar results (p=1).

We also established that those who experience anxiety or depressed humor report more suicidal ideation (p=0.038 and p<0.001, respectively) and, when someone experiences both, suicidal ideation is even more likely (p<0.001). However, experiencing anxiety, depressed humor or both does not seem to impact suicide attempts (p=0.567, p=0.181 and p=0.186, respectively).

Table 2. Nationality

Where Are You From?	**Absolute Frequency**	**Percentage**
North of Continental Portugal	48	40.0%
Centre of Continental Portugal	43	35.8%
South of Continental Portugal	12	10.0%
Azores Archipelago	2	1.7%
Madeira Archipelago	2	1.7%
Brazil	8	6.7%
Mozambique	2	1.7%
Angola	1	0.8%
South Africa	1	0.8%
Venezuela	1	0.8%
TOTAL	120	100.0%

Table 3. Residency

Where do You Live?	**Absolute Frequency**	**Percentage**
North of Continental Portugal	56	46.7%
Centre of Continental Portugal	49	40.8%
South of Continental Portugal	13	10.8%
Azores Archipelago	1	0.8%
Madeira Archipelago	1	0.8%
TOTAL	120	100.0%

Table 4. Employment Status

What's Your Professional Situation?	Absolute Frequency	Percentage
I am a university student	36	30.0%
I am a high school student	4	3.3%
I am employed	59	49.2%
I am unemployed	20	16.7%
I am retired	1	0.8%
TOTAL	**120**	100.0%

Table 5. Marital Status

What's Your Marital Status?	Absolute Frequency	Percentage
Single	71	59.2%
Married	7	5.8%
Divorced	8	6.7%
Widowed	0	0.0%
In a Relationship	34	28.3%
TOTAL	**120**	100.0%

Table 6. Birth-Assigned Sex and Gender

What Sex and Gender Were Assigned to you at Birth?	Absolute Frequency	Percentage
Male	41	34.2%
Female	79	65.8%
TOTAL	**120**	100.0%

Table 7. Gender Identities in the Overall Sample

What's Your Gender Identity?	Absolute Frequency	Percentage
Male	61	50.8%
Female	37	30.8%
Non-Binary	19	15.8%
Agender	1	0.8%
Transmasculine/Demiboy	1	0.8%
Gender Fluid	1	0.8%
TOTAL	**120**	100.0%

Table 8. Gender Identities Based on Birth-Assigned Sex and Gender

Birth-Assigned Sex and Gender	**Male**		**Female**	
What's Your Gender Identity?	**Absolute Frequency**	**Percentage**	**Absolute Frequency**	**Percentage**
Male	0	0.0%	61	77.2%
Female	37	90.2%	0	0.0%
Non-Binary	3	7.3%	16	20.3%
Agender	0	0.0%	1	1.3%
Transmasculine/Demiboy	0	0.0%	1	1.3%
Gender Fluid	1	2.4%	0	0.0%
TOTAL	**41**	**100.0%**	**79**	100.0%

Table 9. Environment

Which Environment Did You Grow Up In?	**Absolute Frequency**	**Percentage**
Rural	39	32.5%
Urban	81	67.5%
TOTAL	**120**	100.0%

Table 10. Family Members in the Household

During your Childhood and Adolescence, who was a part of your household (lived with you):	**Absolute Frequency**	**Percentage**
Dad	100	83.3%
Mom	116	96.7%
Stepfather/Stepmother	13	10.8%
Brothers/Sisters	89	74.2%
Grandparents	29	24.2%
Uncles/Aunts	13	10.8%
Cousins	7	5.8%
Nephews	4	3.3%
Other People who were not related to me	9	7.5%

Table 11. Distribution of Anxiety Feelings according to Gender Identity.

