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DOCTORAL THESIS

PSYCHOSOCIAL ADJUSTMENT IN QUEER WOMEN AND NON-BINARY PEOPLE:

INTERSECTIONS BETWEEN GENDER AND SEXUAL ORIENTATION

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All figures and illustrations are the original work of the author.

CONTENT WARNING

This research work contains information about LGBTQIAphobic violence.

Factors of stigmatization and discrimination that affect the mental health of the LGBTQIAQ+ community are analysed, especially those affecting queer women and non-binary individuals: people who identify as lesbians, bisexual, asexual, and aromantics.

If the reader may be sensitive to this type of content, caution is advised.
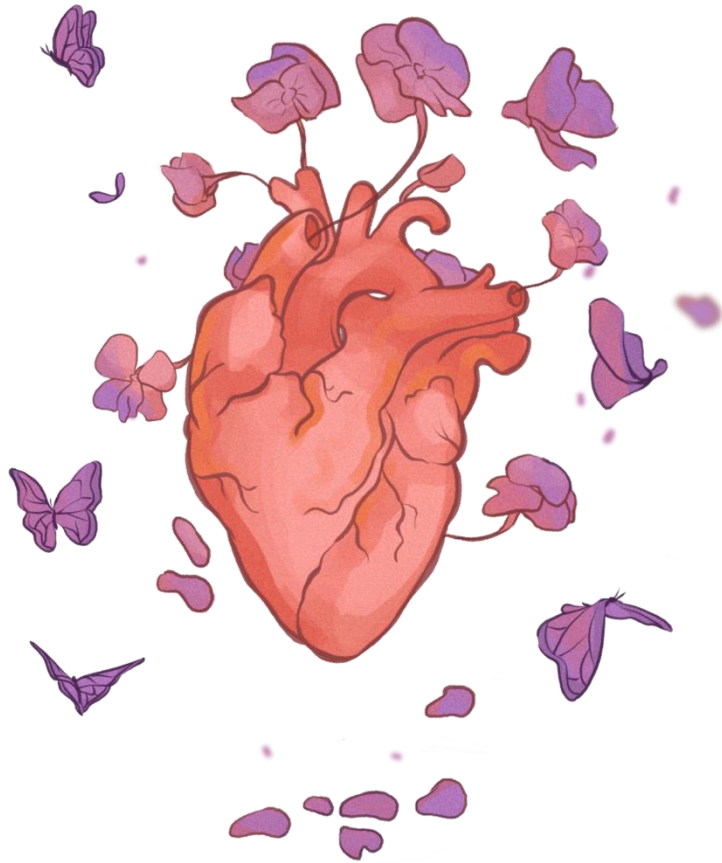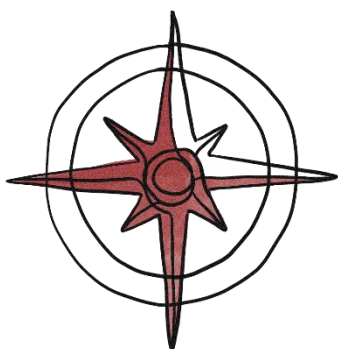

« In order to explore and celebrate something, it must first be allowed to exist.
In order for it to exist in my mind and yours – for its existence to be shared between us – it must first be named. »
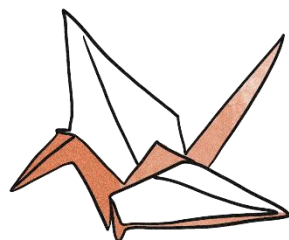
Eris Young, 2023

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ABSTRACT

People with gender and sexual minority identities face specific stressors that may put their psychosocial adjustment at risk. The study of intersectionality indicates that the overlap between stigmatizations could have a synergistic effect on the mental health and well-being of sexual minorities. Therefore, it is important to study the specific factors that influence the psychosocial adjustment of minority identities resulting from the intersection between sexual and gender identity, such as queer women and non-binary people (lesbian, bisexual, pansexual, asexual and aromantic).

The main objective of this study was to analyse the psychosocial and sexual identity-associated factors that influence the psychosocial adjustment of queer women and non-binary people. To this end, the following specific objectives were proposed: (1) Analyse the concordance between sexual and romantic orientation, (2) Analyse the influence of gender and sexual orientation on LB identity dimensions, psychosocial factors, and psychosocial adjustment, (3) Analyse the relationship between LB identity dimensions, psychosocial factors, psychosocial adjustment, and well-being, and (4) Analyse the influence of minority stress on psychosocial adjustment as a function of queer identity as determined by the intersection between gender and sexual orientation.

Following a cross-sectional, descriptive design, 1359 women and non-binary individuals aged 18-68 years (M= 27.69; SD=6.99) participated. Sociodemographic variables, affective-sexual orientation, LGB identity, psychosocial risk factors (minority stress) and protective factors (sense of community, outness, social support, self-esteem and emotional competencies), as well as their psychosocial adjustment (emotional symptomatology and well-being) were assessed.

The results showed that there is concordance between sexual and romantic orientation for lesbians and bisexual and aromantic individuals, but not for asexual participants. Non-binary people presented higher levels of minority stress and worse psychosocial adjustment than cis women. Regarding minority stress, lesbians showed higher levels of distal stressors, and asexual participants showed higher levels of proximal stressors than all other identities. All participants showed levels of psychosocial adjustment below the reference population. Minority stress was positively related to emotional symptomatology and negatively related to protective factors and well-being. In addition, minority stress and self-esteem were

shown to play a mediating role in the relationship between queer identity (determined by the intersection between gender and sexual orientation) and psychosocial adjustment.

In conclusion, these results highlight the synergistic effect of belonging to gender and sexual minorities and their impact on psychosocial adjustment. This study highlights the importance of including stigmatized populations in the scientific literature and studying the specific needs of each sexual identity to ensure their visibility and adequate mental health care.

GLOSSARY

LGBTIAQ+	Community that includes Lesbian, Gay, Bisexual or Pansexual, Trans, Intersex, Asexual and/or Aromantic, Queer and HIV positive people, and more.
Allosexual/Alloromantic	Experiencing sexual and romantic attraction towards other people, respectively.
Asexual/Aromantic	Experiencing low or no sexual or romantic attraction, respectively, towards other people.
Cis/cisgender	Those whose gender identity matches their gender assigned at birth.
Trans	An umbrella term for people whose gender identity does not match the gender assigned at birth. Transsexual, transgender and non-binary are concepts that fall under the umbrella term "trans".
Non-binarisms	All gender identities other than the binary genders "female" and "male". Non-binary gender, gender fluid or genderqueer are non-binarisms.
Queer	An umbrella term that encompasses all non-allosexual and/or heterosexual identities. Lesbians, bisexual and asexual people are queer people fall under this definition.
Heterosexism	A system of beliefs and biases that favours heterosexuality over sexual minorities.
Monosexual	Sexual and/or romantic attraction towards only one gender (homosexuality and heterosexuality are monosexual orientations)

Plurisexual	Sexual and/or romantic attraction towards more than one gender (bisexuality and pansexuality are plurisexual orientations)
Monosexism	A system of beliefs and biases that favours monosexual orientations over plurisexual orientations.
Intersectionality	The interaction between systemic inequalities due to social factors such as ethnicity, gender, or social class.
Allo/heteronormativity	The idea that allosexuality and heterosexuality are the norm, and any identity that is not allo/heterosexual is deviant and therefore open to social rejection. Also referred to as compulsory allo/heterosexuality.

CHAPTER I:

INTRODUCTION

This theoretical introduction will review the literature on the sex/gender system and its relationship with affective-sexual orientation, queer identities, psychosocial adjustment in queer women and non-binary people, and factors related to psychosocial adjustment in this population.

1.1. SEX/GENDER SYSTEM, AFFECTIVE-SEXUAL ORIENTATION AND SEXUAL IDENTITY

In order to understand the identity characteristics of queer women and non-binary people, the first step is to address the most basic concepts of human sexuality. This section will review the literature on the current sex/gender system and the four dimensions in which sexuality is described: biological sex, gender and gender identity, gender expression, and affective-sexual identity.

1.1.1. Biological sex

1.1.2 Gender and Gender Identity

1.1.3 Gender expression

1.1.4. Affective-sexual orientation and identity

1.1. Sex/gender system, affective-sexual orientation and sexual identity

The **sex-gender system** brings together a set of theories that attempt to explain how society organises human beings into social categories on the basis of their sexual differences. (Gupta, 2019). This system allows us to understand how gender-based social structures work, the reasoning behind this classification and its socio-cultural and psychological implications (Hyde et al., 2019).

The distinction between sex and gender is generally based regarding biological attributes (the factors that constitute biological sex) or social attributes (the social construction of gender and its relation to identity), respectively (Carlson, 2016). However, there are now contexts in which the terms sex and gender are used interchangeably. For example, as Cordelia Fine (2017) points out, the term "gender" is used in surveys to divide the sample into men and women, but it is often assumed that people will answer this item according to biological variables and not according to the psychological variables associated with their gender identity. Given this ambiguity, questions arise: What are sex and gender and how do they relate to other aspects of human sexuality, such as affective-sexual orientation? And how are these concepts associated with identity?

Concepts about human sexuality can be grouped into four dimensions, with different and related characteristics (Figure 1): (1) **Biological sex**, (2) **Gender identity**, (3) **Gender expression**, and (4) **Affective-sexual orientation**. To our knowledge, there is no consensus about who coined these terms, as they are part of the collective consciousness outside of scientific research and there does not seem to be a record of the first time they were used.

Figure 1.
Dimensions of human sexuality.
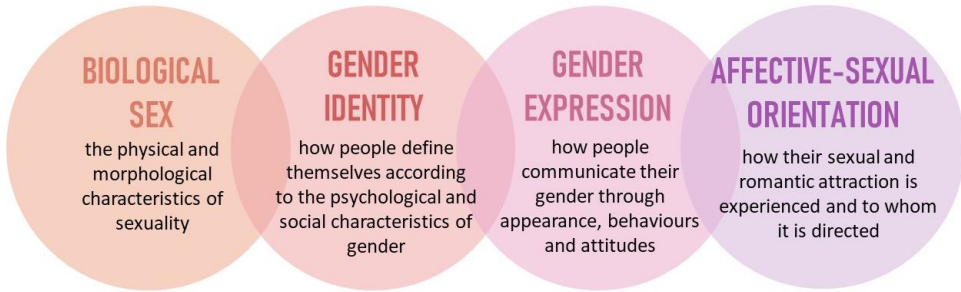
1.1.1. Biological sex

The delimitation of **biological sex** varies across disciplines. In biology, sex is used to divide animal species into males and females, according to biological markers of sexual dimorphism (Carlson, 2016). In medicine, it refers to the anatomical and genetic factors that categorise humans into females and males, which indicate the category to which an infant is assigned at birth (Heise et al., 2019). In neuropsychology, behavioural patterns typical of these categories have been identified, pointing to the existence of a "female brain" and a "male brain". (Fine, 2010). According to these definitions, biological sex could be defined as the set of biological factors that determine whether an individual is male or female, that is, that allow to assign them to a category within the dichotomous classification established by society (Karkazis, 2019).

Studies of biological sex usually refer to the work of John Money in the 1950s at Johns Hopkins University (Money & Ehrhardt, 1972). This team identified a large number of variables that determine biological sex, which can be gathered into four factors: **chromosomes**, **hormones**, **gonads**, and **internal and external genital morphology**. As previous research has shown, each of these traits has more than

two forms in nature (Blackless et al., 2000; Fausto-Sterling, 2012). **Chromosomal sex** is considered female when the sex chromosomes are XX, and male when they are XY. According to this chromosomal sex, the gonadal sex develops, forming ovaries or testes from the XX or XY chromosomes respectively, these gonads are involved in the secretion of their respective sex hormones (hormonal sex), which allows the formation of the internal reproductive organs and external genitalia. This chain in sexual development has traditionally been understood as binary: the XX and XY chromosomes are responsible for the formation of ovaries or testes, which will produce oestrogens or androgens that will result in the development of a vulva or penis respectively. However, from the chromosomal sex that makes up the first layer of sexual development, a multitude of variations have been observed, such as the appearance of XXY, XYY or XO chromosomes, which do not necessarily present physical manifestations at birth or in later sexual development (Hyde, 2005). Furthermore, due to the complexity of this process, a baby with XX chromosomes may be born with a penis and a baby with the XY variant with a vagina, which is also considered a non-pathological form of sexual development (Fausto-Sterling, 2021).. People with variations in their biological sex that do not fit into the binary classification of biological sex are referred to as *intersex* (Carpenter, 2018). A review of the medical literature from 1955 to 2000 (Blackless et al., 2000) estimated that around 1.70%-2% of the world's population is intersex, according to available statistics. There is an open debate when it comes to establishing criteria for detecting intersex characteristics in newborns, with some suggesting chromosomal alterations, while others such as Anne Fausto-Sterling indicate that any non-dimorphism in sexual development is intersexual (Fausto-Sterling, 2012). Therefore, and due to the lack of data in many countries, it is estimated that this percentage could be higher.

One model that can explain this biological variability is the **bimodal model of biological sex** (Carlson, 2016). Unlike the traditional binary model, the bimodal perspective suggests that, in humans, this construct is not explained by two dichotomous categories (male-female), but by a spectrum with two poles: the more "feminine" pole and the more "masculine" pole. In the first pole are the biological sex factors associated with the female category of sex: XX chromosomes, greater presence of oestrogens and morphological sex made up of ovaries, vagina and vulva; in contrast to the male category, made up of XY chromosomes, greater

presence of androgens and genitalia made up of penis and testicles. On a continuum between these two poles are all the other biological sex variants that fall under the intersex label, but have myriad combinations and unique sex characteristics. This spectrum captures the most recent evidence about the biological and physiological functioning of what we consider "sex" in the human species and presents an opportunity to rethink social structures based on sex roles that rely on a binary system of classification (Karkazis, 2019).

Despite this new conceptualisation of biological sex, according to the sex/gender system in the West, intersexuality is still considered an anomaly (Carpenter, 2018). An intersex infant cannot easily be assigned to binary categories such as "boy" and "girl"; however, there is still a legal need to assign them to one of the categories into which society is structured: male or female (C. R. McCann et al., 2020). Historically, intersex people have been raised as either girls or boys, in some cases undergoing surgery to "construct" internal and external genitalia that correspond to one of the two sexes recognised by society: vulva and vagina if the chosen sex is "girl", penis and testicles if the decision is "boy" (Behrens, 2020). This practice is becoming less and less frequent: despite its normalisation and the fact that it still exists, there is growing social awareness of how these surgeries violate human rights and the physical integrity of people after birth (Monro et al., 2020). (Monro et al., 2021; Zeeman & Aranda, 2020).

This allocation largely determines the way in which people will develop in society from childhood onwards, as it places them in a "social position" associated with roles and behaviours for men and women. This position is what we know as gender (Hammack et al., 2022; Hyde et al., 2019).

1.1.2 Gender and Gender Identity

Gender can be defined as the way people feel about the behaviours, functions and roles they perform in society, and the place they occupy on a socially defined gender spectrum, i.e. how they self-identify regarding gender (Hakeem, 2018). In this identification, there are psychological, emotional, social, political and ideological components, reflecting the complexity of this construct and the difficulty of addressing it from scientific disciplines (Diamond, 2020; Luyt, 2013).

As is the case with biological sex, in psychology there are debates and nuances in the delimitation of gender (Baltes-Löhr, 2018). As historically understood in this social context, gender is a dichotomous construct in which there are two categories: women, who present themselves in society with a feminine gender expression, and men, who express themselves through masculinity (Cislaghi & Heise, 2020). Society functions according to these two human categories: women and men, who have their socially assigned characteristics and are compelled to exercise the assigned roles and tasks expected of them (C. R. McCann et al., 2020).

However, since gender is a social construct, it has been delimited in different ways according to **historical and cultural contexts**. For example, among Native peoples in North America, the term "Two-Spirit" described people who did not fit into the male-female gender binarism, and constituted a gender in its own right (Sheppard & Mayo, 2013). "Two-spirit" people presented identities, roles, expressions and activities of both women and men, and they disclose experiencing both genders simultaneously in a fluid way. Today, the LGBTIQ+ community is reclaiming the traditions associated with this gender and reclaiming their presence as part of the preservation of indigenous culture (Robinson, 2019). In the Zapotec community of Istmo, in Mexico, the term "muxe" is used to describe men who adopt a feminine role in the way they express their gender, forming a socially accepted "third gender"; there does not seem to be a gender for women who adopt a masculine role (Molina & Díaz, 2020; Ramirez & Munar, 2022). The Bugis, an ethnic group on the island of Sulawesi, Indonesia, socialise in five distinct genders: women who express themselves in feminine ways are called "makkunrai"; men who express themselves from masculinity are "oroani"; masculine women are "calabai"; feminine men, "calalai"; and people with fluid or mixed identities are called "bissu" (Satrianegara et al., 2021). This cultural diversity suggests that gender is a social construct dependent on cultural context, and like biological sex, can be explained through models that go beyond binarism ((Karkazis, 2019).

In recent decades, literature on gender identity indicates that this phenomenon is better explained as a **continuous spectrum** rather than dichotomous categories (Figure 2) (Monro, 2005; Rahilly, 2020). The **biopsychosocial model of gender** understands this construct on a **bimodal spectrum**, similar to the bimodal model of biological sex (Baltes-Löhr, 2018). According to this model, there are two poles on

a continuum: at one pole is the gender identity "woman" and at the opposite pole, "man", with a multitude of genders between the two poles that we understand as "non-binarisms" (Aparicio-García et al., 2018a). This is an umbrella term that encompasses all genders that are not at the extreme ends of the spectrum: non-binary gender (also known as "the third gender", representing people whose gender is different from female or male), gender fluid (those who fluctuate between identifying as female, male or any other gender), genderqueer (a type of non-binary gender that defines itself as dissenting from traditional gender binarism), among others. There are people who do not identify with any gender, meaning their identity is made up of psychological characteristics that are not related to gender, so they are not women, men, or non-binary people. These people are called *agender* (T. Morrison et al., 2021).

While the bimodal model has been used as an inclusive alternative in the study of gender, recent studies point out that it may be inadequate to describe the reality of non-binary people (Monro, 2019). Non-binary is a gender category that does not necessarily fall in a middle ground between two other genders (woman and man), but is described as a gender beyond the gender binary, fluctuating between genders or rejecting the gender binary altogether (Scandurra et al., 2019; Schudson & Morgenroth, 2022).

Figure 2.
Bimodal gender spectrum.
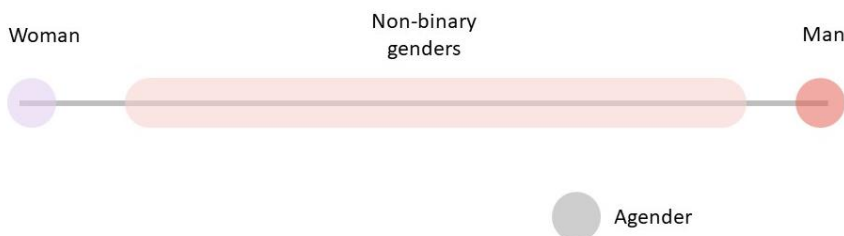
Thus, sex assigned at birth (female or male, girl or boy) does not necessarily correspond to all the factors associated with biological sex (chromosomal, gonadal, hormonal and morphological sex); similarly, the gender category assigned at birth based on sex (female or male) will not necessarily correspond to the person's gender identity (Karkazis, 2019). For most people, sex and gender identity correspond (for example, they were assigned the sex "girl" and in childhood they identify as a girl, and in adulthood as a woman) (Hakeem, 2018). These people are referred to as *cisgender* or *cis*, while people whose sex assigned at birth does not correspond to their gender identity are referred to as *transgender* or *trans* (Darwin, 2020). *Trans* is an umbrella term that encompasses all identities that are not cisgender, both binary (e.g. a trans woman, who was assigned the sex "boy" at birth) and non-binary (e.g. gender non-binary or gender fluid). Thus, in the model shown in Figure 2, at the "female" end would be all people who identify as female, both cisgender and transgender.

Gender identity, being a social construct, is closely related to the processes of socialisation in adulthood (Rivera & Scholar, 2020). According to Judith Butler (1988, 2004), gender has two main components: the identity component, which corresponds to the "being" felt by the person (how a person identifies herself, her gender identity), and the performative component, which refers to the "doing" (how a person communicates her gender in social contexts) (Anderson, 2020; West & Zimmerman, 1987). This second component is referred to as *gender expression*.

1.1.3 Gender expression

Gender expression is the way in which gender is communicated through behaviours, attitudes, appearance and language (Gottlieb, 2019). It is primarily associated with the categories of femininity, which are the characteristics traditionally associated with girls and women, and masculinity, which is attributed to boys and men. Traditionally, both forms of gender expression have been attributed to biological factors. (Anderson, 2020). However, research on gender expression in recent years suggests that socialisation processes in childhood may explain these behavioural differences (Rivera & Scholar, 2020).

Firstly, children learn from the role models around them through vicarious learning (Zosuls et al., 2009). If they grow up in a family with a feminine mother and a masculine father, they are more likely to express the gender that has been assigned to them in accordance with this observed model (Ellemers, 2017). Second, information about which characteristics correspond to one gender or the other is received from sources beyond the family: books, films, series, content in school textbooks, and beliefs or stereotypes conveyed by peers (C. R. McCann et al., 2020).. Finally, the way in which girls and boys are educated can be significantly different depending on their gender: it has been observed that the expectations and beliefs that mothers, fathers, educators and caregivers have about gender have a direct influence on the gender identity and gender expression of girls and boys (Rivera & Scholar, 2020; Witt, 1997). Studies of mothers' behaviour towards their daughters and sons have found that mothers tended to overestimate their sons' motor skills and underestimate their daughters' motor skills, and spoke more frequently and with greater emotional content to girls than to boys (Fine, 2010, 2018; Mondschein et al., 2000). These findings indicate that gender-associated behaviours are part of social learning and may vary according to environmental stimuli across the lifespan.

Given that femininity represents behaviours generally associated with women, and masculinity with men, we could place gender expression in the same scheme as gender itself (Monro, 2005) and be represented as a **continuum** with **two opposing poles** (femininity and masculinity) and, in the middle, ambiguous expressions of gender called androgyny (Sedney, 2020). **Androgyny** combines the Greek roots *andro*, man, and *gyné*, woman, and represents all those expressions of gender that either adopt feminine and masculine characteristics, or just incorporate gender-neutral or gender-blind behaviours and expressions (Butler, 2004; Gunn et al., 2021).

Regardless of the origin (biological and/or environmental) of gender expression, recent research suggests that the attributes associated with femininity and masculinity are expressed differently in each gender (Gupta, 2019; Sedney, 2020). Gender identity and gender expression are associated with how a person relates to others, as they use certain social codes to be perceived as gendered (Anderson,

2020). This way of communicating one's identity is related to other factors of human sexuality, such as affective-sexual orientation and identity (Andler, 2021).

1.1.4. Affective-sexual orientation and identity

Scientific communication about human sexuality emphasises the difference between gender identity, gender expression and sexual orientation (Pecora et al., 2020). Gender identity refers to the way people feel about the behaviours, roles and social positions attributed to women, men, non-binary people and other gender options (Levitt, 2019). Gender expression explains how people communicate or manifest that gender identity in behaviour (Gottlieb, 2019). **Affective-sexual orientation**, or sexual orientation, indicates a person's affective and sexual attraction to others (Schweizer & Brunner, 2013). This term encompasses the different ways a person feels, romantically and sexually, towards other people, and has evolved since the early days of its study as new ways of relating have emerged (van Anders, 2015).

In the mid-20th century the term "sexual preference" was extended by the Kinsey Institute for Research in Sexuality, which was later replaced by "sexual orientation" (Kinsey et al., 1948). The idea of "preference" implied that a person can choose who they are attracted to and that this attraction fluctuates easily as a matter of "taste" (Horley & Clarke, 2016). The concept of "sexual orientation" was alternatively proposed as not having these connotations, indicating only towards whom sexual attraction is directed. However, its delimitation is still debated, as it encompasses very different aspects associated with intimate relationships: sexual attraction, romantic attraction, the gender towards which the attraction is directed, the gender of the person who is attracted, whether the attraction is directed towards one gender or multiple genders, and sexual identity (Antonsen et al., 2020; Diamond, 2000). In current research, the terminology associated with sexual orientation can be grouped into three parameters: (1) **whom the attraction is directed to**, (2) **to what extent sexual attraction exists**, and (3) **to what extent romantic attraction exists** (Carvalho & Rodrigues, 2022; Clark & Zimmerman, 2022; van Anders, 2015).

Regarding the first parameter, attraction to people of the same gender is called *homosexuality* and the most commonly used terms to identify these people are *lesbian* in the case of women and *gay* in the case of men (Salvati et al., 2019). Because traditional sexual orientation labels have been conceived from **gender binarism** (the idea that there are only two genders: male or female), there are no terms to accurately describe non-binary people. As such, they can adopt any of these labels if they suit the way they experience their sexuality (Hord, 2020). People who are attracted to the "opposite gender" (usually women in the case of men and vice versa) are called *heterosexuals* (Travis, 2019). This term is less commonly used by non-binary people as it represents more traditional conceptions of gender and sexuality. People who are attracted to people of the same gender and other genders, or all genders, are called *bisexual* (Shaw, 2022). The terms **bisexual** and **pansexual** (attraction to all people regardless of gender) have often been used interchangeably and the choice of one label or the other is often a matter of personal preference: bisexual is more widely used in science and is part of the LGBTI acronym; pansexual has emerged more recently to emphasise connotations of attraction to people regardless of gender, but they could both function as synonyms (Hayfield, 2020; H. McCann, 2022)..

With regard to the second parameter, **sexual attraction** refers to sexual interest in another person or persons and the desire to establish sexual contact with someone (Yule et al., 2017). It can be experienced in varying degrees: it is possible to feel high sexual attraction, only under certain conditions, or none at all (Cerankowski & Milks, 2014). This variability could be represented as a continuum that fluctuates from the presence of sexual attraction, named *allosexuality*, to the absence of sexual attraction, named *asexuality* (Houdenhove, Gijs, T'Sjoen, et al., 2014). This spectrum is independent of the target of the attraction, if any: for example, women who are attracted to other women would be lesbian and allosexual (Gupta, 2019; Su & Zheng, 2023). Asexuality is a sexual orientation that until recent decades has been underrepresented in research and there is still a scarcity of knowledge about how people on the asexual spectrum experience intimate relationships (Clark & Zimmerman, 2022; Glass, 2022; Gupta, 2019). For example, there is still confusion between sexual desire and sexual attraction (Carvalho & Rodrigues, 2022). Asexual people, although not necessarily so, may feel the same sexual desire as allosexual people, but this desire is not directed towards

other people (Glass, 2022). These manifestations of the asexual spectrum are common and are not associated with psychological or physical pathologies (Gupta, 2019; Kay, 2022). Because it is a spectrum, there are individuals who identify themselves halfway between allosexuality and asexuality. Figure 3 shows a graphical representation popularised by AVEN (2023) that is currently used in scientific research to represent the two parameters of sexuality explained above: the degree to which sexual attraction exists (allosexual-asexual axis) and towards whom, if anyone, sexual attraction is directed (heterosexual-bisexual/pansexual-homosexual axis). People who are at intermediate points on the spectrum are called **demisexual** or *greysexual.* (AVEN, 2023). Although demisexuality is an under-researched term in psychology, there is some consensus in the literature about its definition: demisexual people are those who only experience sexual attraction to another person when there is an emotional attachment to them, or when their relationship has reached a certain level of trust and intimacy (Winer et al., 2023). (Winer et al., 2022).. In the spectrum of asexuality depicted in Figure 3, allosexual people would be at the upper pole, asexual people at the lower pole, and demisexual or greysexual people would be at intermediate points on this spectrum. While it is true that this representation has contributed to the visibility of sexual orientations within the asexual spectrum, one of the criticisms of this graph is that it does not take into account the third parameter of human sexuality: romantic attraction. (Young, 2022).

Figure 3.

Spectrum of asexuality (own elaboration, adapted from AVEN, 2023).
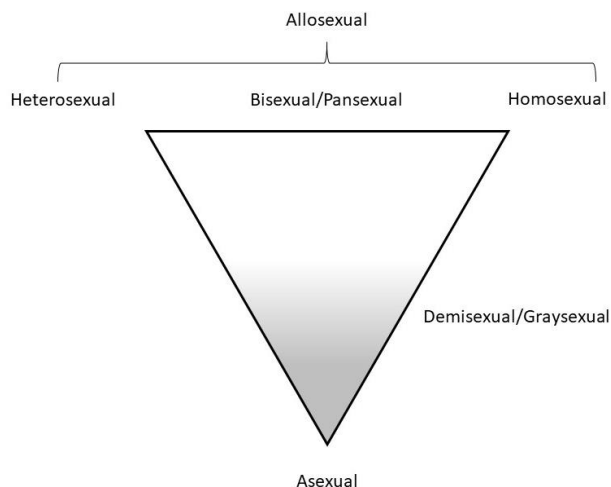
Romantic attraction refers to romantic interest in another person or persons and the desire to form a romantic attachment.(Savin-Williams, 2022). It is described on a continuum similar to sexual attraction: people who experience romantic attraction are called *alloromantic* and people who do not experience romantic attraction are called *aromantic* (Carvalho & Rodrigues, 2022). As with the spectrum of asexuality, on the spectrum of aromanticism there are identities that fall somewhere in between ***alloromanticism*** and ***aromanticism***, commonly referred to as "demiromantic"; however, this term has not yet been studied in depth and there is no consensus in science about its definition (Young, 2022). (Young, 2022).

The three parameters described above are seen as **complementary** and together they aim to explain the very wide variability and manifestations of sexual orientation (Bougie, 2021; van Anders, 2015). Statistically, a majority of people have an allosexual and alloromantic orientation, regardless of the gender to whom they are attracted (Clark & Zimmerman, 2022). However, there are multiple **combinations** between these three parameters (Antonsen et al., 2020; Clark et al., 2023). For example, a person who does not experience sexual attraction but is romantically attracted to all genders could be identified as asexual and biromantic (Kelleher & Murphy, 2022). The consideration of these three parameters,

understood as complementary continuums, gives rise to a series of labels that seek to make visible the wide diversity of forms of human bonding, and the one with which the person identifies is associated to sexual *identity* (Savin-Williams, 2022).

Sexual identity has been extensively studied in the literature in psychology, as the way it is experienced and manifested has significant individual variability: the same identities (labels) can be manifested in different ways by different people (sexual orientation) (Horley & Clarke, 2016). Sexual identity is generally defined as the way in which a person identifies with their sexual orientation, i.e. to what extent and how the way in which a person experiences sexual and romantic attraction and to whom (sexual orientation) is linked to and constitutes a fundamental part of the self (identity) (Walton et al., 2016). Some studies point out that sexual orientation could be defined as the patterns of attraction and their associated behaviours, and sexual identity as the way in which a person identifies regarding these patterns and behaviours (Clark & Zimmerman, 2022; Horley & Clarke, 2016; Su & Zheng, 2023; van Anders, 2015). For example, a woman might be attracted to both men and women, but not necessarily identify as 'bisexual', as identifying as non-heterosexual could have implications beyond attraction, such as exposing herself to social rejection (Savin-Williams, 2022). An accurate understanding of sexual orientation and sexual identity would involve taking this terminological difference into account, assessing sexual orientation by asking questions about towards whom sexual attraction and romantic attraction are directed, and sexual identity by assessing how the person identifies regarding these parameters (Su & Zheng, 2023; Szoko et al., 2023).

Sexual identity has been studied primarily from the perspective of **diversity**, as when it coincides with the norm (heterosexuality) it is less likely that the person will reflect on how they identify according to their sexuality: being normative is assumed to be natural and not necessary (Gordon & Silva, 2015; Savin-Williams, 2022). Studies on sexual identity have mainly taken place in the context of the **LGBTIAQ+** community. These acronyms represent lesbian (L), gay (G), bisexual (B), trans (T) and intersex (I) people, those on the asexual and aromantic spectrum (A), people who identify as *queer* (Q) and other identities that fall on this spectrum, such as pansexuality. The + symbol is intended to represent these identities, as well as people who have experienced discrimination on the basis of their HIV status (if

they are HIV-positive, especially those with non-normative sexual identities) (Tomar et al., 2021).

Summary

Human sexuality can be defined along 4 dimensions:

·   Biological sex: groups physical and morphological characteristics of sexuality.
·   Gender identity: refers to how people define themselves according to the psychological and social characteristics of gender.
·   Gender expression: indicates how people communicate their gender through appearance, behaviours and attitudes.
·   Affective-sexual orientation: describes how a person's sexual and romantic attraction is experienced and to whom it is directed. It is related to sexual identity, which indicates how a person identifies regarding social, cultural and psychological aspects of their sexuality.

1.2. QUEER IDENTITIES

All queer identities are dissident from the social norm, and therefore have common characteristics that can be studied together. However, people with different sexual identities follow different processes of identity development, marked by the socio-political context. That is, each of these identities deviates from the allo/heteronormativity in a unique way and their development and visibility may vary from one to another. According to the intersectionality perspective, belonging to more than one minority group can have a synergistic effect on their experience of stigma and discrimination. Therefore, in this section we will look at the sexual identities of queer women and non-binary people most frequently addressed in the literature: lesbian identity, bisexual and pansexual identities, and asexual and aromantic identities, both together and separately.

1.2.1. Queer identity development

1.2.2 Visibility of queer identity

1.2.3 Intersectionality

1.2.4. Sexual identities of queer women and non-binary people

1.2. Queer identities

The term **queer** was one of the first terms used to refer to people with non-normative sexualities, originally in a pejorative way (Casar, 2021). Since the 1960s, queer has been reappropriated by the community and is now an **inclusive term** that encompasses the full diversity of the collective and can have different nuances depending on the context in which it is used (Fish & Russell, 2018; Horley & Clarke, 2016). The most recent LGBTI research points out that the term "queer" is a "macro-label", i.e. an umbrella term that encompasses other "micro-labels", such as "lesbian" (Glass, 2022). Depending on the approach, "queer" can refer to: (1) gender identities and dissident gender expressions, which do not fit classical gender stereotypes, including all those under the umbrella term "trans"; or (2) non-normative sexual identities, i.e. all those sexual identities that do not fit into heterosexuality: lesbians , gays, bisexual, pansexual, asexual and aromantic people, among others (Bettergarcia et al., 2021; Guyan, 2022; Robertson, 2019). In this study, the term "queer" will be used to refer to the second meaning, reflecting the diversity that exists in relation to affective-sexual identity.

The term became popular in the social sciences with the development of **queer theory** in the mid-1990s (Butler, 1999; Schor & Weed, 1997). This theory explains affective-sexual and gender diversity through a critique of classic notions of human sexuality (Butler, 2020). It suggested that sex and gender are non-binary, socially configured constructs and offered the term "queer" as a way of representing sexuality from outside heteronormativity (the idea that heterosexuality is the "normal" sexual orientation and all other sexualities are a deviation from the social norm) (McDermott et al., 2019). Based on this theory, "queer" can encompass all people whose sexuality lies outside the allo/heteronormativity (Casar, 2021; Szoko et al., 2023)..

Allo/heteronormativity (derived from "allonormativity" and "heteronormativity") refers to the social bias that places allosexuality and heterosexuality as the social norm, and any orientation or identity that is not allosexual or heterosexual as deviant (A. L. Mollet & Lackman, 2021). Alloromanticism would also be part of this type of bias, but has not yet been incorporated into scientific research on these constructs. The term "allonormativity" is more recent than "heteronormativity", and both concepts are

increasingly integrated as part of the same phenomenon: only normative identities are universally socially accepted, and any other identity is outside the norm (Barnett et al., 2020; Kennon, 2021). Under this premise, queer identities (i.e. not allo/heterosexual) such as lesbian, bisexual or asexual identities suffer from the stigma derived from not belonging to what is considered "normative", which is often the reason for discrimination against these communities (C. Brown & Maragos, 2022). In recent decades, research in human sexuality has incorporated the perspective of diversity, developing inclusive models that consider identities beyond allo/heterosexuality (Moagi et al., 2021; Szoko et al., 2023)..

One of the models of sexuality that best explains the relationship between sexual orientation and queer identities is Van Anders' (2015) Theory of Sexual Configurations (Figure 4 shows the parameters of this theory applied to a practical example, in this case, a bisexual person). This theory presents a model that differentiates three parameters in the multiple manifestations of affective-sexual orientation:

1. **Sexual and romantic attraction**. This factor indicates at what level sexual and romantic attraction is present, within the parameters explained above, and to whom it is directed. It is a descriptive factor of the feelings and emotions associated with sexual orientation.

2. **Sexual identity**. This parameter points to the label with which the person identifies. Each sexual identity (lesbian, bisexual, asexual) represents a sub-community with common social and cultural characteristics and may correlate with attraction, but does not always do so. A person may align with an identity (e.g. a lesbian woman), even if her attraction does not exactly match the characteristics of this identity (e.g. she is also attracted to men).

3. **Sexual behaviour**. This indicates with whom, how and how often the person engages in sexual and/or romantic relationships. As with the previous parameters, it does not necessarily correlate with sexual orientation and sexual identity. That is, to whom the attraction is directed and how the person identifies is not always an accurate indicator of with whom the person establishes romantic and sexual links.

Figure 4.
Parameters of human sexuality. Example of a bisexual person (own elaboration, inspired by the model of Van Anders, 2015).
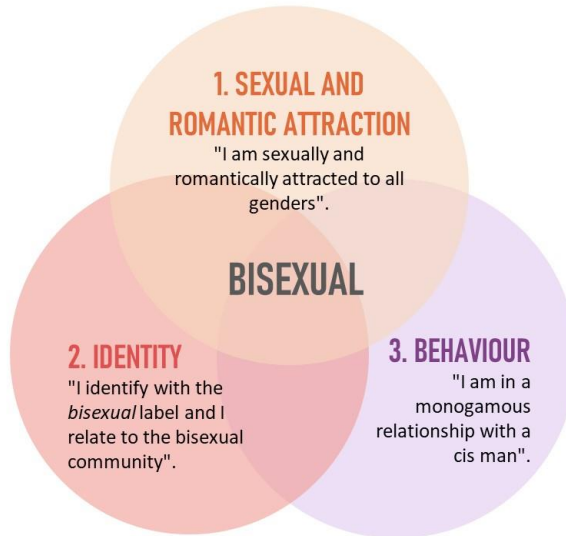
According to the author, these three dimensions encompass the spectrum of human sexuality and more accurately reflect the diverse reality compared to previous models. This theory can be applied to all people, regardless of gender or sexual orientation. However, the author emphasises that this theory has its foundations in feminism and queer theory, and therefore allows for an understanding of human sexuality from the perspective of diversity. According to this model, the three parameters of sexuality are related to each other, but their relationship has great individual variability. For example, a person may (1) be attracted to all genders, (2) identify as homosexual, and (3) have sexual and affectional relationships only with people of the same gender, as well as having had sexual experiences with people of other genders in the past. This suggests that queer identity does not necessarily reflect who a person is attracted to or what their sexual and affectional bonds are like, but always places the person outside of

the heteronormativity (Butler, 2020). Thus, it functions as an umbrella term for all identities beyond allo/heterosexuality (Guyan, 2022).

1.2.1. Queer identity development

Models of affective-sexual identity tend to have two main characteristics: on the one hand, they explain the processes of development and consolidation of sexual identity, explaining it through milestones or stages; on the other hand, they tend to focus on the **LGB** (Lesbian, Gay and Bisexual) **population** (Swan, 2018). Normative sexual identities (heterosexuality and allosexuality) are often explained in terms of the dimensions that comprise it, rather than its development (Martinez & Smith, 2019). This may be because allo/heterosexuality is assumed to be the norm and people assume that they belong to this norm before they consider that they may have a different sexual orientation (Walls, 2008). Developmental models often explain the latter process, the construction of a sexual identity that is different from the norm (Goodrich & Brammer, 2021)..

One of the most widely used models of queer identity is Mohr and Fassinger's (2000) model of sexual identity development as revised by Mohr and Kendra (2008, 2011). These authors developed a dimension-based model, in contrast to previously published linear models. Moreover, it is a model specific to lesbian, gay and bisexual identity, so that it is only applicable to allosexual and alloromantic people. In its latest revision, this model consists of eight dimensions describing different aspects of sexual identity development:

- · **Concerns about acceptance**. These are fears associated with other people's negative evaluation of one's sexual orientation. It is based on the anticipation of negative experiences, one's own or others', about the social acceptance of one's sexual orientation.
- · **Invisibility motivation**. Tendency not to disclose sexual orientation, motivated by a desire to protect oneself from the social consequences of having a dissident sexual identity.
- · **Internalised Homonegativity/Binegativity**. A pattern of negative thoughts and beliefs about homosexuality or bisexuality, which can lead to rejection of one's sexual orientation.

·   **Identity uncertainty**. This dimension refers to the confusion or insecurity associated with the development of a non-normative identity, and is often present in other models of sexual orientation.

·   **Difficulty in the process**. The person's perception of how easy or difficult it is to construct a non-normative sexual identity.

·   **Identity superiority**. The authors suggest that this is a "compensatory" strategy, i.e. a form of coping with external discrimination or internalised homo/binegativity that results in the idealisation of one's own identity over heterosexuality.

·   **Identity affirmation**. This refers to positive thoughts about one's sexual orientation, and involves a sense of belonging to a community of peers with similar sexual identities.

·   **Centrality of identity**. The importance of sexual identity to a person's self, the centrality of homosexual or bisexual orientation to one's identity. For some people, being LGB does not influence their self-perception or the expression of their identity, while for others, their sexual identity is essential and inseparable from who they are and how they present themselves to the world.

On gender and sexual identity differences, there is still a scarcity of literature indicating which groups have higher levels on each of these dimensions. There seem to be no studies on how different genders differ in queer identity processes, especially in the comparison between cis or trans: research tends to be divided between the exploration of gender identity and sexual identity, but does not seem to have studied the combination of both in these dimensions of LGB identity. There are studies that point out that bisexual people tend to have higher levels of identity uncertainty than homosexual people, and highlight that this difference may be due to the monosexist tendency to understand sexual identity as a binary (heterosexual/homosexual), which hinders the development of identity processes for bisexual people (Cramer et al., 2018; Mohr & Kendra, 2011). To our knowledge, there seem to exist no studies exploring these dimensions of asexual identity.

As we will explain below, there are few models that explain the development of asexual identity (Swan, 2018). This could be explained by the fact that models of sexual identity tend to focus on the characteristics of sexual attraction and how this

influences one's identity (Gupta, 2019). A sexual orientation based on the absence of attraction could be difficult to address, especially the development of an asexual identity, as so far it has been attempted to define asexuality from what it "is not" (Kelleher & Murphy, 2022). Along these lines, queer identity models suggest that each of these identities undergoes unique developmental processes, and people belonging to each of these groups experience and communicate their identity in different ways (Edge et al., 2021; Feinstein et al., 2021; Hamilton-Page, 2022). This is where the concept of *visibility* can be addressed.

1.2.2 Visibility of queer identity

Similarly to gender identity, sexual identity can be expressed behaviourally in a variety of different ways (Walton et al., 2016). Queer gender expression in Spanish is known as "***pluma***" in the popular knowledge, meaning the gender-discordant way of behaving and communicating that indicates a non-normative sexuality. *Pluma* is a concept inherent to queerness, as it is a way of expressing a dissident sexual identity (Wahab Kassir et al., 2022).. It can mean masculine expression in queer women and feminine expression in queer men, but not necessarily: any attitude or behaviour that indicates LGBTI membership can already be socially considered as such. One of the most common forms of discrimination against queer people is *plumophobia*, which consists of the rejection of non-normative expressions of sexual identity (de la Torre, 2016; Pérez Díaz et al., 2021). People who are more easily read as dissenting based on their sexual identity (e.g. lesbians, especially masculine lesbians) are more vulnerable to explicit discrimination than those who do not visibly depart from the norm (e.g. bisexual or asexual people), who experience other types of social stigma (Feinstein et al., 2021; Hayfield et al., 2013; K. Tan et al., 2019). Therefore, sexual identity expression influences the visibility of queer identities and may be related to their discrimination (Dewaele et al., 2019). The importance of visibility in each of the queer identities in women and non-binary people, and the importance of belonging to a minority identity, will be discussed below.

1.2.3 Intersectionality

The **association** between **gender and sexual minority identities** may be a **risk factor for** mental health, as may be the case for queer women and non-binary people (Hamilton-Page, 2022). For decades, the literature has emphasised the need to investigate mental health in the LGBTI community, due to the situation of social vulnerability suffered by people outside the normativity and highlights the importance of attending to these social factors in order to detect the most vulnerable groups within this group (Dewaele et al., 2014; Shramko et al., 2018; Toomey et al., 2017). Among the factors that seem to be most related to LGBTI people's adjustment problems are androcentrism and heterosexism (Hildebrandt & Chua, 2017).. Androcentrism consists of the bias of privileging men over women, giving them more social power and facilitating sexist attitudes by putting the focus on men (Thelwall et al., 2022) while heterosexism is a belief system and bias that favours heterosexuality over sexual minorities, placing heterosexual people in a place of social privilege (C. Brown & Maragos, 2022; Pérez Díaz et al., 2021). The **combination** of these factors of discrimination of minority identities has been studied from the perspective of intersectionality (Purdie-Greenaway et al., 2022). Intersectionality is an approach that analyses the way in which the social and political aspects of minority identities explain the overlapping of their discriminations (Dennis, 2020; Goldberg & Kuvalanka, 2018; Rosenkrantz & Mark, 2018).

The experience of being part of a social minority implies being on the other side of a structure that facilitates the conditions and systemic conditions of the majority group on the basis of a socio-demographic characteristic (Evans & Lépinard, 2020). These characteristics can be race, class, gender, sexual identity, age, or physical ability, among others. In people who belong to two or more minority groups (e.g., a black lesbian woman, or a deaf person with few economic resources), their systemic oppressions tend to overlap (Gattamorta et al., 2019; Shurts et al., 2020).

Literature suggests that the **overlap** between **stigmatisations** produces a **synergistic effect** on the mental health and wellbeing of marginalised communities, which is explained by syndemic theory (Logie et al., 2017). This theory proposes to study multiple discriminations in a community together and to explore what

psychosocial factors influence the well-being of people belonging to more than one minority group (Borgogna et al., 2018). It highlights the interactions between gender and sexual identities when belonging to oppressed groups, as their combination can have an exponential impact on the mental health of these minorities (Evans & Lépinard, 2020; Logie et al., 2017).

While there is research on the specific characteristics of minority groups, there is a **gap** in the literature on women and non-binary people with queer identities, who are at the intersection between gender and sexual orientation oppression. (Monro, 2019). It has been noted that this overlap can have a negative impact on the mental health of people who belong to more than one minority, as they may receive discrimination associated with the different minorities to which they belong. For example, being a bisexual woman in a heteropatriarchal society puts them in a position of vulnerability because of the association between patriarchy and heterosexism (Barnett et al., 2020). Furthermore, each sexual identity is developmentally unique, and their differences may influence the way in which LGBTIphobic discrimination affects their psychosocial adjustment (Chan et al., 2020; Flanders et al., 2022). Identity models specific to each sexual identity can contribute to understanding their similarities and differences, and how social stigma may be different for each identity (Lopez et al., 2022; Swan, 2018)..

1.2.4. Sexual identities of queer women and non-binary people

Women and non-binary people with non-allosexual/non-heterosexual identities have been addressed in the literature in recent decades, and their identity development processes and other associated psychosocial factors have been studied. The most studied sexual identities in this population are lesbian identity, bisexual and pansexual identity, and asexual and aromantic identity (Table 1).

Table 1.