		Gender Identity		
		Masculine	**Feminine**	**Non-binary**
	Disagrees	2	2	2
		3.4%	5.9%	11.8%
	Agrees	56	32	15
		96.6%	94.1%	88.2%
Total		58	34	17
100%		100%	100%	

Table 12. Distribution of Depressive Humour according to Gender Identity

		Gender Identity		
		Masculine	**Feminine**	**Non-binary**
	Disagrees	1	1	5
		1.9%	3%	31.3%
	Agrees	53	32	11
		98.1%	97%	68.8%
Total		54	33	16
100%		100%	100%	

Table 13. Distribution of Suicidal Ideation according to Gender Identity

		Gender Identity		
		Masculine	**Feminine**	**Non-binary**
	Disagrees	13	10	11
		31.0%	32.3%	64.7%
	Agrees	29	21	6
		69.0%	67.7%	35.3%
Total		42	31	17
100%		100%	100%	

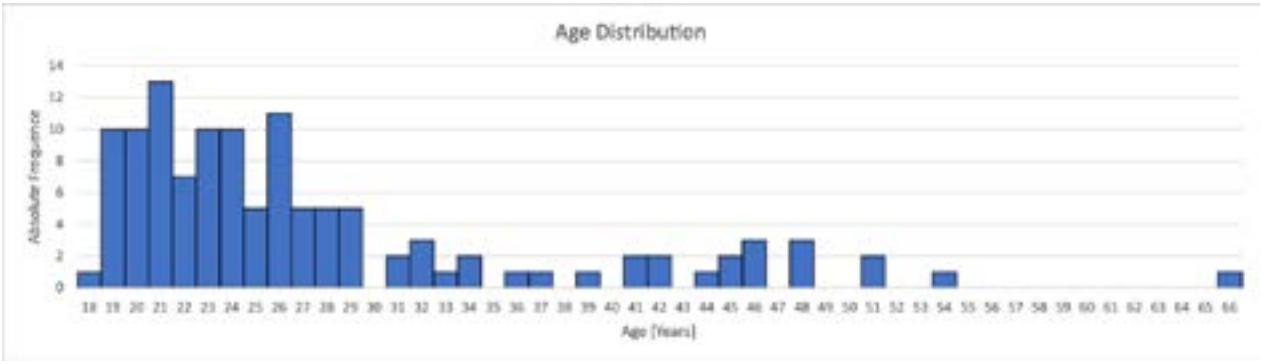

Figure 1. Q1 (Age Distribution)