Summary of the study of the main sexual identities of queer women and non-binary people

	Characteristics	Most commonly used models	Specific discrimination
Lesbian identity	It usually defines women and non-binary people who are sexually and/or romantically attracted to other women and non-binary people. The first sexual identity studied in queer women.	· Cass (1979) · McCarn & Fassinger (1996)	Lesbophobia (related to homophobia and misogyny).
Bisexual / pansexual identity	Sexual and/or romantic attraction to all genders. Plurisexual orientations.	· Cass (1979) · Brown (2002)	Biphobia (related to homophobia, misogyny and monosexism)
Asexual / aromantic identity	Sexual (asexual/ace) or romantic (aromantic) or both (aroace) attraction is not experienced, or is experienced under certain conditions (demisexual/demi-romantic).	· Storms (1980) · Diamond (2003)	Acephobia/ arophobia (related to homophobia, misogyny and allosexism).

1.2.4.1. Lesbian identity

The word "**lesbian**" comes from the Greek "Lesbios", native of Lesbos, where the poet Sappho was from, known for her expressions of love and desire towards other women (Houdeshell, 2019). People who identify as lesbians are often women who are attracted, sexually and/or romantically, to other women (Mackay, 2019) and their identity may vary significantly from those who may include sexual and/or romantic attraction to women, such as bisexual or asexual (Hayfield et al., 2013;

Hazzard et al., 2019). However, today the term "lesbian" can encompass other gender identities, including also non-binary people who are sexually and/or romantically attracted to other women and non-binary people (Hamilton-Page, 2022).

One of the most widely used models of **lesbian identity development** is **Cass's (1979)** model of identity, empirically tested in 1984. This model was initially conceived for homosexual men and women, but the author warns that, due to the different socialisation processes for both genders, the perspectives on sexual identity development will be different, although she does not explain how their experiences differ. This model is based on 6 stages:

1. **Identity confusion**. This stage is based on the perceived incongruence between the preconceived idea that a person is heterosexual and their own feelings of sexual and/or romantic attraction to the same gender. People receive information about homosexuality in their daily lives and it is possible that this knowledge triggers a process of developing their own homosexual identity. For some people, this process does not occur immediately, but they gradually identify with homosexual experiences they observe from their environment until they are unable to ignore this personalisation of information. The incongruence between normativity and their own experiences may facilitate feelings of confusion and the raising of the possibility that the person may have a sexual orientation different from the norm. This may lead to inhibition of romantic or sexual attitudes towards others or denial of one's own sexuality.

2. **Identity comparison**. Once the person considers that they might be homosexual and abandons their self-perception of identity as a heterosexual person, the process of identity comparison begins. The person continues to explore the incongruence between heterosexuality and their possible homosexual identity, and may go through a process of social isolation at this stage. At this point the person realises that the social schemas they had learned about romantic and sexual interactions are no longer relevant. There is a feeling of difference from other people that can lead to feelings of distress or empowerment depending on the person's preconceived idea of homosexuality.

3. **Identity tolerance**. Commitment to the construction of a homosexual identity increases and decreases the confusion caused by incongruence. At this point there is a difference between how the person perceives themselves and how they are perceived by their heterosexual environment, so they seek support from a community of peers and begin to explore the culture associated with LGBTI. The information received at this stage comes from within the community, so that they could correct the prejudices they had about homosexuality and learn about the positive (meeting peers, possibility of establishing sentimental links) and negative (discrimination, exposure to contact with the police) details of homosexual identity. At this point the person explicitly self-perceives himself as homosexual.

4. **Acceptance of identity**. Contact with other homosexual people increases and homosexuality is normalised as a self-identity. Homosexual self-identity is not tolerated, but accepted and becomes a more central aspect of the self. In other words, the centrality of the homosexual identity is assumed. The social environment continues to renew itself, as the person will tend to reduce contact with people who perceive them differently from who they are or from whom they receive negative evaluations because of their homosexuality.

5. **Identity pride**. At this stage there is a re-evaluation of what the person considers it is to be homosexual. There is a more positive appraisal of homosexual identity and a rejection of the values associated with heterosexuality that promote feelings of inferiority in homosexual people. The perceived injustice of homophobic discrimination may provoke feelings of anger, which may motivate the person to take action and become involved in activism.

6. **Identity synthesis**. This stage involves finding a balance between the negative feelings associated with heterosexuality and the idealisation of homosexuality, so that attempts to isolate oneself from heterosexual people diminish. At this point the person may be more motivated to come out as queer, so that the person's personal and public identity are integrated and congruence is achieved.

This model forms the theoretical basis on which early developmental models of sexual orientation are based and contributes to understanding how the study of lesbian identity has been approached in scientific disciplines (T. Brown, 2002; McCarn & Fassinger, 1996). But more recent models of lesbian identity indicate that the process of identity development is often not linear. For example, **McCarn & Fassinger (1996)** present a circular model of lesbian identity: it consists of 4 distinct stages, but emphasise that the process is continuous and often begins again in different relationships and contexts. These stages are:

1. **Awareness**. This phase involves feeling different and knowing that there are sexual orientations beyond heterosexuality. E.g. "I am attracted to women in a way that I don't understand".
2. **Exploration**. Finding out how this attraction works in oneself, analysing the relationship with other women and the possible belonging to a minority. E.g. "The way I feel makes me think that I would like to have sex with a woman".
3. **Commitment**. Deepening self-knowledge and crystallising decisions about one's own sexuality. It involves being aware of oppression and the consequences of belonging to this group. E.g. "Sometimes I have been treated badly because I am a lesbian".
4. **Internalisation or synthesis**. Integration of both sexual and romantic attraction to other women and identity as a member of a sexual minority. E.g. "I feel deeply fulfilled in my relationships with women".

These models approach lesbian identity development from the premise that people who align with this identity are sexually and romantically attracted to other women (Hazzard et al., 2019). As seen above, sexual and romantic attraction can be understood as two distinct parameters in affective-sexual orientation and it has been observed that in lesbians these two axes tend to coincide, although it is possible to identify as lesbian and for sexual or romantic attraction not to be directed exclusively towards women (Savin-Williams, 2022). Models of lesbian identity attempt to synthesise its characteristics and development, but point out that it is a highly individualised process: the way in which a person experiences sexual and romantic attraction, their membership of the lesbian community and how they bond with others as a result of their sexual orientation will determine

their identification process (Clark & Zimmerman, 2022). For example, these individual differences play a fundamental role in the lesbian identification of non-binary individuals (Hamilton-Page, 2022; Hord, 2020).

Traditional sexual identity labels have been created in a binary gender context: they indicate towards which gender (male or female) the attraction of men and women is directed (Swan, 2018). The rise of **non-binary identifications** has created the need to adapt these binary labels to a diverse spectrum of genders, altering their traditional meaning (Nicholas, 2018). A lesbian non-binary person would be a person who does not identify as a man, but also does not identify as a woman, and who is attracted to women (Hord, 2020). Similarly there may be bisexual non-binary people, who may be attracted to more than one gender and do not identify with any of them. Therefore, the sexual identity of these individuals lies in the group they identify with (the lesbian or bisexual group), rather than the characteristics or behaviours with which they manifest their attraction (Hamilton-Page, 2022). (Hamilton-Page, 2022).

As has been noted, the adoption of certain aesthetic characteristics is common in the expression of queer identity (Levitt & Horne, 2002). The **expression of lesbian identity** has historically functioned as a form of communication between women who relate to other women and has become a central element of lesbian culture (Huxley et al., 2014). In this code of communication, categories of appearance or "styles" have been established that have their own characteristics and are generally associated with a lesbian sub-identity (Hord, 2020).

Specifically, there are sub-identities of lesbian identity that are associated with a masculine gender expression. *Butch*, *boyish* or *tomboy* lesbians express their sexual identity through aesthetics, attitudes and roles associated with masculinity, in very different ways and always under the premise that it is an expression directed at other women (Eves, 2004). *Femme* or *lipstick femme* lesbians usually express their sexuality through femininity, adopting characteristics of behaviour and appearance traditionally associated with women (Zheng & Zheng, 2016). In the middle of the spectrum are the *chapstick* or *soft butch*, who express their lesbian identity in an androgynous style (Gunn et al., 2021). These identities may also be culturally or ethnically charged: for example, *stud* (masculine) or *stem*

(androgynous) sub-identities refer to women and non-binary black or Latino people (Lane-Steele, 2011; Miller, 2021).

This diversity in the expression of sexuality is fundamental in the development of lesbian identity (Huxley et al., 2014). It can be important in feeling congruent with oneself, but being recognised as a lesbian through appearance increases vulnerability to discrimination and stigma, especially if this appearance is masculine and therefore gender-discordant (Mackay, 2019). Specific discrimination for being perceived as a lesbian is called *lesbophobia*, which is a more accurate term than homophobia or LGBTIphobia as it refers exclusively to the stigma associated with lesbian identity (Braga et al., 2022). The visibility of lesbian identity is key to understanding the forms of discrimination they face and how they differ from other, less visible identities (Dewaele et al., 2019; H. McCann, 2022).

1.2.4.2 Bisexual and pansexual identity

The definitions of **bisexual** and **pansexual identities** are often similar. They differ in their terminological origin: the prefix "bi-" comes from the Latin "bis", meaning "two" or "double", while "pan" comes from the Greek πᾰν- (pan-), meaning "all" (Obradors-Campos, 2011). According to Hayfield (2020), the word *bisexual* emerged in the mid-19th century from the binary gender system, so that attraction to all genders was reduced to two. As an attempt to make gender diversity visible, the term "pan" was proposed to represent attraction to all possible genders beyond binarism. Bisexual people are often defined as being attracted to more than one gender, and pansexual people to all genders, or to everyone regardless of gender, making identification with one or the other identity highly individualised and dependent on ideological nuance (Hayfield, 2020). However, these terms are still used synonymously today and will be used in this research (Shaw, 2022).

The main defining characteristic of bisexuality/pansexuality are the synonymous concepts of "**non-monosexuality**" or "plurisexuality" (Flanders et al., 2016). Sexual orientations that involve attraction to a single gender, such as heterosexuality or homosexuality, are monosexual orientations; whereas orientations towards more than one gender are referred to as "plurisexual" (such as bisexuality, pansexuality,

polysexuality and related terms). This plurisexuality determines the development of the bisexual identity (Shaw, 2022). As with lesbian identity, the parameters of sexual and romantic attraction often overlap in bisexual identity, so that plurisexuality could be attributed to sexual and/or romantic attraction to more than one gender or all genders (Clark & Zimmerman, 2022).

Studies of plurisexual identities have used models of LGB sexual orientation to explain their development. For example, **Cass's (1979)** model of identity was applied in later revisions to bisexual people, retaining its structure: identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride, and identity synthesis. These processes also seem to occur in the development of bisexual and pansexual identities; however, they present unique characteristics. Authors such as Scherrer (2013) or Dyar et al., (2017) claim that the confusion phase can be critical in the development of plurisexual identity. Lesbian identity is often detected by the absence of normative attraction (attraction of women to men), however, bi and pansexual individuals are aware of their sexual orientation when sexual attraction to other genders appears in addition to normative attraction (Hayfield, 2020). As a result, and because bisexuality and pansexuality are often more invisibilised than homosexuality, these individuals may remain longer in a period of identity confusion or uncertainty (H. McCann, 2022).

Unlike lesbian identity, bisexual identity does not describe the gender of the person who is attracted: anyone who is attracted to all genders or more than one gender can identify as bisexual, regardless of their own gender (Chedid, 2015; Feinstein et al., 2021). Thus, bisexual identity can be applied to both women and non-binary people without a process of gender rationalisation behind it. Thus, most models about bisexual identity would be applicable to all genders (Swan, 2018). However, some studies suggest exploring intra-group bisexual identity in depth, as it has been observed that the bisexual identity of women and men is fundamentally different (Morgenroth et al., 2022).

In this sense, **Brown (2002)** suggests a **model of bisexual identity development** in which he establishes these gender differences, consisting of four stages. Focusing on women, he describes:

1. **Initial confusion**. In women, the process of identity development begins with a period of uncertainty. The author indicates that this process can happen due to monosexism, which is the assumption that everyone is attracted to one gender. This phenomenon could interact with bisexual women's sense of identity shock with lesbian communities and the feminist movement, as biphobic attitudes may exist in these environments, facilitating this sense of doubt.
2. **Finding and applying a label**. This phase is often facilitated by social support or intimate interactions with people of different genders.
3. **Settling into the identity**. It involves a process of finding comfort in this label, usually through social support.
4. **Continued uncertainty**, which leads some people to experience periodic confusion about their bisexual identity.

According to Brown (2002), these four processes can happen in a circular or simultaneous way, meaning they do not follow a linear process. It begins with a period of confusion in which one doubts one's feelings towards more than one gender and the person realises that they are not heterosexual but not homosexual either. In addition, there may be negative reactions from others both within and outside the group, as part of structural *biphobia* (specific discrimination towards bisexual people). On the other hand, there seems to be a scarcity of representation about bisexuality, so that bisexual people may have doubts about how to translate their feelings into an identity. Finally, as Hayfield (2020) points out, bisexual people seem to experience more ongoing uncertainty than heterosexual or homosexual people. There are stressors associated with this period of uncertainty, as belonging or not to a sexual minority carries personal and social implications such as minority stress, which could act as a risk factor for the mental health of bisexual people (Katz-Wise, Mereish, et al., 2017; Morgenroth et al., 2022). All these factors combined may place bisexual people in a position of increased psychological vulnerability, and contribute to the stress they already seem to suffer as part of the LGBTI community (H. McCann, 2022).

The **expression of sexuality** for **women and non-binary bisexual persons has its** own cultural characteristics (Shaw, 2022). In the process of developing their sexual identity, they may adopt appearance norms typical of lesbian identity, which

function to disassociate themselves from heterosexuality and present themselves to the world as a queer person (Huxley et al., 2014). Women and non-binary bisexual people who present an appearance in line with gender stereotypes (e.g. they are bisexual women with a feminine appearance) seem to present greater difficulties in accessing queer communities (Hayfield, 2020). In the absence of aesthetic codes associated with bisexuality, bisexual women may adopt characteristics of lesbian expression in order to be perceived as queer, and this tends to make it easier for them to be read as lesbian rather than bisexual (Shaw, 2022). This difficulty in being perceived as bisexual is part of the invisibility experienced by bisexual people both within and outside the LGBTI community (Morgenroth et al., 2022; Oswald & Matsick, 2021).

1.2.4.3. Asexual and aromantic identities

Asexual identity (also referred to as *ace* or *acesexual*, inspired in their initial A in the LGBTIAQ+ community) and **aromantic identity** (also referred to as *aro*, from "aromantic") are more complex to define than lesbian and bisexual identities, as they have started to be researched more recently and, although the ace community has been using these terms for decades, there is still little research on the identity aspects of these sexual orientations (Winter-Gray & Hayfield, 2021). Even scarcer are those that include *aroace* identity, which define people who are asexual and aromantic (Döring et al., 2022)or demisexual and demiromantic identities, which are found at intermediate points on these allosexual-asexual and alloromantic-aromantic axes (Borgogna et al., 2018; Dennis, 2020; Young, 2022).

Returning to the parameters that shape affective-sexual orientation (section 1.1.4), asexuality and aromanticism can be conceptualised from the parameters of sexual and romantic attraction, respectively (Houdenhove, Gijs, T'Sjoen, et al., 2014). Asexual people can feel romantic attraction and aromantic people can feel sexual attraction, although not necessarily (Kelleher & Murphy, 2022). Unlike lesbian and bisexual identities, where sexual and romantic attraction tend to coincide, asexuality and aromanticism do not necessarily correspond (Clark & Zimmerman, 2022).

There is a wide diversity of attitudes towards sex within the asexual community: despite existing no sexual attraction, there may (or may not) exist sexual desire and willingness to have sex (alone and with others) (Cerankowski & Milks, 2014). There are asexual people who feel a rejection of sexual relations and are often referred to as *sex-repulsed* or *sex-averse* (Houdenhove, Gijs, T'sjoen, et al., 2014). This aversion does not imply a negative view of sex (in fact, many *sex-averse* people view sex as a positive thing, even if they do not engage in it); research on *sex-averse* people is progressively shifting the focus from pathologising to affirming asexual identity (Richards & Barker, 2016). More recent approaches suggest that negative attitudes towards sex in the context of asexuality may be part of a diverse spectrum of sexuality and are not related to pathology (Brotto & Yule, 2017; Bulmer & Izuma, 2018). There are also people who do not feel this rejection, but also have no desire to have sex: these people are called *sex-indifferent* or *sex-neutral* and this category could include all those who are indifferent towards sexual relations and do not feel them as something positive or negative (Houdenhove, Gijs, T'sjoen, et al., 2014; Yule et al., 2017). On the other hand, some asexual people enjoy sex in certain situations and identify themselves as *sex-favourable* (Clark & Zimmerman, 2022)..

Beyond their attitudes towards sexual relationships, and as with other sexual identities, asexual and aromantic identities have been studied through the parameters of sexual and romantic attraction and, in some models, through identity aspects (Winter-Gray & Hayfield, 2021.. One of the most widely used theoretical models to explain asexuality is **Storms' (1980)** model of sexual orientation (Bogaert, 2015; Brotto & Yule, 2017). According to Storms, sexual orientation is formed along two dimensions: heteroeroticism (attraction to people of the opposite gender) and homoeroticism (attraction to people of the same gender). Heterosexual people would have high heteroeroticism and low homoeroticism, as opposed to homosexual people; bisexual people would have high scores on both axes, and asexual people would have no or low scores on both axes. In his model, Storms does not include an in-depth analysis of asexual identity, but he suggests that there is an identity process in asexual people (Storms, 1980).

A more recent model that explains the characteristics of asexual identity is **Diamond's (2003)** biobehavioural model of love and desire. This model contributes to the theory of asexuality through three premises:

1. Sexual desire and romantic love are **functionally independent**. Sexual and romantic attraction are two independent phenomena and can, but do not necessarily, coexist. It is possible to be romantically attracted to someone for whom one is not sexually attracted, and vice versa.
2. Romantic love is not intrinsically oriented towards same-gender or other-gender partners. Like any other type of bonding (for example, the love that exists in a friendship or family), romantic love functions regardless of a person's **gender.**
3. The links between love and desire are **bidirectional**. As hypothesised in premise 1, love and sexual desire are functionally independent. However, there is a correlation between them interpersonal, emotional and cultural factors. Socio-cultural norms that reinforce monogamy, neural pathways of reinforcement and attachment, and the cognitive association between love and desire would explain the relationship between sexual attraction and romantic attraction.

Empirical evidence suggests that this model could explain the functioning of sexual and romantic attraction more accurately than previous models (Antonsen et al., 2020). Comparative studies with romantic and asexual aromantic individuals, who appear to adhere to the premises of the model, suggest that there is a wide range of sexual and romantic orientations within these spectra, beyond the labels already known to exist (Carvalho & Rodrigues, 2022). Other research along the lines of differentiating dimensions of affective-sexual orientation suggests that asexual and romantic attraction may be independent of sexual identity and behaviour (Antonsen et al., 2020; Clark & Zimmerman, 2022; van Anders, 2015).

The **aromantic identity** suffers from an even greater lack of research. The lack of references in the media, of research on aromanticism and of public knowledge that this identity exists makes it difficult to include it in a model of affective-sexual orientation (Carvalho & Rodrigues, 2022). From what has been observed in research on this spectrum, it is rare to identify oneself as an aromantic person, so understanding its functioning is often based on the study of romantic attraction and the way of establishing affective bonds (Bougie, 2021). The process of pathologisation of affective-sexual orientation in aromantic individuals appears to be similar to that of asexuality: although aromanticism has been associated with

avoidant attachment bonds and concern about commitment in relationships, recent research suggests that it may not be reliable to assess aromantic individuals with measures designed for alloromanticism (Carvalho & Rodrigues, 2022).

Gender appears to be a relevant factor in the study of asexuality and aromanticism (Houdenhove, Gijs, T'sjoen, et al., 2014). The literature indicates that there is a higher prevalence of females, trans and non-binary people and non-heterosexual people in the asexual population (de Oliveira et al., 2020; Rothblum et al., 2019). This relationship with gender could be explained in two ways. On the one hand, men tend to have more difficulty identifying as asexual due to gender schemas that link hegemonic masculinity with virility and exacerbation of sexual desire; on the other hand, some studies suggest that asexual identification in women may conflict with traditional values of femininity that assume women should be sexually available to men (Brotto & Yule, 2011; Rothblum et al., 2019). For these reasons, the literature suggests that asexual women who are romantically involved with other women or non-binary people may have less social pressure to behave in an allosexual way (Gupta, 2019). On non-binary identities, research suggests that some asexual people may identify with gender identities outside of binarism, as they identify less with the traditional schemas associated with affective-sexual relationships, and show greater levels of introspection about their gender and sexual identity (de Oliveira et al., 2020). However, there is a scarcity of studies on asexuality in trans people: recent studies have looked at variables such as social support and mental health in this population, but there is little research that combines the processes of identification as a trans and asexual person (Simon et al., 2022).

Discrimination specific to asexual people is called ***acephobia***, and is also often used for discrimination towards aromantic people, as ***arophobia*** is a less commonly used term (McInroy et al., 2020). One of the most characteristic aspects of acephobia is the invisibilisation or erasure of asexual and aromantic people, both in the scientific arena and in contemporary media representation (Parmenter et al., 2020). In a similar way to biphobia, acephobia manifests itself both outside and within the LGBTI community, since, being lesser-known identities, there are sectors that question whether it is legitimate for them to belong to the community (Edge et al., 2021).

Unlike lesbian and bisexual identities, there do not appear to be clear social codes for **expressing asexuality** and **aromanticism** through appearance or behavior (Bulmer & Izuma, 2018) This may add weight to the acephobia experienced by this population, especially in invisibilising their identities (Rothblum et al., 2019). On the one hand, there is still a scarcity of studies on asexual and aromantic identity, and LGBTI-specific protection policies do not always include this population, which may place them in a situation of greater vulnerability for their psychosocial adjustment (A. Mollet & Lackman, 2019). On the other hand, they seem to present greater difficulty in creating an asexual community, as there is still a scarcity of means for asexual people to recognise and establish supportive links with each other, as is the case with lesbian and bisexual identities (Reed, 2023).

Summary

- Queer identities can be defined as ways of identifying oneself outside of allo/heteronormativity.
- Queer women and non-binary people experience an overlap of discrimination because they belong to more than one minority group. This overlapping is studied by the perspective of intersectionality.
- The most studied queer identities of women and non-binary people in psychology are lesbian identity, bisexual/pansexual identity and asexual/aromantic identity.
- These identities have factors in common and differ in terms of their development, visibility and the specific stigma they receive.

1.3. PSYCHOSOCIAL ADJUSTMENT IN QUEER WOMEN AND NON-BINARY PEOPLE

Queer women and non-binary people present unique identity characteristics and this may have a bearing on their individual psychosocial adjustment. In this section, we will present two key dimensions of psychosocial adjustment: emotional symptomatology, studied through symptoms of depression, anxiety and stress, and subjective well-being, studied through life satisfaction and positive and negative affect. In addition, the literature on these dimensions of adjustment in this population will be reviewed.

1.3.1. Emotional symptomatology: depression, anxiety and stress

1.3.2. Subjective well-being

1.3. Psychosocial adjustment in queer women and non-binary people

As we have seen, minority sexual identities such as lesbian, bisexual and asexual present unique identity characteristics, and it seems that these specific characteristics play a fundamental role in the relationship of these people with their environment. Thus, the question arises, what is the **psychosocial adjustment of queer identities like?**

Studies in psychology of minority populations have identified **emotional symptomatology** and **well-being** as key variables in the assessment of their psychosocial adjustment (Cooke & Melchert, 2019; Fernández-Berrocal & Extremera, 2016; D. Johnson et al., 2018). In queer identities, which are in a greater situation of psychosocial vulnerability, the study of their adaptation to the environment and the variables associated with their subjective well-being is of special interest (Aparicio-García et al., 2018b; Moagi et al., 2021).

Psychosocial adjustment can be defined as a person's ability to adapt to their social environment and develop interaction skills with the context (Piqueras et al., 2019). It is a psychological construct that relies on emotional and cognitive variables and reflects adaptation with social and cultural environment (Schoeps, Tamarit, González, et al., 2019). It is related to other variables associated with mental health, such as physical and psychological symptomatology, emotional stability, and psychological and subjective wellbeing (Piqueras et al., 2019). Due to the importance of their relationship with context, adjustment and well-being are often studied in specific population contexts, taking into account the socio-demographic characteristics that affect each group (McKinney et al., 2020). In LGBTI people, minority status has been studied as a major risk factor for their mental health, and has been associated with higher levels of emotional symptomatology (Cooke & Melchert, 2019; Harvey et al., 2021).

1.3.1. Emotional symptomatology: depression, anxiety and stress

Studies on LGBTI **emotional symptomatology** indicate that sexual minority populations may be more exposed to risk factors for their mental health (Steele et al., 2017). Specifically, emotional symptomatology (depression, anxiety and stress)

appears increased in this population, although its prevalence varies according to the identity group to which they belong, or if they belong to more than one minority (Logie et al., 2017).

Risk factors for the presence of depressive and anxiety symptoms include contextual factors such as unemployment, which tends to be higher in women and gender minorities, such as trans and non-binary people (Baboolall et al., 2021).. People with minority sexual identities (especially bisexual and trans people) also have greater symptoms of depression, anxiety and stress than allo/heterosexual people, as well as social adjustment problems and a higher incidence of suicidal ideatiion (Hopwood et al., 2020; Martxueta-Pérez & Etxeberria-Murgiondo, 2014). This prevalence is observed in queer women and non-binary people as a result of the intersection between gender and sexual identity and its impact on emotional symptomatology in this population (Miller, 2021).

The **intersection** between **gender and sexual identity** has also been studied in the context of psychosocial adjustment.

A study by Borgogna et al (2019) empirically analysed the **differences** in **mental health** of different minority sexual and gender identities. Their results show that trans and non-binary people had the highest rates of depression and anxiety, with significantly higher scores than cis people in their sample. The authors highlight that there is an interaction between gender and sexual identity, and that this interaction had a significant impact on mental health. People with minority status in more than one identity group had higher rates of emotional symptomatology than those with only one minority identity. In addition, people with the most invisible sexual identities (bisexual and asexual) had higher levels of depression and anxiety than cisgender and gay- and lesbian-identified people.

In lesbian women, symptoms of depression and stress associated with heterosexism have been observed, which appear to add to the experiences of sexism that they already experience as women (Harvey et al., 2021). This combination of risk factors has also been observed in bisexual women, however, there appears to be a consensus in the literature that bisexual women tend to have higher levels of emotional symptomatology than lesbians (Moagi et al., 2021). In addition to the discriminatory factors affecting lesbian women, bisexual women often experience monosexism, a belief system and bias that favours sexual

orientations that include attraction to a single gender over plurisexual orientations (Feinstein et al., 2021; Flanders et al., 2016). The confusion, indecision and denial associated with sexual identity in bisexual women is related to difficulty in developing bisexual identity processes, and is associated with higher rates of depression, anxiety, self-harm attempts and suicidal ideation (H. McCann, 2022; Moagi et al., 2021). Higher levels of shame associated with their sexuality have also been observed in bisexual women than in lesbians, which has been linked to a greater desire to hide their sexual identity to prevent experiences of social rejection (McLaren & Castillo, 2020b; Shaw, 2022). Regarding asexual women, there are no studies that compare the emotional symptomatology of asexual women compared to other women with minority sexual identities; but higher levels of depressive symptoms and internalised LGBTIphobia have been observed in asexual people compared to homosexuals. (McInroy et al., 2020). The same is true for trans and non-binary people: they seem to present greater psychological vulnerability than other LGBTI identities, but there is a scarcity of literature on those who also have non-allogosexual/non-heterosexual orientations and identities (Aparicio-García et al., 2018b; Krell, 2017; Moagi et al., 2021)..

1.3.2. Subjective well-being

Well-being is defined as the positive appraisal of the quality of one's own life and summarises multiple psychological and emotional variables associated with individual evaluation of life (di Fabio & Kenny, 2016). It is often approached from two different perspectives: **hedonic well-being** and eudaimonic **well-being** (Diener et al., 2018). Hedonic well-being refers to the feeling of satisfaction in relation to experiences in life that are interpreted as pleasant or unpleasant, and focuses on increased pleasure and decreased pain as the fundamental basis for well-being (Joshanloo et al., 2021).

Hedonic well-being according to Diener's (2009) model is studied through the concept of "subjective well-being" (Diener, 2009). This model studies individual assessments of the hedonic or emotional balance related to one's own life, and is therefore usually assessed through two variables: satisfaction with life and positive and negative affect (Monaco et al., 2019). Life satisfaction is considered the

cognitive component of well-being, as it refers to the appraisal of life according to whether it is close to one's ideal (Kong et al., 2019). Hedonic balance is considered the affective component of well-being. Positive affect indicates high levels of well-being, which are associated with vitality and pleasant emotions (Lara et al., 2020; Serrano & Andreu, 2016). Negative affect indicates low levels of well-being, which refer to unpleasant moods and emotional distress (Donahue et al., 2014; Saksvik-Lehouillier et al., 2022).

Eudaimonic well-being, on the other hand, is associated with developing a person's capabilities and working on their potential for achieving fulfilment (Pritchard et al., 2020). Hedonic well-being is related to concepts studied in psychology such as subjective well-being, life satisfaction, positive and negative affect and happiness, while eudaimonic well-being is related to personal growth and positive relationships with the environment (Lee et al., 2021). One of the most widely used models of eudaimonic well-being is Rhyff's (1995) multidimensional model, which studies it from the concept of "psychological well-being" and includes aspects such as autonomy, relationship skills with the environment, purpose in life, self-acceptance and personal growth (Marikutty & Joseph, 2016). It is associated with reduced levels of psychological symptomatology and may be a protective factor in physical and emotional health (Li et al., 2023).

In line with the **biopsychosocial model** of health and in a vulnerable population such as queer people, it is especially relevant to study mental health not only as the absence of mental disorders, but also as the presence of hedonic and eudaimonic wellbeing (Cooke & Melchert, 2019). Queer women and non-binary people find themselves in a situation of multiple victimisation, which may compromise their well-being in the short and long term; however, while emotional symptomatology has been extensively studied in this population, well-being has not been studied in depth across sexual identities separately (Berger et al., 2022; Rosenkrantz & Mark, 2018).

Among the scarce data on well-being indices for different sexual minorities is a report by the European Union Agency for Fundamental Rights (FRA) published in 2021, which reported on the psychological factors associated with discrimination on the grounds of sexual orientation. A total of 139,799 people over the age of 15 who identified themselves as lesbian, gay, bisexual, trans or intersex (LGBTI)

participated in their survey. In their statistics on life satisfaction, it is observed that gay men and lesbian women have the highest average levels of satisfaction (6.7 out of 10, above the European average of 6.5), and trans and intersex people have the lowest (5.6 in both cases). According to the scientific literature, bisexual people seem to have significantly lower levels of well-being than other sexual identities, and this effect seems to be higher for bisexual women. (Liss & Wilson, 2021; Moagi et al., 2021). However, there are still few studies on the well-being levels of asexual and gender-diverse people who are also not allo/heterosexual.

Summary

· Studies in psychology on minority populations have identified emotional symptomatology and well-being as key variables in the assessment of their psychosocial adjustment.
· Emotional symptomatology has been studied mainly through the manifestation of symptoms of depression, anxiety and stress.
· Subjective well-being is generally assessed through the dimensions of life satisfaction and the balance between positive and negative affect.
· The few studies on queer women and non-binary people indicate that these groups generally have higher levels of emotional symptomatology, and lower levels of subjective well-being compared to people with majority gender and sexual identities.

1.4. PSYCHOSOCIAL FACTORS RELATED TO PSYCHOSOCIAL ADJUSTMENT

Differences in psychosocial adjustment in queer women and non-binary people can be explained by psychosocial factors associated with their non-normative identity. There are risk and protective factors that may influence emotional symptomatology and well-being in this population. Among the most important risk factors is minority stress, which in these identities operates through lesbophobia, biphobia, acephobia and transphobia. Among the protective factors we can identify community belonging, outness, social support, emotional competences and self-esteem.

1.4.1. Minority stress

1.4.2. Community belonging

1.4.3. Outness

1.4.4 Social support

1.4.5. Emotional competences

1.4.6. Self-esteem

1.4. Psychosocial factors in queer women and non-binary people

The literature indicates that queer women and non-binary people are in a situation of **psychosocial vulnerability**, reflected by their levels of emotional symptomatology and the presence of risk factors for their well-being (Richards & Barker, 2014). Psychosocial and psychological factors associated with sexual orientation and identity may explain the impact of minority status on the mental health of queer women and non-binary people (Hatchel et al., 2019; McLaren & Castillo, 2020b). In this section, we will look at which protective and risk factors may play a significant role in psychosocial adjustment in this population. The literature indicates that the most prevalent risk factor in people with minority gender and sexual identities is minority stress (McInroy et al., 2020). In terms of protective factors, research highlights LGBTI membership, outness, social support, self-esteem and emotional competences (Buckley, 2022; Feldman & Wright, 2013; Pollitt et al., 2017; R. K. J. Tan et al., 2021).

1.4.1. Minority stress

Minority stress is a variable that has been used to explain the vulnerability of people who belong to a minority group in terms of their mental health (Thomeer & Reczek, 2016). It can be defined as the psychological problems stemming from stigmatisation towards people who belong to a minority, either on the basis of their gender identity, sexual identity, race, class, or other socio-demographic characteristics (Meyer, 2003; Toomey et al., 2017).

People who belong to minority gender and sexual identities are exposed to various types of societal **violence** (Redd & Russell, n.d.). LGBTI membership is criminalised globally, from lack of equal rights in Western countries to imprisonment and the death penalty in others (Braun, 2020; Wilson, 2022). According to a study by the Human Dignity Trust, an agency in the UK that studies the criminalisation of homosexuality around the world, in 2023 there are 14 countries that criminalise trans people's gender identity and expression, and 11 countries that impose the death penalty for consensual same-gender sexual activity (Human Dignity Trust, 2023). Spain is a pioneer in LGBTI rights, being one of the countries in the global north that has achieved the most progress for queer people

in recent history at an activist and legislative level (Calvo & Pichardo, 2020). Nevertheless, LGBTIphobic violence continues to exist on a social, structural and systemic level throughout the world, directly influencing the physical and psychological integrity of LGBTI people (Haynes et al., 2023).

The scientific literature has extensively studied the psychological and social mechanisms that compromise the mental health of LGBTI people, with minority stress being the main focus of this research (Katz-Wise, Rosario, et al., 2017). The most widely used model of minority stress, and the one on which the instruments developed for its assessment are based, is **Meyer's** (2003) **Model of LGBT Minority Stress.**

Meyer (2003, 2013) identifies sources of minority stress: distal stressors and proximal stressors. **Distal stressors** are external events associated with prejudice, which are objective and independent of the person's identification: for example, a woman who has relationships with women may not identify as a lesbian, but suffer lesbophobia when perceived as such. This is associated with the concept of the *pluma* discussed above: by being perceived as a queer marker, the visibly queer person may suffer discrimination through distal stressors by being identified as a member of the community, even if they do not identify as such. **Proximal stressors** are associated with how the person identifies and are specific to the minority to which they belong. Identifying as belonging to a minority group carries proximal stressors, which are internal and subjective. According to Meyer (2003), proximal stressors are related to the hypervigilance experienced by queer people, produced by the anticipation of social rejection; hiding one's identity as a protective mechanism and feeling rejection towards oneself due to internalised stigma. These stressors relate to dimensions of Mohr and Fassinger's (2000) model of identity development as reviewed by Mohr and Kendra (2008, 2011), which detail how minority stress translates into sexual identity development through these stressors.

According to Meyer (2003), there are seven dimensions in this model of minority stress (Table 2). They can be divided into distal stressors (discrimination events, victimisation events and everyday discrimination) and proximal stressors (identity concealment, anticipation of rejection, internalised stigma and community connectedness).

Table 2.
Summary of distal and proximal stressors

Distal stressors	Proximal stressors
Discriminatory events. This refers to those acts of stigmatisation that can be objectively identified, and are often associated with being treated differently because of being *queer*. For example, having received poor service or poor health care as a form of discrimination.	**Identity concealment**. This refers to not wanting to show oneself as *queer*, i.e. not "coming out" or not sharing one's *queer* identity with other known or unknown people. It manifests itself through not participating in social networks, not talking about one's private life and not fighting against anti-LGBTI discourse.
Victimisation events. This dimension refers to variables associated with LGBTIphobic violence. Receiving verbal, physical and/or sexual harassment are forms of victimisation.	**Anticipation of rejection**. Hypervigilance and fear associated with the expectation of discrimination on the grounds of having a *queer* identity.
Everyday discrimination. These are the micro-aggressions received on a daily basis for being LGBTI. Negative comments about the pen, the verbalisation of offensive myths and stereotypes, or the systematic use of the wrong pronouns on trans and non-binary people are forms of everyday discrimination.	**Internalised stigma**. Also called homo/binegativity, or internalised homo/biphobia, this dimension refers to feelings of rejection about one's *queer* identity.
	Community connectedness. This dimension is negatively related to minority stress, as it refers to the protective role of group membership for *queer* people. It identifies those benefits that are obtained by participating in the community, whether at an informational, instrumental, social or emotional level.

People who belong to a social minority are exposed to this type of stress and it has been observed to be greater in people who experience multiple discrimination by belonging to more than one minority identity (Hatchel et al., 2019). In addition, the mechanisms by which minority stress affects minority groups psychologically differ according to the specific characteristics of the stigmatisation of that group, as described below (Feinstein et al., 2021; Z. Kamenov et al., 2016).

1.4.1.1. Lesbophobia

Minority stress in **lesbian identity** is associated with specific discrimination against people who identify as lesbians, known as lesbophobia (Hamilton-Page, 2022).

While lesbian identity may imply a homosexual orientation, lesbophobia is different from homophobia (Hildebrandt & Chua, 2017; Keats, 2016). In a heteropatriarchal society, the superiority of men over women and of heterosexuality over sexual minorities is assumed, and these two mechanisms are combined in this type of discrimination (Barragán-Medero & Pérez-Jorge, 2020). The stigmatising factors responsible for minority stress in lesbians are associated with women who only have relationships with other women and happen for different reasons than violence against gay men. The report of the European Union Agency for Fundamental Rights (FRA, 2021) showed that there were gender differences in discrimination on grounds of sexual orientation. In their responses, respondents indicated the reasons for violence received as a sexual minority: 2% of gay men indicated that their gender was an additional reason for violence received, compared to 29% of lesbian women and 46% of bisexual women.

Among the sexual identities of queer women and non-binary people, lesbian identity has the most social codes to be expressed and communicated to the environment, which might make it more visible, and thus more vulnerable to distal minority stressors (Hayfield et al., 2013; Hord, 2020). Greater visibility of lesbian identity may be associated with greater presence of these stressors compared to bisexual and asexual people, who would face a different type of minority stressors (Reed, 2023; Shaw, 2022).

On the other hand, from the perspective of intersectionality, studies point out that lesbophobic discrimination increases with membership in more than one minority group (Barragán-Medero & Pérez-Jorge, 2020). Trans lesbian women suffer lesbophobia to a greater extent than cis women, as they are discriminated against for establishing affective and sexual bonds only with other women or non-binary people, and their belonging to the "female" gender is also questioned (C. R. McCann et al., 2020). The concept "transmisogyny" explains the accumulated violences of being a woman and being a trans person and being a lesbian would add

a third layer of discrimination (Evans & Lépinard, 2020; Krell, 2017). Something similar is true for non-binary people who identify as lesbian (Hamilton-Page, 2022). If their gender expression is read as dissenting, this discrimination could occur because they are perceived as trans or queer (J. Slater & Liddiard, 2018).

1.4.1.2. Biphobia

Minority stress in **bisexual** people is associated with the specific discrimination received as a result of being bisexual, called **biphobia**. There are common features of biphobia that affect people of all genders, the most studied of which is invisibilisation. Plurisexual identities often experience discrimination through the denial of their identity, arising out of monosexism (Fader, 2018). Monosexism assumes that people will be attracted to only one gender, either the opposite gender, making them heterosexual, or their own gender, making them identify as homosexual (lesbian or gay) (H. McCann, 2022). This phenomenon, which ignores or denies the existence of bisexual people, is a manifestation of the invisibility that this group suffers from (Purdie-Greenaway et al., 2022).

Androcentrism and monosexism can be combined in biphobic discrimination (Katz-Wise, Mereish, et al., 2017). Bisexual women appear to show gender- and sexual identity-specific stressors, such as bisexual women's hypersexualisation and assumption of promiscuity (Klesse, 2011; McLaren & Castillo, 2020a). Attraction to multiple genders may imply that there is a greater availability of sexual and/or romantic partners (Feinstein et al., 2021; Sariyannis, 2016). However, this assumption is discriminatory through two premises: (1) that bisexuality is associated with risky sexual behaviour, and (2) that promiscuity has a negative connotation, either because it is related to a lack of security or care or because of moral and/or religious issues (Dyar et al., 2021). All of these factors can lead to increased vulnerability to psychological problems for bisexual people, especially women and non-binary people who identify with any plurisexual identity (H. McCann, 2022).

Trans and non-binary bisexual people also experience stressors associated with bisexuality (Katz-Wise, Mereish, et al., 2017). Bisexuality does not assume the presupposition of gender binarism, it is a sexual attraction to more than one gender

or to all genders, thereby challenging the status in which monosexism operates and acknowledging the existence of multiple genders beyond the binary (H. McCann, 2022). This is even more visible in non-binary people, as their own gender already represents an identity dissidence, so they might be perceived as part of a minority to a greater extent than cis-bisexual women (Matsuno & Budge, 2017; Shaw, 2022).

1.4.1.3. Acephobia

Acephobia is often the mechanism of discrimination that favours minority stress in **asexual** and aromantic individuals (McInroy et al., 2020). Women and non-binary people who fall on the spectrum of asexuality or aromanticism often suffer the highest levels of invisibilisation of all LGBTI people (Cerankowski & Milks, 2014; Gupta, 2019).

One of the most common forms of discrimination towards asexual and aromantic people is the assumption of allosexuality and alloromanticism, i.e. assuming all people experience sexual attraction in the same way (McInroy et al., 2020). This phenomenon has historically involved the pathologisation of people who fall on these spectrums to some degree (Bogaert, 2015) and it is only in recent years that this identity has begun to be reclaimed as healthy and valid (Brotto & Yule, 2017; Gupta, 2019).

The pathologisation of people on the spectrum of asexuality and aromanticism has historically consisted of associating these identities with psychological problems associated with sexuality and healthy bonding (Cerankowski & Milks, 2014). Research into the clinical practice of these identities indicates that asexuality in therapeutic contexts has been misdiagnosed as 'hypoactive sexual desire' and aromanticism with relationship problems and avoidant attachment (Young, 2022). The making of these diagnoses and subsequent psychological treatment is one form of conversion therapy that has affected the asexual and aromantic population and has influenced the prevalence of minority stress in these groups (Russell, 2023).

In addition, the lack of representation and of real and fictional reference figures contributes to the invisibilisation of these identities and hinders the process of identity development (Sundrud, 2011). As they are mostly unknown identities and

do not have an associated expression of sexual identity, they often have difficulties in expressing their identity and making it visible to others, which in turn reduces their possibilities of establishing links with other queer people and forming support networks (Carvalho & Rodrigues, 2021). Thus, asexual and aromantic people face a double challenge: on the one hand, the difficulty of discovering what their identity is, as limited access to information makes it difficult to make their existence known; and on the other hand, educating the people around them when it comes to revealing their identity or "coming out" (Winer et al., 2022; Young, 2022). This, coupled with the complexity of their relationship with the LGBTI community, could contribute to their minority stress as it would reduce the protective effect of social support in this population (Glass, 2022; Liss & Wilson, 2021).

1.4.1.4. Transphobia

As we have seen above, in addition to stigmatisation on the basis of sexual orientation, **trans** and **non-binary people** also experience discrimination on the basis of **gender**, commonly referred to as transphobia (J. Slater & Liddiard, 2018).

The term 'transnormativity' describes the pressure felt by trans people to express their gender within binary standards (A. H. Johnson, 2016). For example, trans women experience a type of social pressure to "perform" femininity (express their gender according to social norms of femininity), and it seems that those who conform better to beauty standards may have a greater presence within their community (Bradford & Syed, 2019). Racism, ableism, fatphobia and other forms of discrimination towards non-normative bodies and cultures affect trans people to a greater extent than cisgender people, who already experience an overlap of discriminations (Kichler, 2022).

Non-binary people seem to experience something similar to transnormativity, but referring to non-binarisms (Aparicio-García et al., 2018a). It has been observed that, in order to be read as such, non-binary people feel pressure to have an androgynous gender expression and to conform to what the general population understands as this gender (Matsuno & Budge, 2017). Thus, discrimination comes from two places: (1) transnormativity applied to non-binary gender, whereby they are not recognised as non-binary people unless their expression is explicitly

androgynous and (2) transphobia for not conforming to the prevailing gender binarism (Goldberg & Kuvalanka, 2018; Ritholtz, 2022).

Research on mental health in trans and non-binary people agrees on the importance of studying the stress of minorities to explain their high levels of emotional symptomatology and reduced levels of well-being in this population. (K. Tan et al., 2019). Trans and non-binary people who also have a minority sexual identity face overlapping layers of discrimination on the one hand on the basis of gender and on the other hand on the basis of sexual identity (Evans & Lépinard, 2020; Gupta, 2019). There is a scarcity of studies addressing minority stress in non-binary people who are themselves situated outside the allo/heteronormativity, as most studies in this population focus on the stigma they receive with regard to their gender nonconforming gender (Dowers et al., 2020).

Figure 5 shows a graphical representation of the overlap between these types of discrimination for queer women and non-binary people, and how they might be combined according to the different gender and sexual identities that exist.

Minority stress is directly related to **psychosocial adjustment** in queer people (Pease et al., 2022; Shramko et al., 2018; K. Tan et al., 2019). Literature indicates that belonging to various minority groups in terms of gender and sexual orientation may have a negative impact on psychosocial adjustment through experiences associated with minority stress (Hsieh & Ruther, 2016). Numerous research indicates that the various ways in which minority stress operates (including distal and proximal stressors) are predictors of poor psychosocial adjustment, manifested as higher rates of emotional symptomatology and lower levels of well-being in minority groups (Katz-Wise, Rosario, et al., 2017; McConnell et al., 2018).

Despite the tendency to study gender and sexual minorities together as part of the LGBTI community and the common stressors they experience, more recent literature emphasises the importance of identifying those stressors associated with gender and sexual identity that differentially influence psychosocial adjustment (K. Tan et al., 2019) especially when they occur at the same time (Mereish et al., 2021).

Figure 5.

Specific discrimination against queer women and non-binary people on the basis of gender (circles) and sexual identity (rectangles).
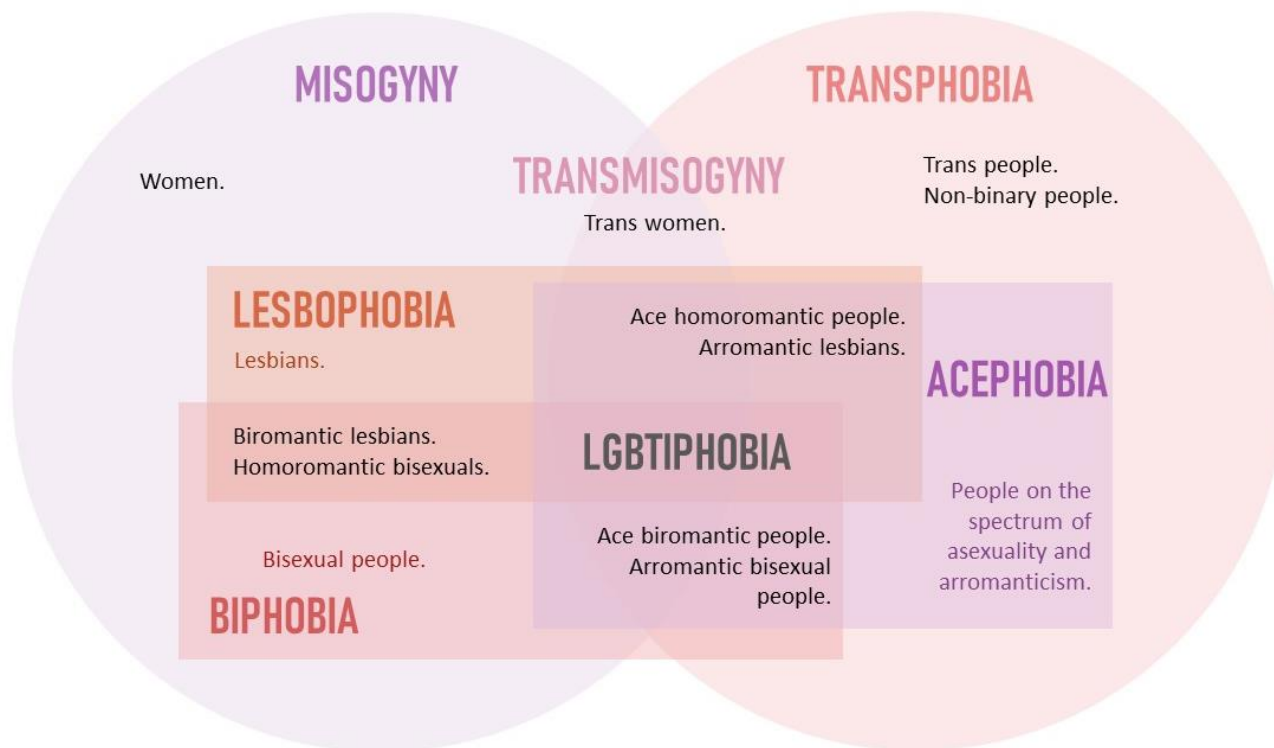
Intersectional discrimination, i.e. the overlapping stigmatisation experienced by people who belong to more than one minority group, is associated with elevated levels of depressive symptoms and suicidal ideation in people with diverse sexual identities, and research indicates that women and non-binary people are at higher risk of experiencing this type of discrimination, which can negatively impact their mental health (Shramko et al., 2018). In women belonging to sexual minorities, proximal stressors, especially those based on fear of social rejection, are associated with the presence of internalising symptoms, such as stress and anxiety (Dyar et al., n.d.; Katz-Wise, Rosario, et al., 2017).

The different forms of discrimination (lesbophobia, biphobia and acephobia) might have a different impact on each of the sexual minorities to which women and non-binary people belong (McInroy et al., 2020). For example, those who are more visibly queer, such as some trans and non-binary people, or those who have more social codes of expression of their sexual identity, such as lesbians, may be more vulnerable to distal stressors as they are exposed to more explicit discrimination than more invisibilised identities (Barragán-Medero & Pérez-Jorge, 2020; K. Tan et al., 2019). It has also been observed that, in women and trans bisexual people, proximal stressors such as higher levels of difficulty in the process, invisibility motivation and internalised binegativity may explain the negative impact of minority stress on psychosocial adjustment (McLaren & Castillo, 2020a). Asexual people also appear to be more affected by proximal stressors than by distal stressors: the experience of stigma in asexual people is associated with greater depressive symptoms and lower levels of well-being than in asexual people (McInroy et al., 2020; Simon et al., 2022).

While minority stress is a risk factor for the psychosocial adjustment of queer women and non-binary people, there are protective factors that may mitigate or reduce the impact of discrimination and stigma violence in this population, such as group membership, self-esteem or emotional competencies (Sanscartier & MacDonald, 2019; R. K. J. Tan et al., 2021).

1.4.2. Community belonging

A **sense of community belonging** can be defined as a person's sense of connection to a community with which they identifies (Demirtas et al., 2017). The literature indicates that frequent social contact and feelings of connectedness to a group are essential elements of belonging, thus combining both psychological and social aspects (Moran, 2022).

For the same person, there are several groups to which they may belong. From the nuclear family, to peer groups, communities based on common interests, social networks, or the country itself, belonging can be applied at different levels (Hatchel et al., 2019). People with non-normative sexual and gender identities may find it difficult to develop a sense of belonging with majority groups, therefore, it is common to develop a sense of belonging towards the minority group with which one shares identity (Chávez, 2010; Demirtas et al., 2017).

The protective role that community membership can play for people who belong to a minority, especially for people who belong to more than one minority group, has been widely documented (Sanscartier & MacDonald, 2019). The transmission of social norms about minority people's resources or habits can contribute to protecting their physical and mental health: for example, in queer people it could be the transmission of safe sexuality habits when engaging in non-cis-heterosexual relationships (McLaren & Castillo, 2020a). In addition, being part of a community may allow greater access to social and material resources beneficial to physical health or psychosocial adjustment (Moran, 2022).Therefore, participation in a community can provide the individual with beneficial resources, and also diminish the impact of systemic and structural discrimination (Caba et al., 2022; Sanscartier & MacDonald, 2019).

Belonging to the LGBTI community can be experienced in different ways. On a more intimate level, direct contact with queer connections and friendships is a form of belonging, as one shares common social codes and interacts through queer culture (de Vries et al., 2020). Official associations or communities are a form of belonging generally related to activism, and the degree of participation can be very diverse (Dunn & Szymanski, 2018). There are people who belong to these associations and participate actively through social work and the fight for causes

associated with affective-sexual and gender diversity, while for others it is just a meeting point between equals (Grau, 2016). The importance of online communities and their impact on sexual minorities' sense of belonging has been investigated in recent decades. (McInroy & Craig, 2018). Online meeting places such as *fandoms* (a community of people with a common interest, such as series, celebrities or hobbies), social networking communities and forums have been a meeting place for queer people since the beginning of the internet (Ramos & Mowlabocus, 2020).

Community belonging has been studied through the construct of "*Psychological Sense of Community*" (PSOC). This variable explains how a person can be part of a social structure in which bonds of support and care are created, as well as responsibility and social awareness. The psychological sense of community, according to various authors (Buckley, 2022; Lin & Israel, 2012) is composed of 6 dimensions:

- · **Influencing other people.** The importance of one's own actions, thoughts and feelings on other queer people.
- · **Influencing of other people**. The importance of the actions and opinions of other queer people on one's own person.
- · **Shared emotional connection.** This dimension describes how the bonds between queer people within the same community are, whether there is a sense of camaraderie and companionship.
- · **Needs fulfilment**. How much the person feels that they help other queer people and whether they feel that the community provides resources to its members.
- · **Membership**. How much the person feels that they are a member of the LGBT Community and their sense of belonging to the community.
- · **Existence of community**. How much the person feels that there is a community for lesbians, gay men, bisexual and transgender people.

LGBT membership has been studied in relation to different sexual identities. Here we will focus on lesbian, bisexual and asexual identities in women and non-binary people, who seem to have different relationships with the queer community. (McLaren & Castillo, 2020a). Historically, lesbian women have found a safe place in the LGBTI community, especially in female-frequented environments (Rupp, 2009; Zheng & Zheng, 2016). One of the most frequent struggles of lesbians in the

community has been to find a place alongside the cis-gay male community which, due to androcentric conceptions even within the community, tends to be more visible and attended to than women (Hildebrandt & Chua, 2017).

As for bisexual people, they do not always experience a sense of belonging, or experience it to a lesser extent than homosexual people do (Hayfield et al., 2013; Katz-Wise, Mereish, et al., 2017). This can be explained for two reasons: on the one hand, as models of bisexual identity development point out, it is possible that the stages of confusion and incongruence are longer for bisexual people, who may enter a circular process of self-doubt about their own identity (Chedid, 2015). On the other hand, monosexist conceptions of society also operate within the community, i.e. within the community there is also stigmatisation (Feinstein et al., 2021). For example, one of the reasons why bisexual people are considered to be more vulnerable to discrimination is the lower presence of links to the LGBTI community than other more visible members of the group, such as lesbians and gay men (H. McCann, 2022; Yule et al., 2015).

While there are many physical and online communities of bisexual and lesbian people, there are few associations aimed at the asexual population (Rothblum et al., 2019). For example, AVEN (*Asexuality Visibility Education Network*) is currently the largest online community for people who identify with the asexual spectrum. It has been observed that people who belong to or have contact with the asexual community also find it easier to recognise themselves as an asexual person and have higher levels of identity affirmation (Carvalho & Rodrigues, 2021; Yule et al., 2015). However, in the absence of clear codes and due to the lack of referents and the lack of knowledge about asexual and aromantic identities, these people often have greater difficulties in developing this sense of belonging to the group (Young, 2022).

For trans and non-binary people, there is a scarcity of literature on their sense of belonging to community, especially addressing intersectionality (Bradford & Syed, 2019; Kichler, 2022). For people who are outside the cis-norm and heteronormativity at the same time, the multiplication of stigmatisations may result in a reduced sense of belonging and increased possibilities of discrimination within the LGBTI community (Goldberg & Kuvalanka, 2018). Therefore, in many

cases trans and non-binary people weave their own support networks, creating a community of equals within the group itself (Kichler, 2022).

Membership has been widely studied as a **protective** factor for queer people's **mental** and **physical health**; it has been associated with lower levels of emotional symptomatology, especially through active participation in a cause and the presence of a social support network (Sanscartier & MacDonald, 2019). A sense of belonging to the community has also been found to be a predictor of self-esteem: queer people who relate to other members of the community appear to have higher levels of self-esteem, functioning as a protective factor for their psychosocial adjustment (Bond & Miller, n.d.). On the other hand, a weak sense of belonging is associated with psychological problems in queer people, acting as a risk factor when there is no community support network (Pakula et al., 2016; Parmenter et al., 2020).

However, there are differences according to specific sexual identities. For example, it has been observed that this variable is only protective for bisexual women when they do not feel that they belong to the heterosexual community, and that their lower levels of belonging to the community are associated with higher levels of emotional symptomatology. (McLaren & Castillo, 2020b). Bisexual identities may experience biphobia both outside and within the LGBTI community, so belonging to a community with other sexual minorities does not always protect bisexual people from discrimination (Shaw, 2022). Furthermore, it has been observed that trans and non-binary bisexual people experience layers of stigmatisation due to this overlap, and find it more difficult to be included in the LGBTI community, which has been associated with increased mental health problems (Kichler, 2022; Sanscartier & MacDonald, 2019).

1.4.3. Outness

Outness is more widely known as "coming out of the closet". This expression means to communicate one's LGBTI identity to other people (close friends, acquaintances or being overtly queer) (Dahlenburg et al., 2021; Ryan et al., 2015). The process of communicating one's sexual identity does not occur in a single event, but is an ongoing process throughout one's lifetime (Kranz & Pierrard, 2018). In

each new environment, the person is compelled to repeat the process of coming out from the beginning, as allo/heteronormativity is usually assumed (Shurts et al., 2020).

The report by the European Union Agency for Fundamental Rights (FRA, 2020) asked participants about their outness. According to their data, 34% of lesbian women reported that they were "very open" in expressing their LGBTI identity, compared to 11% of bisexual women and 19% of transgender people. In this survey it is not known whether trans people's outness refers to their gender identity or sexual orientation, and there is no data on non-binary or asexual people.

Outness is a controversial variable in research, because its consequences can be highly relative (Feldman & Wright, 2013; Garvey et al., 2018; Legate et al., 2012). On the one hand, outness as a protective factor has a great deal of empirical support (Kranz & Pierrard, 2018; Riggle et al., 2017). For queer people, being visible can contribute to greater identity affirmation, reduced stigmatisation through invisibility, a greater sense of belonging to the community and greater ease in establishing links with peers (Feldman & Wright, 2013; Hildebrandt & Chua, 2017). This is especially relevant for people who have fewer social codes to express their queer identity, such as bisexual, asexual, aromantic, or cis lesbians with a female gender expression (Delgado et al., 2013; Garvey et al., 2018; Ryan et al., 2015). Bisexual people have an added difficulty in disclosing their sexual identity, as the prejudices associated with biphobia tend to invisibilise this identity (Hayfield et al., 2013; Katz-Wise, Mereish, et al., 2017). The intersection between heterosexism and monosexism can make bisexual women's outness more complicated than for lesbians, especially in family settings (Doan Van et al., 2019). It has been observed that bisexual women tend to hide their identity when they are with people of the opposite gender as a way of concealing their queer status and in some cases come out as lesbians to avoid the comments and prejudices associated with biphobia, such as connotations of promiscuity and mistaken identity (Pollitt et al., 2017; Shaw, 2022).

On the other hand, greater visibility (as is the case for non-binary, trans and masc-presenting lesbians) exposes the person to higher levels of discrimination (Feldman & Wright, 2013; Riggle et al., 2017). Communicating an LGBTI identity in some contexts can contribute to stigma and put a person's physical and mental

health at risk (Kranz & Pierrard, 2018). In some cases, being completely out as a queer person may not be safe, especially if there are multiple layers of discrimination (Shurts et al., 2020). Trans and non-binary people are the most vulnerable to LGBTIphobic violence (Akhtar & Bilour, 2020; Krell, 2017). In particular, the combination of transphobia and misogyny means that trans women are the group most at risk when it comes to communicating their queer identity (Brumbaugh-Johnson & Hull, 2019; Darwin, 2020). As a way to prevent the negative consequences of coming out, some queer people use selective coming out strategies, which consist of communicating their identity only in certain circles (Berger et al., 2022).

However, there is a consensus in the literature about the **protective role** of outness, especially because of the relationship between queer identity concealment and elevated levels of emotional symptomatology (Pachankis et al., 2020). According to a survey by the European Union Agency for Fundamental Rights (FRA), people who have never disclosed their queer identity indicate lower average levels of life satisfaction (5.7 out of 10) than those who are rarely open (6.1), quite open (6.6) or very open (7.5) about their identity (CITA). Furthermore, respondents who have experienced discrimination in at least one area of life appear to have lower levels of life satisfaction (5.9) than those who have not experienced such stigmatisation (6.9). (European Union Agency for Fundamental Rights (FRA), 2020)..

1.4.4 Social support

Social support refers to the social network around an individual that can provide emotional, instrumental and/or financial psychological resources. Social support can exist in the form of friendships, affectionate and romantic bonds, family, people in the work environment, a religious community, people with common interests, online environments, pets and any other type of social groups (Shen et al., 2021; Watson et al., 2019).

The literature has described multiple forms of social support, among which two main dimensions stand out (Shakespeare-Finch & Obst, 2011):

- · **Emotional support**. This refers to all care that occurs through affection and is associated with companionship and emotional regulation. Physical contact, verbal and non-verbal communication, empathy, trust and love are types of emotional support.
- · **Instrumental support**. These are all caring behaviours that are performed with the intention of helping another person. Acts of service (e.g. helping with household chores), and providing material (e.g. accommodation or tools), non-material (e.g. information) and financial resources are types of instrumental support.

Social support in queer people often functions as a mediating and modulating factor between the stressors associated with minority stress and emotional symptomatology (Paveltchuk et al., 2019). Some studies approach this construct from the concept of "found family": LGBTI people often have lower levels of family support due to LGBTIphobic prejudice that leads their families to sever emotional ties; therefore, many LGBTI people find their network of ties in people from their community (Watson et al., 2019; Williams et al., 2005). Support from relevant people within their peer group could therefore buffer the lack of support from the family of origin.

This may imply that social support is different for different sexual identities (McConnell et al., 2015; Mcdonald, 2018). For people who receive less support from the community, such as bisexual and asexual people, the protective role of peer support may diminish, and family and non-peer support may become more important (Pollitt et al., 2017). The literature indicates that non-binary people are the ones who receive the least social and family support, which increases their psychological vulnerability by not having this protective factor for their mental health (Aparicio-García et al., 2018b).

There is ample empirical evidence on the **protective role** of **social** and family **support** on mental **health** (Chang et al., 2018). Social support in queer people is positively related to well-being, self-esteem and sense of belonging, and family support has been identified as a major protective factor for mental health, especially in young people (Mcdonald, 2018; Watson et al., 2019). It often functions as a mediating factor between the stressors associated with discrimination and stigmatisation and mental health problems, and this mediating role often occurs

through a sense of belonging to a social group (Pollitt et al., 2017; Winderman & Smith, 2019). Queer people who feel part of a network of support and care tend to have lower levels of emotional symptomatology and higher levels of well-being than those who do not have social or family support (Paveltchuk et al., 2019). In addition, some studies show that bisexual women may receive less family support than lesbians due to biphobic family prejudice and difficulties in coming out, which may put them at greater psychological vulnerability (Dyar et al., 2021; Pollitt et al., 2017). The literature indicates that social support in lesbians may be protective through a sense of belonging, and in bisexual women, through self-esteem, which could be explained by the fact that lesbian women appear to have higher levels of support and sense of belonging through the community than bisexual women (McLaren & Castillo, 2020a; Watson et al., 2019).

The influence of social support on the psychosocial adjustment experienced by women and non-binary individuals may be associated with how visible they are and how they communicate their sexual identity to others (Caba et al., 2022; Pollitt et al., 2017). There is still a scarcity of studies on social support in non-binary identities, but there seems to be a tendency to identify lower levels of social and family support in trans and non-binary people compared to cis people (Dowers et al., 2020).

1.4.5. Emotional competences

Emotional competences (also studied as socio-emotional competences) have been defined as a set of knowledge, attitudes and skills that allow for the appropriate use of information or emotions to adapt to the environment ((Bisquerra Alzina & Chao Rebolledo, 2021). One of the fundamental components of the emotional competences is emotional intelligence (Fernandez-Perez & Martin-Rojas, 2022).

Emotional intelligence is a concept that is still debated in the literature, as its definition often depends on the theoretical model from which it is approached (Gardner & Lambert, 2019). There tend to be two main trends when studying emotional intelligence: as a trait or as an ability (González-Yubero et al., 2019; Petrides, 2011).

From the perspective of emotional intelligence as a trait, emotional intelligence is understood as an innate and stable aptitude over time, and is therefore conceptualised as a pattern of behavioural dispositions that enable a person to understand and manage emotions in themselves and others (Gardner & Lambert, 2019). Emotional intelligence as a skill, on the other hand, is understood as a tool developed by the person that can be learnt and trained throughout life (González-Yubero et al., 2019; S. E. Hall et al., 2017). The capacity to understand and manage emotional information, therefore, is studied as a person's abilities to adapt to his or her environment with regard to emotional information. (Aldrup et al., 2020). One of the most widely used models of emotional intelligence as a skill is that of Mayer and Salovey (1997). According to these authors, emotional intelligence involves four basic competencies: (1) emotional perception and expression, (2) facilitation, which is the use of emotions to facilitate thinking, (3) understanding of emotions, and (4) management or handling of emotion in oneself as a form of emotional regulation (J. Mayer et al., 2004; J. D. Mayer & Salovey, 1997). Validation studies of this model usually eliminate the items of the facilitation factor, as they do not have adequate psychometric properties.

Emotional competences, therefore, include the concept of emotional intelligence and integrate it as part of a system of skills and strategies to perceive, understand, process and manage emotional information in the self and others (Bender et al., 2022; Fernandez-Perez & Martin-Rojas, 2022). One of the most widely used approaches to emotional competences (Takšić et al., 2009) describes three factors: (1) perceiving and understanding of emotions, (2) emotion labelling and emotional expression, and (3) emotion management and regulation. This factor structure has been validated through a questionnaire of emotional competences that presents adequate psychometric properties at a cross-cultural level (Faria et al., 2012; Schoeps, Tamarit, Montoya-Castilla, et al., 2019)

There is a scarcity of studies on the characteristics of emotional competences in queer populations. The few studies that have been found indicate that the development of coping strategies associated with experiences of discrimination may be related to higher levels of emotional regulation in people with minority identities (Toomey et al., 2017). Moreover, individuals who have transitioned in terms of their gender or sexual identity may develop emotional regulation

mechanisms that are protective of their mental health (Budge et al., 2013; Mîndru & Năstasă, 2017).

There do not seem to exist many studies on how **emotional competencies** in queer populations function as **protective of mental health** in women and non-binary people with non-heterosexual/non-allogender identities. However, it has been observed that people with greater vulnerability to emotional symptomatology, such as trans people, may have higher levels of emotional regulation due to a greater need to use emotional regulation strategies to combat the psychological harm caused by stigmatisation (Puckett et al., 2020). Literature on emotional symptomatology in sexual and gender minorities suggests that belonging to oppressed minorities is associated with a greater presence of negative emotions, which may imply a greater need for emotional regulation strategies (Shramko et al., 2018). Emotional dysregulation may mediate between minority stress and substance use in women with minority sexual identities, so emotional competencies could play a protective role in this population by decreasing their levels of emotional dysregulation (Fitzpatrick et al., 2020; Fonseca de Freitas et al., 2021). Thus, emotional regulation could play a mediating role in the relationship between internalised stigma (a type of proximal stressor) and emotional symptoms, but literature on specific populations, such as queer women and non-binary people, is still needed (Sommantico & Parrello, 2022).

1.4.6. Self-esteem

Self-esteem is a person's evaluation of themself, and includes beliefs, thoughts and feelings about the self (Thompson et al., 2016). In the general population, low self-esteem is associated with emotional symptomatology, psychological problems and psychosocial maladjustment, whereas high self-esteem is associated with psychological and emotional well-being and stability (Gardner & Lambert, 2019).

Self-esteem has been studied in literature from two main approaches: as a **unidimensional** or a multidimensional **construct** (Rentzsch et al., 2016). From the unidimensional approach, self-esteem is understood as a single, overarching construct of a person's evaluation of themself (Thompson et al., 2016). One of the most recurrent unidimensional approaches in literature is based on the Rosenberg

scale, which assesses global self-esteem, and has been widely used due to its simplicity and adequate psychometric properties (Gardner & Lambert, 2019). Multidimensional models propose that self-esteem is made up of different factors, such as feelings of competence, physical appearance, interpersonal relationships, or moral values, which determine different domains through which the self-evaluation of self-worth operates (Herrmann et al., 2019). The multidimensional approach provides a more in-depth analysis of self-esteem than the unidimensional one, although it can be more costly to apply and interpret, so reduced versions of multidimensional self-esteem scales have been developed (Rentzsch et al., 2021)..

Self-esteem has been studied as a **protective factor** in the **psychosocial adjustment** of queer people (W. J. Hall, 2018). However, it has been observed that people with higher levels of stress associated with their minority status, such as bisexual and asexual people, may also show lower levels of self-esteem (Bridge et al., 2019; Gray & Desmarais, 2014). This is even more relevant in people who, in addition to having a minority sexual identity, are trans and non-binary, as they experience higher levels of explicit discrimination (Austin & Goodman, 2016). There are not many studies on the functioning of self-esteem in people with gender-dissident identities, but it has been observed that identity affirmation in trans people has been associated with high self-esteem, although these factors have high individual variability (van den Brink et al., 2019). It appears that self-esteem may be compromised in populations with higher vulnerability to discrimination, but it also appears to function as a protective variable in people with high queer or trans identity affirmation (Akhtar & Bilour, 2020).

Self-esteem may have a mediating role in the relationship between minority stress and mental health (Akhtar & Bilour, 2020). In queer people, self-esteem is negatively related to distal and proximal stressors of minority stress and positively related to sense of belonging to community (Brewster et al., 2020). In trans and non-binary people this may be a key factor in addressing their emotional symptomatology, as they have lower levels of self-esteem than cisgender people (Akhtar & Bilour, 2020; Austin & Goodman, 2016). The literature indicates that self-esteem may function as a mediating variable between minority stress and psychosocial adjustment, as a risk factor for people with low self-esteem and as a protective factor for high levels of self-esteem (R. K. J. Tan et al., 2021).

Finally, self-esteem is also associated with other protective factors for psychosocial adjustment, such as social support (Chang et al., 2018). Social support from family and friends in queer people could be associated with higher levels of self-esteem, which in turn functions as a protective factor for their mental health (Bond & Miller, 2021; Pollitt et al., 2017). Thus, people who show lower social support (or higher social rejection) may also be in a place of greater vulnerability regarding their levels of self-esteem (Dowers et al., 2020).

Summary

Psychosocial factors related to the psychosocial adjustment of queer women and non-binary people can be differentiated into risk factors and protective factors:

- · Minority stress is the main risk factor in queer identities and is usually studied along two dimensions: distal stressors and proximal stressors. Minority stress in these identities is associated with the specific stigma they experience, which for lesbians, bisexual people and asexual people can focus on lesbophobia, biphobia and acephobia, respectively.
- · Protective factors for queer women and non-binary people include group membership, outness, social support, self-esteem and emotional competences.

1.5. OBJECTIVES AND HYPOTHESES

The main objective of this research, the specific objectives that have been proposed to achieve the main objective, and the hypotheses formulated in each specific objective are presented below.

1.5. Objectives and hypotheses

Reviewing the literature on psychosocial factors for psychosocial adjustment in queer women and non-binary people, research gaps in this population can be identified, suggesting a need in understanding how these factors relate to each other.

According to the syndemic theory, the overlap between stigmatisations may have a synergistic effect on the mental health and well-being of sexual minorities (Evans & Lépinard, 2020; Logie et al., 2017). Studies that have been conducted on women and non-binary people with diverse sexual orientations (lesbian, bisexual, pansexual and asexual) have generally explored their identities separately, so there is a gap in literature about the psychological factors that might similarly influence their psychosocial adjustment (C. R. McCann et al., 2020). In order to study these variables, it is necessary to understand what these minority identities consist of and how to approach them from a scientific perspective.

The main objective of this study was to analyse the psychosocial and sexual identity-related factors that influence the psychosocial adjustment of queer women and non-binary people. To this end, the following specific objectives were proposed:

Objective 1: Analyse the concordance between sexual and romantic orientation.

- Hypothesis 1.1. Depending on sexual orientation, there will be concordance between sexual orientation and romantic orientation for lesbians and bisexuals, but not for asexual people (Clark & Zimmerman, 2022).

Objective 2: Analyse the influence of gender and sexual orientation on dimensions of LB identity, minority stress, psychosocial factors and psychosocial adjustment.

- Hypothesis 2.1. On LB identity variables, bisexual people will show higher levels of identity uncertainty than lesbians (Bregman et al., 2013; Feinstein et al., 2021; Preciado & Johnson, 2014).
- Hypothesis 2.2. In minority stress, non-binary people will have higher levels of distal stressors than cis women, and cis women will have higher levels of

proximal stressors than all other identities (Aparicio-García et al., 2018b; Hayfield, 2020; Liss & Wilson, 2021).

- Hypothesis 2.3. In minority stress, lesbians will show higher levels of distal stressors than other sexual identities. Bisexual and asexual individuals will show higher levels of proximal stressors than lesbians (Aparicio-García et al., 2018b; Hayfield, 2020; Liss & Wilson, 2021).
- Hypothesis 2.4. On psychosocial factors, cis women will show higher levels of social support, self-esteem, well-being, and sense of community than non-binary people (Austin & Goodman, 2016; McLaren & Castillo, 2020a; Sanscartier & MacDonald, 2019).
- Hypothesis 2.5. On psychosocial factors, lesbians will show higher levels of social support, self-esteem, well-being, and sense of community than other identities (Austin & Goodman, 2016; McLaren & Castillo, 2020a; Sanscartier & MacDonald, 2019).
- Hypothesis 2.6. Participants will show high levels of emotional symptomatology and low levels of wellbeing (Flanders et al., 2022; Rothblum, 2020). Specifically, non-binary, bisexual and asexual individuals will have higher levels of emotional symptomatology than all other identities (Colledge et al., 2015; McInroy et al., 2020; Villarreal et al., 2021).

Objective 3: Analyse the relationship between the dimensions of LB identity, psychosocial factors and psychosocial adjustment.

- Hypothesis 3.1. Identity affirmation and identity centrality will be positively associated with protective factors and well-being, and negatively associated with risk factors and emotional symptomatology (Hinton et al., 2021; Rosner et al., 2013; Shramko et al., 2018).
- Hypothesis 3.2. Difficulty factors associated with LB identity (acceptance concerns and difficulty in the process) will be positively related to risk factors and emotional symptomatology and negatively related to protective factors and well-being (Feinstein et al., 2021; Mohr & Kendra, 2011; Qeadan et al., 2021; Scherrer, 2008).
- Hypothesis 3.3. In minority stress, distal stressors will be positively related to outness and community belonging (Brewer & Lyons, 2016; Dunn &

Szymanski, 2018; Hayfield et al., 2013; M. E. Slater et al., 2017) and proximal stressors, to emotional symptomatology (Hayfield, 2020; Morandini et al., 2015).

Objective 4: Analyse the influence of minority stress on psychosocial adjustment as a function of queer identity as determined by the intersection between gender and sexual orientation.

- Hypothesis 4.1. Distal stressors, proximal stressors and self-esteem mediate the relationship between identity and psychosocial adjustment (Ž. Kamenov et al., 2016).
- Hypothesis 4.2. Distal stressors will influence psychosocial adjustment for non-binary people and lesbians (Hamilton-Page, 2022; Shramko et al., 2018).
- Hypothesis 4.3. Proximal stressors will influence psychosocial adjustment for bisexual and asexual individuals (Dyar et al., 2018; Hayfield et al., 2013).
- Hypothesis 4.4. Self-esteem will have a protective influence on the psychosocial adjustment of queer women and non-binary people (W. J. Hall, 2018; R. K. J. Tan et al., 2021).

CHAPTER II:

METHOD

In this section, there will be presented a description
of the participants, the variables and instruments
used, the procedure followed for obtaining the data
and the data analyses conducted.

2.1. Participants

Out of the 1399 participants who filled in the survey, 1359 participants were included in the study after applying the criteria presented below. In order to achieve the proposed objectives, 3 subsamples were studied (Table 3). **Subsample 1** (n=1359) represents the total sample, including all genders and sexual orientations that met the inclusion criteria, and was used to test objective 3. **Subsample 2** (n=1269) included only participants whose gender identities and sexual orientations were known (those who answered "other" were excluded), and was used to test objectives 1 and 2. **Subsample 3** (n=1244) included all participants from the subsample 2, but trans women were excluded due to the small sample size, and was used to test objective 4.

Table 3.
Description of the subsamples used in the current study

Subsample (n)	Gender	Sexual orientation	Romantic orientation	Age	Objective
Subsample 1 (n=1359)	Cis women Trans women Non-binary Other	Lesbian Bisexual Asexual Other	Homoromantic Biromantic Heteroromantic Aromantic Other	18 to 68 (*M*= 27.69; *SD*=6.99)	Objective 3
Subsample 2 (n=1269)	Cis women Trans women Non-binary	Lesbian Bisexual Asexual	Homoromantic Biromantic Heteroromantic Aromantic	18 to 68 (*M*= 27.60; *SD*=6.84)	Objectives 1 and 2
Subsample 3 (n=1244)	Cis women Non-binary	Lesbian Bisexual Asexual	Homoromantic Biromantic Heteroromantic Aromantic	18 to 68 (*M*= 27.60; *SD*=6.76)	Objective 4

Inclusion criteria were (1) identifying as a woman (cis or trans) or as non-binary, (2) being queer, that is, having a sexual orientation other than heterosexual (e.g.,

lesbian, bisexual, asexual, or other), (3) being 18 years old or older, (4) understanding Spanish, since the survey was entirely written in this language and (5) scoring less than 50% in the infrequency scale applied together with the questionnaires. The Oviedo Infrequency Scale (INF-OV) (Fonseca-Pedrero et al., 2009) was applied to detect participants that answered randomly. Participants who incorrectly answered more than 50% of the scale were removed from the study.

2.1.1. Description of the sample

In this section, the sample will be described through socio-demographic statistics (frequencies, percentages and graphic distribution).

2.1.1.1. Variables related to gender, sexual identity and age

Gender

Total sample (Subsample 1) was composed of 1359 participants. Regarding gender, there were 985 cis women (72.50%), 26 trans women (1.90%), 312 non-binary people (23%) and 36 participants (2.60%) whose gender did not match the previous categories (10 identified as genderfluid, 8 as agender, and the remaining 18 explained their diverse gender status, such as "demiboy", "demigirl", or "questioning").

Figure 6.
Gender distribution in the total sample.
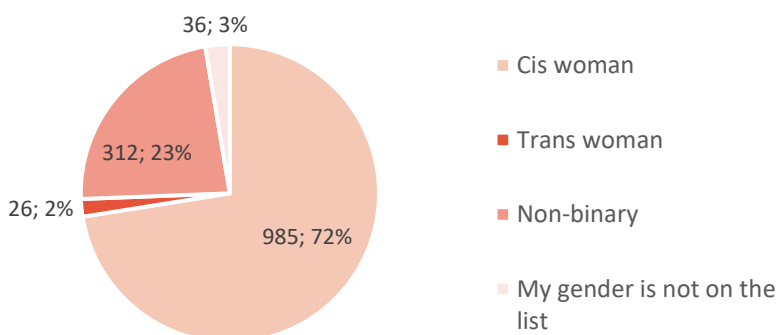
Sexual identity

The participants' sexual identity was measured according to two parameters: sexual orientation and romantic orientation. Regarding sexual orientation, 258 (19%) identified as a lesbian, 822 (60.50%) as bisexual/pansexual, 237 as asexual (17.40%) and 42 (3.10%) indicated their sexual orientation was not on the list, 27 disclosing they identified as "demisexual" and the remaining 15 disclosed other sexual orientations, or that they were not sure about it (Figure 7). Regarding romantic orientation, 342 (25.20%) identified as a homoromantic, 825 (60.70%) as biromantic/panromantic, 71 as heteroromantic (5.20), 88 as aromantic (6.50%) and 33 (2.40%) indicated their romantic orientation was not on the list, 13 disclosing they identified as "demiromantic" and the remaining 46 disclosed other romantic orientations, or that they were not sure about it (Figure 8.

Figure 7.
Sexual orientation distribution in the total sample.
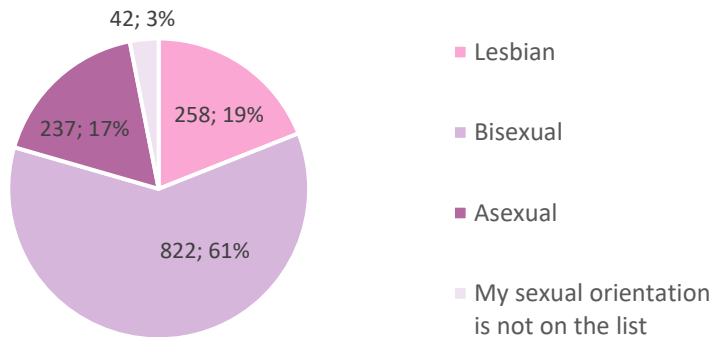
Figure 8.
Romantic orientation distribution in the total sample.
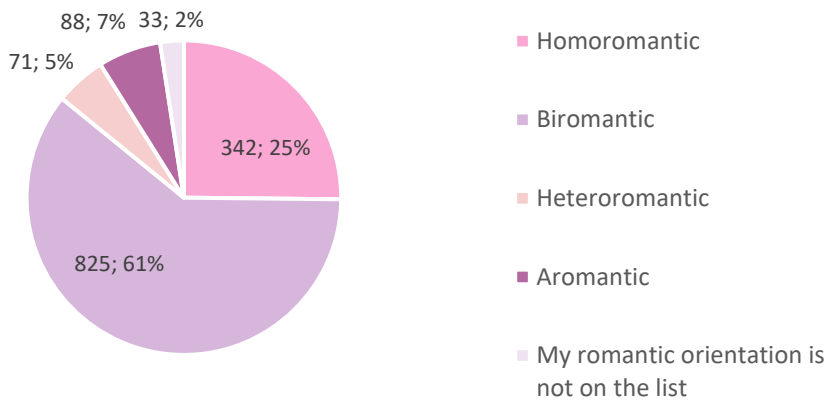
Gender expression

Participants' gender expression was calculated in a spectrum ranging from 0 "more masculine" to 10 "more feminine", considering scores near 5 an androgynous expression. Figure 9 shows the participants distribution in this scale. Scores for cis women were less variable, falling in the upper side of the spectrum (M= 7.41, SD= 1.57), but there were a lot of outliers, representing extreme scores (99 out of 966, 10.25%). They were followed by trans women (M= 6.12, SD= 1.99), and non-binary people having the most androgynous gender expression (M= 5.29, SD= 1.83).

Figure 9.

Gender expression distribution of the participants by gender.
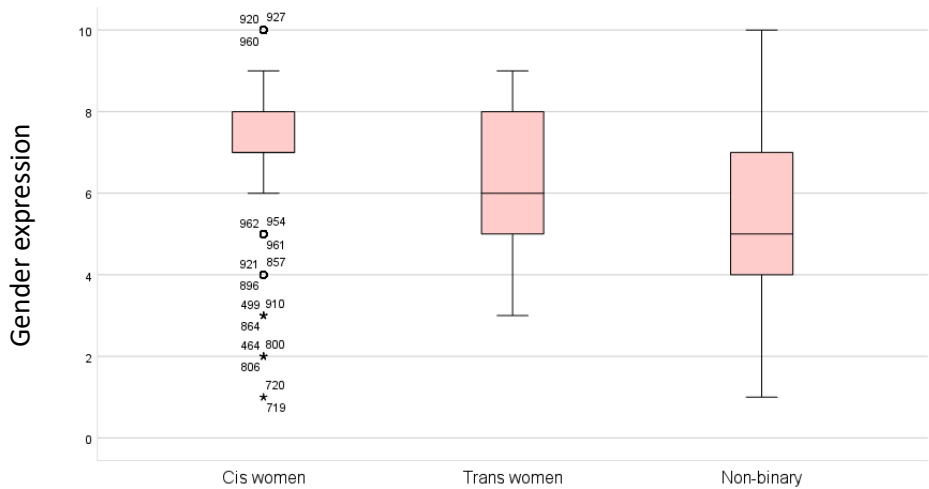
Distribution of gender expression by sexual and romantic orientations showed less variability. Average scores are similar for sexual orientation, showing a higher standard deviation for lesbians (*M*= 6.53, *SD*= 1.97), but with similar scores for bisexual (*M*= 7.10, *SD*= 1.79) and asexual participants (*M*= 6.74 1, *SD*= 1.90). There were outliers for bisexual (9 out of 799, 1.13%) and asexual participants (5 out of 219, 2.28%).

Figure 10.
Gender expression distribution of the participants by sexual orientation.
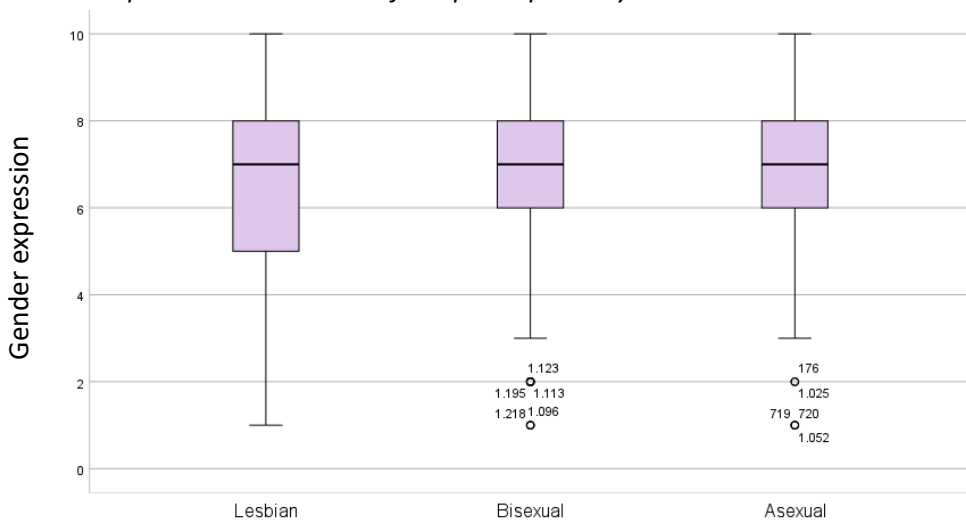
As for romantic orientation, homoromantic (*M*= 6.56, *SD*= 1.95), biromantic (*M*= 6.02, *SD*= 1.84) and aromantic participants (*M*= 6.73, *SD*= 1.58) showed similar scores, only slightly different for heteroromantic participants (*M*= 7.76, *SD*= 1.60), whose gender expression tended toward the feminine side of the spectrum. There were outliers for all romantic orientations except for aromantic: homoromantic (13 out of 333, 3.90%), biromantic (10 out of 787, 1.27%), heteroromantic (1 out of 66, 1.52%).

Figure 11.

Gender expression distribution of the participants by romantic orientation.
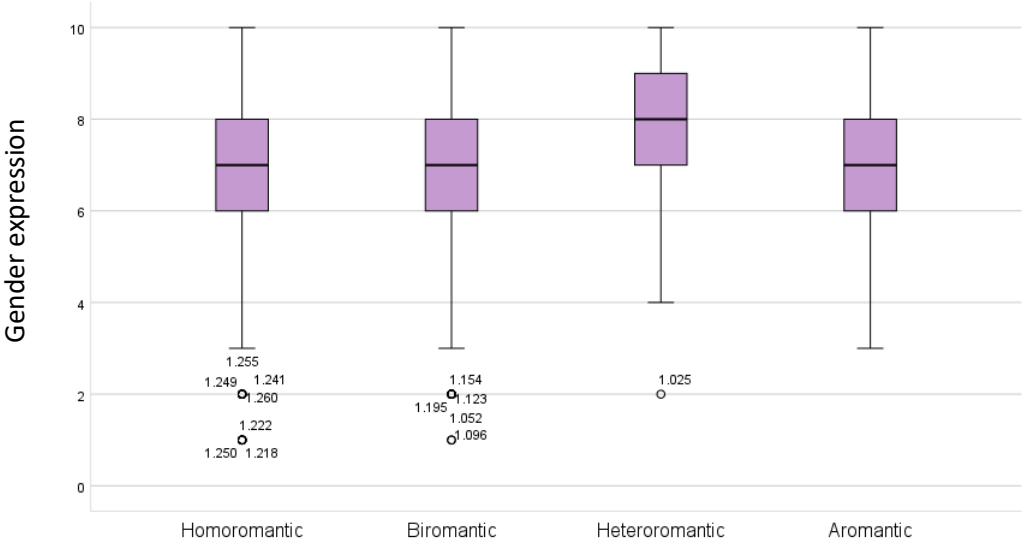
Age

Age ranged from 18 to 68 years old (*M*= 27.69; *SD*=6.99), and participants were mainly adults under 30 (Figure 12).

Figure 12.

Age frequencies (n) in the total subsample.
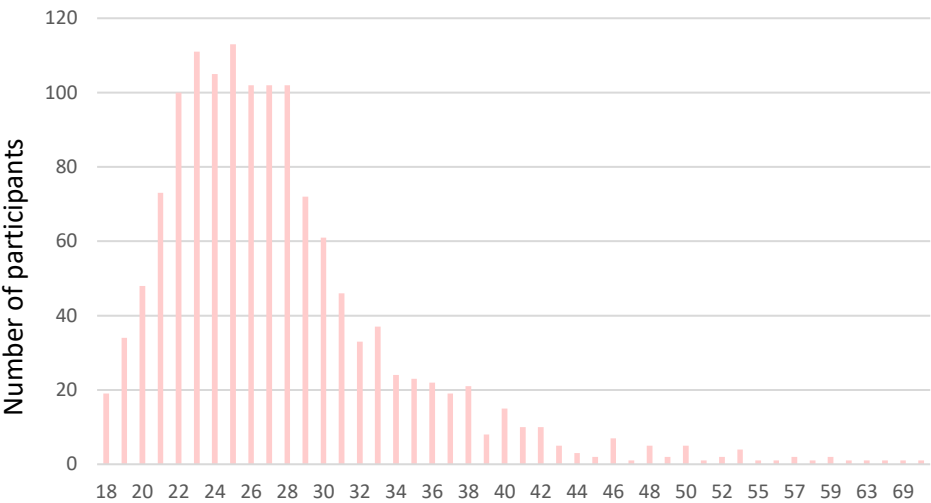
A deeper analysis of the age distribution across genders is shown in Table 4 Age groups were made according to the National Institute of Mental Health criteria (2021): young adults can be ranged from 18 to 25 years old, adults may range from 26 to 49 years old, and older adults are ranged older than 50, which in this sample is 50 to 68 years old (Askari et al., 2022) and made up only 1.80% of the total sample. The rest of the participants were equally divided into young adults (44.40%) and adults (53.90%).

Table 4.

Frequencies of gender and age in the total sample

	Cis women N (%)	Trans women N (%)	Non-binary N (%)	My gender is not on the list N (%)	Total N (%)
Young adults (18 to 25)	431 (71.50%)	12 (2%)	151 (25%)	9 (1.50%)	603 (44.40%)
Adults (26 to 49)	541 (73.90%)	12 (1.60%)	157 (21.40%)	22 (3%)	732 (53.90%)
Older adults (50 to 68)	13 (54.20%)	2 (8.30%)	4 (16.70%)	5 (20.80%)	24 (1.80%)
Total	985 (72.50%)	26 (1.90%)	312 (23%)	36 (2.60%)	1359 (100%)

Other demographic variables

Regarding their **ethnicity**, the majority of the participants indicated they were White/Caucasian (n=850, 62.50%), followed by Hispanic/Latina (n=462, 34%), Biracial/Multiracial (n=30, 2.20%), Black/Afro-American (n=3, 0.2%) and Asian/Pacific (n=3, 0.2%). Some participants indicated their ethnicity was not on the list (n=11, 0.80%).

As for the **country of origin**, 982 (72.30%) indicated Spain, while 377 (27.70%) selected other countries, most of them Spanish-speaking countries (120 participants were from Mexico, 74 from Chile, 68 from Venezuela, 42 from Argentina and 23 from Colombia, and the remaining 50 from other countries). A majority of the participants **resided** in Spain (1008, 74.20%), and 351 (25.80%) resided in other countries (114 participants resided in Mexico, 71 in Chile, 47 in Venezuela, 41 in Argentina and 20 in Colombia, and the remaining 58 in other countries).

Out of the total sample, 783 (57.60%) of the participants were in a **sexual** and/or **romantic relationship**, in contrast to 576 (42.40%) who were not. Of the participants who were in a relationship, 723 had one partner and 43 had two or more partners. The gender of the partners was cis and trans women, cis and trans men, and non-binary.

When asked about their **main occupation**, 394 (29%) indicated they were currently studying, 544 (40%) were working, 306 (22.50%) were studying and working, and 115 (8.50%) were not studying nor working.

Regarding **cohabitation**, 650 (47.80%) participants lived with their family of origin, 39 (2.90%) with their children, 135 (9.90%) lived alone, 301 (9.90%) with their partner, 200 (14.70%) shared with flatmates, and 34 (2.50%) moved frequently. The majority of the sample (n=1297, 95.40%) had no children, while 62 (4.60%) had at least one child.

As for their **net income**, 472 (34.70%) earned less than 999€, 358 (26.30%) earned from 1.000 to 9.999€, 365 (26.90%) earned from 10.000€ to 24.999€, 137 (10.10%) earned from 25.000€ to 49.999€, 18 (1.30%) earned from 50.000€ to 74.999€, 6 (0.40%) earned from 75.000 to 99.999€ and 3 (0.20%) earned 100.000€ or more.

2.2. Variables and questionnaires

Table 5.