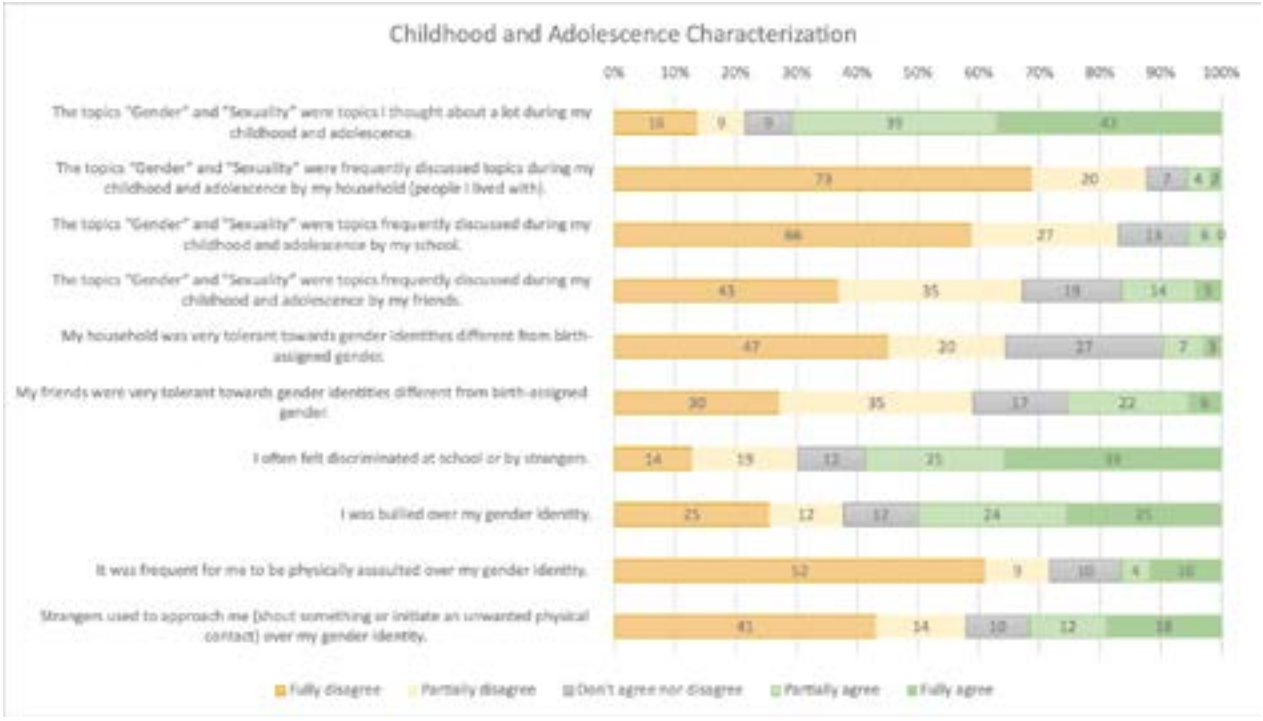

Figure 2. Q10 (Childhood and Adolescence Characterization).

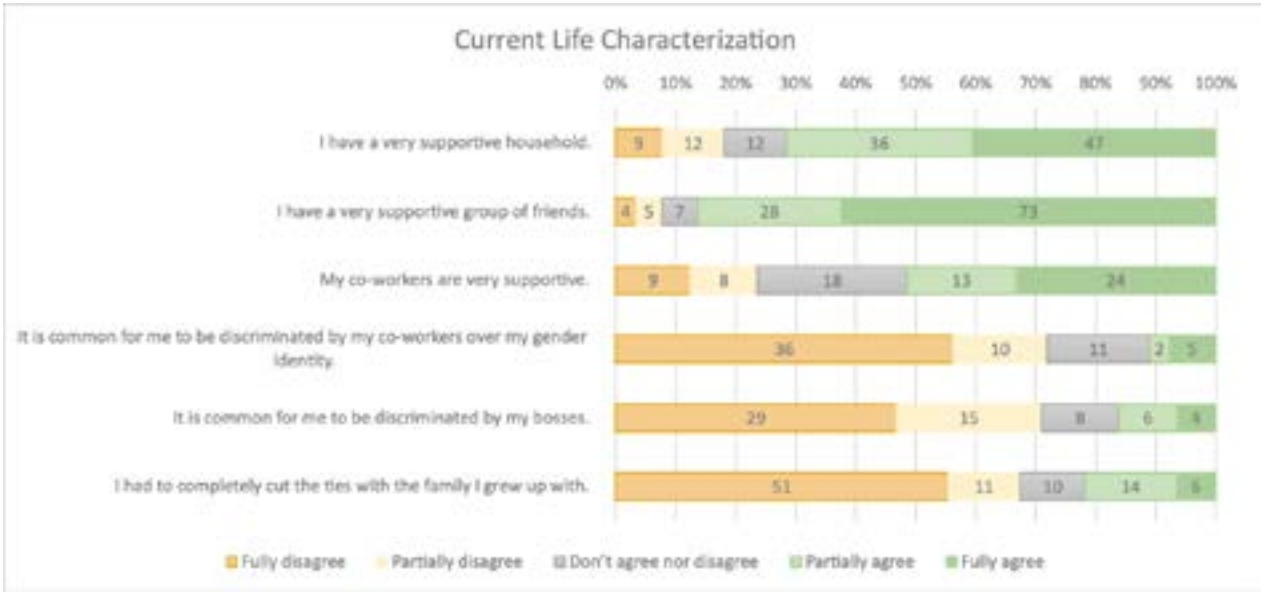

Figure 3. Q11 (Current Life Characterization)