Variables and instruments used in the current study

Variable	Questionnaire
Socio-demographic variables	Ad hoc questionnaires.
Variables associated with sexual identity	
Sexual-affective orientation	Ad hoc questionnaires.
LB identity	The Lesbian, Gay, & Bisexual Identity Scale, LGBIS (Mohr & Kendra, 2011; Vinces, 2016).
Psychosocial factors	
Minority stress	The LGBT Minority Stress Measure, MSS (Nebot-Garcia et al., 2021; Outland, 2016).
Community belonging	The Psychosocial Sense of Community Scale PSOC-LGBT (Lin & Israel, 2012).
Outness	Ad hoc questionnaire
Social support	The Multidimensional Scale of Perceived Social Support, MSPSS (Landeta & Calvete Zumalde, 2002; Zimet et al., 1988).
Self-esteem	The Rosenberg Self-esteem Scale, RSES (Atienza et al., 2000; Rosenberg, 1965).
Emotional competence	The Emotional Competencies and Skills Questionnaire, ESCQ-21 (Schoeps et al., 2019; Takšić et al., 2009).
Psychosocial adjustment	
Emotional symptomatology	The Depression, Anxiety and Stress Scale DASS-21 (Fonseca-Pedrero et al., 2010; Lovibond & Lovibond, 1995).
Well-being	The Satisfaction with Life Scale, SWLS (Diener et al., 1985; Vázquez et al., 2013).
	Scale of Positive and Negative Experience, SPANE (Diener et al., 2010; Espejo et al., 2020).

2.2.1. Sociodemographic variables

Sociodemographic variables were assessed through *ad hoc* questionnaires.

Gender identity was assessed with an item asking "How do you identify?". Single-option response alternatives were cis woman, trans woman, non-binary and "my gender is not on the list", given a free space to fill in the answer.

Gender expression was assessed through an item asking "What is your gender expression like most of the time? Gender expression refers to behaviours, attitude, way of dressing, etc.", scored in a 10-point Likert scale ranging from 1 (masculine) to 10 (feminine), with a label in the middle indicating that 5 was considered "androgynous".

Ethnicity was assessed with single-option response alternatives. Black/Afroamerican, Asian/Pacific, Hispanic/Latina, White/Caucasian, Biracial/Multiracial and "other", given a free space to fill in the answer.

Other sociodemographic variables were age, country of birth, country of residence, whether they were in a romantic relationship, their partner's gender, whether they had children, cohabitation, education level, whether they were studying, working, or both, and their approximate net income.

2.2.2. Variables associated with sexual identity

Sexual identity. Participant's sexual identity was assessed through an ad hoc questionnaire formed by two parameters: sexual orientation and romantic orientation. According to the literature, there is a distinction between (1) sexual identity, (2) sexual and romantic orientation and (3) sexual behaviour (Qeadan et al., 2021; van Anders, 2015). The dimensions associated with sexual identity and the psychosocial variables measured in this study made it necessary to assess sexual identity rather than sexual practices or simply the target of attraction. However, it was also of interest to distinguish between the sexual and the romantic aspects of this construct, and their possible association. Therefore, this variable was assessed through two different items. The first assessed the sexual component of

sexual identity, which in this study is going to be named "sexual orientation". The item presentation was the following:

Sexual orientation is determined by sexual/physical attraction, and is independent of romantic attraction. Asexuality is a sexual orientation can be defined as the absence of sexual interest or attraction to other people. According to your sexual attraction, which of these options do you most identify with?

- *Homosexual/Lesbian*
- *Bisexual/Pansexual*
- *Heterosexual*
- *Asexual*
- *My sexual orientation is not on the list (free space)*

The second item assessed the romantic component of sexual identity, which in this study is named "romantic orientation". The item presentation was the following:

Romantic orientation is determined by romantic attraction, and is usually determined by the desire to establish a romantic relationship. Aromanticism can be defined as the absence of romantic interest or attraction to other people. According to your romantic attraction, which of these options do you most identify with?

- *Homoromantic/Lesbian (romantic)*
- *Biromantic/Panromantic*
- *Heteroromantic*
- *Aromantic*
- *My romantic orientation is not on the list (free space)*

In this study, bisexual and biromantic are considered broad terms that encompass participants who identify as pansexual and panromantic, respectively.

LB identity. The Lesbian, Gay, & Bisexual Identity Scale, LBIS (Mohr & Kendra, 2011) was used which assesses the dimensions that form queer identity. The Spanish version, translated and validated into Spanish in adult population, was used (Vinces, 2016). This 27-item questionnaire was originally made only for homosexual

individuals, and through Mohr & Kendra's revision it is now targeted to people identifying as lesbian, gay or bisexual. However, there is to our knowledge no version of this questionnaire directed towards individuals identifying as non-allosexual or alloromantic. Therefore, in the instructions it was specified that if the participant was asexual but could relate with the items displayed in this questionnaire, they could respond from their experiences as homoromantic or biromantic, if applicable. This allowed to include asexual participants in the analyses related to this questionnaire, together with the allosexual part of the sample. Thus, even if this questionnaire originally assessed "LGB" identity, we will refer to this variable as "LB" identity, since there are no gay participants in this study.

It consists of 8 dimensions with 6 response alternatives, ranging from 1: "Strongly Disagree" to 6: "Strongly Agree". The dimensions are: Acceptance Concerns (e.g. "*I often wonder whether others judge me for my sexual orientation*"), Concealment Motivation (e.g. "*I think very carefully before coming out to someone*"), Internalised Homo/binegativity (e.g. "*I wish I were heterosexual*"), Identity Uncertainty (e.g. "*I'm not totally sure what my sexual orientation is*"), Difficulty in the Process (e.g. "*Admitting to myself that I'm an LB person has been a very painful process*"), Identity Superiority (e.g. "*I look down on heterosexuals*"), Identity Affirmation (e.g. "*I am glad to be an LB person*"), and Identity Centrality (e.g. "*My sexual orientation is a central part of my identity*"). The scale presents adequate psychometric properties (Cronbach's α = .77; $\alpha_{Acceptance\ Concerns}$ = .78; $\alpha_{Concealment\ motivation}$ = .80; $\alpha_{Internalised\ Homo/binegativity}$ = .80; $\alpha_{Identity\ Uncertainty}$ = .64; $\alpha_{Difficulty\ in\ the\ Process}$ = .54; $\alpha_{Identity\ Superiority}$ = .78; $\alpha_{Identity\ Affirmation}$ = .79; $\alpha_{Identity\ Centrality}$ = .77).

2.2.3. Psychosocial factors

Minority Stress. The LBT Minority Stress Measure assesses specific stressors experienced by LGTBI individuals (Outland, 2016). The version translated into Spanish (Nebot-Garcia et al., 2021) was used. Formed by 25 items, it consists of 7 dimensions with 5 response alternatives, between 1 "It never happens to me" to 5 "It always happens to me". The dimensions are divided between distal stressors and proximal stressors. Distal stressors refer to the explicit and overt discrimination,

and they assess objective events of violence toward the individual. Three subscales measure distal stressors:

- Discrimination events (e.g. "*I have received poor service at a business because I am LBT*", α = .72).
- Victimization events (e.g. "*I have been verbally harassed or called names because I am LBT*", α = .86).
- Everyday discrimination (e.g. "*People have re-labelled my identity, or referred to me by a name/pronouns that are different than how I identify myself*", α = .71).

Proximal stressors refer to the individual's subjective experience of stigma, and their personal evaluation of their discrimination. Four subscales assess proximal stressors:

- Identity concealment (e.g. "*I avoid telling people about certain things in my life that might imply I am LBT*", α = .82).
- Anticipation of rejection (e.g. "*When I meet someone new, I worry that they secretly do not like me because I am LBT*", α =.85).
- Internalised stigma (e.g. "*If I was offered the chance to be someone who is not LBT, I would accept the opportunity*", α =.86).
- Community Connectedness, which is inverted (e.g. "*I feel that I could find professional services for LBT issues if I needed to*" α =.82). From this point forward, this dimension will be named "Community Disconnectedness" to facilitate interpretation.

The questionnaire presented adequate reliability indices (α_{Total} = .86, α_{Distal} = .84, $\alpha_{Proximal}$ = .84).

Outness. Outness was measures through an ad hoc questionnaire. Participants were asked "In these environments, do they know your affective-sexual orientation?" and 4 response alternatives were given, from 1 "no one" to 4 "everyone". The 7 items of the questionnaire corresponded to a social environment each: (1) close family, (2) extended family, (3) close friends, (4) acquaintances, (5) work environment, (6) social media and (7) strangers. The questionnaire showed adequate psychometric properties (Cronbach's α = .86).

Community belonging. This variable was assessed through the Psychological Sense of Community Scale, PSOC-LBT (Lin & Israel, 2012). This questionnaire was translated into Spanish, following the World Health Organization guidelines (The World Health Organization, 2020). Two independent bilingual translators were involved in the process. The first translator, a native Spaniard, translated the items from English into Spanish, and had expert knowledge of the area covered by the instrument. Secondly, an independent bilingual translator with no knowledge of the questionnaire translated the items back into English. Finally, they discussed the translation together and decided on the wording of the items in the final version. This questionnaire is composed of 23 items grouped in 6 scales: Influencing (e.g. "*How much do you feel able to influence the actions, thoughts, and feelings of other LBT people?*"), Influenced by Others (e.g. "*How much do other LBT people influence your thoughts and actions?*"), Shared Emotion (e.g. "*In general, how friendly do LBT people feel toward each other?*"), Needs Fulfilment (e.g. "*How much do you feel that you help other LBT people when they need help?*"), Membership (e.g. "*In general, how often do you feel that you are a member of the LBT community?*"), Existence of Community (e.g. "*How much do you feel that an LBT community exists?*"). Factor analyses were conducted to test the psychometric fit of the translated scale. The instrument showed adequate indices in the Exploratory Factor Analysis (RMSEA = .04; CFI =.99; GFI = .997) and in the Confirmatory Factor Analysis (χ^2 (df)= 1554.99 (216); RMSEA (CI) = .068 (.064 - .07); CFI = .93; TLI =.91). The global score of the questionnaires was used, and presented adequate reliability indices (α= .89; AVE = .66; CRC = .98).

Social support. Social support was evaluated through the Multidimensional Scale of Perceived Social Support, MSPSS (Zimet et al., 1988), translated and adapted into Spanish (Landeta & Calvete Zumalde, 2002). It is composed of three dimensions, 12 items in total, which evaluate the amount and quality of social support from three different sources: family, friends and significant others. Items are scored in a 5-point Likert scale (0 = strongly disagree, 5 = strongly agree). All scales showed adequate reliability scores: friendship support (e.g., "*I can count on my friends when things go wrong*", α = .95), family support (e.g. "*My family really tries to help me*", α = .94), and significant other support (e.g. "*I have a special person who is a real source of comfort to me*", α = .92).

Self-esteem. Self-esteem was assessed through the Rosenberg Self-esteem Scale (Rosenberg, 1965), validated and translated into Spanish (Atienza et al., 2000). It is a 10-item unidimensional scale that assesses the participant's opinion of themselves and their self-value. Items range in a 5-point Likert scale from 1=strongly disagree to 4=strongly agree (e.g., "*I feel that I have a number of good qualities*"). The reliability of the scale is satisfactory (α=.92).

Emotional competencies. The Emotional Competence and Skills Questionnaire (ESCQ-21) was used (Takšić et al., 2009). This questionnaire was originally created with 24 items, and a shorter version was created and adapted and translated into Spanish (Schoeps, Tamarit, Montoya-Castilla, et al., 2019). The 21-item scale comprises 3 scales, each one composed of 7 items scored on a 5-point Likert scale ranging from 1 = Never to 5 = Always). These scales are Perception and understanding, which assesses the ability to detect and interpret emotions in the individual and in others (e.g., "*When I see how someone feels, I usually know what has happened to them*"); Expressing and labelling, which refers to the ability to communicate those emotions (e.g., "*I am able to express my emotions well*"), and Management and regulation, which measures skills related to adjustment and coping through the adequate regulation of emotions (e.g., "*When I am in a good mood, every problem seems soluble*"). The scale shows adequate reliability indices ($\alpha_{\text{Perception and understanding}}$ = .91; $\alpha_{\text{Expressing and labelling}}$ = .96; $\alpha_{\text{Management and regulation}}$ = .77).

2.2.4. Psychosocial adjustment

Emotional symptomatology. The Depression, Anxiety and Stress Scale, DASS-21 (P. F. Lovibond & Lovibond, 1995) was used to assess depression, anxiety and stress symptoms experienced over the past week, and the Spanish version of the scale was used, adapted into Spanish population (Fonseca-Pedrero et al., 2010). It is formed by three subscales of 7 items each: Depression (e.g. "*I couldn't seem to experience any positive feeling at all*"), Anxiety (e.g. "*I was worried about situations in which I might panic and make a fool of myself*") and Stress (e.g. "*I was aware of dryness of my mouth*"), ranging from 0 (not applicable to me) to 2 (very applicable to me). These three dimensions can be summed together in a global scale of emotional symptomatology or psychological distress, since depression, anxiety and stress symptoms have been observed to overlap (Valencia, 2019). The reliability of

each scale was adequate ($\alpha_{Depression}$= .95, $\alpha_{Anxiety}$= .94; α_{Stress}= .92), including the reliability of the total score (α = .94). Cross-cut scores for this scale are shown in Table 6 (S. H. Lovibond & Lovibond, 1995b).

Table 6.
Cross-cut scores for the DASS-21 (Lovibond & Lovibond, 1995).

	Depression	Anxiety	Stress
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely Severe	28+	20+	34+

Well-being. It was measured by three variables: satisfaction with life and positive and negative affect. Satisfaction with life was measured through the Satisfaction With Life Scale, SWLS (Diener et al., 1985), specifically the version translated and validated in Spanish general population (Vázquez et al., 2013). It is formed by 5 items in a 7-point Likert scale that assess the overall evaluation of the respondent's life (e.g. "*In most ways my life is close to the ideal"),* with adequate reliability indices (α= .87). Cross-cuts extracted from the original publication are:

-   31 – 35: Extremely satisfied
-   26 – 30: Satisfied
-   21 – 25: Slightly satisfied
-   20: Neutral
-   15 – 19: Slightly dissatisfied
-   10 – 14: Dissatisfied
-   5 – 9: Extremely dissatisfied

Positive and negative affect was assessed with the Scale of Positive and Negative Experience, SPANE (Diener et al., 2010), using the version translated and validated in adult Spanish population (Espejo et al., 2020). This 20-item scale evaluates the emotions experienced over the past week, scored in a 5-point Likert scale ranging from 1 (very slightly or nothing at all) to 5 (extremely). The two subscales, formed by 10 items each, are positive affect (e.g., enthusiastic, interested) and negative affect (e.g., distressed, upset). These scores can be summed together to form the

dimension affective balance, which indicates the global measure of positive and negative affect. Reliability scores for positive affect (α= .93) and negative affect (α= .85) were adequate. As a cross-cut reference, the means and standard deviations for these dimensions were extracted from the original publication for positive (*M*=22.10; *SD*=3.7) and negative affect (*M*=15.60; *SD*=3.90).

2.2.5. Infrequency

The Oviedo Infrequency Scale (INF-OV) (Fonseca-Pedrero et al., 2009) was applied to detect participants that answered randomly. This self-report scale was originally conceived in Spanish, composed of 10 items 5-point Likert-scale ranging from 1 (completely disagree) to (5 = completely agree). Items asked questions depicting everyday or universal experiences, e.g. "*I have seen people who wear glasses*". Participants who incorrectly answered more than 50% of the scale were removed from the study.

2.3. Design and procedure

This study was conducted in the University of Valencia, and it was approved by the university Ethics Committee (registry number 2350193). It followed a cross-sectional, descriptive and comparative design, with data gathered in one single time.

This study followed the guidelines of the Helsinki declaration (World Medical Association, 2013). Participants were contacted through social networks such as Twitter and Instagram, and LGTBI+ associations, such as PRISMA, MariCorners and AVEN, which voluntarily helped with the diffusion of the questionnaires. Participants completed a survey through the Limesurvey platform, which included an informed consent in which the participants confirmed their voluntary collaboration and were informed of the confidentiality and anonymity of the data provided. Convenience sampling was used, since all observations gathered were used for this study. The data collected was only used by the members of the research team, and was only used for scientific and transference purposes.

2.4. Data analyses

Data were analysed using the statistical programs SPSS (28.0 version) for Windows 10 and MPlus (version 6.12). Data analyses are described below.

Reliability analyses: Cronbach's α was used to test for the internal consistency of each variable and the dimensions it comprises.

Descriptive analyses: frequencies, percentages, arithmetic means (*M*) and standard deviation (*SD*) informed about central tendency of the data and their variability or dispersion. Range indicates the minimum and maximum scores that were reached in the application of the questionnaires. Skewness indicates the asymmetry found in the data: lower skewness scores indicate the data distribution fall towards the middle of a normal distribution, therefore, it is considered as symmetrical. Kurtosis is a measure of outliers in the distribution: lower kurtosis scores indicate that the data generally lies around the mean. Values of skewness lower than 2 and values of kurtosis lower than 4 are considered acceptable when analysing the data distribution (Mishra et al., 2019).

Chi-squared (χ^2): chi-square tests were conducted to examine the association between two categorical variables in a cross-table. A Montecarlo simulation was conducted, since the small sample size of some groups made violated the conditions for chi-squared analyses (no cells with expected values <1). Size effect was tested through the Cramer's V estimate. Values of .01 indicate a small effect, a value of .03 indicates a medium effect, and a value larger than .05 is considered a large effect (Ceran Serdar et al., 2021).

Student's t-test for independent samples: they were conducted to analyse the means of the variables by a reference dichotomic category. Cohen's d was calculated to test for effect size. Effect sizes up to .20 are considered small, from .20 to .80 are considered moderate, and above .80 are considered large (Funder & Ozer, 2019).

Student's t-test for one sample: these t-test analyses were conducted to compare the means of the variable with a reference value. Cohen's d was calculated to test for effect size.

One-factor ANOVA: they were used to analyse the means of the variables by a reference category with three or more levels. Partial eta squared (η^2) was

calculated to test for effect size. Effect sizes up to .01 are considered small, from .01 to .06 are considered moderate, and above .14 are considered large (Metsämuuronen, 2023).

Pearson correlation coefficient: it was calculated to test for a relationship between the variables. Significant relationships can either be positive (when one variable increases, the second variable increases as well) or negative (when one variable increases, the second variable decreases). Correlations up to .29 are considered weak, from 0.30-0.69 as moderate, and .70 or higher are considered strong (Akoglu, 2018).

Multiple regression analyses: They were conducted to assess the direct effect that one or more variables have on a dependent variable. The method used for this analysis was "enter", which forces all variables to be in the model, since all variables used were expected to explain a significant amount of variance.

Path analysis: this statistical method analyses the relationship among multiple variables simultaneously. In this model, independent (IV), mediator (M) and dependent (ID) variables were introduced. Path analysis requires dependent variables to be continuous, but it allows for independent variables to be categorical. They can use latent variables (the separate items of a variable are introduced), which are depicted by ovals in a model graph, or observable variables (the calculated score of a variable is introduced), which are depicted as squares. Path analysis provides model fit indices that indicate the psychometric goodness of the model introduced: chi-square, which should be non-significant; Comparative Fit Index (CFI) and Tucker Lewis Index (TLI), for which acceptable values should be $\geq$ .90, Root Mean Square Error of Approximation (RMSEA) and Standardized Root Mean Square Residual (SRMR), which should be <.05 to inform of a good fit (Collier, 2020). In the current study, path analysis was conducted to analyse the effect of belonging to each minority group on psychosocial adjustment. Therefore, six different groups are made: cis lesbian, cis bisexual, cis asexual, non-binary lesbian, non-binary bisexual and non-binary asexual (Table 7). Trans women were not included in this model because of the small sample size (n=26), which is not compatible with path analysis.

Table 7.

Distribution of the population from subsample 3 by gender and sexual orientation

	Lesbian N (%)	Bisexual N (%)	Asexual N (%)	Total N (%)
Cis woman	196 (20.30%)	623 (64.50%)	147 (15.20%)	966 (100%)
Non-binary	49 (17.60%)	160 (57.60%)	69 (24.80%)	278 (100%)
Total	245 (19.70%)	783 (62.90%)	216 (17.40%)	1244 (100%)

Note: Trans women were not included in this analysis due to the small sample size (n=26).

In order to transform the concept of belonging to a minority group into a quantitative variable, dummy variables were created, one dummy variable for each of the groups described above. Dummy variables are made by coding the categorical variable into a "0" and "1", 0 meaning "not belonging to this group" and 1 meaning "belonging to this group" (e.g., in the dummy variable "non-binary lesbian", every participant whose gender is "non-binary" and whose sexual orientation is "lesbian" is coded 1, and every other participant is coded 0). This allows to operate with each group of participants as categorical variables, each variable indicating whether they belong to each group or not (Henseler & Roldán, 2021).

Using dummy variables as independent categories in Structural equation modelling is made by comparison analyses to a reference category. For example, if there are only two variables, e.g. "lesbian" vs "bisexual", we select one of them as the reference category and the analyses provides an estimate (unstandardised) that informs how the model works for the dummy variable ("bisexual") in comparison to the reference category ("lesbian"). If the estimate is positive, it means that values coded as 1 in the dummy variable (i.e, bisexual participants) had a stronger effect on the dependent variable than values coded as 0 (i.e., lesbian participants). If the estimate is negative, it means that being bisexual had a weaker effect on the dependent variable than being lesbian.

In a multicategorical analysis, one of the categories must be used as a "reference", such as the "lesbian" group in the example described above (Hayes & Preacher, 2014). This will serve as a comparison category to all the other categories.

At this point, the question ensues, which category should be used as a reference group in the six-group categorisation for gender and sexual orientation?

Literature indicates that the group chosen as a reference should be the one that would make sense as a control group (Collier, 2020). For this purpose, all data provided by the analyses preceding the path analysis needed to be consulted, in order to determine which of these six groups could serve as the best reference group for this analysis. Finally, "cis lesbian" was the group selected as a reference, and the rationale for this decision is presented in section 3.4 of the results.

CHAPTER III:

RESULTS

Results of the study are presented below. First, descriptive statistics and frequency analysis will serve to explore the associations between sexual and romantic attraction. Second, the influence of gender and sexual orientation on the variables studied will be analysed mainly by mean comparisons. Third, correlation analyses among the variables will be presented. Finally, path analysis will test the mediating role of minority stress and self-esteem on the relationship between identity and psychosocial adjustment.

3.1. Concordance between sexual orientation and romantic orientation

In order to analyse the association between gender, sexual orientation and romantic orientation, cross-table analyses were conducted. These analyses were conducted on the subsample 2, due to the small sample size in groups who labelled their gender, sexual orientation and romantic orientation as different from the main categories shown below. Since the results violated the chi-square condition of no cells with expected values <1, a Monte Carlo simulation was conducted.

A **chi-square test** was conducted to account for the association between sexual and romantic orientation. It was significant for the total of the sample (χ^2 = 1209.14, p <.001, V = .55), cis women (χ^2 = 841.31, p <.001, V = .66), trans women (χ^2 = 17.69, p = .001, V = .60) and non-binary people (χ^2 = 187.96, p <001, V = .58), indicating these variables are associated.

Regarding the distribution, the values indicate if the number of participants in that group is higher or lower than it would be expected if sexual and romantic orientation were independent. Thus, the expected values tended to be higher in the bisexual and biromantic categories, since a higher number of participants identified with those orientations. These results suggested that the analyses would overrepresent bisexual and biromantic participants, as it can be observed in the expected count scores.

The distribution of participants of all genders (cis women, trans women and non-binary participants) according to their sexual and romantic orientation is shown in Table 8. There seemed to be a concordance between sexual and romantic orientation for lesbian and bisexual participants: lesbians were more likely to be homoromantic (238, 94.82%) and bisexual people tended to be biromantic (679, 84.98%), which could mean that they tended to be sexually and romantically attracted towards the same genders. This concordance did not apply to asexual participants, who were more likely to be bisexual (99, 45.21%), but distributed between all romantic orientations: homoromantic (25, 11.42%), heteroromantic (31, 14.16%) and aromantic (64, 29.22%). In contrast, when looking at romantic orientations, there seems to be a concordance between homoromantic (238, 71.47%) and biromantic (679, 86.28%) orientations, as well as aromantic, who

tended to be asexual (64, 77.11%), which indicates an aroace identity. This was not true for heteroromantic, who distributed almost equally between bisexual (34, 51.52%) and asexual (31, 46.97%).

Table 8.
Observed and expected (in parenthesis) counts (n) of sexual and romantic orientation for all genders.

	Homoromantic	Biromantic	Heteroromantic	Aromantic	Total
Lesbian	238 (65.90)	9 (155.70)	1 (13.10)	3 (16.40)	251
Bisexual	70 (209.70)	679 (495.50)	34 (41.60)	16 (52.30)	799
Asexual	25 (57.50)	99 (135.80)	31 (11.40)	64 (14.30)	219
Total	333	787	66	83	1269

For cis women (Table 9), this pattern was maintained: sexual and romantic orientation corresponded for women who identified as lesbian and bisexual, but not for those identifying as asexual. Cis lesbians were more likely to be homoromantic and cis bisexual women tended to be biromantic, but asexual women tended to be biromantic rather than aromantic. As for romantic orientation, aromantic cis women tended to be asexual (aroace).

Table 9.
Observed and expected (in parenthesis) counts (n) of sexual and romantic orientation for cis women

	Homoromantic	Biromantic	Heteroromantic	Aromantic	Total
Lesbian	187 (51.74)	7 (121.54)	1 (12.78)	1 (9.94)	196
Bisexual	55 (164.46)	528 (386.31)	33 (40.63)	7 (31.60)	623
Asexual	13 (38.80)	64 (91.15)	29 (9.59)	41 (7.46)	147
Total	255	599	63	49	966

Results for trans women showed there were 6 cells with expected values under 5 (50%), which violates the chi-square condition of no more than 20% of cells with values <5 (Table 10). A similar concordance tendency to the cis women sexual and romantic orientations was observed, however, the small sample size prevented from accurately interpreting the results.

Table 10.

Observed and expected (in parenthesis) counts (n) of sexual and romantic orientation for trans women

	Homoromantic	Biromantic	Aromantic	Total
Lesbian	6 (2.16)	0 (83.36)	0 (0.48)	6
Bisexual	2 (5.76)	13 (8.96)	1 (1.28)	16
Asexual	1 (1.08)	1 (1.68)	2 (0.24)	3
Total	9	14	2	25

For non-binary people, the concordance between sexual and romantic orientations was maintained (Table 11). Lesbian non-binary people were more likely to be homoromantic and bisexual non-binary people were more likely to be biromantic. Asexual non-binary people were more likely to be biromantic and aromantic than the rest of the romantic orientations, and aromantic non-binary participants tended to be asexual (aroace).

Table 11.

Observed and expected (in parenthesis) counts (n) of sexual and romantic orientation for non-binary people

	Homoromantic	Biromantic	Heteroromantic	Aromantic	Total
Lesbian	45 (12.16)	2 (30.67)	0 (0.53)	2 (5.64)	49
Bisexual	13 (39.71)	138 (100.14)	1 (1.73)	8 (18.42)	160
Asexual	11 (17.13)	34 (43.19)	2 (0.74)	22 (7.94)	69
Total	69	174	3	32	278

Summary of results

· Sexual and romantic orientation were highly associated.
· There was a concordance between sexual and romantic orientations for lesbian and bisexual participants, but not for asexual participants.
· Aromantic participants also tended to be asexual.

3.2 Influence of gender and sexual orientation in the studied variables

After exploring the concordance between sexual and romantic orientation, it is of interest to analyse if these groups differ in all variables studied: LB identity dimensions, minority stress, protective psychosocial factors and psychosocial adjustment. Results regarding objectives 2, 3 and 4 only considered sexual orientation. Because of the high concordance between the two constructs for participants identifying as lesbian/homoromantic and bisexual/biromantic, analysing both sexual and romantic orientation would have caused redundancy in the results.

Mean differences were assessed through **t-tests** for gender differences, and these analyses were conducted on Subsample 3, not including trans women due to the small sample size. Sexual orientation differences were assessed through **ANOVA** with post-hoc Bonferroni tests, and these analyses were conducted on Subsample 2, including trans women who were lesbian, bisexual or asexual.

Additionally, a psychosocial adjustment profile is provided through a comparison of their emotional symptomatology and well-being levels with cut-off scores. This analysis is going to be provided across (1) genders (cis women, trans women, non-binary participants and participants with other gender identities and (2) sexual orientation (lesbian, bisexual, asexual and participants with other sexual orientations).

3.2.1. Influence of gender and sexual orientation in LB identity

Mean comparisons were conducted in order to examine the differences in LB identity by gender (including only cis women and non-binary people), assessed through the LBIS questionnaire. Effect sizes ranged from medium-large (Cohen's *d*= 0.72) to very large (Cohen's *d*= 1.36). Results showed statistically significant differences for several dimensions, as depicted in Table 12. Cis women showed statistically higher scores in concealment motivation and internalised homo/binegativity than non-binary people. In contrast, non-binary people showed high scores in acceptance concerns, identity superiority, identity affirmation, and

identity centrality. These results suggest that non-binary people seem more comfortable in their queer identity, as reflected by the higher affirmation and centrality scores, and lower homo/binegativity, but could be more affected by external discrimination, as shown by the higher acceptance concerns scores and lower concealment motivation.

Table 12.
Mean differences in LB identity by gender

	Cis women	Non-binary				
	Mean (SD)	Mean (SD)	*t*	*p*	*d*	
AC	3.26 (1.35)	3.54 (1.38)	-2.76	.003	1.36	NB > CW
CM	3.03 (1.35)	2.69 (1.29)	3.43	<.001	1.34	CW > NB
IU	2.00 (1.14)	2.02 (1.11)	-0.22	.411	1.13	
IH	1.35 (0.74)	1.24 (0.60)	2.24	.013	0.72	CW > NB
DP	2.55 (1.03)	2.56 (0.97)	-0.11	.456	1.02	
IS	1.87 (0.99)	2.25 (1.12)	-4.77	<.001	1.02	NB > CW
IA	5.19 (0.86)	5.37 (0.80)	-3.05	.001	0.85	NB > CW
IC	4.03 (1.14)	4.53 (1.15)	-6.00	<.001	1.14	NB > CW

AC = Acceptance Concerns, CM = Concealment Motivation, IC = Identity Uncertainty, IH = Internalised Homo/binegativity, DP = Difficulty in the Process, IS = Identity Superiority, IA = Identity Affirmation, IC = Identity Centrality; NB = Non-binary; CW = Cis women.
SD = Standard Deviation; *t* = *t* value; *p* = statistical significance; *d* = Cohen's *d*.

Regarding sexual orientation, there were differences in LB identity dimensions (Table 13). Effect sizes ranged from small (eta squared = .01) to large (eta squared = .05). Bonferroni post-hoc tests showed the significant differences between each of the groups (lesbian, bisexual and asexual). Asexual participants seemed to have higher levels of those LB dimensions that are associated with difficulties. They scored higher than bisexual participants in acceptance concerns and difficulty in the process. Asexual participants scored higher than lesbian and bisexual people in concealment motivation, identity uncertainty and internalised homo/binegativity. Bisexual participants scored higher than lesbians in concealment motivation. Lesbian participants, in contrast, scored higher than bisexual people in identity

superiority and identity centrality, and higher than bisexual and asexual participants in identity affirmation. These results suggest that sexual identity may be more central and affirmed in lesbians, and asexual participants seem to encounter more difficulties in their identification process.

Table 13.
Mean differences in LB identity by sexual orientation

	Lesbian	Bisexual	Asexual				
	Mean (SD)	Mean (SD)	Mean (SD)	*F*	*p*	η²	
AC	3.38 (1.45)	3.26 (1.34)	3.68 (1.31)	4.64	.010	.01	A > B
CM	2.65 (1.30)	2.96 (1.32)	3.43 (1.43)	13.00	<.001	.02	B > L A > L, B
IU	1.82 (1.12)	1.99 (1.09)	2.56 (1.33)	16.70	<.001	.03	A > L, B
IH	1.30 (0.77)	1.31 (0.67)	1.52 (0.89)	4.16	.016	.01	A > L, B
DP	2.65 (1.09)	2.49 (0.97)	2.77 (1.11)	5.21	.006	.01	A > B
IS	2.19 (1.22)	1.89 (0.97)	1.93 (1.01)	8.16	<.001	.01	L > B
IA	5.39 (0.83)	5.21 (0.85)	5.07 (1.04)	6.58	.001	.01	L > B, A
IC	4.60 (1.16)	3.97 (1.12)	4.30 (1.16)	29.93	<.001	.05	L > B

Note: AC = Acceptance Concerns, CM = Concealment Motivation, IC = Identity Uncertainty, IH = Internalised Homo/binegativity, DP = Difficulty in the Process, IS = Identity Superiority, IA = Identity Affirmation, IC = Identity Centrality; L = Lesbian; B = Bisexual; A = Asexual.
SD = Standard Deviation; *F* = *F* value; *p* = statistical significance; η² = Eta squared.

3.2.2. Influence of gender and sexual orientation on psychosocial factors

Mean comparisons were conducted to analyse the differences in psychosocial factors by gender and sexual orientation. These analyses were carried out in (1) risk factors and (2) protective factors.

3.2.2.1. Risk factors: minority stress

There were statistically significant differences between cis women and non-binary people in the minority stress dimensions (Table 14), with effect sizes ranging from medium (Cohen's *d*= .50) to large (Cohen's *d*= .99). Non-binary people

showed higher scores than cis women in discrimination events, victimisation events, everyday discrimination, and rejection anticipation. They also showed significantly higher scores in both distal and proximal stressors on the total of the scale. These results showed that non-binary people disclose higher levels of minority stress than cis women, especially those regarding external stigmatisation.

Table 14.
Mean differences in minority stress by gender

	Cis women Mean (SD)	Non-binary Mean (SD)	t	p	d	
DE	1.23 (0.43)	1.58 (0.69)	-7.93	<.001	0.50	NB > CW
VE	1.63 (0.76)	2.24 (1.10)	-8.59	<.001	0.85	NB > CW
ED	2.33 (0.78)	3.64 (0.89)	-23.85	<.001	0.81	NB > CW
DS	1.73 (0.52)	2.49 (0.71)	-16.36	<.001	0.57	NB > CW
IC	2.32 (0.89)	2.42 (0.95)	-1.58	.058	0.90	
RA	2.31 (0.98)	2.97 (1.02)	-9.59	<.001	0.99	NB > CW
IS	1.43 (0.79)	1.49 (0.87)	-0.99	.161	0.81	
CD	2.17 (0.93)	2.13 (0.84)	0.63	.264	0.91	
PS	2.06 (0.61)	2.25 (0.61)	-4.67	<.001	0.61	NB > CW
T	1.92 (0.45)	2.35 (0.52)	-12.66	<.001	0.47	NB > CW

Note: DE = Discrimination Events, VE = Victimization Events, ED = Everyday Discrimination, IC = Identity Concealment, RA = Rejection Anticipation, IS = Internalised Stigma, CD = Community Disconnectedness, DS = Distal Stressors, PS = Proximal Stressors, T = Total; NB = Non-binary; CW = Cis women.
SD = Standard Deviation; *t* = *t* value; *p* = statistical significance; *d* = Cohen's *d*.

Minority stress was divided between distal and proximal stressors, and mean differences were calculated (Table 15), which showed small effect sizes (eta squared = .01-.04). Bonferroni post-hoc tests showed lesbians scored higher than bisexual participants in discrimination events and higher than bisexual and asexual participants in victimisation events. In contrast, asexual participants scored higher in everyday discrimination than both lesbian and bisexual participants. Asexual

participants scored higher than the rest of the participants in all proximal stressors: they had significantly higher scores than bisexual people in identity concealment and rejection anticipation, and higher than all participants in internalised stigma, community disconnectedness, overall proximal stressors and the total of the scale.

Table 15.
Mean differences in minority stress by sexual orientation.

	Lesbian	Bisexual	Asexual				
	Mean (SD)	Mean (SD)	Mean (SD)	*F*	*p*	η²	
DE	1.43 (0.60)	1.29 (0.50)	1.32 (0.58)	6.40	.002	.01	L > B
VE	2.02 (1.01)	1.74 (0.84)	1.69 (0.93)	11.23	.000	.02	L > B, A
ED	2.57 (0.96)	2.60 (0.95)	2.82 (1.94)	4.93	.007	.01	A > L, B
DS	2.01 (0.71)	1.88 (0.63)	1.94 (0.71)	3.85	.022	.01	L > B
IC	2.34 (0.99)	2.29 (0.88)	2.53 (0.91)	6.01	.003	.01	A > B
RA	2.52 (1.12)	2.42 (0.99)	2.67 (1.08)	5.55	.004	.01	A > B
IS	1.42 (0.83)	1.36 (0.70)	1.82 (1.06)	28.75	.000	.04	A > L, B
CD	2.06 (0.92)	2.10 (0.88)	2.46 (0.95)	15.85	.000	.02	A > L, B
PS	2.08 (0.63)	2.04 (0.58)	2.37 (0.65)	26.04	.000	.04	A > L, B
T	2.05 (0.52)	1.97 (0.48)	2.19 (0.55)	16.28	.000	.03	A > L, B

Note: DE = Discrimination Events, VE = Victimization Events, ED = Everyday Discrimination, IC = Identity Concealment, RA = Rejection Anticipation, IS = Internalised Stigma, CD = Community Disconnectedness, DS = Distal Stressors, PS = Proximal Stressors, T = Total; L = Lesbian; B = Bisexual; A = Asexual.
SD = Standard Deviation; *F* = F value; *p* = statistical significance; η² = Eta squared.

In order to analyse the influence of the intersection between gender and sexual orientation, participants were grouped into six different clusters to analyse their mean differences: cis lesbian, cis bisexual, cis asexual, non-binary lesbian, non-binary bisexual, and non-binary asexual (Figure 13 and Figure 14). Significant differences were observed for distal (F_5= 77.92, $p<.001$) and proximal stressors (F_5= 14.40, $p<.001$). Bonferroni post-hoc tests showed non-binary participants of all sexual orientations scored higher in distal stressors than cis women of all sexual orientations. As for proximal stressors, cis asexual women scored higher than cis

lesbians and bisexual women, and non-binary asexual participants scored higher than all other clusters except for cis asexual participants. These results suggest that non-binary people seem to be more affected by distal stressors and asexual participants by proximal stressors than other gender and sexual identities, respectively.

Figure 13.
Mean scores by gender and sexual orientation in distal stressors.
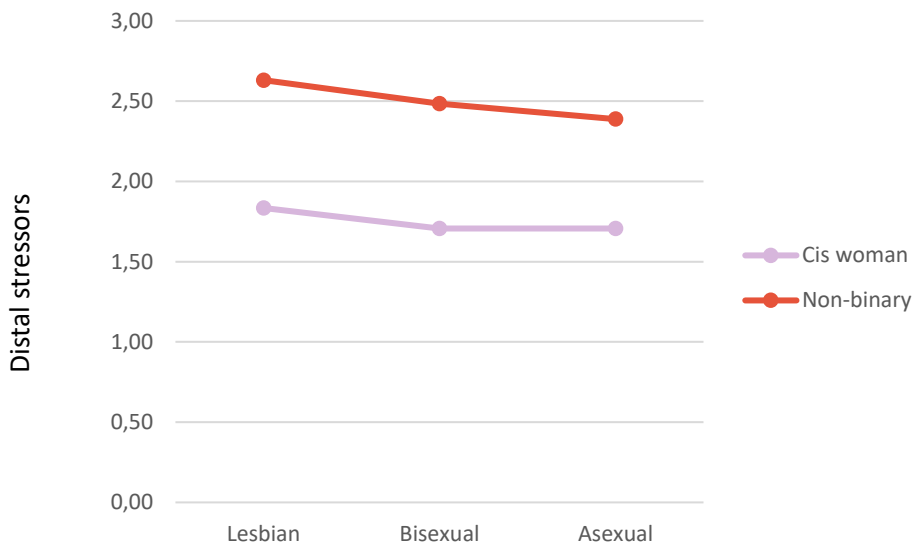
Figure 14.
Mean scores by gender and sexual orientation in proximal stressors.
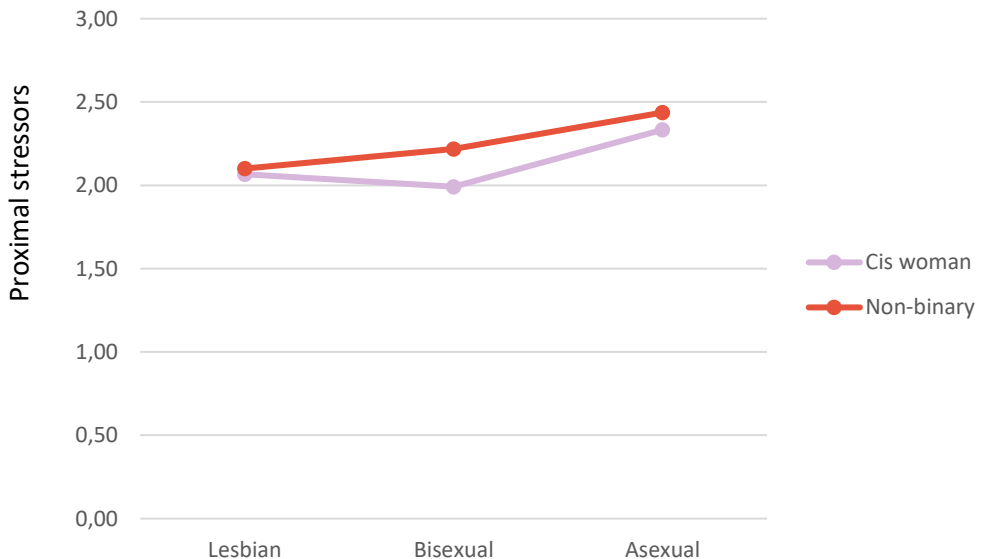
3.2.2.2. Protective factors

As for protective psychosocial factors by gender, effect sizes were very large, ranging from 3.42 to 6.44 (Table 16). Non-binary people showed significantly higher scores than cis women in community belonging and outness, suggesting they are more aware of their queer identity and that they participate more in LBTQ+ community settings. In contrast, cis women showed higher levels of friendship and family support than non-binary people, higher self-esteem, and higher scores in emotional competence such as perception, expression, and regulation of emotions. These results suggest that cis women might receive more support than non-binary people, have a better opinion of themselves and could have more advanced emotional skills.

Table 16.
Mean differences in protective psychosocial factors by gender

	Cis women	Non-binary				
	Mean (SD)	Mean (SD)	*t*	*p*	*d*	
CB	20.35 (3.40)	21.42 (3.48)	-4.61	<.001	3.42	NB > CW
O	16.95 (5.08)	18.04 (4.86)	-3.18	.001	5.03	NB > CW
FRS	23.53 (5.03)	22.80 (5.40)	2.09	.018	5.12	CW > NB
FAS	17.94 (6.76)	16.48 (6.76)	3.18	.001	6.76	CW > NB
RS	23.08 (5.81)	22.55 (6.06)	1.32	.094	5.86	
SE	26.21 (6.40)	24.85 (6.61)	3.11	.001	6.44	CW > NB
EP	30.55 (5.14)	29.09 (6.69)	3.38	<.001	5.52	CW > NB
EE	29.13 (7.42)	27.00 (8.35)	3.83	<.001	7.64	CW > NB
ER	28.07 (5.18)	27.22 (5.60)	2.36	.009	5.28	CW > NB

Note: CB = Community Belonging, O = Outness, FRS = Friendship Support, FAS = Family Support, RS = Relevant Support, SE = Self–esteem, EP = Emotional Perception, EE = Emotional Expression, ER = Emotional Regulation; NB = Non-binary; CW = Cis women. *SD* = Standard Deviation; *t* = *t* value; *p* = statistical significance; *d* = Cohen's *d*.

Differences by sexual orientation (Table 17) revealed significant differences between lesbians, bisexual and asexual participants. Bonferroni post-hoc tests showed that lesbian and bisexual participants scored higher in these factors than asexual participants, with small size effects ranging from .01 to .18. Lesbian and bisexual participants showed significantly higher scores than asexual participants in community belonging, all sources of social support and all emotional competencies. Lesbians scored higher than bisexual and asexual participants in openness and self-esteem and bisexual showed higher levels of openness than asexual people.

Table 17.

Mean differences in other psychosocial factors by sexual orientation.

	Lesbian	Bisexual	Asexual				
	Mean (SD)	Mean (SD)	Mean (SD)	*F*	*p*	η²	
CB	21.17 (3.59)	20.67 (3.32)	19.80 (3.55)	9.67	<.001	.02	L, B > A
O	20.43 (4.84)	17.25 (4.60)	13.48 (4.19)	134.4	<.001	.18	L > B, A B > A
FRS	23.94 (5.02)	23.51 (4.86)	21.97 (5.91)	10.08	<.001	.02	L, B > A
FAS	18.11 (6.88)	17.70 (6.80)	16.27 (6.62)	4.92	.007	.01	L, B > A
RS	23.45 (5.86)	23.42 (5.52)	20.43 (6.62)	24.23	<.001	.04	L, B > A
SE	27.51 (6.48)	25.63 (6.42)	25.01 (6.26)	10.76	<.001	.02	L > B, A
EP	30.10 (5.74)	30.74 (5.14)	28.31 (6.31)	16.87	<.001	.03	L, B > A
EE	28.17 (7.89)	29.30 (7.46)	26.43 (7.96)	12.63	<.001	.02	L, B > A
ER	28.50 (5.29)	28.01 (5.21)	26.60 (5.49)	8.38	<.001	.01	L, B > A

Note: CB = Community Belonging, O = Outness, FRS = Friendship Support, FAS = Family Support, RS = Relevant Support, SE = Self–esteem, EP = Emotional Perception, EE = Emotional Expression, ER = Emotional Regulation; L = Lesbian; B = Bisexual; A = Asexual.

SD = Standard Deviation; *F* = *F* value; *p* = statistical significance; η² = Eta squared.

3.2.3. Influence of gender and sexual orientation in psychosocial adjustment

3.2.3.1. Psychosocial adjustment profile description by gender in the total sample: emotional symptoms and well-being outcomes.

A psychosocial adjustment profile is depicted below showing the emotional symptoms and well-being scores for all genders. All cut-off scores were extracted from the original publication of the scales. Norms for depression, anxiety and stress had five severity levels, from lower to higher: "normal", "mild", "moderate", "severe" and "extremely severe" (S. H. Lovibond & Lovibond, 1995a). Regarding well-being, norms for life satisfaction were "Extremely satisfied", "Satisfied", "Slightly satisfied", "Dissatisfied" and "Extremely dissatisfied", (Diener et al., 1985), and for positive and negative affect the means for the total sample were displayed. One sample t-tests were conducted in order to compare mean scores in positive

and negative affect with the mean scores of the reference population provided by the authors of the original scale (Diener et al., 2010). The reference population from the original samples was composed of young adults.

Results for cis women are displayed in Table 18. Taking cut-off scores as a reference, they showed moderate levels of depression, anxiety and stress. They appeared to be slightly dissatisfied with their life, and they showed significantly lower positive affect (t_{984}= -20.75, p<.001, Cohen's d= 4.24) and significantly higher negative affect (t_{984}= 13.41, p<.001, Cohen's d= 4.24) compared to the cut-off value. These results indicate that they showed lower levels of positive emotions and higher levels of negative emotions than the reference population.

Table 18.
Descriptive statistics of emotional symptomatology and well-being scores in cis women (n= 985).

	Mean	*SD*	Min.	Max.	Cut-off reference
Depression	15.90	11.42	0	42	Moderate
Anxiety	14.10	9.89	0	42	Moderate
Stress	20.42	9.60	0	42	Moderate
Life Satisfaction	17.98	6.77	5	35	Slightly dissatisfied
Positive Affect	19.30	4.24	6	30	Lower than reference
Negative Affect	17.41	4.24	6	30	Higher than reference

Results for trans women are displayed in Table 19. Taking cut-off scores as a reference, they showed severe levels of depression and anxiety and moderate levels of stress. They appeared to be dissatisfied with their life, and they showed significantly lower positive affect (t_{25}= -4.87, p<.001, Cohen's d= 4.17) and significantly higher negative affect (t_{25}= 4.56, p<.001, Cohen's d= 4.45) compared to the cut-off value.