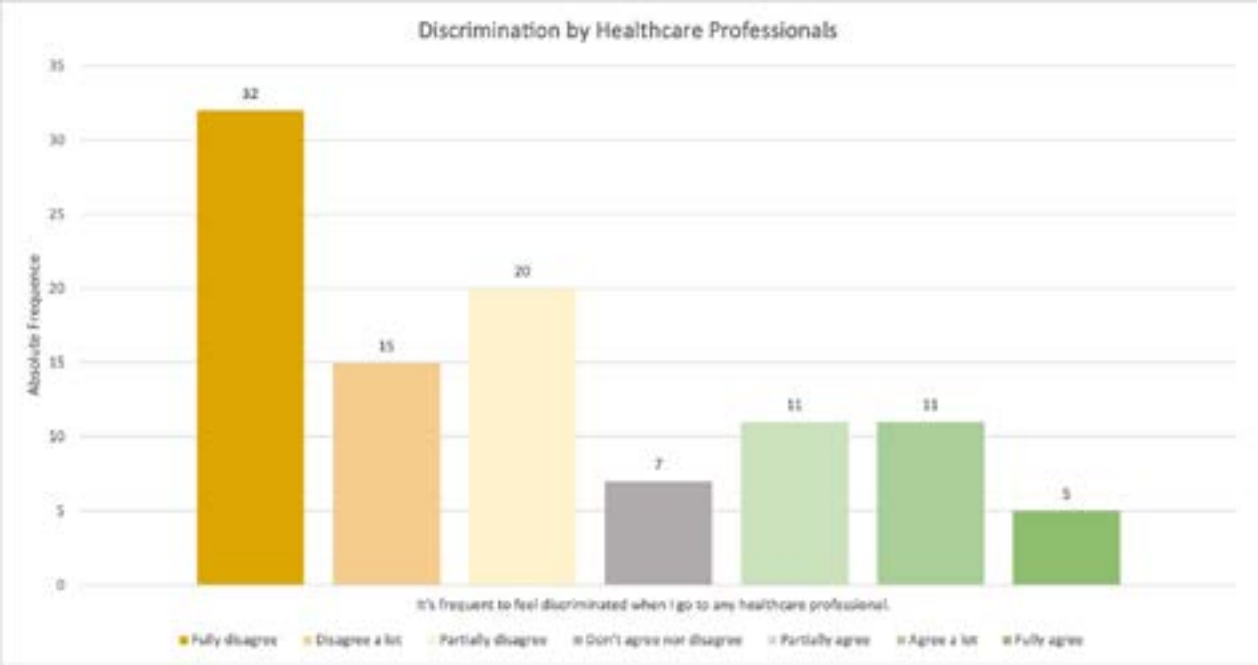

Figure 4. Q16 (Discrimination by Healthcare Professionals)

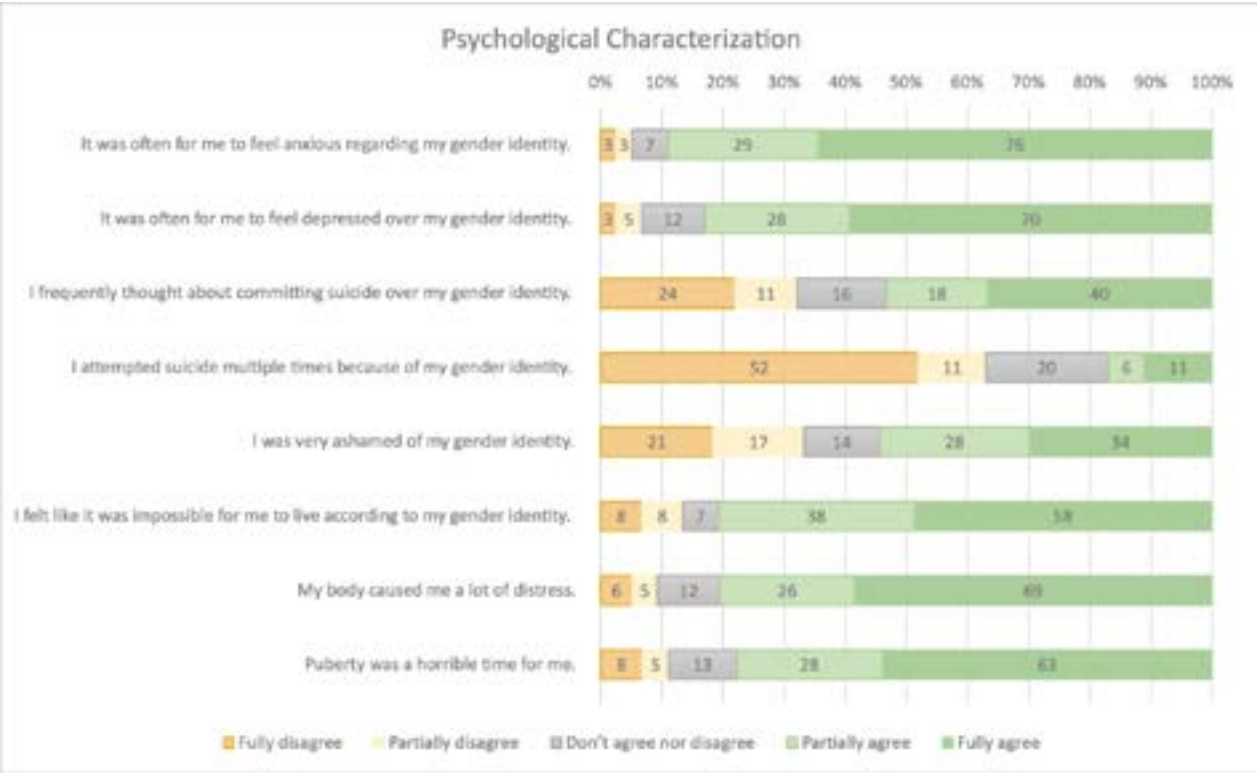

Figure 5. Q12 (Psychological Characterization)

DISCUSSION

a. Sociodemographic Characteristics

We verified an unemployment rate three times higher than the national unemployment rate for the same period (January 2022).[18] This may suggest some form of discrimination/added difficulty in securing employment or a source of personal income, constituting a clear obstacle to trans people's autonomy. However, the present study does not clarify the reasons behind this employment difference, nor does it claim to represent the entire Portuguese trans community. For those who do work, lack of support from peers and superiors seems to be an issue; however, our sample size might not be sufficient to draw any solid conclusions and forming them at this stage or generalizing them towards Portuguese reality might be perilous.

b. Childhood and Adolescence

As for the childhood and adolescence characterization, even though no statistically significant difference was found between how much the trans youth thought about gender and sexuality and how often these topics were discussed by their households, schools or peers, we still believe it to be relevant information, since that, without proper follow-up, the trans youth might explore these topics alone, especially since information (both true and false) is increasingly more accessible through the Internet. Being so, they might encounter erroneous, biased, or prejudicial information or use dubious sources, which might negatively impact their welfare and biopsychosocial development.

Regarding intolerance, it became clear that, when the household is intolerant, so are the peers, and vice-versa. Assuming that there is some geographic proximity between the household and the peers, and since this intolerance is somewhat homogeneously distributed throughout the national territory, we formulated "The Microclimate Model", where we believe that this intolerance could correspond to small microclimates uniformly dispersed throughout the country, whereas, nearby, tolerant microclimates could also be found (once again, homogeneously distributed throughout national territory). This impacts educational and social measures: rather than only take nationwide social awareness campaigns regarding trans issues, more intolerant nuclei could be identified and specific educational campaigns that could be contextualized in that nucleus' experience (religions, employment fields, educational level, etc.) could be implemented. This way, we hope to increase efficiency and trans people's social welfare.

c. Current Life

As for current life, a noteworthy increase in tolerance was substantiated. We admit two different explanations for this: on one hand, the household and peers present in current life could be different from the ones present during childhood and adolescence; on the other hand, these could be the same and that tolerance could have grown over time. For the first explanation, it is a positive thing that a large part of PwGD could find a tolerant microclimate, which might suggest that, within the Portuguese culture, these could be fairly accessible. As for the second explanation, it would be interesting to research, hereafter, how these households and peers evolved, to identify which elements might have contributed to this growing tolerance. These explanations are not mutually exclusive, so they can coexist; however, 20% of our sample claims to have completely cut ties with the family they grew up with, so the second explanation cannot be responsible for the entirety of the encountered difference.

d. Psychological Welfare

Regarding psychological characteristics, feelings of anxiety or depression were remarkably common. This may have an important impact on their autonomy, since it might harm their academic or professional performance, motivate prolonged absences, hinder job searches, or constitute financial costs (aggravating an already acknowledged financially challenged community). It is also concerning how 50% of our sample exhibited suicidal ideation and an important part has attempted it. All these mental health challenges were less prevalent in non-binary people, compared to trans men and trans women. This suggests that a non-binary gender identity might be a protective factor amidst gender diversity, and we admit two possible reasons why. Firstly, it is possible that non-binary people might view gender as a spectrum, whereas trans men and trans women might be more inclined to view it binarily – this allows for an integration of one's gender identity within a psycho-cultural model, resulting in a higher validation of their identity and decreasing mental health challenges. Secondly, under a spectrum view of gender, we theorize that, phenotypically, a non-binary gender identity might distance less from the birth-assigned sex; thus, phenotypic parameters, such as non-correspondence between body and gender identity, might be less intense than in trans men and trans women. It might be fruitful to dwell deeper on these considerations, in future studies, for better comprehension.