Table 19.
Descriptive statistics of emotional symptomatology and well-being scores in trans women (n=26).

	Mean	SD	Min.	Max.	Cut-off reference
Depression	22.31	11.24	4	42	Severe
Anxiety	15.31	9.29	0	40	Severe
Stress	21.31	7.42	10	36	Moderate
Life Satisfaction	14.19	6.69	5	26	Dissatisfied
Positive Affect	18.12	4.17	11	28	Lower than reference
Negative Affect	19.58	4.45	10	26	Higher than reference

Results for non-binary people are displayed in Table 20 Taking cut-off scores as a reference, they showed moderate levels of depression, and stress and severe levels of anxiety. They appeared to be slightly dissatisfied with their life. They showed significantly lower positive affect (t_{312}= -14.18, p<.001, Cohen's d= 4.37) and significantly higher negative affect (t_{311}= 10.75, p<.001, Cohen's d= 4.37) compared to the cut-off value.

Table 20.
Descriptive statistics of emotional symptomatology and well-being scores in non-binary people (n=312).

	Mean	SD	Min.	Max.	Cut-off reference
Depression	18.73	12.10	0	42	Moderate
Anxiety	16.04	10.01	0	42	Severe
Stress	21.72	9.37	0	42	Moderate
Life Satisfaction	16.55	6.67	5	35	Slightly dissatisfied
Positive Affect	18.59	4.37	7	30	Lower than reference
Negative Affect	18.26	4.37	6	30	Higher than reference

Results displayed in Table 21 correspond to scores obtained by participants who identified with other diverse gender identities. Taking cut-off scores as a reference, they showed moderate levels of depression and anxiety, and mild levels of stress. They appeared to be slightly dissatisfied with their life, and they showed significantly lower positive affect (t_{35}= -2.28, p=.01, Cohen's d= 4.71) and

significantly higher negative affect (t_{35}= 1.67, p<.001, Cohen's d= 4.63) compared to the cut-off value.

Table 21.
Descriptive statistics of emotional symptomatology and well-being scores in people with other gender identities (n=36).

	Mean	SD	Min.	Max.	Cut-off reference
Depression	16.44	10.87	0	34	Moderate
Anxiety	13.28	9.67	0	34	Moderate
Stress	18.17	8.08	2	34	Mild
Life Satisfaction	17.67	6.02	5	31	Slightly dissatisfied
Positive Affect	20.31	4.71	11	30	Lower than reference
Negative Affect	16.89	4.63	8	26	Higher than reference

Results regarding emotional symptomatology indicate trans women showed severe levels of depression and anxiety symptoms, while non-binary people showed severe levels of anxiety symptoms. Cis women showed moderate levels of all emotional symptoms, trans women showed moderate levels of stress symptoms, non-binary people showed moderate levels of depression and stress symptoms and people with other gender identities showed moderate levels of depression and anxiety symptoms. This last group disclosed mild levels of stress symptoms, the lowest scored in the sample.

As for well-being, trans women seemed dissatisfied with their lives, while the rest of the sample (cis women, non-binary people and people with other gender identities) disclosed being slightly dissatisfied with their lives. All groups showed scores significantly lower in positive affect and significantly higher in negative affect than the reference population.

3.2.3.2. Psychosocial adjustment profile description by sexual orientation in the total sample: emotional symptoms and well-being outcomes.

The psychosocial adjustment profile for all sexual orientations is depicted below. It was not calculated for all romantic orientations, due to the concordance observed between sexual and romantic orientations, which could render these data redundant.

Table 22 shows the descriptive statistics for participants who identified as lesbians according to their sexual orientation. They appeared to show moderate levels of all emotional symptoms (depression, anxiety and stress). Regarding well-being, they seemed slightly dissatisfied with their lives, and they showed significantly lower positive affect (t_{257}= -8.28, p<.001, Cohen's d= 4.19) and significantly higher negative affect (t_{257}= 4.94, p<.001, Cohen's d= 4.39) compared to the cut-off value.

Table 22.
Descriptive statistics of emotional symptomatology and well-being scores in lesbians (n=258).

	Mean	SD	Min.	Max.	Cut-off reference
Depression	14.59	11.79	0	42	Moderate
Anxiety	13.34	10.45	0	42	Moderate
Stress	19.35	10.04	0	42	Moderate
Life Satisfaction	18.71	6.60	5	33	Slightly dissatisfied
Positive Affect	19.94	4.19	6	30	Lower than reference
Negative Affect	16.95	4.39	8	30	Higher than reference

For people identifying as bisexual (Table 23), they showed moderate levels of all emotional symptoms. As for well-being, their scores suggested they were slightly dissatisfied with their lives, and they showed significantly lower positive affect (t_{821}= -19.67, p<.001, Cohen's d= 4.33) and significantly higher negative affect (t_{821}= 15.45, p<.001, Cohen's d= 4.21) compared to the reference population.

Table 23.
Descriptive statistics of emotional symptomatology and well-being scores in bisexual participants (n=822).

	Mean	SD	Min.	Max.	Cut-off reference
Depression	16.91	11.41	0	42	Moderate
Anxiety	14.82	9.66	0	42	Moderate
Stress	21.21	9.24	0	42	Moderate
Life Satisfaction	17.46	6.89	5	35	Slightly dissatisfied
Positive Affect	19.13	4.33	6	30	Lower than reference
Negative Affect	17.87	4.21	6	30	Higher than reference

Asexual participants showed moderate levels of all emotional symptoms (Table 24). Regarding well-being, they appeared to be slightly dissatisfied with their lives, and they showed significantly lower positive affect (t_{236}= -13.47, p<.001, Cohen's d= 4.10) and significantly higher negative affect (t_{236}= 6.10, p<.001, Cohen's d= 4.45) compared to the reference population.

Table 24.
Descriptive statistics of emotional symptomatology and well-being scores in asexual participants (n=237).

	Mean	SD	Min.	Max.	Cut-off reference
Depression	17.85	11.73	0	42	Moderate
Anxiety	14.32	10.03	0	40	Moderate
Stress	19.83	9.53	0	42	Moderate
Life Satisfaction	16.69	6.08	5	31	Slightly dissatisfied
Positive Affect	18.51	4.10	7	30	Lower than reference
Negative Affect	17.36	4.45	6	30	Higher than reference

As for people identifying with other sexual orientations (Table 3.25), they showed moderate levels for depression and stress, and severe levels of anxiety. Regarding well-being, they seemed slightly dissatisfied with their lives, and they showed significantly lower positive affect (t_{41}= -5.97, p<.001, Cohen's d= 4.61) and significantly higher negative affect (t_{41}= 4.81, p<.001, Cohen's d= 4.26) compared to the reference population.

Table 25.
Descriptive statistics of emotional symptomatology and well-being scores in people identifying with other sexual orientation (n=42).

	Mean	SD	Min.	Max.	Cut-off reference
Depression	18.67	13.13	0	42	Moderate
Anxiety	17.76	10.34	2	42	Severe
Stress	23.33	9.40	0	38	Moderate
Life Satisfaction	17.83	8.08	5	31	Slightly dissatisfied
Positive Affect	17.86	4.61	7	24	Lower than reference
Negative Affect	18.76	4.26	10	28	Higher than reference

The psychosocial adjustment profile of participants appeared to be more homogeneous across sexual orientations than across genders. Participants identifying as lesbian, bisexual and asexual showed similar scores in emotional

symptoms and well-being when compared with the cut-off thresholds, only showing more severe levels of anxiety in participants with other diverse sexual orientations. These results contrast with the psychological adjustment profile of participants with different gender identities, whose results seemed more variable.

3.2.4. Mean differences in psychosocial adjustment

Regarding psychosocial adjustment depending on gender, size effects were very large, ranging from 4.27 to 11.55 (Table 26). Non-binary people showed significantly higher levels of depression, anxiety and stress symptoms and also higher levels of negative affect. Cis women showed higher levels of satisfaction with life and positive affect than non-binary people. These results showed that non-binary people seem to have poorer psychological adjustment than cis women, reflected in their higher emotional symptomatology scores and lower subjective well-being.

Table 26.
Mean differences in psychosocial adjustment by gender

	Cis women	Non-binary				
	Mean (SD)	Mean (SD)	t	p	d	
D	15.84 (11.40)	18.90 (12.07)	-3.89	<.001	11.55	NB > CW
A	14.04 (9.88)	16.07 (10.05)	-3.01	.001	9.92	NB > CW
S	20.38 (9.56)	21.74 (9.51)	-2.10	.018	9.55	NB > CW
SL	18.01 (6.75)	16.44 (6.53)	3.43	<.001	6.70	CW > NB
PA	19.32 (4.24)	18.61 (4.31)	2.44	.007	4.25	CW > NB
NA	17.38 (4.24)	18.22 (4.40)	-2.89	.002	4.27	NB > CW

Note: D = Depression, A = Anxiety, S = Stress, SL = Satisfaction with life, PA = Positive Affect, NA = Negative Affect; NB = Non-binary; CW = Cis women.

There are significant differences in psychosocial adjustment by sexual orientation (Table 27), with very small size effects (eta squared = .01). Bonferroni post-hoc tests showed bisexual and asexual participants scored higher than lesbians in depression symptoms, and bisexual people have higher scores in stress symptoms and negative affect than lesbians. Furthermore, lesbians scored higher

than bisexual and asexual participants in satisfaction with life and positive affect, and bisexual participants scored higher than asexual people in positive affect. These results indicate that lesbians showed lower levels of emotional symptoms and higher levels of well-being than the rest of the participants.

Table 27.

Mean differences in psychosocial adjustment by sexual orientation.

	Lesbian	Bisexual	Asexual				
	Mean (SD)	Mean (SD)	Mean (SD)	F	p	η²	
D	14.69 (11.72)	16.86 (11.47)	18.12 (11.93)	5.49	.004	.01	B, A > L
A	13.45 (10.49)	14.80 (9.67)	14.68 (10.18)	1.81	.164	.00	
S	19.54 (10.01)	21.19 (9.29)	20.18 (9.69)	3.28	.038	.01	B > L
SL	18.72 (6.65)	17.49 (6.89)	16.61 (6.17)	5.95	.003	.01	L > B, A
PA	19.90 (19.90)	19.12 (19.12)	18.32 (18.32)	8.15	<.001	.01	L > B, A B > A
NA	17.03 (4.33)	17.85 (4.20)	17.37 (4.54)	3.90	.020	.01	B > L

Note: D = Depression, A = Anxiety, S = Stress, SL = Satisfaction with life, PA = Positive Affect, NA = Negative Affect; L = Lesbian; B = Bisexual; A = Asexual.

In order to analyse the intersectional effects between gender and sexual orientation, means differences were calculated between the six clusters analysed earlier for emotional symptomatology (Figures 15, 16 and 17). Significant differences were observed for depression (F_5= 4.85, $p<.001$), anxiety, (F_5= 2.92, p=.01) stress symptoms (F_5= 2.34, p=.04), satisfaction with life (F_5= 5.55, $p<.001$), positive affect (F_5= 4.62, $p<.001$) and negative affect (F_5= 3.31, p=.01). Bonferroni post-hoc tests were conducted to observe which groups had the most significant differences. Non-binary bisexual and asexual participants had significantly higher rates of depression, anxiety and stress symptoms than cis lesbians, and non-binary bisexual participants scored higher in depression symptoms than cis bisexual women.

Figure 15.
Mean scores by gender and sexual orientation in depression symptoms.
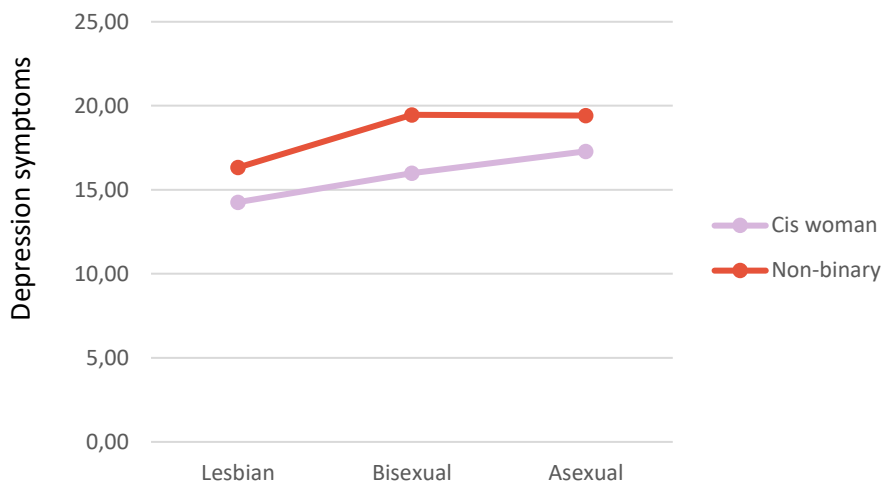
Figure 16.
Mean scores by gender and sexual orientation in anxiety symptoms.
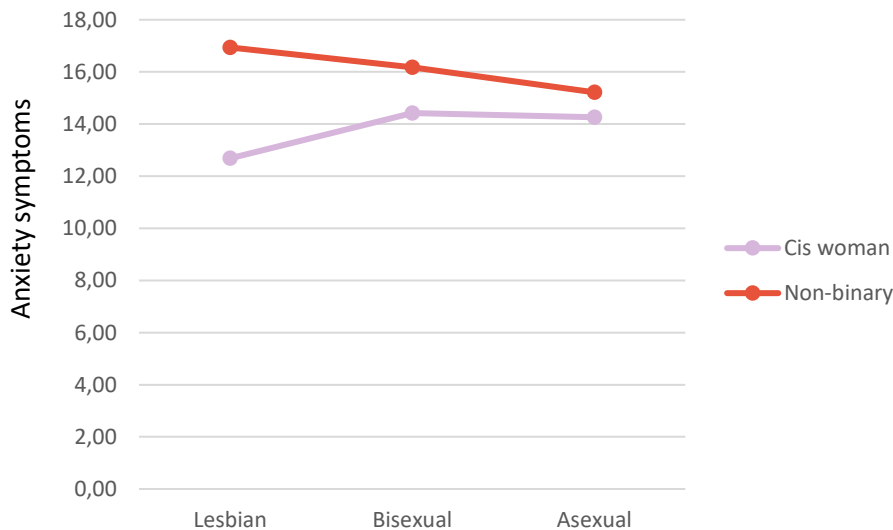
Figure 17.
Mean scores by gender and sexual orientation in stress symptoms.
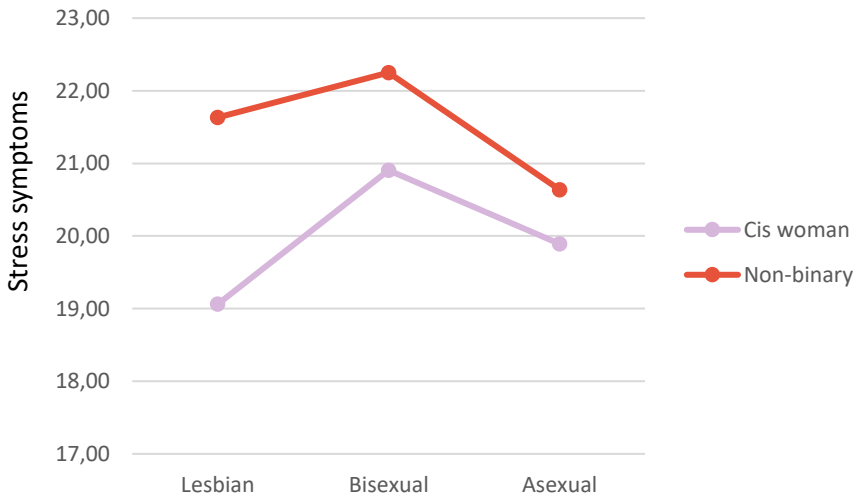
As for well-being, cis lesbians scored higher than non-binary bisexual and asexual participants in satisfaction with life and positive affect, and cis bisexual women scored higher than non-binary asexual people in satisfaction with life (Figures 18 and 19). Non-binary lesbians scored higher than non-binary asexual participants in positive affect. As for negative affect, non-binary bisexual participants scored higher than cis lesbians and cis asexual participants. These results indicate that non-binary participants and bisexual and asexual people tend to experience worse emotional symptomatology than cis and lesbian participants respectively, and this pattern is maintained when gender identities and sexual orientations are considered together.

Figure 18.

Mean scores by gender and sexual orientation in satisfaction with life.
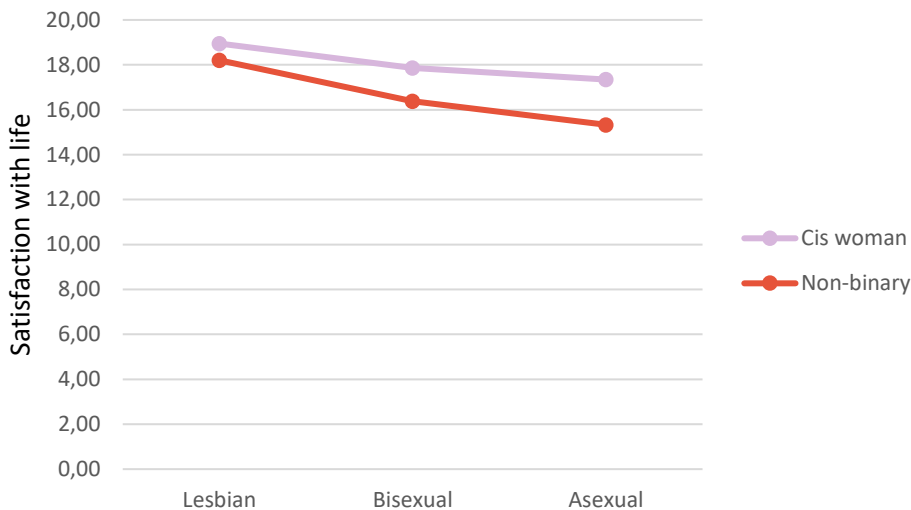
Figure 19.

Mean scores by gender and sexual orientation in positive affect (left) and negative affect (right).
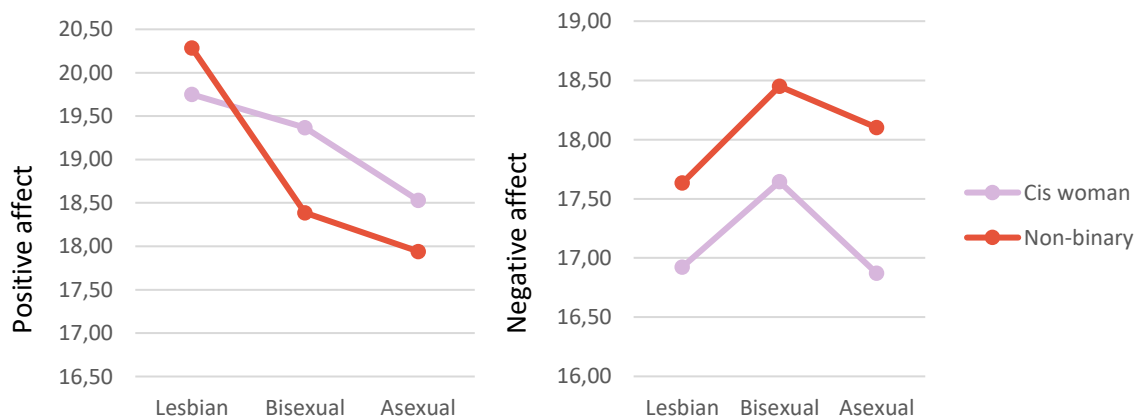
Summary of results

· Cis women showed higher concealment motivation and internalised homo/binegativity than non-binary people, as well as higher levels of social support, self-esteem and emotional competences. Non-binary people showed higher acceptance concerns, identity superiority, affirmation and centrality than cis women. They also showed higher minority stress, community belonging and outness and worse psychosocial adjustment than cis women.

· Lesbians showed higher levels of identity superiority, affirmation and centrality, as well as higher distal stressors, compared to bisexual and asexual participants. They also showed higher levels of psychosocial adjustment than bisexual and asexual people. Bisexual participants showed higher levels of concealment motivation than lesbians, and asexual people showed higher acceptance concerns, concealment motivation, internalised homo/binegativity and difficulty in the process, as well as proximal stressors, than lesbian and bisexual participants. They also showed lower levels of protective factors than lesbian and bisexual people.

· Cis women showed moderate levels of emotional symptoms and lower levels of well-being.

· Non-binary participants showed moderate and severe levels of emotional symptoms and lower levels of well-being.

· Trans women showed severe levels of emotional symptoms and substantially lower levels of well-being.

· Participants of all sexual orientations showed moderate levels of emotional symptoms and lower levels of well-being.

3.3. Relationship among the studied variables

After analysing the differences between groups, the following analysis were focused in studying the relationship among the studied variables. **Pearson correlations** and **multiple linear regressions** are conducted to analyse the association between LB identity dimensions, minority stress, protective psychosocial factors and psychosocial adjustment in the total sample (subsample 1).

3.3.1. Intercorrelations

Descriptive values for **LB identity** dimensions are presented in Table 28. Values of skewness and kurtosis were within the acceptable range (≤2 for skewness and ≤4 for kurtosis). Intercorrelations between the LB identity dimensions ranged from low to moderate (Table 28). Acceptance concerns, concealment motivation, identity uncertainty, internalised homo/binegativity and difficulty in the process were positively correlated. Identity superiority was positively correlated with acceptance concerns, identity uncertainty, identity affirmation, and identity centrality. Identity affirmation was negatively correlated with all identity dimensions except for identity superiority and centrality. Identity centrality was positively correlated with acceptance concerns and negatively correlated with contentment motivation, identity uncertainty, and internalised homo/binegativity.

Table 28.

Descriptive statistics and intercorrelations between the LB identity dimensions.

	1	2	3	4	5	6	7	8
1. AC	–							
2. CM	.37**	–						
3. IU	.16**	.18**	–					
4. IH	.23**	.32**	.24**	–				
5. DP	.38**	.34**	.24**	.44**	–			
6. IS	.09**	−.05	.09**	−.01	.04	–		
7. IA	−.08**	−.36**	−.18**	−.46**	−.29*	.12**	–	
8. IC	.23**	−.20**	−.11**	−.12**	.04	.31**	.40**	–
Mean	3.32	2.94	2.03	1.34	2.55	1.97	5.22	4.14
SD	1.37	1.34	1.15	0.73	1.01	1.05	0.86	1.16
Range	1-6	1-6	1-6	1-5.67	1-5.67	1-6	1-6	1-6
Skewness	-0.03	0.31	1.17	2.90	0.29	1.12	-1.37	-0.39
Kurtosis	-0.94	-0.82	0.65	9.11	-0.60	0.63	1.88	-0.34

Note: *$p<.01$; **$p<.001$.

AC = Acceptance Concerns, CM = Concealment Motivation, IC = Identity Uncertainty, IH = Internalised Homo/binegativity, DP = Difficulty in the Process, IS = Identity Superiority, IA = Identity Affirmation, IC = Identity Centrality.

Skewness and kurtosis for **minority stress** dimensions were considered acceptable, except for discrimination events, which were higher than the recommended range. All minority stress dimensions were positively correlated (Table 29) except for community disconnectedness, which was only positively correlated with identity concealment, rejection anticipation, and internalised stigma. Distal and proximal stressors showed a positive but weak correlation. There were some high correlations: distal stressors are highly correlated with discrimination events, victimisation events and everyday discrimination, which can be explained as it is the sum of these dimensions. Proximal stressors also showed high correlations with some of the dimensions it comprises: rejection anticipation, internalised stigma and community disconnectedness. The total of the scale also showed a high correlation with rejection anticipation.

Table 29.

Intercorrelations between minority stress dimensions (risk factors).

		1	2	3	4	5	6	7	8	9	10
Distal	1. DE	–									
	2. VE	.62**	–								
	3. ED	.45**	.50**	–							
Proximal	4. IC	.10**	.09**	.07*	–						
	5. RA	.35**	.36**	.48**	.16**	–					
	6. IS	.06*	.04	.04	.13**	.25**	–				
	7. CD	.03	–.01	.04	.17**	.50**	.34**	–			
	8. DS	.77**	.86**	.83**	.10**	.49**	.05	.02	–		
	9. PS	.21**	.19**	.25**	.54**	.75**	.62**	.76**	.26**	–	
	10. T	.58**	.62**	.64**	.43**	.79**	.45**	.53**	.75**	.84**	–
	Mean	1.30	1.80	2.68	2.34	2.49	1.47	2.15	1.94	2.11	2.04
	SD	.55	.91	.99	.91	1.03	.83	.91	.67	.62	.51
	Range	1-5	1-5	1-5	1-5	1-5	1-5	1-5	1-4.75	1-4.77	1-4.69
	Skewness	2.42	1.43	0.30	0.66	0.47	2.13	0.81	1.11	0.66	0.73
	Kurtosis	7.41	1.81	-0.61	0.25	-0.52	4.45	0.19	1.34	0.47	0.81

Note: *p<.05; **p<.01; ***p<.001. Only significant correlations are displayed.
DE = Discrimination Events, VE = Victimization Events, ED = Everyday Discrimination, IC = Identity Concealment,
RA = Rejection Anticipation, IS = Internalised Stigma, CD = Community Disconnectedness, DS = Distal Stressors,
PS = Proximal Stressors, T = Total.

Skewness and kurtosis for **protective factors** were considered acceptable. Protective factors were positively and moderately correlated (Table 30), except for community belonging, which did not correlate with self-esteem, and shows the weakest correlations. The strongest correlations were between friendship support and relevant people support, self-esteem and emotional regulation and intercorrelations among emotional competencies.

Table 30.
Intercorrelations between protective psychosocial factors

	1	2	3	4	5	6	7	8	9
1. CB	–								
2. O	.37**	–							
3. FRS	.26**	.26**	–						
4. FAS	.10**	.21**	.31**	–					
5. RS	.18**	.25**	.58**	.35**	–				
6. SE		.17**	.30**	.31**	.29**	–			
7. EP	.16**	.10**	.20**	.17**	.22**	.18**	–		
8. EE	.08**	.14**	.21**	.25**	.24**	.42**	.52**	–	
9. ER	.12**	.17**	.31**	.28**	.26**	.60**	.36**	.49**	–
Mean	20.58	17.22	23.32	17.47	22.89	25.87	30.17	28.60	27.86
SD	3.47	5.03	5.13	6.85	5.90	6.51	5.54	7.66	5.38
Range	8.53-30	7-28	4-28	4-28	4-40	10.00	7-42	7-42	9-42
Skewness	0.10	-1.42	-0.30	-1.39	0.06	-0.95	-0.55	-0.46	-.55
Kurtosis	0.05	-0.75	1.98	-0.91	1.29	-0.42	1.62	-0.31	0.33

Note: $^*p<.01$; $^{**}p<.001$. Only significant correlations are displayed.
CB = Community Belonging, O = Outness, FRS = Friendship Support, FAS = Family Support, RS = Relevant Support, SE = Self–esteem, EP = Emotional Perception, EE = Emotional Expression, ER = Emotional Regulation.

Regarding **psychosocial adjustment** (Table 31), skewness and kurtosis were considered acceptable. As for the intercorrelations, emotional symptoms were positively and strongly correlated. Satisfaction with life was positively correlated with positive affect and negatively correlated with negative effect, and positive and negative affect were negatively correlated. Emotional symptomatology and well-being variables were negatively correlated. These correlations ranged from moderate to strong.

Table 31.
Intercorrelations between psychosocial adjustment dimensions.

	1	2	3	4	5	6
1. D	–					
2. A	.63**					
3. S	.63**	.78**				
4. SL	−.56**	−.37**	−.36**			
5. PA	−.71**	−.46**	−.51**	.56**		
6. NA	.70**	.60**	.64**	−.48**	−.64**	–
Mean	3.32	2.94	2.03	1.34	2.55	1.97
SD	1.37	1.34	1.15	0.73	1.01	1.05
Range	0-42	0-42	0-42	5-35	6-30	6-30
Skewness	0.51	0.55	0.05	0.14	-0.07	0.25
Kurtosis	-0.78	-0.43	-0.77	-0.74	-0.16	-0.11

Note: $^*p<.01$; $^{**}p<.001$. Only significant correlations are displayed.
D = Depression, A = Anxiety, S = Stress, SL = Satisfaction with Life, PA = Positive Affect, N = Negative affect.

3.3.2. Correlations between the studied variables

Results presented below depict the relationship between the LB identity dimensions, minority stress, protective factors and psychosocial adjustment dimensions.

3.3.2.1. LB identity

LB identity dimensions showed correlations with **minority stress** dimensions (Table 32). Acceptance concerns showed the strongest positive relationship with distal and proximal stressors, especially with rejection anticipation, with which it showed a moderate and positive relationship. Concealment motivation, identity uncertainty, and internalised homo/binegativity showed a similar pattern of correlations, weak or no relationship with distal stressors and a moderate and positive relationship with proximal stressors. Difficulty in the process showed a weak and positive correlation with distal stressors and moderate and positive with proximal stressors. Identity superiority and identity centrality showed a weak correlation with distal stressors and no relationship with proximal stressors. Lastly, identity affirmation showed a weak positive relationship with distal stressors and a moderate negative relationship with proximal stressors.

Table 32.
Correlations between the LB identity dimensions and the rest of the studied variables.

		AC	CM	IU	IH	DP	IS	IA	IC
Minority Stress	DE	.23**	−.04		.06*	.01**	.12**		.20**
	VE	.25**	−.07*	−.06*		.09**	.12**	.09**	.25**
	ED	.29**	−.07*			.10**	.19**	.14**	.32**
	IC	.12**	.13**	.06*	.09**	.11**		−.11**	
	RA	.60**	.35**	.10**	.18**	.28**	.09**	−.07*	.23**
	IS	.26**	.31**	.20**	.74**	.35**		−.41**	−.08**
	CD	.41**	.68**	.16**	.35**	.34**		−.34**	−.08**
	DS	.32**	−.07*			.11**	.18**	.12**	.32**
	PS	.53**	.55**	.18**	.47**	.40**		−.33**	
	T	.54**	.33**	.11**	.33**	.34**	.12**	−.16**	.20**
Protective factors	CB	.13**	−.26**	−.06*	−.17**	−.08**	.19**	.53**	.46**
	O	−.20**	−.64**	−.22**	−.26**	−.20**	.10**	.38**	.31**
	FRS	−.11**	−.16**	−.09**	−.17**	−.09**	−.06*	.20**	.08**
	FAS	−.12**	−.16**		−.03	−.07*	−.12**	.06*	
	RS	−.10**	−.17**	−.13**	−.12**	−.10**	−.09**	.13**	
	SE	−.20**	−.10**	−.15**	−.11**	−.12**		.07*	
	EP			−.10**				.08**	
	EE	−.10**	−.11**	−.23**	−.11**	−.13**		.10**	.06*
	ER	−.13**	−.08**	−.15**		−.08**	−.09**	.11**	
Psychosocial adjustment	D	.18**	.15**	.12**	.10**	.09**	.15**	−.09**	
	A	.23**	.12**	.10**	.10**	.13**	.11**		.08**
	S	.22**	.13**	.12**	.11**	.14**	.10**		.07*
	SL	−.18**	−.11**	−.09**	−.07*	−.09**	−.10**	.09**	
	PA	−.14**	−.14**	−.11**	−.10**	−.12**	−.10**	.12**	
	NA	.21**	.13**	.12**	.12**	.12**	.12**	−.07*	

Note: *p<.01; **p<.001. Only significant correlations are displayed.

AC = Acceptance Concerns, CM = Concealment Motivation, IC = Identity Uncertainty, IH = Internalised Homo/binegativity, DP = Difficulty in the Process, IS = Identity Superiority, IA = Identity Affirmation, IC = Identity Centrality.

DE = Discrimination Events, VE = Victimization Events, ED = Everyday Discrimination, IC = Identity Concealment, RA = Rejection Anticipation, IS = Internalised Stigma, CD = Community Disconnectedness, DS = Distal Stressors, PS = Proximal Stressors, T = Total.

CB = Community Belonging, O = Outness, FRS = Friendship Support, FAS = Family Support, RS = Relevant Support, SE = Self–esteem, EP = Emotional Perception, EE = Emotional Expression, ER = Emotional Regulation.

D = Depression, A = Anxiety, S = Stress, SL = Satisfaction with Life, PA = Positive Affect, N = Negative affect.

Acceptance concerns, concealment motivation, identity uncertainty, internalised homo/binegativity, and difficulty in the process showed weak and negative relationships with all protective factors. Exceptions were moderate and negative relationship between concealment motivation and outness, and a positive relationship between acceptance concerns on community belonging, and no relationships with emotional perception, except for a weak and negative relationship between this variable and identity uncertainty. These identity variables, together with identity superiority, correlated weakly and positively with emotional symptomatology (depression, anxiety and stress) and negatively with well-being (negatively with life satisfaction and positive affect and positively with negative affect). Identity superiority showed a positive relationship with community belonging and outness, and negative with social support. As for identity affirmation, it correlated positively and weakly with all protective factors, except for community belonging, with which it shows were moderate and positive relationship. It correlated negatively with depression symptoms and positively with well-being. Identity centrality correlated positively and moderately with community belonging and outness, and it shows a weak and positive relationship with friendship support and emotional expression. It correlated positively and weakly with anxiety and stress and shows no relationship with well-being.

3.3.2.2. Minority Stress

Correlations between the **minority stress** dimensions with **protective factors** and **psychosocial adjustment** are shown in Table 33. Distal stressors showed a moderate and positive relationship with community belonging and outness, and a weak and negative relationship with family support, self-esteem, expression and regulation of emotions. Proximal stressors showed a negative and moderate relationship with outness and a weak and negative relationship with all other psychosocial factors. Both distal and proximal stressors showed moderate to low positive relationships with emotional symptoms and negative with well-being.

Table 33.

Correlations between the minority stress dimensions with protective factors and psychosocial adjustment

		DE	VE	ED	IC	RA	IS	CD	DS	PS	T
Protective factors	CB	.11**	.20**	.33**	−.26**	.13**	−.18**	−.20**	.28**	−.18**	
	O	.17**	.21**	.15**	−.18**	−.19**	−.26**	−.58**	.21**	−.45**	−.19**
	FRS	−.08**			−.18**	−.14**	−.14**	−.21**		−.25**	−.20**
	FAS	−.16**	−.13**	−.16**	−.18**	−.18**		−.16**	−.18**	−.22**	−.25**
	RS	−.03	−.01	−.03	−.14**	−.10**	−.12**	−.20**	−.03	−.21**	−.16**
	SE	−.06*	−.15**	−.17**	−.15**	−.22**	−.11**	−.10**	−.17**	−.22**	−.25**
	EP				−.08**	−.08**		−.07*		−.09**	−.07*
	EE		−.06*	−.11**	−.14**	−.17**	−.12**	−.17**	−.09**	−.22**	−.21**
	ER		−.08*	−.11**	−.13**	−.18**	−.07**	−.11**	−.08**	−.16**	−.17**
Psychosocial adjustment	D	.15**	.20**	.204**	.16**	.22**	.11**	.16**	.23**	.25**	.30**
	A	.23**	.29**	.29**	.12**	.29**	.08**	.12**	.33**	.24**	.35**
	S	.18**	.25**	.24**	.10**	.25**	.08**	.13**	.28**	.22**	.31**
	SL	−.13**	−.18**	−.16**	−.17**	−.21**	−.10**	−.13**	−.19**	−.23**	−.27**
	PA	−.09**	−.13**	−.14**	−.16**	−.16**	−.11**	−.12**	−.15**	−.21**	−.23**
	NA	.15**	.18**	.21**	.14**	.25**	.11**	.14**	.23**	.25**	.30**

Note: *p<.05; **p<.01; ***p<.001. Only significant correlations are displayed.

DE = Discrimination Events, VE = Victimization Events, ED = Everyday Discrimination, IC = Identity Concealment, RA = Rejection Anticipation, IS = Internalised Stigma, CD = Community Disconnectedness, DS = Distal Stressors, PS = Proximal Stressors, T = Total.

CB = Community Belonging, O = Outness, FRS = Friendship Support, FAS = Family Support, RS = Relevant Support, SE = Self–esteem, EP = Emotional Perception, EE = Emotional Expression, ER = Emotional Regulation.

D = Depression, A = Anxiety, S = Stress, SL = Satisfaction with Life, PA = Positive Affect, N = Negative affect.

3.3.2.3. Psychosocial adjustment

Depression, **anxiety**, and **stress symptoms** were negatively correlated with all psychosocial factors (Table 34), except for community belonging, with which only anxiety showed a positive and weak relationship, and self-esteem and emotional regulation, with which there were moderate to high negative relationships. **Life satisfaction** and **positive affect** showed a weak relationship with all psychosocial factors, except for community belonging, with which they showed a positive and weak relationship, and self-esteem and emotional regulation with which they showed a positive and moderate relationship. **Negative affect** showed a similar but inverse pattern of correlations.

Table 34.
Correlations between the psychosocial adjustment dimensions and protective factors.

		D	A	S	SL	PA	NA
Protective factors	CB		.06*		.08**	.10**	
	O	−.19**	−.08**	−.10**	.22**	.20**	−.11**
	FRS	−.34**	−.16**	−.16**	.33**	.34**	−.26**
	FAS	−.32**	−.21**	−.19**	.37**	.31**	−.26**
	RS	−.33**	−.15**	−.11**	.33**	.34**	−.25**
	SE	−.70**	−.52**	−.51**	.60**	.65**	−.60**
	EP	−.10**			.10**	.16**	
	EE	−.32**	−.26**	−.23**	.28**	.32**	−.26**
	ER	−.51**	−.36**	−.39**	.46**	.57**	−.47**

Note: *$p<$.01; **$p<$.001. Only significant correlations are displayed.
CB = Community Belonging, O = Outness, FRS = Friendship Support, FAS = Family Support, RS = Relevant Support, SE = Self–esteem, EP = Emotional Perception, EE = Emotional Expression, ER = Emotional Regulation.
D = Depression, A = Anxiety, S = Stress, SL = Satisfaction with Life, PA = Positive Affect, N = Negative affect.

Lastly, psychosocial adjustment was correlated with socio-demographical variables to control their effects before proceeding with the rest of the analyses. **Age** correlated weakly and negatively with depression (r=−.08; p=.003), anxiety (r=−.17; $p<$.001), stress (r=−.14; $p<$.001), and negative affect (r=−.11; $p<$.001), and weakly and positively with positive affect (r=.05; p=.04), indicating that levels of psychosocial adjustment might increase slightly with age. **Income levels** showed low but significant correlations with all psychosocial adjustment dimensions: it

correlated negatively with depression (r=−.19; p<.001), anxiety (r=−.18; p<.001), stress (r=−.11; p<.001), and negative affect (r=−.16; p<.001), and positively with life satisfaction (r=.27; p<.001)and positive affect (r=.14; p<.001). These results indicate that as net income increases, so does emotional symptomatology and well-being.

3.3.3. Predictive relationships between the studied variables

After analysing the correlations between the variables, **multiple regression analyses** were conducted in order to assess the predictive relationships between the variables. Psychosocial adjustment dimensions were introduced as the outcome variables, and they were predicted by (1) the LB identity dimensions (Table 35), (2) minority stress and (3) protective factors (the latter in Table 36).

First, regression analyses indicated the amount of variance of psychosocial adjustment that was explained by the LB identity dimensions (Table 35). All LB identity dimensions combined explained a small percentage of variance of emotional symptomatology and well-being: they explained 6% off all psychosocial adjustment factors, except for life satisfaction and positive affect, of which they explained 5%. The best predictor of both emotional symptoms and well-being were acceptance concerns and identity superiority, followed by concealment motivation, which was only a significant predictor of depression symptoms, and identity uncertainty, which was a significant predictor of depression and stress symptoms.

As for psychosocial factors, we examined minority stress and protective factors in two different models. Minority stress accounted for a small amount of variance of the dependant variables, 9% of depression, 13% of anxiety, 10% of stress, 7% of life satisfaction, 5% of positive affect and 9% of negative affect. Both distal and proximal stressors were significant predictors of all psychosocial adjustment dimensions.

Table 35.

Multiple linear regression depicting the effect of LB identity dimensions on psychosocial adjustment

	Depression		Anxiety		Stress		Life sat.		Pos. Aff.		Neg. Aff.	
	β	t	β	t	β	t	β	t	β	t	β	t
LB identity												
AC	0.14	4.08***	0.19	5.69***	0.16	4.87***	-0.18	-5.29***	-0.10	-2.99**	0.18	5.44***
CM	0.08	2.47**	0.04	1.19	0.06	1.80	-0.01	-0.28	-0.06	-1.80	0.04	1.07
IU	0.06	2.11*	0.05	1.63	0.07	2.31*	-0.03	-1.15	-0.05	-1.52	0.05	1.79
IH	0.02	0.48	0.04	1.28	0.04	1.09	0.01	0.35	0.00	-0.08	0.05	1.45
DP	-0.03	-0.84	0.02	0.60	0.02	0.61	0.01	0.21	-0.02	-0.54	0.00	-0.06
IS	0.15	5.01***	0.08	2.73**	0.07	2.28*	-0.10	-3.39**	-0.11	-3.54***	0.11	3.70***
IA	-0.05	-1.37	0.04	1.22	0.00	-0.02	0.07	1.90	0.08	2.11*	-0.02	-0.45
IC	-0.03	-0.79	0.00	0.00	0.03	0.84	0.06	1.65	0.04	1.14	-0.03	-0.86
R^2	.06***		.06***		.06***		.05***		.05***		06***	
F	11.21***		11.03***		11.02***		8.15***		8.00***		11.16***	

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

AC = Acceptance Concerns, CM = Concealment Motivation, IC = Identity Uncertainty, IH = Internalised Homo/binegativity, DP = Difficulty in the Process, IS = Identity Superiority, IA = Identity Affirmation, IC = Identity Centrality.

Table 36.

Multiple linear regression depicting the effect of minority stress and protective factors on psychosocial adjustment.

	Depression		Anxiety		Stress		Life satisfaction		Positive Affect		Negative Affect	
	β	t	β	t	β	t	β	t	β	t	β	t
Minority Stress												
DS	0.18	6.62***	0.29	11.08***	0.24	8.87***	-0.14	-5.27***	-0.10	-3.68***	0.17	6.33***
PS	0.20	7.36***	0.16	6.07***	0.16	5.83***	-0.19	-7.11***	-0.18	-6.66***	0.20	7.48***
R^2	.09***		.13***		.10***		.07***		.05***		.09***	
F	66.49***		104.94***		75.20***		52.77***		38.09***		65.07***	
Protective factors												
CB	0.03	1.39	0.09	3.57***	0.07	2.73**	-0.02	-0.71	0.01	0.64	0.03	1.43
O	-0.03	-1.60	0.00	-0.20	-0.03	-1.10	0.06	2.70**	0.02	1.08	0.02	1.04
FRS	-0.08	-3.40**	-0.03	-0.99	-0.04	-1.28	0.07	2.46*	0.06	2.59*	-0.06	-2.26*
FAS	-0.07	-3.45**	-0.06	-2.18*	-0.04	-1.67	0.15	6.60***	0.05	2.40*	-0.06	-2.43*
RS	-0.07	-2.91**	0.02	0.58	0.06	2.17*	0.08	3.17**	0.09	3.85***	-0.04	-1.66
SE	-0.57	-23.29***	-0.43	-14.25***	-0.41	-13.71***	0.43	16.09***	0.44	17.45***	-0.46	-16.56***
EP	0.10	4.36	0.16	5.65***	0.15	5.44***	-0.09	-3.74***	-0.06	-2.40*	0.15	5.84***
EE	-0.02	-0.72	-0.10	-3.40**	-0.06	-1.97*	0.01	0.19	-0.01	-0.59	-0.02	-0.68
ER	-0.13	-5.13***	-0.10	-3.22**	-0.16	-5.23***	0.14	4.97***	0.27	10.31***	-0.20	-7.17***
R^2	.53***		.30***		.29***		.43***		.50***		.40***	
F	174.29***		64.60***		68.84***		114.51***		151.46***		103.38***	

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

DS = Distal Stressors, PS = Proximal Stressors, CB = Community Belonging, O = Outness, FRS = Friendship Support, FAS = Family Support, RS = Relevant Support, SE = Self–esteem, EP = Emotional Perception, EE = Emotional Expression, ER = Emotional Regulation

As for protective factors, they explained a significant amount of variance of psychosocial adjustment. Altogether, they explained 53% of the variance of depression, 30% of anxiety, and 29% of stress, 43% of life satisfaction, 50% of positive affect and 40% of negative affect. The best predictor were self-esteem and emotional regulation, which were significant predictors of all psychosocial adjustment dimensions. Emotional perception was a significant predictor of all psychosocial adjustment variables, except for depression. Social support also showed a significant predictive role. Depression symptoms, life satisfaction and positive affect were predicted by all sources of social support, negative affect was predicted by friendship and family support, anxiety symptoms were predicted by family support, and stress symptoms were predicted by the support of relevant people. Community belonging was a significant predictor of anxiety symptoms only, and outness was a significant predictor of life satisfaction.

Analysing psychosocial factors altogether, there was a great difference between the amount of variance explained by minority stress and protective factors, with a gap ranging from 5% to 53% respectively. This could suggest that, while protective factors such as self-esteem maintain their relationship with psychosocial adjustment across sexual and gender identities, minority stress could be sensitive to the inter-group differences observed. Further analyses considering the differences between identity groups could explain this gap observed.

These results suggest that the variables that show direct effects on psychosocial adjustment could play a significant role in a mediation analysis. The psychosocial factors that were good predictors of psychosocial adjustment, such as **minority stress**, **social support**, **self-esteem** and **emotional competencies**, could serve as protective factors of mental health across gender and sexual orientation. However, social support variables were not consistent in their effect on psychosocial adjustment. As for emotional competencies, they were good predictors of only some psychosocial adjustment variables, and not all competencies predict the same dimensions. Therefore, of all risk and protective factors, the three best predictors of psychosocial adjustment were **distal** stressors, **proximal** stressors and **self esteem**.

These three variables combined could explain psychosocial adjustment, due to their predictive role on emotional symptomatology and well-being. Nonetheless,

there were significant differences across genders and sexual orientations, hence **identity variables** could be key to explain how minority stressors and self-esteem influence psychosocial adjustment.

Summary of results

- All variables were intercorrelated, and these correlations ranged from weak to moderate for LB identity, from weak to high for minority stress, and from moderate to strong for protective factors and psychosocial adjustment.
- All variables correlated with each other. Generally, minority stress correlated positively with emotional symptomatology and negatively with protective factors and well-being.
- LB identity, minority stress and protective factors explained from 5% to 53% of the variance of psychosocial adjustment variables. The best predictors were acceptance concerns, distal and proximal stressors, emotional regulation and self-esteem.
- Distal stressors, proximal stressors and self-esteem were the risk and protective factors that explained a greater amount of variance of psychosocial adjustment dimensions.

3.4. Path analysis predicting emotional symptomatology in queer cis women and non-binary people

Path modelling was conducted to examine whether distal stressors, proximal stressors and self-esteem would mediate the association of belonging to each minority group (grouped by gender and sexual orientation) with psychosocial adjustment.

The relationship between risk and protective factors and psychosocial adjustment seems to be sensitive to gender identity and sexual orientation: the demographic characteristics of each group could affect the mediation analyses. Therefore, the six clusters previously made combining gender and sexual orientation were made into categorical variables. These variables were coded as CisLes (cis and lesbian), CisBi (cis and bisexual), CisAce (cis and asexual), NBLes (non-binary and lesbian), NBBi (non-binary and bisexual) and NBAce (non-binary and asexual). In order to facilitate interpretation, these variables are going to be theoretically grouped in a conceptual variable named "identity".

As it was mentioned in the method section, a reference category must be chosen to serve as control group for every other categorical variable. The selection of this reference variable must be based on theoretical as well as evidence-based data. According to literature, cis individuals tend to have lower levels of mental health problems and higher levels of well-being than non-binary individuals (Aparicio-García et al., 2018b). Similarly, lesbians tend to show better mental health and well-being outcomes than bisexual and asexual people (Liss & Wilson, 2021; Rosner et al., 2013). This is also reflected by the previous results shown in section 3.1.3 and 3.1.4: non-binary participants and bisexual and asexual people tend to experience worse emotional symptomatology than cis and lesbian participants respectively, and this pattern is maintained when gender identities and sexual orientations are grouped together. Thus, cis lesbians seem to serve as a reference group for the purposes of the analyses depicted below.

In order to respect the principle of parsimony in SEM, psychosocial adjustment was coded into fewer categories (Collier, 2020). According to the literature indicating that depression, anxiety and stress symptoms tend to overlap, it is methodologically adequate to group them into a single dimension of emotional

symptomatology, which is also supported by the intercorrelations observed above (Valencia, 2019). Furthermore, well-being is composed of three variables: satisfaction with life, positive affect and negative affect. Thus, emotional symptomatology was entered as one variable, the result of the sum of depression, anxiety and stress symptoms, and positive affect and negative affect were summed to form the variable "affective balance". The resulting model included 3 dependent variables: emotional symptomatology, life satisfaction and affective balance. Figure 20 depicts the model tested including these variables.

Figure 20.
Graphic depiction of the Structural equation model tested.
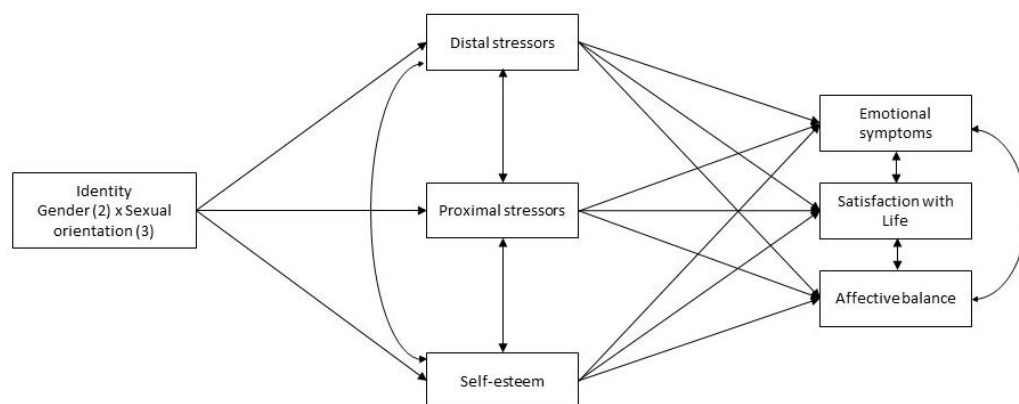
The model was run with all direct and indirect effects. However, due to the non-normality of the independent variables, the resulting degrees of freedom was rendered to 0, making it impossible to calculate the model fix indices. According to the principle of parsimony, testing direct effects in a mediation model such as the one tested would overidentify it, becoming unnecessarily restrictive (Hoyle, 2022; Memon et al., 2018). Therefore, the direct effects from the independent variable to the dependent variables were calculated separately, and were not drawn on the depicted model. Every other relationship was included in the path analysis. Standardized parameter estimates are shown in Figure 21.

The model fit showed adequate fit indices (χ^2 (*df*)= 25.07 (15); CFI = .99; TLI = .99; RMSEA = .02; RMSEA CI = .002/.039, SRMR = .01).

3.4.1. Direct effects

Being CisBi had a direct positive effect on emotional symptoms (estimate = .09, *SE* = .04, *p*<.001) and had a direct negative effect on satisfaction with life (estimate = -.08, *SE* = .04, *p*=.048), but not affective balance (estimate = -.07, *SE* = .04, *p*=.08). Being CisAce had a direct negative effect on satisfaction with life (estimate = -.08, *SE* = .04, *p*=.03), but not emotional symptoms (estimate = .06, *SE* = .04, *p*=.07) or affective balance (estimate = -.05, *SE* = .04, *p*=.16). Being NBLes had a direct positive effect on emotional symptoms (estimate = .06, *SE* = .03, *p*=.04) but not satisfaction with life (estimate = -.02, *SE* = .03, *p*=.48), or affective balance (estimate = -.001, *SE* = .03, *p*=.88). Being NBBi had a direct positive effect on emotional symptoms (estimate = .14, *SE* = .03, *p*<.001) and had a direct negative effect on satisfaction with life (estimate = -.13, *SE* = .04, *p*<.001), and affective balance (estimate = -.13, *SE* = .03, *p*<.001). Being NBAce had a direct positive effect on emotional symptoms (estimate = .08, *SE* = .03, *p*=.02) and a direct negative effect on satisfaction with life (estimate = -.12, *SE* = .04, *p*<.001), and affective balance (estimate = -.09, *SE* = .03, *p*=.01).

Direct effects from identity towards the mediator variables are shown in Figure 21. Being CisBi had a direct negative effect on distal stressors and self-esteem, but not proximal stressors. Being CisAce had a direct negative effect on distal stressors and self-esteem, and a direct positive effect on proximal stressors. Being NBLes only had a positive effect on distal stressors. Being NBBi, as well as being NBAce, had a direct positive effect on distal and proximal stressors, and had a direct negative effect on self-esteem.

Direct effects from the mediator variables predicting psychosocial adjustment were also calculated (Figure 21). Distal and proximal stressors had a direct positive effect on emotional symptoms, and a direct negative effect on well-being (satisfaction with life and affective balance). In contrast, self-esteem had a direct negative effect on emotional symptoms and a direct positive effect on well-being.

Figure 21.
Path model depicting the moderating effect of distal stressors, proximal stressors and self-esteem on the relationship between psychosocial adjustment.
Note. Coefficients are reported in standardized format. Only significant coefficients are presented.
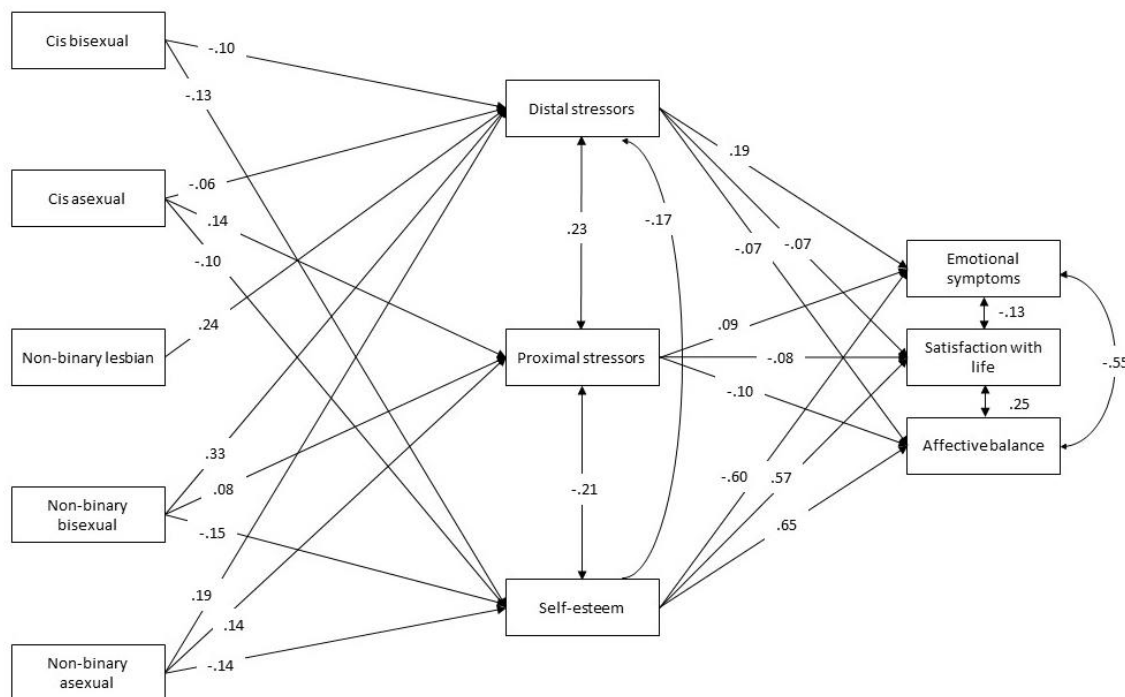
Distal stressors had a direct positive effect on emotional symptoms, and a direct negative effect on satisfaction with life and affective balance. Proximal stressors had a direct positive effect on emotional symptoms, and a direct negative effect on satisfaction with life and affective balance. Self-esteem had a direct negative effect on emotional symptoms, and a direct positive effect on satisfaction with life and affective balance.

3.4.2 Indirect effects

The indirect effects of identity on psychosocial adjustment are shown in Table 37. Table 38 provides a graphic summary of these effects, serving as a visual guide depicting the general direction of each index.

Table 37.
Graphic summary of indirect effects of the model.

	Distal stressors			Proximal stressors			Self-esteem		
	ES	SL	AB	ES	SL	AB	ES	SL	AB
CisBisex	−		+				+	−	−
CisAsex	−			+	−	−	+	−	−
NBLes	+	−	−						
NBBisex	+	−	−	+	−		+	−	−
NBAsex	+	−	−	+	−	−	+	−	−

Note: "+" indicates positive effect, the mediation is stronger compared to the reference group (CisLes); "−" indicates negative effect, the mediation is weaker compared to the reference group (CisLes).
ES = Emotional symptomatology; SL = Satisfaction with Life; AB = Affective balance.

Table 38.
Indirect effects of identity groups on psychosocial adjustment through distal stressors, proximal stressors and self-esteem.

VI	Emotional symptoms				Satisfaction with Life				Affective balance			
	Estimate	SE	p	95% CI	Estimate	SE	p	95% CI	Estimate	SE	p	95% CI
Mediating: Distal stressors												
CB	−.02	.01	.01	[−.04, −.01]	.01	.00	.08	[−.01, .01]	.01	.00	.05	[.00, .01]
CA	−.01	.01	.05	[−.03, −.01]	.00	.00	.14	[−.01, .01]	.01	.00	.10	[−.01, .01]
NBL	.05	.01	<.001	[.03, .05]	−.02	.01	.03	[−.03, −.02]	−.02	.01	.01	[−.93, −.02]
NBB	.07	.01	<.001	[.05, .07]	−.02	.01	.02	[−.04, −.02]	−.03	.01	<.01	[−.04, −.03]
NBA	.04	.01	<.001	[.03, .04]	−.01	.01	.03	[−.03, −.01]	−.02	.01	.01	[−.03, −.02]
Mediating: Proximal stressors												
CB	−.01	.00	.17	[−.02, −.01]	.01	.00	.20	[−.01, .01]	.01	.01	.17	[−01, .01]
CA	.01	.01	.01	[.01, .01]	−.01	.01	.02	[−.02, −.01]	−.01	.01	.01	[−.02, −.01]
NBL	.001	.00	.75	[−.01, .01]	−.00	.00	.75	[−.01, .00]	−.00	.00	.75	[−.01, −.00]
NBB	.01	.00	.05	[.00, .01]	−.01	.00	.08	[−.01, −.01]	−.01	.00	.05	[−.02, −.01]
NBA	.01	.01	.01	[.01, .01]	−.01	.00	.01	[−.02, −.01]	−.01	.01	<.01	[−.02, −.01]
Mediating: Self-esteem												
CB	.08	.03	<.01	[.03, .08]	−.07	.03	<.01	[−.12, −.07]	−.08	.02	<.01	[−.14, −.08]
CA	.06	.02	.01	[.02, .06]	−.06	.02	.01	[−.10, −.06]	−.06	.02	.01	[−.11, −.06]
NBL	.01	.02	.63	[−.03, .01]	−.01	.02	.63	[−.04, −.01]	−.01	.02	.63	[−.05, −.01]
NBB	.09	.02	<.001	[.05, .09]	−.09	.02	<.001	[−.13, −.09]	−.10	.02	<.001	[−.15, −.01]
NBA	.08	.02	<.001	[.04, .08]	−.08	.02	<.001	[−.01, −.08]	−.09	.02	<.001	[−.13, −.09]

Note: CB = cis bisexual, CA = cis asexual, NBL = non-binary lesbian, NBB = non-binary bisexual and NBA = non-binary asexual.

3.4.2.1. Distal stressors

Distal stressors significantly mediated the relationship between all identities and emotional symptoms. When distal stressors mediated, being CisBi and CisAce had a weaker effect than being CisLes on emotional symptoms. Being NBLes, NBBi and NBAce had a stronger effect than being CisLes on emotional symptoms. These results indicate that distal stressors have a stronger effect on emotional symptoms for cis lesbians than other cis women with other identities; but they have a weaker effect for cis lesbians than for non-binary people regardless of their sexual orientation.

As for the mediating effect of distal stressors on the relationship between identity and well-being, there are no differences between CisBi, CisAce and CisLes on satisfaction with life, but the mediating effect was stronger for CisBi regarding affective balance. Being CisLes had a stronger effect than being NBLes, NBBi and NBAce on well-being. These results suggest that for all non-binary people regardless of their sexual orientation, distal stressors had a weaker effect on well-being than for cis lesbians.

3.4.2.2 Proximal stressors

Proximal stressors had different patterns on mediation than distal stressors. Their mediating effect was stronger on emotional symptoms for CisAce, NBbi and NBAce than for CisLes, which indicates that for cis and bisexual women, or asexual people regardless of gender, proximal stressors pose a greater risk for emotional symptoms than for cis lesbians. A similar but opposite effect occurred in well-being. Proximal stressors had a stronger effect on well-being for CisLes than CisAce, NBbi and NBAce, except for the effect of proximal stressors on affective balance, which was not different for NBBi and CisLes. These results indicate that proximal stressors were a more significant risk factor for well-being for cis lesbians than for cis and bisexual women, or asexual people regardless of gender.

3.4.2.3. Self-esteem

As for **self-esteem**, its mediating effect was similar for all identities, except for NBLes, for which it had a similar mediating role than for CisLes. Self-esteem had a stronger mediating effect on emotional symptoms and a weaker effect on well-

being for bisexual and asexual people regardless of their gender, compared to cis lesbians. These results mean that self-esteem could be a stronger protective factor on emotional symptoms, but weaker on well-being, for bisexual and asexual people compared to cis lesbians.

In conclusion, risk and protective factors have different effects on psychosocial adjustment for the various queer identity groups. Direct and indirect effects altogether predicted a significant amount of the variance of emotional symptoms (48.60%), satisfaction with life (37.40%) and affective balance (48.70%).

Overall, distal stressors seem more sensitive than proximal stressors and self-esteem to gender identity, showing greater differences across cis women and non-binary participants than across sexual orientations. Proximal stressors, in contrast, seem more sensitive to sexual orientation than to gender, showing greater differences between asexual participants and other sexual orientations than across genders. Self-esteem also seems more sensitive to sexual orientation than to gender, showing a different pattern for bisexual and asexual participants than lesbians regardless of gender identity.

Summary of results

- Distal stressors, proximal stressors and self-esteem mediated the relationship between queer identity and psychosocial adjustment.
- Distal stressors showed greater differences across genders, regardless of sexual orientation, and proximal stressors and self-esteem showed greater differences across sexual orientations, regardless of gender identity.
- Results showed that both risk and protective factors tend to have a weaker effect on emotional symptoms for cis lesbians than for the rest of the identities, and they tend to have a stronger effect on well-being for cis lesbians than for the rest of the identities.

Table 39.
Summary of results

Section		Analyses (subsample)	Results
3.1. Concordance between sexual orientation and romantic orientation		Chi-squared analyses. (subsample 1)	· Sexual and romantic orientation are associated. · There is a concordance between sexual and romantic orientations for lesbian and bisexual participants, as well as for aromantic participants. This concordance was not observed on asexual participants.
3.2 Influence of gender and sexual orientation	3.2.1. Influence of gender and sexual orientation in LB identity	t-test ANOVA Linear general models. (subsample 3)	· Cis women show higher concealment motivation and internalised homo/binegativity than non-binary people, as well as higher levels of social support, self-esteem and emotional competences. Non-binary people show higher acceptance concerns, identity superiority, affirmation and centrality than cis women. They also show higher minority stress, community belonging and outness and worse psychosocial adjustment than cis women.
	3.2.2. Influence of gender and sexual orientation in psychosocial factors.		· Lesbians show higher levels of identity superiority, affirmation and centrality, as well as higher distal stressors, compared to bisexual and asexual participants. They also show higher levels of psychosocial adjustment than bisexual and asexual people. Bisexual participants show higher levels of concealment motivation than lesbians, and asexual people showed higher acceptance concerns, concealment motivation, internalised

			homo/binegativity and difficulty in the process, as well as proximal stressors, than lesbian and bisexual participants. They also show lower levels of protective factors than lesbian and bisexual people.
	3.2.3. Influence of gender and sexual orientation in psychosocial adjustment	Descriptive and frequency analyses. (Subsample 1)	· Cis women showed moderate levels of emotional symptoms and lower levels of well-being. · Non-binary participants showed moderate and severe levels of emotional symptoms and lower levels of well-being. · Trans women showed severe levels of emotional symptoms and substantially lower levels of well-being. · Participants of all sexual orientations showed moderate levels of emotional symptoms and lower levels of well-being.
3.3. Relationship between the studied variables	3.3.1. Intercorrelations	Pearson correlations. (subsample 1)	· All variables are intercorrelated, and these correlations range from weak to moderate for LB identity and minority stress, and from moderate to strong for protective factors and psychosocial adjustment.
	3.3.2. Correlations between the studied variables		· All variables correlate with each other. Generally, minority stress correlates positively with emotional symptomatology and negatively with protective factors and well-being.
	3.3.3. Predictive influence between	Linear regression analyses.	· LB identity, minority stress and protective factors explain from 5% to 53% of the variance of psychosocial adjustment variables.

	the studied variables.	(subsample 1)	· The best predictors are acceptance concerns, distal and proximal stressors, emotional regulation and self-esteem.
3.4. Predicting emotional symptomatology from minority stress in queer cis women and non-binary people	3.4.1. Direct effects 3.4.2 Indirect effects	Path analysis. (subsample 3)	· Distal stressors, proximal stressors and self-esteem mediated the relationship between queer identity and psychosocial adjustment. · Distal stressors show greater differences across genders, regardless of sexual orientation, and proximal stressors and self-esteem show greater differences across sexual orientations, regardless of gender identity. · Risk and protective factors tend to have a weaker effect on emotional symptoms for cis lesbians than for the rest of the identities, and they tend to have a stronger effect on well-being for cis lesbians than for the rest of the identities.

CHAPTER IV:

DISCUSSION

This section will review the objectives and hypotheses set out in the introduction, interpret the results obtained and offer a reflection on the limitations of the study and future lines of research.

The study of intersectionality suggests that belonging to more than one minority group may lead to an overlap between the stigmatisations experienced, and as a consequence may have a synergistic effect on the mental health and well-being of sexual minorities (Evans & Lépinard, 2020; Logie et al., 2017). There are risk and protective factors that play a key role in the relationship between minority identities and psychosocial adjustment, and these relationships are sensitive to gender identity and diverse sexual identities.

The main aim of this study was to analyse the psychosocial and sexual orientation-related factors that influence the psychosocial adjustment of queer women and non-binary people. Table 39 presents a summary of the hypotheses which are discussed below.

Table 40.
Summary of objectives and hypotheses.

Specific objective	Hypothesis	Result
Objective 1: Analyse the concordance between sexual and romantic orientation.	Hypothesis 1.1. Depending on sexual orientation, there will be concordance between sexual orientation and romantic orientation for lesbians and bisexuals, but not for asexual persons.	Supported.
Objective 2: Analyse the dimensions of LB identity, psychosocial factors and psychosocial adjustment according to gender and sexual orientation.	Hypothesis 2.1. On LB identity variables, bisexuals will show higher levels of identity uncertainty than lesbians.	Rejected.
	Hypothesis 2.2. In minority stress, non-binary people will show higher levels of distal stressors than cis women, and cis women will show higher levels of proximal stressors than all other identities.	Partially supported.
	Hypothesis 2.3. In minority stress, lesbians will show higher levels of distal stressors than other sexual identities. Bisexual and asexual people will show	Partially supported.

	higher levels of proximal stressors than lesbians.	
	Hypothesis 2.4. On psychosocial factors, cis women will show higher levels of social support, self-esteem, well-being and sense of community than non-binary people.	Partially supported.
	Hypothesis 2.5. On psychosocial factors, lesbians will show higher levels of social support, self-esteem, well-being and sense of community than other identities.	Supported.
	Hypothesis 2.6. Participants will show high levels of emotional symptomatology and low levels of well-being. Specifically, non-binary, bisexual and asexual individuals will show higher levels of emotional symptomatology than other identities.	Partially supported.
Objective 3: Analyse the relationship between the dimensions of LB identity, psychosocial factors, psychosocial adjustment and well-being.	Hypothesis 3.1. Identity affirmation and centrality will be positively associated with protective factors and well-being and negatively associated with risk factors and emotional symptomatology.	Rejected.
	Hypothesis 3.2. Difficulty factors associated with LB identity (acceptance concerns and difficulty in the process) will be positively related to risk factors and emotional symptomatology and negatively related to protective factors and well-being.	Supported.
	Hypothesis 3.3. In minority stress, distal stressors will be positively related to outness, community belonging, and proximal stressors will be positively related to emotional symptomatology.	Supported.

Objective 4: Analyse the influence of minority stress on psychosocial adjustment as a function of queer identity as determined by the intersection between gender and sexual orientation.	Hypothesis 4.1. Distal stressors, proximal stressors and self-esteem mediate the relationship between identity and psychosocial adjustment.	Supported.
	Hypothesis 4.2. Distal stressors will influence psychosocial adjustment for non-binary and lesbian individuals.	Partially supported.
	Hypothesis 4.3. Proximal stressors will influence psychosocial adjustment for bisexual and asexual individuals.	Partially supported.
	Hypothesis 4.4. Self-esteem will have a protective influence on the psychosocial adjustment of queer women and non-binary people.	Rejected.

OBJECTIVE 1

Analyse the concordance between sexual and romantic orientation.

Hypothesis 1.1. indicated that there would be concordance between sexual orientation and romantic orientation for lesbians and bisexual people, but not for asexual people. When reviewing the results, it should be noted that the sexual identity variable consists of the parameters sexual orientation and romantic orientation, and always refers to identity aspects. This implies that it is not possible to make inferences about how the people in this study establish affective, sexual and romantic bonds, and the interpretation is limited exclusively to how they experience their identity regarding the aforementioned parameters.

The chi-square analyses conducted to test this hypothesis indicated that there was an association between sexual orientation and romantic orientation for all

three genders analysed: cis women, trans women and non-binary people. According to these data, the difference between the observed and expected values is significant, indicating that there is a relationship between sexual orientation and romantic orientation, as the distribution of participants on these variables is different from how it would be if these variables were independent. These results contribute to research supported by Diamond's (2003) biobehavioural model that postulates that the links between love and desire are bidirectional: although sexual and romantic attraction are functionally independent, there is a correlation between them through interpersonal, emotional and cultural factors (Antonsen et al., 2020).

Thus, the results allow us to **accept hypothesis 1.1**: participants who identified themselves as lesbian and bisexual in terms of their sexual orientation tended to be homoromantic and biromantic, respectively, and this correspondence was not found in asexual people. Following Diamond's (2003) proposal, although sexual and romantic attraction are related, they seem to maintain a degree of independence. For example, in participants who identify as lesbian, the majority are homoromantic (94.82%). However, there is a small sample of lesbians who identify as biromantic according to their romantic attraction (3.59%), and a minority who indicate that they are homoromantic or aromantic (0.04% and 0.12% respectively). The same is true for people who identify as bisexual. These data suggest that the way in which people identify according to their sexual and romantic orientation is individualised and could be a manifestation of the fluidity of affective-sexual orientation.

In the case of asexual people, these parameters do not necessarily correspond. In fact, there is a higher proportion of asexual people who identify themselves as biromantic (45.21%) than as aromantic (29.22%). These results are in line with the (still scarce) literature indicating that there tends to be greater heterogeneity of forms of romantic attraction within asexuality than in other sexual orientations (Clark & Zimmerman, 2022; Su & Zheng, 2023).

However, in the case of people who identify as aromantic, their sexual orientation is mostly asexual (77.11%). This suggests that, for the aromantic individuals in this study, the parameters of sexual orientation and romantic orientation tend to coincide, as they tend to also identify as asexual regarding their sexual orientation. The literature suggests that this could be due to a scarcity of

information and popular knowledge about aromanticism (Bougie, 2021). People who identify as asexual and know how the sexual and romantic orientation spectrum work seem to be more informed about aromanticism than allosexual people (Carvalho & Rodrigues, 2022; Clark & Zimmerman, 2022). Thus, it is more likely that it is asexual people who also identify as aromantic than allosexual people (in this sample, lesbians and bisexuals), and that there are some allosexual people who are unaware of aromanticism even though they do not experience romantic attraction in an allonormative way.

OBJECTIVE 2

Analyse the influence of gender and sexual orientation on dimensions of LB identity, minority stress, psychosocial factors and psychosocial adjustment.

Hypothesis 2.1. referred to **LB identity** variables in different **sexual orientations**, since there seems to be no research on how different genders differ in the dimensions of LB identity. The hypothesis stated that bisexual people would show higher levels of identity uncertainty than lesbians. To test this hypothesis, mean difference analyses were conducted and people who identified as lesbian, bisexual or asexual were compared to each other within this parameter.

This hypothesis must be rejected on the basis of the data obtained. Mean difference analyses reveal that there are no significant differences between the identity uncertainty of lesbians and bisexuals. Furthermore, the group with the highest identity uncertainty is asexual people, significantly above lesbians and bisexual people. No previous evidence has been found in the literature about differences in identity uncertainty between people who identify as lesbian, bisexual and asexual, as asexuality does not seem to have been studied in depth from a dimensional perspective. Research has found that bisexual people tend to have more identity uncertainty than homosexual people and attributes this difference to the monosexist tendency not to recognise bisexuality as a valid sexual identity and the biphobia that occurs both outside and within the LGBTI community (Dyar et al.,

2017; Mohr & Kendra, 2011). However, these data are not apparent in the results obtained, indicating that bisexual people in the sample do not differ from lesbians in identity uncertainty. Furthermore, when data from asexual people are taken into account in this variable, the results indicate that this group scores significantly higher on identity uncertainty than the bisexual and lesbian people in this sample. Following the line of interpretation observed in the literature, it is possible that alosexism plays a significant role in this difference and that the lack of information and referents characteristic of structural acephobia has the consequence that asexual people go through more frequent periods of confusion in the development of their queer identity than other identities. (A. Mollet & Lackman, 2019; Reed, 2023).

Although the rest of the dimensions of LB identity are not part of this hypothesis due to the lack of research on the subject, it is interesting to dwell on the other differences observed; something similar happens with the concern for acceptance and difficulty in the process (asexual people score higher than bisexual people) and internalised homo/binegativity (asexual people score higher than all identities). These results support the literature indicating that asexuality is a stigmatised identity on many levels: acephobia operates through pathologisation, invisibilisation and erasure of asexual people, among other phenomena, and this may mean that when assessed on the same dimensions as bisexuals and lesbians, their scores on difficulties in identity development are significantly higher. (A. L. Mollet & Lackman, 2021; Reed, 2023). In terms of invisibility, asexual people also score significantly higher than other identities, and bisexual people score higher than lesbians. These results are difficult to interpret, as research indicates that bisexuality and asexuality are highly invisibilised identities and may therefore have a lower desire to remain invisible (Edge et al., 2021; A. Mollet & Lackman, 2019). In this case, what could explain these significantly higher invisibility motivation scores? According to research on minority stress, biphobia and acephobia, these identities receive specific forms of discrimination and this is combined with a lack of referents, connection with the LGBTI community and higher levels of difficulty in the development of their sexual identity (Carvalho & Rodrigues, 2021; Dyar et al., 2017; Young, 2022). This could mean that these individuals feel that they lack support and resources to disclose their queer identity to their environment and enter into the paradox of being doubly stigmatised: they experience discrimination

both when they are visible and when they remain invisible to the world (Feinstein et al., 2020; Hayfield, 2020; Morgenroth et al., 2022; Pachankis et al., 2020).

In the rest of the LB identity variables, lesbians were found to have higher levels of identity superiority and identity centrality than bisexuals, and higher levels of identity affirmation than the rest of the identities. These results are congruent with previous literature indicating that bisexual and asexual people may experience greater layers of stigmatisation than lesbians, as monosexism and allosexism are added to the LGBTIphobia they already experience as queer identities (Edge et al., 2021; Gupta, 2019; Shaw, 2022). This could mean that people who identify as lesbian have more positive experiences of their identity than bisexual and asexual people, which could explain why for them their identity is more affirming, more central and also perceived as superior to heterosexuality.

Although it was also not possible to hypothesise about **gender differences** in the different dimensions of LB identity, the means of cis women and non-binary people were compared to explore this variable (excluding trans women due to their small sample size). The results show that cis women have higher levels of internalised invisibility motivation and homo/binegativity than non-binary people. These results can be explained by recent research, non-binary people are perceived as queer more often than cis women, as their gender does not fit the binary standards of cisheteropatriarchy (Hamilton-Page, 2022; K. Tan et al., 2019). One fact that could help explain these differences is gender expression, and how the adequation or non-adequation to hegemonic canons varies between cis women and non-binary people and contributes to them being more visible. Looking at their differences in this variable previously discussed, the non-binary individuals in this study appear to have a more androgynous gender expression than cis women. Thus, it is possible that for non-binary people it is not an option to remain invisible to the world, and, as the results show, they also present greater identity affirmation and centrality, as they already inhabit a dissident identity.

Hypothesis 2.2. referred to **minority stress**, hypothesising that non-binary people will have higher levels of distal stressors than cis women, and cis women will have higher levels of proximal stressors than all other identities.

The results obtained partially support this hypothesis. Non-binary people present higher levels of **distal stressors** than cis women. This is in line with the literature that suggests that people who are more visible in their queer identity might receive higher levels of explicit discrimination and both verbal and physical aggression than identities that suffer greater invisibility, as might be the case for LGBTI cis women (Hayfield et al., 2013; K. Tan et al., 2019)..

However, the results about **proximal stressors are** not in line with the hypothesis formulated. In the case of gender differences, it is again non-binary people who show higher levels than cis women, indicating that their levels of minority stress in both explicit discrimination and experiencing stigma are significantly higher than cis women. These results may be explained by the fact that dissident (non-cisgender) identities experience higher rates of discrimination than cis people, resulting in higher levels of minority stress (Aparicio-García et al., 2018b; Fiani & Han, 2019). The literature on gendered minority stress emphasises the importance of studying the specific stressors affecting trans people and those who do not fit within gender binarisms (K. Tan et al., 2019). These findings corroborate previous research indicating that structural transphobia may be responsible for non-binary people having higher levels of both distal and proximal stressors than cis women, something that is also observed in this study (Barnett et al., 2020; Darwin, 2020).

Hypothesis 2.3 referred to **minority stress** by **sexual orientation**, hypothesising that lesbians would have higher levels of distal stressors than other sexual identities, and bisexual and asexual people would have higher levels of proximal stressors than lesbians.

The results partially accept this hypothesis: lesbians presented higher levels of **distal stressors** compared to the other identities, and asexual participants presented significantly higher scores on proximal stressors than lesbians and bisexuals. These results are in line with the literature indicating that lesbians may be the most visible sexual identities compared to bisexuals and asexual participants, as they may have more social codes to express their sexual identity and also have a higher social representation of their identity (Hayfield, 2020; Shaw, 2022). This may expose people who identify as lesbian to greater levels of explicit discrimination, at individual and structural levels, and this may mean that they have

higher levels of distal stressors (Hord, 2020; Salvati et al., 2019). Lesbophobia is a phenomenon documented in the scientific literature that could explain these differences in minority stress, as each sexual identity seems to present different characteristics in terms of its social stigmatisation (Barragán-Medero & Pérez-Jorge, 2020; Braga et al., 2022).

However, the results in terms of **proximal stressors** are different from those expected. According to the literature, bisexual people might have higher levels of proximal stressors than those observed in lesbians, however, asexual people have not been included in this hypothesis due to the scarcity of studies on minority stress in the asexual community (Katz-Wise, Mereish, et al., 2017). The results indicate that asexual people have higher levels of proximal stressors than bisexuals and lesbians: by including asexual people in the study, they stand out in their levels of minority stress above bisexual people, as well as lesbians. Women and non-binary bisexual people experience LGBTIphobia and the misogyny and transmisogyny experienced by lesbians, but the invisibilisation they suffer may explain their higher levels of proximal stressors. Monosexism and negative attitudes towards bisexuality, in addition to the lack of knowledge about this sexual identity, explain why, both in this study and in the literature, bisexual people experience very high minority stressors in comparison with other monosexual identities (Feinstein et al., 2021; Shaw, 2022). However, asexual individuals in this study have even higher levels of proximal stressors than bisexuals.

According to the literature reviewed, asexual people may have a specific stigma overlap that could explain these elevated levels in proximal stressors (Houdenhove, Gijs, T'sjoen, et al., 2014). The pathologisation of people on the spectrum of asexuality and aromanticism still manifests itself today in conversion therapies, and a lack of knowledge about these sexual identities as a healthy way of experiencing sexuality and bonding (Russell, 2023). In addition, the invisibilisation they experience can affect their self-identity affirmation and the formation of affective networks, as well as their relationship with the queer community (Reed, 2023; Young, 2022). All these factors could explain the high levels of proximal stressors in asexual people, which exceed the already high levels in bisexual people.

Hypotheses 2.2 and **2.3** can be reviewed together. When grouping participants according to gender and sexual identity, it is observed that non-binary lesbians have

the highest levels of distal stressors, and non-binary people have higher levels of distal stressors than all cis identities. This could indicate that distal stressors may not only affect the more visible members of the group to a greater extent, but that the overlap between two visible identities may be related to higher levels of explicit discrimination. Adding the discriminations stemming from lesbophobia and transmisogyny experienced by non-binary lesbians could have a synergistic effect on their minority stress (specifically, distal stressors) and, consequently, on their psychosocial adjustment.

In terms of proximal stressors, asexual people have significantly higher scores than all other sexual identities on proximal stressors regardless of gender. Following the line of interpretation of the literature on asexual identity, which indicates that asexual individuals experience multiple forms of acephobic discrimination (Gupta, 2019; McInroy et al., 2020). This may be consistent across genders: asexual people in this study (both cis- and non-binary) have the highest levels of proximal stressors. These results highlight the importance of attending to the specific discriminations experienced by asexual people, as they seem to transcend the relevance of gender in their minority stress levels.

Hypothesis 2.4. addressed **psychosocial factors** in relation to **gender,** postulating that cis women would have higher levels of **social support**, **self-esteem**, **well-being** and **community belonging** than non-binary people. The observed results are partially in line with this hypothesis. Cis women score significantly higher than non-binary people on all protective factors, except for sense of community and outness, where non-binary people score higher than cis women. These data contradict the hypothesis formulated and could be explained by the previously observed levels of affirmation, superiority and identity centrality in non-binary people. The observed relationship between sense of community and outness and identity affirmation will be interpreted below, but it is possible that non-binary people have a stronger relationship with their LGBT community than cis women due to their higher levels of identity affirmation. In line with previous literature, people whose queer identity is more central and affirming may be more actively involved in the LGBT community (Hinton et al., 2021; Rosner et al., 2013). On the other hand, non-binary people have previously been found to have significantly lower levels of invisibility motivation, which might explain their higher levels of

outness, as they might be perceived as queer more often than cis people due to their dissident gender identity. According to the proposed hypothesis, cis women have higher scores than non-binary people on social support and self-esteem, except in the case of social support from gender-relevant people, for which there are no differences. These results are consistent with the literature indicating that people who are further away from the cisheteronormativity may be more vulnerable to social rejection, which is also related to lower levels of self-esteem in the absence of this protective factor (Aparicio-García et al., 2018b; Dowers et al., 2020).

Hypothesis 2.5 referred to **protective factors** in relation to **sexual orientation**, hypothesising that lesbians would have higher levels of **social support, self-esteem**, **well-being** and **community belonging** than other identities. The observed results allow us to accept this hypothesis. Lesbians score significantly higher than bisexuals and asexual people on all protective factors. Similar to non-binary people, lesbians have higher levels of sense of belonging to the community and outness than the other identities, and this could be explained by their higher levels of superiority, affirmation and identity centrality.

In line with this hypothesis, lesbians score higher than other sexual identities on social support and self-esteem. According to previous research, bisexual and asexual people experience multiple layers of discrimination that could explain their lower levels on these dimensions (Aparicio-García et al., 2018b; Borgogna et al., 2018). Research indicates that dissident identities may have lower levels of social support, in relation to their greater exposure to social rejection, and this could be associated with lower levels of self-esteem (Dowers et al., 2020; Gougis, 2013).

Finally, **Hypothesis 2.6.** referred to the **psychosocial profile** of the participants, hypothesising that they will present high levels of emotional symptomatology and low levels of well-being. This hypothesis is accepted, since, although not all gender and sexual identities present the same levels of psychosocial adjustment, they do present low levels of psychosocial adjustment in comparison with the reference scales (Diener, 2009; Diener et al., 2010; S. H. Lovibond & Lovibond, 1995b).

These levels were studied by **gender** and **sexual orientation** separately. Regarding emotional symptomatology, all the people in the sample showed

moderate to severe levels of depression, anxiety and stress symptoms, above what are considered normal levels for these variables, with the only exception of the stress levels of people with gender identities other than those studied, which were mild. Regarding the level of well-being, all people in the sample showed mild levels of dissatisfaction with life, except transgender women who showed levels of dissatisfaction compared to the baseline. All groups showed lower levels of positive affect and higher levels of negative affect than the baseline scores, which, together with the levels of dissatisfaction with life, indicate low levels of well-being for all groups. While this is in line with the hypothesis that the sample would have low levels of well-being, the scores on positive and negative affect do not seem to discriminate between groups, so perhaps scales would be needed to analyse their levels of affect in more depth. These results contribute to the literature that indicates that queer women and non-binary people are in a situation of psychological vulnerability, presenting lower levels of psychosocial adjustment than the general population reference values (Flanders et al., 2022; Rothblum, 2020; Rothblum et al., 2019).

Furthermore, it was hypothesised that non-binary, bisexual and asexual people would have **higher levels of emotional symptomatology** than other identities. The results partially support this hypothesis. In terms of gender, the expected differences between women and non-binary people are observed: women score significantly lower in emotional symptomatology and significantly higher in well-being than non-binary people. These results could be explained by literature indicating that non-binary people may have lower levels of psychosocial adjustment than cis people in the sample due to the overlap between gender and sexual identities that are not allo/heteronormative (Aparicio-García et al., 2018b; Matsuno & Budge, 2017). In fact, non-binary people of all sexual orientations had higher levels of depression, anxiety and stress symptoms than all cis women.

As for sexual orientation, the results are not exactly as expected. Bisexual and asexual people experience significantly higher levels of depressive symptoms than lesbians, as hypothesised. However, there are no differences in anxiety symptoms, and in stress symptoms bisexuals score significantly higher than lesbians, but no differences are observed in asexual participants. Regarding well-being, lesbians have significantly higher life satisfaction than bisexuals and asexual people, as

hypothesised. However, on positive affect, lesbians score higher than all other identities, and bisexuals score higher than asexual participants. On negative affect, bisexuals score higher than lesbians and no differences are found in asexual people. These results may indicate that the levels of psychosocial adjustment for bisexuals are especially critical in their symptoms of stress and negative affect, while asexual participants score significantly higher in their symptoms of depression. These results are in line with what was previously expressed about the psychological vulnerability that could be involved in inhabiting a bisexual and an asexual identity, and that the psychosocial manifestations of these experiences are different for these two identities (Borgogna et al., 2018; Feinstein et al., 2020; McInroy et al., 2020).

OBJECTIVE 3

Analyse the relationship between the dimensions of LB identity, psychosocial factors and psychosocial adjustment.

Hypothesis 3.1. expected that **LB identity affirmation** and **centrality** would be positively associated with **protective factors** and **well-being** and negatively associated with **risk factors** and **emotional symptomatology**. Results reject this hypothesis, so it is necessary to take a closer look at each of these relationships to understand how identity affirmation and centrality function in this sample.

In general, unlike other dimensions of LB identity, the identity affirmation and identity centrality variables do not seem to present consistent relationships with the risk and protective factors and psychosocial adjustment in this study. The relationship between these two variables and the factors studied is generally weak and not in line with expectations.

Regarding **protective factors**, identity affirmation is significantly related to all these variables, although the relationships are generally weak, and centrality has

only a few significant relationships. The relationships between sense of community and outness are consistent for both dimensions: people who have high levels of identity affirmation and centrality also feel a high sense of community and tend to disclose their queer identity to more people around them (Caba et al., 2022; Feldman & Wright, 2013). In terms of social support and emotional competences, identity affirmation and identity centrality show a very weak relationship with friendship support and emotional expression respectively, but not with the other protective factors. These results suggest that people with high identity affirmation may also have higher support from close friends and higher emotional competences, but this is not the case for people whose queer identity is more central. As for self-esteem, only identity affirmation shows a weak relationship with self-esteem, suggesting that people who feel affirmation of their queer identity might also have a better opinion of themselves. This different relationship than expected suggests that identity affirmation and identity centrality are ambiguously related to protective factors, presenting very varied relationships, so they cannot be considered inherently positive aspects of LB identity. Their influence on psychosocial adjustment, therefore, could vary as a function of other factors, so it is of interest to explore their relationship with other psychological variables.

In relation to **risk factors**, the minority stress dimensions, both identity affirmation and identity centrality are positively related to distal stressors. This could be explained by the relationship between these dimensions and outness: people with higher levels of identity affirmation and identity centrality are also out with more social circles and to a greater extent, which contributes to their visibility and might put them at risk of experiencing explicit discrimination referred to in the distal stressors. In contrast, affirmation is negatively related to proximal stressors and centrality has no significant relationship. This could be explained by the relationships observed in the minority stress dimensions: the fact that people whose queer identity is more affirmed may have lower negative feelings associated with belonging to the group and show higher levels of connectedness to their community (Harvey et al., 2021; Heck et al., 2013; McKinney et al., 2020). These results may explain the previously observed relationships with protective factors: these variables may not necessarily be protective in psychosocial adjustment, due to nuances in their relationship with minority stress.

Regarding **psychosocial adjustment**, results are inconsistent. Identity affirmation is only negatively related to depressive symptoms, and shows no relationship with anxiety and stress symptoms. It also shows weak relationships with well-being, positively with life satisfaction and positive affect and negatively with negative affect. Centrality, on the other hand, has only a weak positive relationship with anxiety and stress symptoms. These results indicate that people with high identity affirmation may also have high levels of psychosocial adjustment. This could be explained by the fact that, when queer identity is highly embedded in self-perception, it is possible that LGBTIphobic discrimination is associated with higher levels of anxiety and stress. In contrast, identity affirmation may protect the person from the negative effects of living as a *queer* person in a cisheteropatriarchal society, perhaps through other factors to which it relates (Harvey et al., 2021; McKinney et al., 2020). This seems not to be true for identity centrality: people for whom their queer identity is more central may be more vulnerable to symptoms of anxiety and stress, perhaps because perceived discrimination impacts more directly (more centrally) on their identity. Linear regression analyses show that, perhaps because of the weak relationship these variables have with psychosocial adjustment, they do not have a direct effect on levels of emotional symptomatology or well-being. This could mean that perhaps the observed relationship between identity affirmation and psychosocial adjustment can be explained by other factors in the absence of a direct effect.

Hypothesis 3.2. refers to the difficulty factors associated with LB identity (**acceptance concerns** and **difficulty in the process**), hypothesising that they would be positively related to risk factors and emotional symptomatology and negatively related to protective factors and well-being.

Results support this hypothesis. Both dimensions are positively related to **minority stress**, both distal and proximal stressors, indicating that difficulty in queer identity development and fear of social rejection are associated with higher levels of explicit discrimination and internalised stigma. On the other hand, these dimensions are negatively related to all but two **protective factors**: concern for acceptance is positively related to psychological sense of community, suggesting that people who feel more connected to their community also feel more fear of social rejection; and difficulty in processing is unrelated to perception and

understanding of emotions. In terms of **psychosocial adjustment**, both dimensions are positively related to emotional symptomatology and negatively related to well-being, indicating that people who experience greater difficulties in developing a queer identity also have worse levels of psychosocial adjustment. Returning to the results observed in the previous objective, it is possible that this relationship explains the observed levels of psychosocial adjustment in some identity groups: people who experience greater difficulty in the development of their identity, such as asexual people, also have worse levels of psychosocial adjustment. This is in line with literature indicating that asexual people experience an overlap of discrimination associated with allo/heteronormativity that may place them at higher risk for mental health (McInroy et al., 2020).

Looking at the regression analyses, acceptance concern had a significant direct effect on psychosocial adjustment, but this was not the case for difficulty in the process. This could mean that, while difficulty in the process is associated with poorer psychosocial adjustment, worry about acceptance also has a direct influence on emotional symptomatology and well-being. This could indicate that the fear associated with discrimination processes of people with dissident sexual identities could be a more relevant factor in terms of its impact on psychosocial adjustment than individual difficulties in the process of developing a queer identity (Borgogna et al., 2018; Feinstein et al., 2020).

As for **hypothesis 3.3**, it was expected that **distal stressors** would be positively related to outness and group membership, and **proximal** stressors would be positively related to emotional symptomatology. The results support this hypothesis. Outness was positively related to distal stressors and negatively related to proximal stressors. This could be explained by the literature indicating that coming out is associated with greater visibility, and this may make the person more vulnerable to external discrimination. However, the invisibility associated with non-disclosure may result in lower levels of subjective experience of stigma and fear of social rejection, as they are less exposed to explicit violence, despite the problems associated with keeping their identity hidden (Pachankis et al., 2020). The same is true for the psychological sense of community: it is associated with higher levels of distal stressors, which could be explained by the fact that greater participation in LGBTI communities could make the person more visible as a queer person, and

perhaps greater community support could be related to less experience of stigma, which is reflected in lower levels of proximal stressors. Taking into account the positive correlations between the sense of community and the protective factors, and the risk factor of disconnection from the community, the protective role of connection to the LGBTI community is evidenced.

Both **distal** and **proximal stressors** are positively related to emotional symptomatology and negatively related to well-being, which is in line with the literature suggesting that minority stress is associated with worse levels of psychosocial adjustment. These results are corroborated through regression analyses, as a direct impact of distal and proximal stressors on psychosocial adjustment is observed. These results are in line with the literature indicating that minority stress is a predictor of difficulties in psychosocial adjustment, and that it is a significant risk factor for emotional symptomatology and well-being in queer women and non-binary people (Dyar et al., 2018; Katz-Wise, Rosario, et al., 2017; McInroy et al., 2020; Pease et al., 2022). In addition, self-esteem and emotional competencies were shown to be significant predictors of better levels of psychosocial adjustment, which is in line with the literature indicating that these constructs function as protective factors in queer people.

Although these data were not included in the hypothesis, it is interesting to observe the relationship between psychosocial adjustment and the socio-demographic data of **age** and **income** level. The results show a tendency for all dimensions of emotional symptomatology to decrease with age and income level, and for well-being dimensions to increase as these variables increase. These results indicate that older people may have better psychosocial adjustment, perhaps due to greater access to resources or by overcoming the situation of psychosocial vulnerability experienced by younger people. In terms of income level, these data suggest that people with higher net annual incomes also have better psychosocial adjustment, which may be explained by better quality of life, better security conditions, economic stability and access to mental health care services.

OBJECTIVE 4

Analyse the influence of minority stress on psychosocial adjustment in terms of queer identity as determined by the intersection between gender and sexual orientation.

Hypothesis 4.1 postulated that **distal stressors**, **proximal stressors** and **self-esteem** would mediate the relationship between **identity** and **psychosocial adjustment**. Results support this hypothesis.