It seems plausible that, considering the intolerance, discrimination and different forms of violence described presently, this community ends up developing mental health challenges that hinder their quality of life. Given their prevalence, it seems important, in initial clinical contact, to ask about feelings of anxiety, depression, suicidal ideation, intent or previous attempts. Making these questions an integral and routine part of the initial approach could improve healthcare and follow-up. This way, the healthcare professional can, with the patient, prioritize and establish therapeutic targets and goals and formulate an intervention plan together.

e. Critical Analysis and Final Considerations

It is our understanding that the present paper managed to bring a brief look into PwGD's perspective over their childhood, adolescence, current life and psychological welfare. This and the numerical measurement and analysis of data was important to us, as this is a topic of great social debate, where proper information is often not used, not available or misused. We believe to have introduced some interesting explanations and concepts to the field and tried to bring some consensus to an increasingly evolving area (for example, with the designing of an original questionnaire for mental welfare evaluation, social and family conditions for further studies to use and compare results [A1], as well as the creation of a small syllabus to avoid misconceptions with the various concepts [Table 1]).

Nevertheless, some limitations are worth mentioning, to avoid the drawing of misleading conclusions. For one, we mean to highlight the sample size, which made it difficult to analyze certain variables as originally intended. We also acknowledge how the study sample may be unclear (for example, if they represent a sample harvested from a certain institution). We hoped to make a population-based study with a bigger sample size; however, resources were too short to accomplish this goal, and so we resorted to multiple professionals and organizations of different backgrounds (such as health and social associations) to help increase the sample size and make our sample as

diverse as possible, to make it as close as possible to a true population-based study.

We also acknowledge that some language may be too vague. However, this was done intentionally, as the mindset was to do an initial characterization of the family, social and psychological settings for PwGD, do a brief description and analysis and, from that point, according to our findings, motivate more concrete and directed studies to more specific issues. We believe to have achieved this goal and hope that these broad results motivate further research, per our original intention.

Finally, we believe to have been able to provide some insight into the challenges Portuguese PwGD face in their families, social environment and mental health. We believe this to be of great value, given how many people are still unaware of how common these challenges truly are, or question if these issues also occur in this country. We hope that these results bring some clarity on this matter and help raise some awareness and promote a more educated and empathic relationship with those who may be struggling.

RESPONSABILIDADES ÉTICAS

Conflitos de Interesse: Os autores declaram a inexistência de conflitos de interesse na realização do presente trabalho.
Fontes de Financiamento: Não existiram fontes externas de financiamento para a realização deste artigo.
Confidencialidade dos Dados: Os autores declaram ter seguido os protocolos da sua instituição acerca da publicação dos dados de doentes.
Proteção de Pessoas e Animais: Os autores declaram que os procedimentos seguidos estavam de acordo com os regulamentos estabelecidos pela Comissão de Ética responsável e de acordo com a Declaração de Helsínquia revista em 2024 e da Associação Médica Mundial.
Proveniência e Revisão por Pares: Não comissionado; revisão externa por pares.

ETHICAL DISCLOSURES

Conflicts of Interest: The authors have no conflicts of interest to declare.
Financing Support: This work has not received any contribution, grant or scholarship
Confidentiality of Data: The authors declare that they have followed the protocols of their work center on the publication of data from patients.
Protection of Human and Animal Subjects: The authors declare that the procedures followed were in accordance with the regulations of the relevant clinical research ethics committee and with those of the Code of Ethics of the World Medical Association (Declaration of Helsinki as revised in 2024).
Provenance and Peer Review: Not commissioned; externally peer-reviewed.

DECLARAÇÃO DE CONTRIBUIÇÃO

JLG: Contribuições importantes para a concetualização e desenho do estudo, recolha, análise e tratamento de dados, bem como para a interpretação dos resultados, elaboração de conclusões e redação do manuscrito.
CLL: Contribuições importantes para a conceção do estudo, análise dos dados, interpretação dos resultados, elaboração das conclusões e revisão do manuscrito.
ZMF: Contribuições importantes para a recolha de dados, interpretação dos resultados, elaboração das conclusões e revisão do manuscrito.
Todos os autores aprovaram a versão final a ser publicada.