Path analysis was conducted in which minority stress and self-esteem functioned as mediating factors in the relationship between gender and sexual identity and psychosocial adjustment in queer women and non-binary people. The fit indices of this model were adequate, so that it is statistically a suitable model to explain the influence of identity and protective and risk factors on psychosocial adjustment in this sample. These results contribute to the literature by emphasising the important role of minority stress and self-esteem in the relationship between minority identities and psychosocial adjustment, especially when combining their effects in a single statistical model (Dyar et al., 2018; Gougis, 2013; Hatzenbuehler & Pachankis, 2016).

Hypothesis 4.2 postulated that **distal stressors** would influence psychosocial adjustment for non-binary and lesbian individuals.

This hypothesis was formulated based on literature stating that distal stressors may have a greater influence on the mental health of people who are more visibly queer (Shramko et al., 2018).. According to the literature, lesbians and non-binary people may be the groups in this sample that receive higher levels of distal stressors because they are more readily perceived as queer people (Hamilton-Page, 2022; Hayfield et al., 2013). This hypothesis is supported by the observed mean differences: non-binary people have the highest distal stressors, regardless of their sexual orientation, and lesbians are the sexual identity with the highest perceived distal stressors compared to all other sexual identities for cis women.

Results partially support this hypothesis. Distal stressors have a greater mediating effect between cis lesbians' identity and emotional symptomatology compared to all other cis women, while having a smaller effect on cis lesbians than on all non-binary identities. This is in line with the literature indicating that more visible identities might be more affected by distal stressors, observing a higher mediating effect on their emotional symptomatology (Coyne et al., 2020; Matsuno & Budge, 2017; K. Tan et al., 2019). However, the opposite is true for their well-being: distal stressors are a significantly higher risk factor for well-being in cis lesbians than in non-binary people. This could be explained by literature indicating that non-binary people may have lower levels of well-being: with lower levels of life satisfaction and higher levels of negative affect in non-binary people of any sexual orientation, the impact of minority stress may be less significant as they start from lower baseline levels than cis-lesbians (Aparicio-García et al., 2018b). These results suggest that overlapping stigmatised identities may be a greater risk factor for more visible identities in terms of emotional symptomatology, but only have a significant effect on their well-being in individuals with higher levels on this variable.

Hypothesis 4.3. expected that **proximal stressors** would influence psychosocial adjustment for bisexual and asexual individuals.

The results partially supported this hypothesis. In terms of emotional symptomatology, proximal stressors had a more significant mediating influence on emotional symptomatology for bisexual and asexual people (regardless of gender identity) than for cis lesbians; with the exception of cis bisexuals, with whom there was no difference. However, there was also no difference between cis lesbians and non-binary lesbians, indicating that proximal stressors may be more sensitive to sexual orientation than to gender. On the contrary, the influence of proximal stressors on well-being was greater for cis lesbians than for all other sexual identities. This means that proximal stressors have a similar influence on cis and non-binary women, but their influence is very different among lesbians and bisexual and asexual people. This could indicate that more invisibilised identities with more overlapping stigma associated with this lack of visibility might be more vulnerable to their experience of stigma, or at least these types of stressors might better explain their lower levels of emotional symptomatology. However, the opposite effect occurs on well-being. As with distal stressors, it is possible that the

negative impact of proximal stressors on well-being is stronger for those identities that started from higher levels on this variable. These results indicate that, in terms of emotional symptomatology, proximal factors may be a higher risk factor in sexual identities that are more visible and more stigmatised. In terms of well-being, proximal factors may have a more significant mediating effect on those identities with higher baseline levels of well-being, in this case, cisgender lesbians (Dyar et al., 2018; Hayfield et al., 2013).

Hypothesis 4.4. stated that **self-esteem** would have a similar protective influence on psychosocial adjustment for queer women and non-binary people.

Results reject this hypothesis. This hypothesis was formulated in accordance with the literature indicating that self-esteem is a protective factor for psychosocial adjustment in the general population, suggesting that there may be no differences in this sample in the effect of self-esteem on emotional symptomatology and well-being (Bridge et al., 2019). The results indicated that, as with proximal stressors, self-esteem appears to be more sensitive to sexual orientation than gender, as its impact is different for people with different sexual orientations than cis lesbians, but there are no differences compared to non-binary lesbians. For bisexual and asexual people (regardless of their gender identity), self-esteem has a mediating effect on the relationship between identity and emotional symptomatology than for cis lesbians. However, compared to these identities, self-esteem has a stronger protective effect on the well-being of cis lesbians. The interpretation of these results could be similar to that of the proximal stressors: self-esteem could be a more important protective factor in those identities that start from higher levels of emotional symptomatology, such as bisexual and asexual people, and in the well-being of those people who presented higher levels in this variable, in this case cis lesbians.

4.1. Limitations and future lines of research

This study is not without **limitations**. The first limitation refers to the small sample size of certain identity groups. With only 26 trans women participating, some quantitative analyses could not be carried out, leaving out valuable information about this population. There are few studies on the queer experiences

of trans women, as studies in psychology on trans people tend to focus on gender characteristics and not on their sexual identity. Something similar has happened with aromantic people: although certain patterns in sexual identity characteristics have been observed, such as the concordance between sexual and romantic orientation in this group, which makes aroace identities visible, it has not been possible to conduct other quantitative analyses in this population due to the small sample size. People who identified as demisexual or demiromantic were also not included for the same reason. These identity groups are still stigmatised and underrepresented in science, something that was noted in the literature review at the beginning of this study. In future research, it would be important to prioritise data collection from these populations to ensure their inclusion in all phases of the study.

The second limitation relates to data collection. The survey used to collect the responses to the questionnaires was disseminated through social networks and most of the people who took part found out about the study through Twitter. This is a limitation, as the sample is biased in this respect and over-represents people who use social media and Internet. These people may have common characteristics associated with community membership, social support or psychosocial adjustment that may be different in people who do not regularly use these forms of communication. Therefore, for future studies, it is recommended that questionnaires be administered through other means, such as non-Internet-dependent random sampling. In addition, some queer associations contributed to the dissemination of the research, so that the circles through which this survey was most widely disseminated were already in contact with LGBTI associations. This could have interfered with the interpretation of the results, and perhaps the participants had more information about the processes of queer identity development or had more relationships within the community than the general queer population.

The third limitation relates to socio-demographic data, which have not been controlled for in this study. On the one hand, participants were not asked about whether they had any physical or mental health problems, whether they were undergoing psychological treatment, whether there were any health-related conditions that could better explain their levels of psychosocial adjustment, or

whether they considered themselves to be neurodivergent, which would have helped to interpret the data regarding their psychosocial adjustment. On the other hand, no questions were asked about where they live (urban or rural settings). Research asserts that queer people living in rural settings may experience different processes of identity development, discrimination and stigma compared to those in urban settings (Thomsen, 2021). This may have been a relevant factor in interpreting the impact of minority stress on their psychosocial adjustment.

The fourth limitation refers to the use of self-report questionnaires. This type of assessment is subject to both self-perception and social desirability biases, so it is important to interpret these results with caution. However, there are few methods of assessing minority stress and psychosocial adjustment that contribute to the objectivity of the study, as this information depends on the subjective experience of the individual. Some protective factors, such as social support or emotional competencies, could be collected with observational measures to ensure scientific rigour in future similar research.

The fifth limitation refers to the reliability of the instruments. Scales with low reliability indices, such as "identity superiority", must interpreted with caution, as this could have biased the results.

Beyond these recommendations, this study highlights the urgency of including the most invisible LGBTI populations in research on identity and the factors associated with minority groups that may have an impact on the mental health of these populations. Research associated with non-binary identities and those that fall within the spectrum of asexuality and aromanticism is still scarce, and there are large gaps that urgently need to be filled in order to detect risk and protective factors for the mental health of these groups.

CHAPTER V:

CONCLUSIONS

The main conclusions of this study are presented below. This section aims to summarise the main findings and present them in a coherent and comprehensive light. It will highlight the main contributions of this project and its scientific, social and political implications.

The main objective of this study was to analyse the psychosocial and sexual identity-associated factors that influence the psychosocial adjustment of queer women and non-binary people. This study produced some valuable insights on the various pathways in which gender and sexual identity intersect, and how they could influence psychosocial adjustment through the individual experience of minority stress and self-esteem.

First, there was an **association** between **sexual and romantic orientation**: a concordance was observed between sexual and romantic orientations for lesbian and bisexual participants, as well as for aromantic participants. This concordance was not observed on asexual participants. These results contribute to the literature in highlighting the wide **diversity** within minority identities, especially in the asexual and aromantic spectrums. Sexual and romantic orientation are two different parameters of human sexuality, and although they can be experienced independently from one another, their association can reveal very valuable information about the identity characteristics of sexual minorities. The ever-changing constellations of sexual identities are constantly defying our current notions about sexual and romantic attraction, and showing the existence of numerous identities that until today have remained unnamed. Similarly, these results emphasise the importance of an adequate assessment of sexual identity. Because this diversity exists, it is crucial to develop accurate measures that acknowledge the difference between attraction, identity and behaviour, allowing the representation of most, if not all, of the identities that now exist both inside and outside the allo/heteronorm.

Second, these results show several **gender** and **sexual orientation differences** that reveal important aspects of the experiences of queer women and non-binary people. Gender differences show a pattern of stigmatisation of non-binary identities that is manifested throughout all psychosocial variables. The higher levels of minority stressors and lower levels of social support, self-esteem, emotional competencies, as well as a poorer psychosocial adjustment, are indicators of the vulnerability of identities outside the gender norm. In the absence of data on trans women in this study, their higher levels of emotional symptomatology and low levels of well-being alone serve to highlight the dangers these identities face regarding their mental health. Regarding sexual orientation differences, lesbians

showed better psychosocial adjustment outcomes than bisexual and asexual participants, but also higher levels of distal stressors. Asexual participants showed lower levels of protective factors, higher proximal stressors and poorer psychosocial adjustment than lesbian and bisexual participants. Considering these results, it can be concluded that **all sexual identities** experience **unique stressors** that **impact differently on their adjustment**. While lesbians disclose more protective factors and show a better adjustment, they also seem to experience a more direct violence than bisexual and asexual people, possibly because they are less invisibilised in society and, consequently, more exposed to discrimination. As for bisexual and asexual participants, the monosexism and allosexism documented in literature could explain their situation of vulnerability compared to lesbians.

Furthermore, the main contribution of this study was to analyse the **intersections between gender and sexual orientation** in these identities, showing that there is an overlap in the discriminations experienced by these minority groups. There seemed to be patterns of visibility influencing minority stress: highly visible identities, such as non-binary lesbians, experienced the highest overt discrimination; whereas the most invisibilised identities, such as asexual participants of all genders, suffered most from the internal experience of stigma. It is important to clarify that, even if the data on asexual participants might mask other results, bisexual participants in this sample also disclose stigma and poor psychosocial adjustment that cannot go unaddressed. Bisexuality remains to this day an invisibilised sexual identity that experiences a very specific kind of discrimination, especially when it intersects with a minority gender identity. This study provides evidence on the **singularity** of **each minority group** and the experiences of stigmatisation and mental health outcomes they undergo.

Third, this study observed the **relationship** between these variables. It contributes to the existing literature on the already documented relationship between **minority stress**, **protective factors** and **psychosocial adjustment**, by presenting data on an **understudied population**, but also adding crucial information on the LB identity dimensions that are also associated with these constructs.

Finally, this study provides a **comprehensive model** that analyses the effect of **intersecting identities** on **psychosocial adjustment**, through the **mediating effect**

of **minority stress** and **self**-**esteem**. Distal and proximal stressors draw different pathways depending on the minority group individuals belong to, as does self-esteem. Distal stressors seem to be more sensitive to gender, and proximal stressors and self-esteem, to sexual orientation. These results present a unique contribution to literature, as they display the specific ways in which the intersection of gender and sexual orientation affect psychosocial adjustment in queer women and non-binary people.

The implications of this study reach different areas of research, and could go beyond the realm of science. At a purely **methodological level**, this work could serve as a basis for a better **assessment** of **gender** and **sexual-affective orientation** in psychological research. This wide sample size of over 1300 participants only belonging to minority groups could serve as an example of the vast number of gender and sexual minority individuals that exist in our society. An accurate evaluation of their socio-demographic characteristics alone could have a great impact on how science is made, not only in queer individuals but also in general population. An ill-constructed measure of these variables could miss a wide diversity of identities that would otherwise be included in mainstream studies. Therefore, by constructing **adequate**, **inclusive** and **psychometrically sound instruments**, we do not only guarantee social equality in research, but it also produces better, more rigorous science.

In a **psychological level**, **intervention programmes** designed to train certain psychosocial aspects such as self-esteem could be useful in specific populations. Programmes targeting self-esteem could contribute to mitigate the impact of belonging to a minority group on psychosocial adjustment. However, individual interventions focusing on a single variable could become a short-sighted approach, given the importance of intersecting identities and the multiplicity of variables that play a role in their mental health outcomes. Therefore, it could also be necessary to examine the roots of the mental health problems observed in gender and sexual minorities, so that psychological interventions do not exclusively focus on the symptoms.

There is an overarching theme in this study that remains at the basis of its contribution: the **importance of social and cultural contexts and their impact on entire gender and sexual minority groups**. One of the main implications of this

research is providing evidence of the damaging effect of hate and prejudice on individuals based on their gender and sexual identity, and how these factors **overlap** when **multiple minority identities intersect**. Queer women and non-binary people are currently being harassed, stigmatised, abused and killed on the basis of their gender and sexual identity, and the consequences of this discrimination on their mental health is reflected in most research in the LGBTIAQ+ community. The scientific implications of queer research such as the present study expose social and political gaps: there is an urgent need of direct actions to **stop** and **prevent LGBTIphobia**, both inside and outside academia. Lesbian, bisexual, ace and aro (cis and trans) women and non-binary people, as well as other minority queer identities, are neglected and disregarded in research, and that could only contribute to their invisibilisation and the perpetuation of violence against them. Their **inclusion** in **scientific work** is the first step for a more inclusive, egalitarian society.

While it is important to speak of inequality and violence in queer populations, it is also crucial to extract the **positive aspects** observed in this study. One of the most relevant conclusions we could draw from these results is the importance of the **sense of community** in **marginalised populations**. It is associated with higher social support and outness, which lead to a more authentic and affirmed experience of the own queer identity, and its absence is considered a risk factor characteristic of minority stress. Consequently, one of the main implications of this study is asserting the **importance of community in LGBTIAQ+ individuals**, and the positive impact of forming nurturant bonds with other queer people. Providing the necessary resources to form physical and online associations that serve as a safe space for queer individuals might be indispensable for their well-being, especially those who honour diverse identities and acknowledge the most invisibilised and stigmatised groups. Together, individuals belonging to minority groups can join their efforts into accessing mainstream spaces, and tackling the roots of structural inequalities to transform society as we know it. Meanwhile, it is necessary for groups who remain at the top of these structures to give up their privilege, and listen to these identities who are striving to make their voices heard.

CHAPTER VI:

REFERENCES

All references used in this study are presented below.

Akhtar, M., & Bilour, N. (2020). State of Mental Health Among Transgender Individuals in Pakistan: Psychological Resilience and Self-esteem. *Community Mental Health Journal*, *56*(4), 626–634. https://doi.org/10.1007/S10597-019-00522-5/TABLES/4

Akoglu, H. (2018). User's guide to correlation coefficients. *Turkish Journal of Emergency Medicine*, *18*(3), 91–93. https://doi.org/10.1016/J.TJEM.2018.08.001

Aldrup, K., Carstensen, B., Köller, M. M., & Klusmann, U. (2020). Measuring Teachers' Social-Emotional Competence: Development and Validation of a Situational Judgment Test. *Frontiers in Psychology*, *11*, 892. https://doi.org/10.3389/FPSYG.2020.00892/BIBTEX

Anderson, S. M. (2020). Gender Matters: The Perceived Role of Gender Expression in Discrimination Against Cisgender and Transgender LGBQ Individuals. *Https://Doi.Org/10.1177/0361684320929354*, *44*(3), 323–341. https://doi.org/10.1177/0361684320929354

Andler, M. (2021). The Sexual Orientation/Identity Distinction. *Hypatia*, *36*(2), 259–275. https://doi.org/10.1017/HYP.2021.13

Antonsen, A. N., Zdaniuk, B., Yule, M., & Brotto, L. A. (2020). Ace and Aro: Understanding Differences in Romantic Attractions Among Persons Identifying as Asexual. In *Archives of Sexual Behavior* (Vol. 49, Issue 5, pp. 1615–1630). https://doi.org/10.1007/s10508-019-01600-1

Aparicio-García, M. E., Díaz-Ramiro, E. M., Rubio-Valdehita, S., López-Núñez, M. I., & García-Nieto, I. (2018a). Health and well-being of cisgender, transgender and non-binary young people. *International Journal of Environmental Research and Public Health*, *15*(10), 2133. https://doi.org/10.3390/ijerph15102133

Aparicio-García, M. E., Díaz-Ramiro, E. M., Rubio-Valdehita, S., López-Núñez, M. I., & García-Nieto, I. (2018b). Health and well-being of cisgender, transgender and non-binary young people. *International Journal of Environmental Research and Public Health*, *15*(10). https://doi.org/10.3390/ijerph15102133

Askari, M. S., Mauro, P. M., Kaur, N., & Keyes, K. M. (2022). Age, Period, and Cohort Trends in Perceived Mental Health Treatment Need and Differences by Mental Health Severity in the United States, 2008–2019. *Community Mental Health Journal*. https://doi.org/10.1007/s10597-022-01044-3

Atienza, F. L., Moreno, Y., & Balaguer, I. (2000). Análisis de la dimensionalidad de la escala de autoestima de Rosenberg en una muestra de adolescentes valencianos. *Revista de Psicología Universitas Tarraconensis*, *22*(1), 29–42.

Austin, A., & Goodman, R. (2016). The Impact of Social Connectedness and Internalized Transphobic Stigma on Self-Esteem Among Transgender and Gender Non-Conforming Adults. *Http://Dx.Doi.Org/10.1080/00918369.2016.1236587*, *64*(6), 825–841. https://doi.org/10.1080/00918369.2016.1236587

AVEN. (2023). *AVEN:The Asexual Visibility and Education Network*. https://www.asexuality.org/?q=overview.html

Baboolall, D., Greenberg, S., Obeid, M., & Zucker, J. (2021). *Being transgender at work*. https://www.mckinsey.com/featured-insights/diversity-and-inclusion/being-transgender-at-work

Baltes-Löhr, C. (2018). What Are We Speaking About When We Speak About Gender? Gender as a Continuum. *Cultural and Religious Studies*, *6*(1), 1–32. https://doi.org/10.17265/2328-2177/2018.01.001

Barnett, M., Fotheringham, F., Hutton, V., & O'loughlin, K. (2020). Heterosexism and Cisgenderism. In *Multicultural Responsiveness in Counselling and Psychology* (pp. 153–178). https://doi.org/10.1007/978-3-030-55427-9_6

Barragán-Medero, F., & Pérez-Jorge, D. (2020). Combating homophobia, lesbophobia, biphobia and transphobia: A liberating and subversive educational alternative for desires. *Heliyon*, *6*(10), e05225. https://doi.org/10.1016/J.HELIYON.2020.E05225

Behrens, K. G. (2020). A principled ethical approach to intersex paediatric surgeries. *BMC Medical Ethics*, *21*(1), 1–9. https://doi.org/10.1186/S12910-020-00550-X/PEER-REVIEW

Bender, A. E., McKinney, S. J., Schmidt-Sane, M. M., Cage, J., Holmes, M. R., Berg, K. A., Salley, J., Bodell, M., Miller, E. K., & Voith, L. A. (2022). Childhood Exposure to Intimate Partner Violence and Effects on Social-Emotional Competence: A Systematic Review. *Journal of Family Violence*, *37*(8), 1263–1281. https://doi.org/10.1007/S10896-021-00315-Z/TABLES/1

Berger, M. N., Taba, M., Marino, J. L., Lim, M. S. C., & Skinner, S. R. (2022). Social Media Use and Health and Well-being of Lesbian, Gay, Bisexual, Transgender, and Queer Youth: Systematic Review. *J Med Internet Res 2022;24(9):E38449 Https://Www.Jmir.Org/2022/9/E38449*, *24*(9), e38449. https://doi.org/10.2196/38449

Bettergarcia, J., Matsuno, E., & Conover, K. J. (2021). Training Mental Health Providers in Queer-Affirming Care: A Systematic Review. *Psychology of Sexual Orientation and Gender Diversity*, *8*(3), 365–377. https://doi.org/10.1037/SGD0000514

Bisquerra Alzina, R., & Chao Rebolledo, C. (2021). Social and Emotional Learning and Wellbeing: towards a Scientifically Grounded Educational Practice. *Revista Internacional de Educación Emocional y Bienestar*, 9–29.

Blackless, M., Charuvastra, A., Derryck, A., Fausto-Sterling, A., Lauzanne, K., & Lee, E. (2000). How Sexually Dimorphic Are We? Review and Synthesis. *American Journal of Human Biology*, *12*, 151–166.

Bogaert, A. F. (2015). Asexuality : What It Is and Why It Matters. In *Journal of Sex Research* (Vol. 52, Issue 4, pp. 362–379). http://dx.doi.org/10.1080/00224499.2015.1015713

Bond, B. J., & Miller, B. (n.d.). *YouTube as my space: The relationships between YouTube, social connectedness, and (collective) self-esteem among LGBTQ individuals*. https://doi.org/10.1177/14614448211061830

Borgogna, N. C., Mcdermott, R. C., Aita, S. L., & Kridel, M. M. (2018). *Anxiety and Depression Across Gender and Sexual Minorities: Implications for Transgender, Gender Nonconforming, Pansexual, Demisexual, Asexual, Queer, and Questioning Individuals*. https://doi.org/10.1037/sgd0000306

Bougie, C. (2021). *Composing Aromanticism*.

Bradford, N. J., & Syed, M. (2019). Transnormativity and Transgender Identity Development: A Master Narrative Approach. *Sex Roles*, *81*(5–6), 306–325. https://doi.org/10.1007/S11199-018-0992-7/TABLES/2

Braga, K. D. da S., Ribeiro, A. I. M., & Caetano, M. R. V. (2022). Lesbofobia familiar: técnicas para produzir e regular feminilidades heterocentradas. *Pro-Posições*, *33*. https://doi.org/10.1590/1980-6248-2019-0082

Braun, T. (2020). Dignity in Diversity: Dismantling the Criminalisation of Sexual Orientation and Gender Identity Using the Right to Dignity. *Human Dignity and International Law*, 138–153. https://doi.org/10.1163/9789004435650_014

Bregman, H. R., Malik, N. M., Page, M. J. L., Makynen, E., & Lindahl, K. M. (2013). Identity Profiles in Lesbian, Gay, and Bisexual Youth: The Role of Family Influences. *JOURNAL OF YOUTH AND ADOLESCENCE*, *42*(3), 417–430. https://doi.org/10.1007/s10964-012-9798-z

Brewer, G., & Lyons, M. (2016). Discrimination of sexual orientation: Accuracy and confidence. *PAID*, *90*, 260–264. https://doi.org/10.1016/j.paid.2015.11.019

Brewster, M. E., Velez, B. L., Geiger, E. F., & Sawyer, J. S. (2020). It's like herding cats: Atheist minority stress, group involvement, and psychological outcomes. *Journal of Counseling Psychology*, *67*(1), 1–13. https://doi.org/10.1037/COU0000392

Bridge, L., Smith, P., & Rimes, K. A. (2019). Sexual orientation differences in the self-esteem of men and women: A systematic review and meta-analysis. *Psychology of Sexual Orientation and Gender Diversity*, *6*(4), 433–446. https://doi.org/10.1037/sgd0000342

Brotto, L. A., & Yule, M. (2017). Asexuality: Sexual Orientation, Paraphilia, Sexual Dysfunction, or None of the Above? *Archives of Sexual Behavior*, *46*. https://doi.org/10.1007/s10508-016-0802-7

Brotto, L. A., & Yule, M. A. (2011). Physiological and subjective sexual arousal in self-identified asexual women. *Archives of Sexual Behavior*, *40*(4), 699–712. https://doi.org/10.1007/S10508-010-9671-7/TABLES/2

Brown, C., & Maragos, A. C. (2022). *Internalized heterosexism and psychological distress: A relationship mediated by self-compassion*. https://doi.org/10.1080/10538720.2022.2050454

Brown, T. (2002). A proposed model of bisexual identity development that elaborates on experiential differences of women and men. *Journal of Bisexuality*, *2*(4), 67–91. https://doi.org/10.1300/J159v02n04_05

Brumbaugh-Johnson, S. M., & Hull, K. E. (2019). Coming Out as Transgender: Navigating the Social Implications of a Transgender Identity. *Journal of Homosexuality*, *66*(8), 1148–1177. https://doi.org/10.1080/00918369.2018.1493253

Buckley, T. D. (2022). A Scoping Review of Psychological Sense of Community among Community-Dwelling Older Adults. In *International Journal of Environmental Research and Public Health* (Vol. 19, Issue 14). MDPI. https://doi.org/10.3390/ijerph19148395

Budge, S. L., Katz-Wise, S. L., Tebbe, E. N., Howard, K. A. S., Schneider, C. L., & Rodriguez, A. (2013). Transgender Emotional and Coping Processes: Facilitative and Avoidant Coping Throughout Gender Transitioning. *The Counseling Psychologist*, *41*(4), 601–647. https://doi.org/10.1177/0011000011432753/ASSET/IMAGES/LARGE/10.1177_0011000011432753-FIG1.JPEG

Bulmer, M., & Izuma, K. (2018). Implicit and Explicit Attitudes Toward Sex and Romance in Asexuals. In *Journal of Sex Research* (Vol. 55, Issue 8, pp. 962–974). https://doi.org/10.1080/00224499.2017.1303438

Butler, J. (1999). Feminism and the Subversion of Identity. In *Judith Butler. Gender Trouble*. Routledge Press.

Butler, J. (2004). *Undoing gender*. Routledge. https://www.routledge.com/Undoing-Gender/Butler/p/book/9780415969239

Butler, J. (2020). Critically Queer. *Playing with Fire: Queer Politics, Queer Theories*, 11–29. https://doi.org/10.4324/9780203760505-3

Caba, A. E., Mallory, A. B., Simon, K. A., Rathus, T., & Watson, R. J. (2022). Complex Outness Patterns Among Sexual Minority Youth: A Latent Class Analysis. *Journal of Youth and Adolescence*, *51*(4), 746–765. https://doi.org/10.1007/S10964-022-01580-X/TABLES/4

Calvo, K., & Pichardo, J. I. (2020). Spain's LGBT Movement. *Oxford Research Encyclopedia of Politics*. https://doi.org/10.1093/ACREFORE/9780190228637.013.1284

Carlson, Å. (2016). Sex, Biological Functions and Social Norms: A Simple Constructivist Theory of Sex. *NORA - Nordic Journal of Feminist and Gender Research*, *24*(1), 18–29. https://doi.org/10.1080/08038740.2015.1136681

Carpenter, M. (2018). The "Normalization" of Intersex Bodies and "Othering" of Intersex Identities in Australia. *Journal of Bioethical Inquiry 2018 15:4*, *15*(4), 487–495. https://doi.org/10.1007/S11673-018-9855-8

Carvalho, A. C., & Rodrigues, D. L. (2021). Identifying with Asexuality and Belonging to the Ace Spectrum: More than Lacking Sexual Attraction. *PsyArXiv*.

Carvalho, A. C., & Rodrigues, D. L. (2022). Sexuality, Sexual Behavior, and Relationships of Asexual Individuals: Differences Between Aromantic and Romantic Orientation. *Archives of Sexual Behavior*, *51*(4), 2159–2168. https://doi.org/10.1007/s10508-021-02187-2

Casar, A. (2021). Queer Stance: Metalinguistic attitudes towards slur reclamation among LGBTQ young adults. *Lavender Languages and Linguistics Conference*. https://digitalcommons.ciis.edu/lavlang/2021/friday/31

Ceran Serdar, C., Cihan, M., Yücel, D., & Serdar, M. A. (2021). Sample size, power and effect size revisited: simplified and practical approaches in pre-clinical, clinical and laboratory studies. *Biochemical Medicine*, *31*(1). https://doi.org/10.11613/BM.2021.010502

Cerankowski, K. J., & Milks, M. (2014). *Asexualities: Feminist and Queer perspectives* (Routledge).

Chan, R. C. H., Operario, D., & Mak, W. W. S. (2020). Bisexual individuals are at greater risk of poor mental health than lesbians and gay men: The mediating

role of sexual identity stress at multiple levels. *Journal of Affective Disorders*, *260*, 292–301. https://doi.org/10.1016/J.JAD.2019.09.020

Chang, C. W., Yuan, R., & Chen, J. K. (2018). Social support and depression among Chinese adolescents: The mediating roles of self-esteem and self-efficacy. *Children and Youth Services Review*, *88*, 128–134. https://doi.org/10.1016/J.CHILDYOUTH.2018.03.001

Chávez, K. R. (2010). Border (In)Securities: Normative and Differential Belonging in LGBTQ and Immigrant Rights Discourse. *Http://Dx.Doi.Org/10.1080/14791421003763291*, *7*(2), 136–155. https://doi.org/10.1080/14791421003763291

Chedid, J. (2015). *Bisexuality: An Exploration of Women's Relationships*. University of Roehampton.

Cislaghi, B., & Heise, L. (2020). Gender norms and social norms: differences, similarities and why they matter in prevention science. *Sociology of Health & Illness*, *42*(2), 407–422. https://doi.org/10.1111/1467-9566.13008

Clark, A. N., Lefkowitz, E. S., & Zimmerman, C. (2023). Sexual and Affectionate Behaviors in Asexual and Allosexual Adults. *The Journal of Sex Research*, *60*(2), 242–252. https://doi.org/10.1080/00224499.2022.2051161

Clark, A. N., & Zimmerman, · Corinne. (2022). Concordance Between Romantic Orientations and Sexual Attitudes: Comparing Allosexual and Asexual Adults. *Archives of Sexual Behavior*, *51*, 2147–2157. https://doi.org/10.1007/s10508-021-02194-3

Colledge, L., Hickson, F., Reid, D., & Weatherburn, P. (2015). Poorer mental health in UK bisexual women than lesbians: evidence from the UK 2007 Stonewall Women's Health Survey. *JOURNAL OF PUBLIC HEALTH*, *37*(3), 427–437. https://doi.org/10.1093/pubmed/fdu105

Collier, J. E. (2020). *Applied Structural Equation Modeling Using AMOS: Basic to Advanced Techniques*. Routledge.

Cooke, P. J., & Melchert, T. P. (2019). Bisexual well-being: Assessing a model of predictors of psychosocial well-being for bisexual men. *Psychology of Sexual*

Orientation   and   Gender   Diversity,   *6*(2),   242–255.
https://doi.org/http://dx.doi.org/10.1037/sgd0000324

Coyne, C. A., Poquiz, J. L., Janssen, A., & Chen, D. (2020). Evidence-Based
Psychological Practice for Transgender and Non-Binary Youth: Defining the
Need, Framework for Treatment Adaptation, and Future Directions.
Https://Doi.Org/10.1080/23794925.2020.1765433,   *5*(3),   1–14.
https://doi.org/10.1080/23794925.2020.1765433

Cramer, R. J., Golom, F. D., Gemberling, T. M., Trost, K., Lewis, R., & Wright, S.
(2018). Examining the Lesbian, Gay, and Bisexual Identity Scale Among
Members of an Alternative Sexuality Special Interest Group. *Archives of Sexual
Behavior*, *47*(4), 1251–1264. https://doi.org/10.1007/S10508-017-1120-4

Dahlenburg, S. C., Hutchinson, A. D., & Gleaves, D. H. (2021). How coming out and
community involvement affects body image: An in-depth examination of
lesbian women's personal experiences. *JOURNAL OF LESBIAN STUDIES*, *25*(4),
356–376. https://doi.org/10.1080/10894160.2021.1937844

Darwin, H. (2020). Challenging the Cisgender/ transgender Binary nonbinary People
and the transgender label. *GENDER & SOCIETY*, *34*(3), 357–380.
https://doi.org/10.1177/0891243220912256

de la Torre, M. (2016). *La primavera rosa: identidad cultural y derechos humanos
LGBTI   en   el   mundo*.   Universitat   Oberta   de   Catalunya.
https://dialnet.unirioja.es/servlet/libro?codigo=729045

de Oliveira, L., Carvalho, J., Sarikaya, S., Urkmez, A., Salonia, A., & Russo, G. I. (2020).
Patterns of sexual behavior and psychological processes in asexual persons: a
systematic review. *International Journal of Impotence Research 2020 33:6*,
33(6), 641–651. https://doi.org/10.1038/s41443-020-0336-3

de Vries, J. M. A., Downes, C., Sharek, D., Doyle, L., Murphy, R., Begley, T., McCann,
E., Sheerin, F., Smyth, S., & Higgins, A. (2020). An exploration of happiness
within the Irish LGBTI community. *Journal of Gay and Lesbian Mental Health*,
24(1), 40–76. https://doi.org/10.1080/19359705.2019.1646689

Delgado, O. M., Torras, D. M., Aina, F., & Fontdevilla, P. (2013). *Plumofobia in the air: El estereotipo de la lesbiana ultrafemme*. http://diposit.ub.edu/dspace/handle/2445/55163

Demirtas, A. S., Yildiz, M. A., & Baytemir, K. (2017). General belongingness and basic psychological needs as predictors of self-esteem in adolescents. *Journal of Educational Sciences & Psychology*, *7*(2), 48–58.

Dennis, J. (2020). Demi-Romantic Non-Binary Pansexual: Learning from Micro-Identities in the Classroom. *Scholars at Work Conference*. https://cornerstone.lib.mnsu.edu/scholarsatwork-conference/2020/track02/1

Dewaele, A., Mieke, •, Houtte, V., & Vincke, J. (2014). Visibility and Coping with Minority Stress: A Gender-Specific Analysis Among Lesbians, Gay Men, and Bisexuals in Flanders. *Archives of Sexual Behavior*, *43*, 1601–1614. https://doi.org/10.1007/s10508-014-0380-5

Dewaele, A., van Houtte, M., Buysse, A., Lyubayeva, A., Trippas, M., & Baeken, A. S. (2019). What Predicts Visibility Management at Work? A Study of Gay, Lesbian, and Bisexual Flemish Government Employees. *Psychologica Belgica*, *59*(1), 78. https://doi.org/10.5334/PB.443

di Fabio, A., & Kenny, M. E. (2016). Promoting well-being: The contribution of emotional intelligence. *Frontiers in Psychology*, *7*(AUG), 1–13. https://doi.org/10.3389/fpsyg.2016.01182

Diamond, L. M. (2000). Sexual identity, attractions, and behavior among young sexual-minority women over a 2-year period. *Developmental Psychology*, *36*(2), 241–250. https://doi.org/10.1037/0012-1649.36.2.241

Diamond, L. M. (2020). Gender Fluidity and Nonbinary Gender Identities Among Children and Adolescents. *Child Development Perspectives*, *14*(2), 110–115. https://doi.org/10.1111/CDEP.12366

Diener, E. (2009). *Subjective Well-Being*. 11–58. https://doi.org/10.1007/978-90-481-2350-6_2

Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The Satisfaction With Life Scale. *Journal of Personality Assessment*, *49*(1), 71–75. https://doi.org/10.1207/s15327752jpa4901_13

Diener, E., Oishi, S., & Tay, L. (2018). Advances in subjective well-being research. *Nature Human Behaviour*, *2*(4), 253–260. https://doi.org/10.1038/s41562-018-0307-6

Diener, E., Wirtz, D., Tov, W., Kim-Prieto, C., Choi, D. won, Oishi, S., & Biswas-Diener, R. (2010). New well-being measures: Short scales to assess flourishing and positive and negative feelings. *Social Indicators Research*, *97*(2), 143–156. https://doi.org/10.1007/S11205-009-9493-Y/TABLES/8

Doan Van, E. E., Mereish, E. H., Woulfe, J. M., & Katz-Wise, S. L. (2019). Perceived Discrimination, Coping Mechanisms, and Effects on Health in Bisexual and Other Non-Monosexual Adults. *Archives of Sexual Behavior*, *48*(1), 159–174. https://doi.org/10.1007/S10508-018-1254-Z/TABLES/3

Donahue, J. J., Goranson, A. C., McClure, K. S., & van Male, L. M. (2014). Emotion dysregulation, negative affect, and aggression: A moderated, multiple mediator analysis. *Personality and Individual Differences*, *70*, 23–28. https://doi.org/10.1016/j.paid.2014.06.009

Döring, N., Bhana, D., & Albury, K. (2022). Digital sexual identities: Between empowerment and disempowerment. *Current Opinion in Psychology*, *48*, 101466. https://doi.org/10.1016/J.COPSYC.2022.101466

Dowers, E., White, C., Cook, K., & Kingsley, J. (2020). Trans, gender diverse and non-binary adult experiences of social support: A systematic quantitative literature review. *Https://Doi.Org/10.1080/26895269.2020.1771805*, *21*(3), 242–257. https://doi.org/10.1080/26895269.2020.1771805

Dunn, T. L., & Szymanski, D. M. (2018). Heterosexist discrimination and LGBQ activism: Examining a moderated mediation model. *Psychology of Sexual Orientation and Gender Diversity*, *5*(1), 13–24. https://doi.org/10.1037/SGD0000250

Dyar, C., Feinstein, B. A., & Anderson, R. A. E. (2021). An Experimental Investigation of Victim Blaming in Sexual Assault: The Roles of Victim Sexual Orientation,

Coercion Type, and Stereotypes About Bisexual Women. *Journal of Interpersonal Violence*, *36*(21–22), 10793–10816. https://doi.org/10.1177/0886260519888209

Dyar, C., Feinstein, B. A., Eaton, N. R., & London, B. (n.d.). The Mediating Roles of Rejection Sensitivity and Proximal Stress in the Association Between Discrimination and Internalizing Symptoms Among Sexual Minority Women. *Archives of Sexual Behavior*, *47*. https://doi.org/10.1007/s10508-016-0869-1

Dyar, C., Feinstein, B. A., Eaton, N. R., & London, B. (2018). The Mediating Roles of Rejection Sensitivity and Proximal Stress in the Association Between Discrimination and Internalizing Symptoms Among Sexual Minority Women. *ARCHIVES OF SEXUAL BEHAVIOR*, *47*(1), 205–218. https://doi.org/10.1007/s10508-016-0869-1

Dyar, C., Feinstein, B. A., Schick, V., & Davila, J. (2017). Minority Stress, Sexual Identity Uncertainty, and Partner Gender Decision Making Among Nonmonosexual Individuals. *Psychology of Sexual Orientation and Gender Diversity*, *4*(1), 87–104. https://doi.org/10.1037/sgd0000213

Edge, J. M., Vonk, J., & Welling, L. L. M. (2021). *Asexuality and relationship investment: visible differences in relationship investment for an invisible minority*. https://doi.org/10.1080/19419899.2021.2013303

Ellemers, N. (2017). *Gender Stereotypes*. https://doi.org/10.1146/annurev-psych-122216

Espejo, B., Checa, I., Perales-Puchalt, J., & Lisón, J. F. (2020). Validation and Measurement Invariance of the Scale of Positive and Negative Experience (SPANE) in a Spanish General Sample. *International Journal of Environmental Research and Public Health*, *17*(22), 1–15. https://doi.org/10.3390/IJERPH17228359

European Union Agency for Fundamental Rights (FRA). (2020). *A long way to go for LGBTI equality*. https://doi.org/10.2811/582502

Evans, E., & Lépinard, E. (2020). *Intersectionality in feminist and queer movements : confronting privileges*. Routledge.

https://www.routledge.com/Intersectionality-in-Feminist-and-Queer-Movements-Confronting-Privileges/Evans-Lepinard/p/book/9781032084404

Eves, A. (2004). Queer Theory, Butch/Femme Identities and Lesbian Space. *Sexualities*, *7*(4), 480–496. https://doi.org/10.1177/1363460704047064

Fader, R. (2018). *THE SPACE BETWEEN: EXPERIENCES OF BISEXUAL ADULTS WITH A MONOSEXUAL PARTNER*.

Faria, L., Lima-santos, N., & Pessoa, F. (2012). *Emotional intelligence in the portuguese academic context : validation studies of " The Emotional Skills And Competence Questionnaire " (ESCQ) Introduction Emotional intelligence as one of the most novel , popular , and innovative concepts in psychology*. *20*, 91–102.

Fausto-Sterling, A. (2012). *Sex/gender : biology in a social world*. 142.

Fausto-Sterling, A. (2021). A Dynamic Systems Framework for Gender/Sex Development: From Sensory Input in Infancy to Subjective Certainty in Toddlerhood. *Frontiers in Human Neuroscience*, *15*. https://doi.org/10.3389/fnhum.2021.613789

Feinstein, B. A., Dyar, C., Milstone, J. S., Jabbour, J., & Davila, J. (2021). Use of different strategies to make one's bisexual+ identity visible: Associations with dimensions of identity, minority stress, and health. *Stigma and Health*, *6*(2), 184–191. https://doi.org/10.1037/SAH0000225

Feinstein, B. A., Xavier Hall, C. D., Dyar, C., & Davila, J. (2020). Motivations for Sexual Identity Concealment and Their Associations with Mental Health among Bisexual, Pansexual, Queer, and Fluid (Bi+) Individuals. *Https://Doi.Org/10.1080/15299716.2020.1743402*, *20*(3), 324–341. https://doi.org/10.1080/15299716.2020.1743402

Feldman, S. E., & Wright, A. J. (2013). Dual Impact: Outness and LGB Identity Formation on Mental Health. *Journal of Gay and Lesbian Social Services*, *25*(4), 443–464. https://doi.org/10.1080/10538720.2013.833066

Fernández-Berrocal, P., & Extremera, N. (2016). Ability Emotional Intelligence, Depression, and Well-Being. *Emotion Review*, *8*(4), 311–315. https://doi.org/10.1177/1754073916650494

Fernandez-Perez, V., & Martin-Rojas, R. (2022). Emotional competencies as drivers of management students' academic performance: The moderating effects of cooperative learning. *The International Journal of Management Education*, *20*(1), 100600. https://doi.org/10.1016/J.IJME.2022.100600

Fiani, C. N., & Han, H. J. (2019). Navigating identity: Experiences of binary and non-binary transgender and gender non-conforming (TGNC) adults. *International Journal of Transgenderism*, *20*(2–3), 181–194. https://doi.org/10.1080/15532739.2018.1426074

Fine, C. (2010). *Delusions of Gender: How Our Minds, Society, and Neurosexism Create Difference*. W. W. Norton & Company. https://books.google.es/books?hl=es&lr=&id=s2ZtdAx83yMC&oi=fnd&pg=PR15&dq=delusions+of+gender&ots=GXcDLICJUW&sig=rt5s2CkXDuRz6Kf1Fj934FhhI7s#v=onepage&q=delusions of gender&f=false

Fine, C. (2018). *Testosterone Rex: Unmaking the myths of our gendered minds* (Icon Books). Paidós. https://www.casadellibro.com/libro-testosterona-rex/9788449334993/7081782

Fish, J. N., & Russell, S. T. (2018). Queering Methodologies to Understand Queer Families. *Family Relations*, *67*(1), 12–25. https://doi.org/http://dx.doi.org/10.1111/fare.12297

Fitzpatrick, S., Dworkin, E. R., Zimmerman, L., Javorka, M., & Kaysen, D. (2020). Stressors and drinking in sexual minority women: The mediating role of emotion dysregulation. *Psychology of Sexual Orientation and Gender Diversity*, *7*(1), 46–54. https://doi.org/10.1037/SGD0000351

Flanders, C. E., Robinson, M., Legge, M. M., & Tarasoff, L. A. (2016). Negative identity experiences of bisexual and other non-monosexual people: A qualitative report. *JOURNAL OF GAY & LESBIAN MENTAL HEALTH*, *20*(2), 152–172. https://doi.org/10.1080/19359705.2015.1108257

Flanders, C. E., Tarasoff, L. A., & VanKim, N. (2022). Sexual violence and mental health among young bi+ and lesbian women and gender minoritized people. *Journal of Gay & Lesbian Mental Health*, 1–20. https://doi.org/10.1080/19359705.2022.2072036

Fonseca de Freitas, D., Silva, C., & Coimbra, S. (2021). Discrimination and Mental Health: Mediation Effects of Coping Strategies in LGB and Heterosexual Youth. *Psykhe (Santiago)*, *30*(1), 1–18. https://doi.org/10.7764/psykhe.2018.22185

Fonseca-Pedrero, E., Paino, M., Lemos-Giráldez, S., & Muñiz, J. (2010). Propiedades psicométricas de la depression anxiety and stress scales-21 (dass-21) en universitarios españoles. *Ansiedad y Estres*, *16*(2–3), 215–226.

Fonseca-Pedrero, E., Paíno-Piñeiro, M., Lemos-Giráldez, S., Villazón-García, Ú., & Muñiz, J. (2009). Validation of the Schizotypal Personality Questionnaire—Brief Form in adolescents. *Schizophrenia Research*, 53–60.

Funder, D. C., & Ozer, D. J. (2019). Evaluating Effect Size in Psychological Research: Sense and Nonsense. *Advances in Methods and Practices in Psychological Science*, *2*(2), 156–168. https://doi.org/10.1177/2515245919847202

Gardner, A. A., & Lambert, C. A. (2019). Examining the interplay of self-esteem, trait-emotional intelligence, and age with depression across adolescence. *Journal of Adolescence*, *71*(February), 162–166. https://doi.org/10.1016/j.adolescence.2019.01.008

Garvey, J. C., Matsumura, J. L., Silvis, J. A., Kiemele, R., Eagan, H., & Chowdhury, P. (2018). Sexual Borderlands: Exploring Outness Among Bisexual, Pansexual, and Sexually Fluid Undergraduate Students. *Journal of College Student Development*, *59*(6), 666–680. https://doi.org/http://dx.doi.org/10.1353/csd.2018.0064

Gattamorta, K. A., Salerno, J. P., & Castro, A. J. (2019). Intersectionality and Health Behaviors Among US High School Students: Examining Race/Ethnicity, Sexual Identity, and Sex. *JOURNAL OF SCHOOL HEALTH*, *89*(10), 800–808. https://doi.org/10.1111/josh.12817

Glass, V. Q. (2022). Queering Relationships: Exploring Phenomena of Asexual Identified Persons in Relationships. *Contemporary Family Therapy*, *44*(4), 344–359. https://doi.org/10.1007/S10591-022-09650-9/METRICS

Goldberg, A. E., & Kuvalanka, K. A. (2018). Navigating identity development and community belonging when "there are only two boxes to check": An

exploratory study of nonbinary trans college students. *Journal of LGBT Youth*, *15*(2), 106–131. https://doi.org/10.1080/19361653.2018.1429979

González-Yubero, S., Palomera Martín, R., & Lázaro-Visa, S. (2019). Trait and ability emotional intelligence as predictors of alcohol consumption in adolescents. *Psicothema*, *31*(3), 292–297. https://doi.org/10.7334/psicothema2018.315

Goodrich, K. M., & Brammer, M. K. (2021). Cass's Homosexual Identity Formation: A Critical Analysis. *JOURNAL OF MULTICULTURAL COUNSELING AND DEVELOPMENT*, *49*(4), 239–253. https://doi.org/10.1002/jmcd.12228

Gordon, L. E., & Silva, T. J. (2015). Inhabiting the Sexual Landscape: Toward an Interpretive Theory of the Development of Sexual Orientation and Identity. *Journal of Homosexuality*, *62*(4), 495–530. https://doi.org/10.1080/00918369.2014.986417

Gottlieb, I. (2019). *Seeing Gender: an illustrated guide to identity and expression*. Chronicle Books LLC. https://ereader.perlego.com/1/book/1093652/10?element_originalid=page _18

Gougis, D. D. (2013). The Effect of Internal and External Discrimation on the Psychological Well-Being and Self-Esteem of Lesbian, Gay, Bisexual, and Queer Black Women. *ProQuest Dissertations and Theses*, 156. https://libproxy.wlu.ca/login?url=https://www.proquest.com/dissertations-theses/effect-internal-external-discrimination-on/docview/1538065226/se-2?accountid=15090

Grau, B. E. (2016). Activismo y Prácticas Digitales en la Construcción de una Esfera LGTB en España. *Dados*, *59*(3), 755–787. https://doi.org/10.1590/00115258201691

Gray, A., & Desmarais, S. (2014). Not all one and the same: Sexual identity, activism, and collective self-esteem. *Canadian Journal of Human Sexuality*, *23*(2), 116–122. https://doi.org/10.3138/CJHS.2400

Gunn, A., Hoskin, R., & Blair, K. L. (2021). The new lesbian aesthetic? Exploring gender style among femme, butch and androgynous sexual minority women.