CONTRIBUTORSHIP STATEMENT

JLG: Major contributions to study conceptualization and design, collecting, analysing and treating data, as well as interpreting results, drawing conclusions and writing the manuscript.
CLL: Major contributions to study design, data analysis, result interpretation, drawing conclusions and manuscript review.
ZMF: Major contributions to data collection, result interpretation, drawing conclusions and manuscript review.
All authors approved the final version to be published.

References

1. American Psychiatric Association. DSM-5 Task Force. Diagnostic and Statistical Manual of Mental Disorders: DSM-5. Chicago:APA; 2013.
2. Tangpricha V, Safer JD. Transgender women: Evaluation and management. [accessed Jan 2024] Available at: https://www.uptodate.com/contents/transgender-women-evaluation-and-management
3. Tangpricha V, Safer JD. Transgender Men: Evaluation and Management. [accessed Jan 2024]

Available at: https://www.uptodate.com/contents/transgender-men-evaluation-and-management
4. Forcier M, Olson-Kennedy J. Gender Development and Clinical Presentation of Gender Diversity in Children and Adolescents. [accessed Jan 2024] Available at: https://www.uptodate.com/contents/gender-development-and-clinical-presentation-of--gender-diversity-in-children-and-adolescents
5. World Health Organization. Defining Sexual Health. Geneva: WHO;2006.
6. World Health Organization. Gender and Health. [accessed Nov 2021] Available at: https://www.who.int/health-topics/gender#tab=tab_1
7. Coleman E, Radix AE, Bouman WP, Brown GR, de Vries AL, Deutsch MB, et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. Int J Transgend Health. 2022;23:S1-S259. doi: 10.1080/26895269.2022.2100644.
8. Collin L, Reisner SL, Tangpricha V, Goodman M. Prevalence of transgender depends on the "case" definition: a systematic review. J Sex Med. 2016;13:613-26. doi:10.1016/j.jsxm.2016.02.001
9. Johns MM, Lowry R, Andrzejewski J, Barrios LC, Demissie Z, McManus T, et al. Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students - 19 States and Large Urban School Districts, 2017. MMWR Morb Mortal Wkly Rep. 2019;68:67-71. doi: 10.15585/mmwr.mm6803a3.
10. Winter S, Diamond M, Green J, Karasic D, Reed T, Whittle S, et al. Transgender people: health at the margins of society. Lancet. 2016;388:390-400. doi:10.1016/S0140-6736(16)00683-8
11. Portugal. Lei no 38-2018. [accessed Jan 2022] Available at: https://dre.pt/dre/detalhe/lei/38-2018-115933863
12. Olson J, Forbes C, Belzer M. Management of the transgender adolescent. Arch Pediatr Adolesc Med. 2011;165:171-6.doi:10.1001/archpediatrics.2010.275.
13. Hoxmeier JC, Madlem M. Discrimination and interpersonal violence: reported experiences of trans* undergraduate students. Violence Gend. 2018;5:12-8. doi:10.1089/vio.2017.0003
14. Ellis SK. Accelerating Acceptance 2021. [accessed Jan 2022] Available at: https://assets.glaad.org/m/68ba2ac10bb87a16/original/Accelerating--Acceptance-2021.pdf
15. ILGA Portugal. Relatório Anual 2019 - Discriminação Contra Pessoas LGBTI+ 2020. [accessed Jan 2022] Available at: https://ilga-portugal.pt/ficheiros/pdfs/observatorio/ILGA_Relatorio_Discriminacao_2019.pdf
16. Rodrigues J, Lemos C, Figueiredo Z. Discriminação e Barreiras ao Acesso ao Serviço Nacional de Saúde Percecionados por Pessoas Trans. Rev Port Psiquiatria Saúde Mental. 2020;6:98–108. doi: 10.51338/rppsm.2020.v6.i3.152
17. Grossman AH, D'Augelli AR. Transgender Youth and Life-Threatening Behaviors. Suicide Life Threat Behav. 2007;37:527-37. doi:10.1521/suli.2007.37.5.527
18. República Portuguesa. Taxa de desemprego em janeiro é a mais baixa dos últimos 20 anos. [accessed April 2022] Available at: https://www.portugal.gov.pt/pt/gc22/comunicacao/noticia?i=taxa-de-desemprego--em-janeiro-e-a-mais-baixa-dos-ultimos-20-anos