Women's Studies International Forum, *88*, 102504. https://doi.org/10.1016/J.WSIF.2021.102504

Gupta, K. (2019). Gendering asexuality and asexualizing gender: A qualitative study exploring the intersections between gender and asexuality. In *Sexualities* (Vol. 22, Issues 7–8, pp. 1197–1216). https://doi.org/10.1177/1363460718790890

Guyan, K. (2022). Queer Data. *Queer Data*. https://doi.org/10.5040/9781350230767

Hakeem, A. (2018). *Trans: Exploring Gender Identity and Gender Dysphoria* (A. Hakeem, Ed.). Trigger Press. https://ereader.perlego.com/1/book/3515888/10

Hall, S. E., Wrench, J. M., Health, A., & Sarah Wilson, A. J. (2017). Assessment of Emotion Processing Skills in Acquired Brain Injury Using an Ability-Based Test of Emotional Intelligence. *Psychological Asessment*, *30*(4), 524–538. https://doi.org/10.1037/pas0000501

Hall, W. J. (2018). Psychosocial Risk and Protective Factors for Depression Among Lesbian, Gay, Bisexual, and Queer Youth: A Systematic Review. *Journal of Homosexuality*, *65*(3), 263–316. https://doi.org/10.1080/00918369.2017.1317467

Hamilton-Page, M. (2022). *Unbound leadership: How gender non-conforming, or non-binary lesbians navigate the workplace from a place of visibility*. Royal Roads University.

Hammack, P. L., Hughes, S. D., Atwood, J. M., Cohen, E. M., & Clark, R. C. (2022). Gender and Sexual Identity in Adolescence: A Mixed-Methods Study of Labeling in Diverse Community Settings. *Journal of Adolescent Research*, *37*(2), 167–220. https://doi.org/10.1177/07435584211000315/FORMAT/EPUB

Harvey, R., Murphy, M. J., Bigner, J. J., & Wetchler, J. L. (2021). *Handbook of LGBT-Affirmative Couple and Family Therapy* (2nd Edition). Routledge.

Hatchel, T., Valido, A., de Pedro, K. T., Huang, Y., & Espelage, D. L. (2019). Minority Stress Among Transgender Adolescents: The Role of Peer Victimization,

School Belonging, and Ethnicity. *Journal of Child and Family Studies*, *28*(9), 2467–2476. https://doi.org/10.1007/S10826-018-1168-3/FIGURES/1

Hatzenbuehler, M. L., & Pachankis, J. E. (2016). Stigma and minority stress as social determinants of health among lesbian,gay, bisexual, and transgender youth: research evidence and clinical implications. *Pediatric Clinics*, 985–997.

Hayes, A. F., & Preacher, K. J. (2014). Expert Tutorial Statistical mediation analysis with a multicategorical independent variable. *British Journal of Mathematical and Statistical Psychology*, *67*, 451–470. https://doi.org/10.1111/bmsp.12028

Hayfield, N. (2020). *Bisexual and pansexual identities : exploring and challenging invisibility and invalidation*. Routledge. https://www.routledge.com/Bisexual-and-Pansexual-Identities-Exploring-and-Challenging-Invisibility/Hayfield/p/book/9781138613775

Hayfield, N., Clarke, V., Halliwell, E., & Malson, H. (2013). Visible lesbians and invisible bisexuals: Appearance and visual identities among bisexual women. *Women's Studies International Forum*, *40*, 172–182. https://doi.org/10.1016/J.WSIF.2013.07.015

Haynes, A., Schweppe, J., & Garland, J. (2023). The production of hate crime victim status: Discourses of normalisation and the experiences of LGBT community members. *Https://Doi.Org/10.1177/17488958231160252*. https://doi.org/10.1177/17488958231160252

Hazzard, V. M., Schaefer, L. M., Schaumberg, K., Bardone-Cone, A. M., Frederick, D. A., Klump, K. L., Anderson, D. A., & Thompson, J. K. (2019). Testing the Tripartite Influence Model among heterosexual, bisexual, and lesbian women. *BODY IMAGE*, *30*, 145–149. https://doi.org/10.1016/j.bodyim.2019.07.001

Heck, N. C., Flentje, A., & Cochran, B. N. (2013). Intake Interviewing with Lesbian, Gay, Bisexual, and Transgender Clients: Starting from a Place of Affirmation. *Journal of Contemporary Psychotherapy*, *43*, 23–32. https://doi.org/10.1007/s10879-012-9220-x

Heise, L., Greene, M. E., Opper, N., Stavropoulou, M., Harper, C., Nascimento, M., Zewdie, D., Darmstadt, G. L., Greene, M. E., Hawkes, S., Henry, S., Heymann, J., Klugman, J., Levine, R., Raj, A., & Rao Gupta, G. (2019). Gender inequality

and restrictive gender norms: framing the challenges to health. *The Lancet*, *393*(10189), 2440–2454. https://doi.org/10.1016/S0140-6736(19)30652-X

Henseler, J., & Roldán, J. L. (2021). Review of Composite-based Structural Equation Modeling: Analyzing Latent and Emergent Variables. *Structural Equation Modeling: A Multidisciplinary Journal*, *28*(5), 823–825. https://doi.org/10.1080/10705511.2021.1910038

Herrmann, J., Koeppen, K., & Kessels, U. (2019). Do girls take school too seriously? Investigating gender differences in school burnout from a self-worth perspective. *Learning and Individual Differences*, *69*, 150–161. https://doi.org/10.1016/J.LINDIF.2018.11.011

Hildebrandt, T., & Chua, L. J. (2017). Negotiating In/visibility: The Political Economy of Lesbian Activism and Rights Advocacy. *Development and Change*, *48*(4), 639–662. https://doi.org/10.1111/dech.12314

Hinton, J. D. X., de la Piedad Garcia, X., Kaufmann, L. M., Koc, Y., & Anderson, J. R. (2021). A Systematic and Meta-Analytic Review of Identity Centrality among LGBTQ Groups: An Assessment of Psychosocial Correlates. *Https://Doi.Org/10.1080/00224499.2021.1967849*, *59*(5), 568–586. https://doi.org/10.1080/00224499.2021.1967849

Hopwood, M., Cama, E., de Wit, J., & Treloar, C. (2020). Stigma, Anxiety, and Depression Among Gay and Bisexual Men in Mixed-Orientation Marriages. *Qualitative Health Research*, *30*(4), 622–633. https://doi.org/10.1177/1049732319862536

Hord, L. C. R. (2020). Specificity without identity: Articulating post-gender sexuality through the "non-binary lesbian." *Https://Doi.Org/10.1177/1363460720981564*, *25*(5–6), 615–637. https://doi.org/10.1177/1363460720981564

Horley, J., & Clarke, J. (2016). Experience, Meaning and Identity in Sexuality: A psychosocial theory of sexual stability and change. In *Experience, Meaning, and Identity in Sexuality*. Palgrave Macmillan UK. https://doi.org/10.1057/978-1-137-40096-3_1

Houdenhove, E. van, Gijs, L., T'Sjoen, G., & Enzlin, P. (2014). Asexuality: A Multidimensional Approach. *Http://Dx.Doi.Org/10.1080/00224499.2014.898015*, *52*(6), 669–678. https://doi.org/10.1080/00224499.2014.898015

Houdenhove, E. Van, Gijs, L., T'sjoen, G., & Enzlin, P. (2014). *Stories About Asexuality: A Qualitative Study on Asexual Women*. https://doi.org/10.1080/0092623X.2014.889053

Houdeshell, A. (2019). Putting lesbians in the spotlight with Lesbian Visibility Day. *UWIRE Text*, 1–1. https://go.gale.com/ps/i.do?p=AONE&sw=w&issn=&v=2.1&it=r&id=GALE%7CA583517734&sid=googleScholar&linkaccess=fulltext

Hoyle, R. (2022). *Handbook of Structural Equation Modeling*. Guilford Publications.

Hsieh, N., & Ruther, M. (2016). Sexual Minority Health and Health Risk Factors: Intersection Effects of Gender, Race, and Sexual Identity. *American Journal of Preventive Medicine*, *50*(6), 746–755. https://doi.org/10.1016/j.amepre.2015.11.016

Human Dignity Trust. (2023). *Map of Countries that Criminalise LGBT People*. https://www.humandignitytrust.org/lgbt-the-law/map-of-criminalisation/

Huxley, C., Clarke, V., & Halliwell, E. (2014). Resisting and conforming to the "Lesbian Look": The importance of appearance norms for lesbian and bisexual women. *Journal of Community and Applied Social Psychology*, *24*(3), 205–219. https://doi.org/10.1002/CASP.2161

Hyde, J. S. (2005). The Genetics of Sexual Orientation. In *Biological substrates of human sexuality* (pp. 9–20). American Psychological Association. https://doi.org/10.1037/11196-002

Hyde, J. S., Bigler, R. S., Joel, D., Tate, C. C., & van Anders, S. M. (2019). The future of sex and gender in psychology: Five challenges to the gender binary. *American Psychologist*, *74*(2), 171–193. https://doi.org/10.1037/amp0000307

Johnson, A. H. (2016). Transnormativity: A New Concept and Its Validation through Documentary Film About Transgender Men. *Sociological Inquiry*, *86*(4), 465–491. https://doi.org/10.1111/SOIN.12127

Johnson, D., Dupuis, G., Piche, J., Clayborne, Z., & Colman, I. (2018). Adult mental health outcomes of adolescent depression: A systematic review. *Depression and Anxiety*, *35*(8), 700–716. https://doi.org/10.1002/da.22777

Joshanloo, M., Jovanović, V., & Park, J. (2021). Differential Relationships of Hedonic and Eudaimonic Well-Being with Self-Control and Long-Term Orientation. *Japanese Psychological Research*, *63*(1), 47–57. https://doi.org/10.1111/JPR.12276

Kamenov, Z., Huic, A., & Jelic, M. (2016). Minority stress and mental health of homosexual and bisexual men and women: A review of research on the minority stress model from a Croatian perspective. *Kriminologija & Socijalna Integracija*, *23*(2), 40–78. https://www.proquest.com/scholarly-journals/minority-stress-mental-health-homosexual-bisexual/docview/1821426461/se-2?accountid=14777

Kamenov, Ž., Huić, A., & Jelić, M. (2016). Minority stress and mental health of homosexual and bisexual men and women: A review of research on the minority stress model from a Croatian perspective. *Kriminologija & Socijalna Integracija*, *23*(2), 40–78. https://www.proquest.com/scholarly-journals/minority-stress-mental-health-homosexual-bisexual/docview/1909167709/se-2?accountid=14777

Karkazis, K. (2019). The misuses of "biological sex." *The Lancet*, *394*(10212), 1898–1899. https://doi.org/10.1016/S0140-6736(19)32764-3

Katz-Wise, S. L., Mereish, E. H., & Woulfe, J. (2017). Associations of Bisexual-Specific Minority Stress and Health Among Cisgender and Transgender Adults with Bisexual Orientation. *Journal of Sex Research*, *54*(7), 899–910. https://doi.org/10.1080/00224499.2016.1236181

Katz-Wise, S. L., Rosario, MP. , Calzo, J. PA. , Scherer, E. A., Sarda, V., & Austin S., B. (2017). Associations of timing of sexual orientation developmental milestones and other sexual minority stressors with internalizing mental health

symptoms among sexual minority young adults. *Archives of Sexual Behavior*, *46*(5), 1441–1452.

Kay, C. M. (2022). *Challenges of Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual (LGBTQIA) Students in Higher Education*.

Keats, T. (2016). Lesbophobia as a Barrier to Women in Coaching. *Taboo: The Journal of Culture and Education*, *15*. https://doi.org/10.31390/taboo.15.1.08

Kelleher, S., & Murphy, M. (2022). Asexual identity development and internalisation: a thematic analysis. *Https://Doi.Org/10.1080/14681994.2022.2091127*, 1–29. https://doi.org/10.1080/14681994.2022.2091127

Kennon, P. (2021). Asexuality and the Potential of Young Adult Literature for Disrupting Allonormativity. *The International Journal of Young Adult Literature*, *2*(1), 1. https://doi.org/10.24877/IJYAL.41

Kichler, R. (2022). "What Has Kept Me Alive": Transgender Communities and Support. *Journal of Homosexuality*, *69*(14), 2463–2482. https://doi.org/10.1080/00918369.2021.1943277

Kinsey, A. C., Pomery, W. B., & Martin, C. E. (1948). Kinsey Scale. In *Sexual Behavior in the Human Male*. American Psychological Association (APA). https://doi.org/10.1037/t17515-000

Klesse, C. (2011). Shady Characters, Untrustworthy Partners, and Promiscuous Sluts: Creating Bisexual Intimacies in the Face of Heteronormativity and Biphobia. *Https://Doi.Org/10.1080/15299716.2011.571987*, *11*(2–3), 227–244. https://doi.org/10.1080/15299716.2011.571987

Kong, F., Gong, X., Sajjad, S., Yang, K., & Zhao, J. (2019). How Is Emotional Intelligence Linked to Life Satisfaction? The Mediating Role of Social Support, Positive Affect and Negative Affect. *Journal of Happiness Studies*. https://doi.org/10.1007/s10902-018-00069-4

Kranz, D., & Pierrard, M. (2018). Beyond coming out: Relations between lesbian and gay identity formation and psychosocial well-being in young and middle adulthood. *Psychology of Sexual Orientation and Gender Diversity*, *5*(3), 283–293. https://doi.org/http://dx.doi.org/10.1037/sgd0000270

Krell, E. C. (2017). Is Transmisogyny Killing Trans Women of Color?Black Trans Feminisms and the Exigencies of White Femininity. *TSQ: Transgender Studies Quarterly*, *4*(2), 226–242. https://doi.org/10.1215/23289252-3815033

Landeta, Ó., & Calvete Zumalde, E. (2002). Adaptación y validación de la Escala Multidimensional de Apoyo Social Percibido. *Ansiedad y Estrés, ISSN 1134-7937, Vol. 8, Nº 2-3, 2002, Págs. 173-182*, *8*(2), 173–182. https://dialnet.unirioja.es/servlet/articulo?codigo=306806

Lane-Steele, L. (2011). Studs and Protest-Hypermasculinity: The Tomboyism within Black Lesbian Female Masculinity. *Https://Doi.Org/10.1080/10894160.2011.532033*, *15*(4), 480–492. https://doi.org/10.1080/10894160.2011.532033

Lara, R., Vázquez, M. L., Ogallar, A., & Godoy-Izquierdo, D. (2020). Psychosocial Resources for Hedonic Balance, Life Satisfaction and Happiness in the Elderly: A Path Analysis. *International Journal of Environmental Research and Public Health*, *17*(16), 5684. https://doi.org/10.3390/ijerph17165684

Lee, M. T., Kubzansky, L. D., & VanderWeele, T. J. (2021). Measuring Well-Being: Interdisciplinary Perspectives from the Social Sciences and the Humanities. In *Measuring Well-Being: Interdisciplinary Perspectives from the Social Sciences and the Humanities*. Oxford University Press. https://doi.org/10.1093/OSO/9780197512531.001.0001

Legate, N., Ryan, R. M., & Weinstein, N. (2012). Is Coming Out Always a "Good Thing"? Exploring the Relations of Autonomy Support, Outness, and Wellness for Lesbian, Gay, and Bisexual Individuals. *SOCIAL PSYCHOLOGICAL AND PERSONALITY SCIENCE*, *3*(2), 145–152. https://doi.org/10.1177/1948550611411929

Levitt, H. M. (2019). A Psychosocial Genealogy of LGBTQ+ Gender: An Empirically Based Theory of Gender and Gender Identity Cultures. *Https://Doi.Org/10.1177/0361684319834641*, *43*(3), 275–297. https://doi.org/10.1177/0361684319834641

Levitt, H. M., & Horne, S. G. (2002). Explorations of lesbian-queer genders: Butch, femme, androgynous or "other." *Journal of Lesbian Studies*, *6*(2), 25–39. https://doi.org/10.1300/J155V06N02_05

Li, C., Zhu, N., Zhang, L., Li, W., & Kong, F. (2023). The relation between childhood maltreatment and hedonic and eudaimonic well-being in emerging adults: A daily diary study. *Child Abuse & Neglect*, *138*, 106057. https://doi.org/10.1016/J.CHIABU.2023.106057

Lin, Y. J., & Israel, T. (2012). Development and validation of a psychological sense of lgbt community scale. *Journal of Community Psychology*, *40*(5), 573–587. https://doi.org/10.1002/jcop.21483

Liss, M., & Wilson, L. C. (2021). Mental health and general psychological processes among asexual, bisexual, and gay/lesbian college students in the United States. *Psychology and Sexuality*. https://doi.org/10.1080/19419899.2021.1979634

Logie, C. H., Lacombe-Duncan, A., Poteat, T., & Wagner, A. C. (2017). Syndemic Factors Mediate the Relationship between Sexual Stigma and Depression among Sexual Minority Women and Gender Minorities. *Women's Health Issues*, *27*(5), 592–599. https://doi.org/10.1016/J.WHI.2017.05.003

López, G., Yeater, E. A., Veldhuis, C. B., Venner, K. L., Verney, S. P., & Hughes, T. L. (2022). Sexual Assault, Psychological Distress, and Protective Factors in a Community Sample of Black, Latinx, and White Lesbian and Bisexual Women. *Journal of Interpersonal Violence*. https://doi.org/10.1177/08862605221090570

Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy*, *33*(3), 335–343. https://doi.org/10.1016/0005-7967(94)00075-U

Lovibond, S. H., & Lovibond, P. F. (1995a). *Manual for the Depression Anxiety & Stress Scales* (2nd ed.). Psychology Foundation.

Lovibond, S. H., & Lovibond, P. F. (1995b). *Manual for the Depression Anxiety Stress Scales*. Psychology Foundation.

Luyt, R. (2013). Beyond traditional understanding of gender measurement: the gender (re)presentation approach. *Http://Dx.Doi.Org/10.1080/09589236.2013.824378*, *24*(2), 207–226. https://doi.org/10.1080/09589236.2013.824378

Mackay, F. (2019). Always endangered, never extinct: Exploring contemporary butch lesbian identity in the UK. *Women's Studies International Forum*, *75*, 102241. https://doi.org/10.1016/J.WSIF.2019.102241

Marikutty, P. J., & Joseph, M. I. (2016). Effects of emotional intelligence on stress, psychological well-being, and academic achievement of adolescents. *Indian Journal of Health and Wellbeing*, *7*(7), 699–702.

Martinez, L. R., & Smith, N. A. (2019). Development of a scale to measure heterosexual identity. *Psychology of Sexual Orientation and Gender Diversity*, *6*(2), 138–148. https://doi.org/http://dx.doi.org/10.1037/sgd0000313

Martxueta-Pérez, A., & Etxeberria-Murgiondo, J. (2014). *Análisis de la salud mental y psicosocial en Lesbianas, Gais y Bisexuales, que fueron objeto de bullying homofóbico en la escuela*. https://www.infocop.es/view_article.asp?id=5262

Matsuno, E., & Budge, S. L. (2017). Non-binary/Genderqueer Identities: a Critical Review of the Literature. *Current Sexual Health Reports*, *9*(3), 116–120. https://doi.org/10.1007/s11930-017-0111-8

Mayer, J. D., & Salovey, P. (1997). What is emotional intelligence? In P. Salovey & D. Sluyter (Eds.), *Emotional development and emotional intelligence: implications for educators* (pp. 3–31). Basic Books.

Mayer, J., Salovey, P., & Caruso, D. (2004). Emotional Intelligence:Theory,Findings, and Implications. In *Psychological Inquiry* (Vol. 15, Issue 3, pp. 197–215).

McCann, C. R., Kim, S.-K., & Ergun, E. (Professor). (2020). *Feminist theory reader : local and global perspectives*. https://www.routledge.com/Feminist-Theory-Reader-Local-and-Global-Perspectives/McCann-Kim-Ergun/p/book/9780367430801

McCann, H. (2022). The Refusal to Refuse: Bisexuality Trouble and the Hegemony of Monosexuality. *Journal of Bisexuality*, *22*(1), 71–89. https://doi.org/10.1080/15299716.2022.2045243

McCarn, S., & Fassinger, R. (1996). Revisioning Sexual Minority Identity Formation: A New Model of Lesbian Identity and Its Implications for Counseling and Research. *The Counseling Psychologist*, *24*(3), 508–534.

McConnell, E. A., Birkett, M. A., & Mustanski, B. (2015). Typologies of Social Support and Associations with Mental Health Outcomes Among LGBT Youth. *Https://Home.Liebertpub.Com/Lgbt*, *2*(1), 55–61. https://doi.org/10.1089/LGBT.2014.0051

McConnell, E. A., Janulis, P., Phillips, G., Truong, R., & Birkett, M. (2018). Multiple minority stress and LGBT community resilience among sexual minority men. *Psychology of Sexual Orientation and Gender Diversity*, *5*(1), 1–12. https://doi.org/10.1037/SGD0000265

McDermott, E., Gabb, J., Eastham, R., & Hanbury, A. (2019). Family trouble: Heteronormativity, emotion work and queer youth mental health. *Https://Doi.Org/10.1177/1363459319860572*, *25*(2), 177–195. https://doi.org/10.1177/1363459319860572

Mcdonald, K. (2018). Social Support and Mental Health in LGBTQ Adolescents: A review of the literature. *Issues in Mental Health Nursing*, *39*(1), 16–29. https://doi.org/10.1080/01612840.2017.1398283

McInroy, L. B., Beaujolais, B., Leung, V. W. Y., Craig, S. L., Eaton, A. D., & Austin, A. (2020). Comparing asexual and non-asexual sexual minority adolescents and young adults: stressors, suicidality and mental and behavioural health risk outcomes. *Https://Doi.Org/10.1080/19419899.2020.1806103*, *13*(2), 387–403. https://doi.org/10.1080/19419899.2020.1806103

McInroy, L. B., & Craig, S. L. (2018). Online fandom, identity milestones, and self-identification of sexual/gender minority youth. *Journal of LGBT Youth*, *15*(3), 179–196. https://doi.org/10.1080/19361653.2018.1459220

McKinney, R., Desposito, M., & Yoon, E. (2020). Promoting Identity Wellness in LGBTGEQIAP+ Adolescents Through Affirmative Therapy. *Journal of LGBT Issues in Counseling*, *14*(3), 176–190. https://doi.org/10.1080/15538605.2020.1790464

McLaren, S., & Castillo, P. (2020a). The Relationship between a Sense of Belonging to the LGBTIQ + Community, Internalized Heterosexism, and Depressive Symptoms among Bisexual and Lesbian Women. *Journal of Bisexuality*, *21*(1), 1–23. https://doi.org/10.1080/15299716.2020.1862726

McLaren, S., & Castillo, P. (2020b). What About Me? Sense of Belonging and Depressive Symptoms among Bisexual Women. *Https://Doi.Org/10.1080/15299716.2020.1759174*, *20*(2), 166–182. https://doi.org/10.1080/15299716.2020.1759174

Memon, M. A., Cheah, J. H., Ramayah, T., Ting, H., & Chuah, F. (2018). Mediation analysis issues and recommendations. In *Journal of Applied Structural Equation Modeling* (Vol. 2, Issue 1, pp. I–IX). Sarawak Research Society. https://doi.org/10.47263/JASEM.2(1)01

Mereish, E. H., Luis, ·, Parra, A., Watson, R. J., & Fish, J. N. (2021). Subtle and Intersectional Minority Stress and Depressive Symptoms Among Sexual and Gender Minority Adolescents of Color: Mediating Role of Self-Esteem and Sense of Mastery. *Prevention Science*. https://doi.org/10.1007/s11121-021-01294-9

Metsämuuronen, J. (2023). Artificial systematic attenuation in eta squared and some related consequences: attenuation-corrected eta and eta squared, negative values of eta, and their relation to Pearson correlation. *Behaviormetrika*, *50*(1), 27–61. https://doi.org/10.1007/S41237-022-00162-2/FIGURES/4

Meyer, I. H. (2003). Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence. *Psychological Bulletin*, *129*(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

Miller, M. (2021). The Impact of Patriarchy on Stud Lesbians. *Undergraduate Research Awards*. https://digitalcommons.hollins.edu/researchawards/61

Mîndru, M. A., & Năstasă, L. E. (2017). The relation between emotional intelligence, sexual identity and sexual orientation. *Bulletin of the Transilvania University of Braşov-Special Issue Series VII: Social Sciences • Law •*, *10*(59).

Mishra, P., Pandey, C. M., Singh, U., Gupta, A., Sahu, C., & Keshri, A. (2019). Descriptive Statistics and Normality Tests for Statistical Data. *Annals of Cardiac Anaesthesia*, *22*(1), 67. https://doi.org/10.4103/ACA.ACA_157_18

Moagi, M. M., van der Wath, A. E., Jiyane, P. M., & Rikhotso, R. S. (2021). Mental health challenges of Lesbian, gay, bisexual and transgender people: An integrated literature review. *Health SA Gesondheid*, *26*, 1–12. https://doi.org/10.4102/HSAG.V26I0.1487

Mohr, J. J., & Kendra, M. S. (2011). Revision and extension of a multidimensional measure of sexual minority identity: The lesbian, gay, and bisexual identity scale. *Journal of Counseling Psychology*, *58*(2), 234–245. https://doi.org/10.1037/A0022858

Molina, F. E. R. M., & Díaz, O. H. (2020). Affirmative Action as a Means to Preserve the Tradition of the Third Gender (muxe') in the Isthmus of Tehuantepec (Mexico). *Via Inveniendi et Iudicandi*, *15*(2), 13–36. https://doi.org/10.15332/19090528/6241

Mollet, A. L., & Lackman, B. (2021). Allonormativity and Compulsory Sexuality. In *Encyclopedia of Queer Studies in Education*. Brill. https://brill.com/display/book/9789004506725/BP000013.xml

Mollet, A., & Lackman, B. (2019). Asexual student invisibility and erasure in higher education. In *Rethinking LGBTQIA Students and Collegiate Contexts*. https://books.google.es/books?hl=es&lr=&id=L9CwDwAAQBAJ&oi=fnd&pg=PT123&dq=invisibility+asexual&ots=I3tVm8LT5l&sig=Jp4dTrPnQHgb-QjgPE6I-wfUmVc#v=onepage&q=invisibility%20asexual&f=false

Mónaco, E., Schoeps, K., & Montoya-Castilla, M. (2019). Attachment Styles and Well-Being in Adolescents : How Does Emotional Development Affect This Relationship? *International Journal of Environmental Research and Public Health Article*, *16*, 2554. https://doi.org/10.3390/ijerph16142554

Mondschein, E. R., Adolph, K. E., & Tamis-LeMonda, C. S. (2000). Gender Bias in Mothers' Expectations about Infant Crawling. *Journal of Experimental Child Psychology*, *77*(4), 304–316. https://doi.org/10.1006/JECP.2000.2597

Money, J., & Ehrhardt, A. (1972). *Desarrollo de la sexualidad humana: diferenciación y dimorfismo de la identidad de género*. The Johns Hopkins University Press. https://books.google.es/books?hl=es&lr=&id=-RTurjggjQcC&oi=fnd&pg=PA1&dq=john+money+gender+1950&ots=QjSYxLat0J&sig=1btwuB0nls48wbfr_RhJ5DHwUhE#v=onepage&q=john%20money%20gender%201950&f=false

Monro, S. (2005). Beyond Male and Female: Poststructuralism and the Spectrum of Gender. *International Journal of Transgenderism*, *8*(1), 3–22. https://doi.org/10.1300/J485v08n01_02

Monro, S. (2019). Non-binary and genderqueer: An overview of the field. *Https://Doi.Org/10.1080/15532739.2018.1538841*, *20*(2–3), 126–131. https://doi.org/10.1080/15532739.2018.1538841

Monro, S., Carpenter, M., Crocetti, D., Davis, G., Garland, F., Griffiths, D., Hegarty, P., Travis, M., Cabral Grinspan, M., & Aggleton, P. (2021). Intersex: cultural and social perspectives. *Https://Doi.Org/10.1080/13691058.2021.1899529*, *23*(4), 431–440. https://doi.org/10.1080/13691058.2021.1899529

Moran, P. (2022). *Do We Belong? Promoting a Sense of Belonging in LGBTQ Youth Through Artistic Community Engagement: A Literature Review* [Lesley University]. https://digitalcommons.lesley.edu/expressive_theses/619

Morandini, J. S., Blaszczynski, A., Ross, M. W., Costa, D. S. J., & Dar-Nimrod, I. (2015). Essentialist Beliefs, Sexual Identity Uncertainty, Internalized Homonegativity and Psychological Wellbeing in Gay Men. *JOURNAL OF COUNSELING PSYCHOLOGY*, *62*(3), 413–424. https://doi.org/10.1037/cou0000072

Morgenroth, T., Kirby, T. A., Cuthbert, M. J., Evje, J., & Anderson, A. E. (2022). Bisexual erasure: Perceived attraction patterns of bisexual women and men. *European Journal of Social Psychology*, *52*(2), 249–259. https://doi.org/10.1002/EJSP.2773

Morrison, T., Dinno, A., & Salmon, T. (2021). The Erasure of Intersex, Transgender, Nonbinary, and Agender Experiences Through Misuse of Sex and Gender in Health Research. *American Journal of Epidemiology*, *190*(12), 2712–2717. https://doi.org/10.1093/AJE/KWAB221

Nebot-Garcia, J. E., Elipe-Miravet M., Martínez-Gómez, N., & Ballester-Arnal, R. (2021). Adaptación de la Escala de Estrés de las Minorías LGTBI en población española: datos preliminares. *IV Jornadas de Investigación Para El Alumnado de La Facultad de Ciencias de La Salud de La Universidad Jaume I*.

Nicholas, L. (2018). Queer ethics and fostering positive mindsets toward non-binary gender, genderqueer, and gender ambiguity. *Https://Doi.Org/10.1080/15532739.2018.1505576*, *20*(2–3), 169–180. https://doi.org/10.1080/15532739.2018.1505576

Obradors-Campos, M. (2011). Deconstructing Biphobia. *Https://Doi.Org/10.1080/15299716.2011.571986*, *11*(2–3), 207–226. https://doi.org/10.1080/15299716.2011.571986

Oswald, F., & Matsick, J. L. (2021). Understanding body size and bisexuality via femme theory: An investigation of self- and meta-perceptions of gender expression. *Https://Doi.Org/10.1080/21604851.2021.1970899*, *12*(1), 100–119. https://doi.org/10.1080/21604851.2021.1970899

Outland, P. L. (2016). *Developing the LGBT Minority Stress Measure*.

Pachankis, J. E., Mahon, C. P., Jackson, S. D., Fetzner, B. K., & Bränström, R. (2020). Sexual orientation concealment and mental health: A conceptual and meta-analytic review. *Psychological Bulletin*, *146*(10), 831–871. https://doi.org/10.1037/BUL0000271

Pakula, B., Carpiano, R. M., Ratner, P. A., & Shoveller, J. A. (2016). Life stress as a mediator and community belonging as a moderator of mood and anxiety disorders and co-occurring disorders with heavy drinking of gay, lesbian, bisexual, and heterosexual Canadians. *Social Psychiatry and Psychiatric Epidemiology*, *51*. https://doi.org/10.1007/s00127-016-1236-1

Parmenter, J. G., Galliher, R. v., & Maughan, A. D. A. (2020). LGBTQ+ emerging adults perceptions of discrimination and exclusion within the LGBTQ+ community. *Https://Doi.Org/10.1080/19419899.2020.1716056*, *12*(4), 289–304. https://doi.org/10.1080/19419899.2020.1716056

Paveltchuk, F. de O., Damásio, B. F., & Borsa, J. C. (2019). Impact of sexual orientation, social support and family support on minority stress in lgb people. *Trends in Psychology*, *27*(3), 735–748. https://doi.org/10.9788/TP2019.3-10

Pease, M., Le, T. P., & Iwamoto, D. K. (2022). Minority Stress, Pandemic Stress, and Mental Health Among Gender Diverse Young Adults: Gender Dysphoria and Emotion Dysregulation as Mediators. *Psychology of Sexual Orientation and Gender Diversity*. https://doi.org/10.1037/SGD0000574

Pecora, L. A., Hancock I, G., Hooley, M., Demmer, D. H., Attwood, T., Mesibov, G. B., & Stokes, M. A. (2020). Gender identity, sexual orientation and adverse sexual experiences in autistic females. *MOLECULAR AUTISM*, *11*(1). https://doi.org/10.1186/s13229-020-00363-0

Pérez Díaz, Roselina., Romera Hiniesta, F., & Peña Calzado, Elena. (2021). *Estudios de Diversidad Sexual y Género Desde la Perspectiva de Los Derechos Humanos*. http://www.dykinson.com/libros/estudios-de-diversidad-sexual-y-genero-desde-la-perspectiva-de-los-derechos-humanos/9788413778136/

Petrides, K. V. (2011). Ability and Trait Emotional Intelligence. In *The Wiley-Blackwell handbooks of personality and individual differences. The Wiley-Blackwell handbook of individual differences* (pp. 656–678). Wiley-Blackwell. http://www.psychometriclab.com/adminsdata/files/Trait%20EI%20-%20HID.pdf

Piqueras, J. A., Mateu-Martínez, O., Cejudo, J., & Pérez-González, J. C. (2019). Pathways into psychosocial adjustment in children: Modeling the effects of trait emotional intelligence, social-emotional problems, and gender. *Frontiers in Psychology*, *10*(MAR), 1–11. https://doi.org/10.3389/fpsyg.2019.00507

Pollitt, A. M., Muraco, J. A., Grossman, A. H., & Russell, S. T. (2017). Disclosure Stress, Social Support, and Depressive Symptoms Among Cisgender Bisexual Youth. *JOURNAL OF MARRIAGE AND FAMILY*, *79*(5), 1278–1294. https://doi.org/10.1111/jomf.12418

Preciado, M. A., & Johnson, K. L. (2014). Perceived Consequences of Hypothetical Identity-Inconsistent Sexual Experiences: Effects of Perceiver's Sex and Sexual

Identity. *ARCHIVES OF SEXUAL BEHAVIOR*, *43*(3), 505–518. https://doi.org/http://dx.doi.org/10.1007/s10508-013-0113-1

Pritchard, A., Richardson, M., Sheffield, D., & McEwan, K. (2020). The Relationship Between Nature Connectedness and Eudaimonic Well-Being: A Meta-analysis. *Journal of Happiness Studies*, *21*(3), 1145–1167. https://doi.org/10.1007/S10902-019-00118-6/TABLES/4

Puckett, J. A., Maroney, M. R., Wadsworth, L. P., Mustanski, B., & Newcomb, M. E. (2020). Coping with discrimination: The insidious effects of gender minority stigma on depression and anxiety in transgender individuals. *Journal of Clinical Psychology*, *76*(1), 176–194. https://doi.org/10.1002/JCLP.22865

Purdie-Greenaway, V., Eibach, R., & Camp, N. (2022). Intersectional Invisibility and the Experience of Ontological Exclusion: The Case of Black Gay Christians. *The Sexual Politics of Black Churches*, 128–144. https://doi.org/10.7312/SORE18832-010/HTML

Qeadan, F., Barbeau, W. A., Shan, L., & Azagba, S. (2021). Associations between sexual identity-attraction discordance, and prescription opioid misuse among adults. *PREVENTIVE MEDICINE*, *145*. https://doi.org/10.1016/j.ypmed.2020.106401

Rahilly, E. (2020). Trans-Affirmative Parenting: Raising kids across the gender spectrum. *Trans-Affirmative Parenting*. https://doi.org/10.18574/NYU/9781479820559.001.0001

Ramirez, J., & Munar, A. M. (2022). Hybrid gender colonization: The case of muxes. *Gender, Work & Organization*, *29*(6), 1868–1889. https://doi.org/10.1111/GWAO.12884

Ramos, R., & Mowlabocus, S. (2020). Queer Sites in Global Contexts. In *Queer Sites in Global Contexts*. Routledge. https://doi.org/10.4324/9781003002338/QUEER-SITES-GLOBAL-CONTEXTS-REGNER-RAMOS-SHARIF-MOWLABOCUS

Redd, C., & Russell, E. K. (n.d.). "It all started here, and it all ends here too": Homosexual criminalisation and the queer politics of apology. *Criminology &*

Criminal Justice, *2020*(5), 590–603. https://doi.org/10.1177/1748895820939244

Reed, K. (2023). Erasing Invisibility: Asexuality in the Media. In *Global LGBTQ+ Concerns in a Contemporary World: Politics, Prejudice, and Community* (pp. 30–57). IGI Global. https://doi.org/10.4018/978-1-6684-5568-5.CH002

Rentzsch, K., Erz, E., & Schütz, A. (2021). Development of Short and Ultra-Short Forms of the Multidimensional Self-Esteem Scale. *Https://Doi.Org/10.1027/1015-5759/A000660*, *38*(4), 270–281. https://doi.org/10.1027/1015-5759/A000660

Rentzsch, K., Wenzler, M. P., & Schütz, A. (2016). The structure of multidimensional self-esteem across age and gender. *Personality and Individual Differences*, *88*, 139–147. https://doi.org/10.1016/J.PAID.2015.09.012

Richards, C., & Barker, M. (2014). *Sexuality & gender for mental health professionals*. Sage Publications.

Richards, C., & Barker, M. (2016). Sexuality & Gender for Mental Health Professionals: A Practical Guide. *Sexuality & Gender for Mental Health Professionals: A Practical Guide*. https://doi.org/10.4135/9781473957817

Riggle, E. D. B., Rostosky, S. S., Black, W. W., & Rosenkrantz, D. E. (2017). Outness, concealment, and authenticity: Associations with LGB individuals' psychological distress and well-being. *Psychology of Sexual Orientation and Gender Diversity*, *4*(1), 54–62. https://doi.org/http://dx.doi.org/10.1037/sgd0000202

Ritholtz, S. (2022). Is queer-and-trans youth homelessness a form of displacement? A queer epistemological review of refugee studies' theoretical borders. *Https://Doi.Org/10.1080/01419870.2022.2099747*. https://doi.org/10.1080/01419870.2022.2099747

Rivera, A., & Scholar, J. (2020). Traditional Masculinity: A Review of Toxicity Rooted in Social Norms and Gender Socialization. *Advances in Nursing Science*, *43*(1), E1–E10. https://doi.org/10.1097/ANS.0000000000000284

Robertson, M. (2019). *Growing Up Queer: Kids and the Remaking of LGBTQ Identity*. NYU Press. https://nyupress.org/9781479876945/growing-up-queer/

Robinson, M. (2019). Two-Spirit Identity in a Time of Gender Fluidity. *Https://Doi.Org/10.1080/00918369.2019.1613853*, *67*(12), 1675–1690. https://doi.org/10.1080/00918369.2019.1613853

Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton University Pess.

Rosenkrantz, D. E., & Mark, K. P. (2018). The Sociocultural Context of Sexually Diverse Women's Sexual Desire. *Sexuality and Culture*, *22*(1), 220–242. https://doi.org/10.1007/s12119-017-9462-6

Rosner, C. M., Armstrong, T. W., Walsh, M. V, Castillo, L. G., & Sahu, A. (2013). Identity Centrality and Well-being in Lesbian and Bisexual Women College Students. *International Journal of Psychology and Educational Studies*, *2020*(3), 70–80. https://doi.org/10.17220/ijpes.2020.03.007

Rothblum, E. D. (2020). The Oxford Handbook of Sexual and Gender Minority Mental Health. *The Oxford Handbook of Sexual and Gender Minority Mental Health*, 1–466. https://doi.org/10.1093/OXFORDHB/9780190067991.001.0001

Rothblum, E. D., Krueger, E. A., Kittle, K. R., & Meyer, I. H. (2019). Asexual and Non-Asexual Respondents from a U.S. Population-Based Study of Sexual Minorities. *Archives of Sexual Behavior*, *49*(2), 757–767. https://doi.org/10.1007/S10508-019-01485-0/TABLES/1

Rupp, L. J. (2009). *Sapphistries : a global history of love between women*. 303.

Russell, J. (2023). The sex lives of asexuals. *Erotically Queer*, 59–74. https://doi.org/10.4324/9781003260608-5

Ryan, W. S., Legate, N., & Weinstein, N. (2015). Coming Out as Lesbian, Gay, or Bisexual: The Lasting Impact of Initial Disclosure Experiences. *SELF AND IDENTITY*, *14*(5), 549–569. https://doi.org/10.1080/15298868.2015.1029516

Saksvik-Lehouillier, I., Langvik, E., Saksvik, S. B., Kallestad, H., Follesø, H. S., Austad, S. B., Dahlberg, J., Ringen, H., Tanum, T., Sørengaard, T. A., Karlsen, H. R., Smedbøl, T., & Olsen, A. (2022). High neuroticism is associated with reduced negative affect following sleep deprivation. *Personality and Individual Differences*, *185*. https://doi.org/10.1016/J.PAID.2021.111291

Salvati, M., Piumatti, G., Giacomantonio, M., & Baiocco, R. (2019). Gender stereotypes and contact with gay men and lesbians: The mediational role of sexism and homonegativity. *Journal of Community & Applied Social Psychology*, *29*(6), 461–473. https://doi.org/10.1002/CASP.2412

Sanscartier, S., & MacDonald, G. (2019). Healing Through Community Connection? Modeling Links Between Attachment Avoidance, Connectedness to the LGBTQ plus Community, and Internalized Heterosexism. *JOURNAL OF COUNSELING PSYCHOLOGY*, *66*(5), 564–576. https://doi.org/10.1037/cou0000381

Sariyannis, P. (2016). Sexual Orientation Microaggressions on Campus: Prevalence and Outcomes among Lesbian/Gay and Bisexual Students. *Theses and Dissertations (Comprehensive)*. https://scholars.wlu.ca/etd/1846

Satrianegara, M. F., Juhannis, H., Lagu, A. M. H. R., Habibi, Sukfitrianty, & Alam, S. (2021). Cultural traditional and special rituals related to the health in Bugis Ethnics Indonesia. *Gaceta Sanitaria*, *35*, S56–S58. https://doi.org/10.1016/J.GACETA.2020.12.016

Savin-Williams, R. C. (2022). Sexual and romantic spectrums: Mostly straights and mostly gays/lesbians. *Current Opinion in Psychology*, *48*, 101503. https://doi.org/10.1016/J.COPSYC.2022.101503

Scandurra, C., Mezza, F., Maldonato, N. M., Bottone, M., Bochicchio, V., Valerio, P., & Vitelli, R. (2019). Health of non-binary and genderqueer people: A systematic review. In *Frontiers in Psychology* (Vol. 10). Frontiers Media S.A. https://doi.org/10.3389/fpsyg.2019.01453

Scherrer, K. S. (2008). Coming to an Asexual Identity: Negotiating Identity, Negotiating Desire. *Sexualities*, *11*(5). https://doi.org/10.1177/1363460708094269

Schoeps, K., Tamarit, A., González, R., & Montoya-Castilla, I. (2019). Emotional competence and self-esteem in adolescence: Impact on psychological adjustment. *Revista de Psicologia Clinica Con Ninos y Adolescentes*, *6*(1). https://doi.org/10.21134/rpcna.2019.06.1.7

Schoeps, K., Tamarit, A., Montoya-Castilla, I., & Takšić, V. (2019). Factorial structure and validity of the emotional skills and competences questionnaire (Escq) in Spanish adolescents. *Behavioral Psychology/ Psicologia Conductual*, *27*(2).

Schor, N., & Weed, E. (1997). *Feminism Meets Queer Theory*. Indiana University Press. https://bookshop.org/p/books/feminism-meets-queer-theory-naomi-schor/19052274?ean=9780253211187

Schudson, Z. C., & Morgenroth, T. (2022). Non-binary gender/sex identities. In *Current Opinion in Psychology* (Vol. 48). Elsevier B.V. https://doi.org/10.1016/j.copsyc.2022.101499

Schweizer, K., & Brunner, F. (2013). Sexual orientations | Sexuelle Orientierungen. *Bundesgesundheitsblatt - Gesundheitsforschung - Gesundheitsschutz*, *56*(2), 231–239. https://doi.org/10.1007/s00103-012-1608-y

Sedney, M. A. (2020). Conceptual and Methodological Sources of Controversies about Androgyny. *Representations: Social Constructions of Gender*, 126–144. https://doi.org/10.4324/9781315223810-12

Serrano, C., & Andreu, Y. (2016). Perceived Emotional Intelligence, Subjective Well-Being, Perceived Stress, Engagement and Academic Achievement of Adolescents. *Revista de Psicodidáctica*, *21*(2). http://www.ehu.eus/ojs/index.php/psicodidactica/article/view/14887/14484

Shakespeare-Finch, J., & Obst, P. L. (2011). The Development of the 2-Way Social Support Scale: A Measure of Giving and Receiving Emotional and Instrumental Support. *Journal of Personality Assessment*, *93*(5), 483–490. https://doi.org/10.1080/00223891.2011.594124

Shaw, J. (2022). *BI : the science of the sexually in-between.* Canongate Books.

Shen, S., Chen, Z., Qin, X., Zhang, M., & Dai, Q. (2021). Remote and adjacent psychological predictors of early-adulthood resilience: Role of early-life trauma, extraversion, life-events, depression, and social-support. *PLoS ONE*, *16*(6 June). https://doi.org/10.1371/JOURNAL.PONE.0251859

Sheppard, M., & Mayo, J. B. (2013). The Social Construction of Gender and Sexuality: Learning from Two Spirit Traditions.

Https://Doi.Org/10.1080/00377996.2013.788472, *104*(6), 259–270. https://doi.org/10.1080/00377996.2013.788472

Shramko, M., Toomey, R. B., & Anhalt, K. (2018). *Profiles of Minority Stressors and Identity Centrality Among Sexual Minority Latinx Youth*. https://doi.org/10.1037/ort0000298

Shurts, W. M., Kooyman, L., Rogers, R. C., & Burlew, L. (2020). Assessing the Intersectionality of Religious and Sexual Identities During the Coming-Out Process. *COUNSELING AND VALUES*, *65*(1), 15–37. https://doi.org/10.1002/cvj.12120

Simon, K. A., Hawthorne, H. M., Clark, A. N., Renley, B. M., Farr, R. H., Eaton, L. A., & Watson, R. J. (2022). Contextualizing the Well-being of Asexual Youth: Evidence of Differences in Family, Health, and School Outcomes. *Journal of Youth and Adolescence*, *51*(1), 128–140. https://doi.org/10.1007/S10964-021-01500-5/TABLES/4

Slater, J., & Liddiard, K. (2018). Why Disability Studies Scholars Must Challenge Transmisogyny and Transphobia. *Canadian Journal of Disability Studies*, *7*(2), 83–93. https://doi.org/10.15353/CJDS.V7I2.424

Slater, M. E., Godette, D., Huang, B., Ruan, W. J., & Kerridge, B. T. (2017). Sexual Orientation-Based Discrimination, Excessive Alcohol Use, and Substance Use Disorders Among Sexual Minority Adults. *LGBT HEALTH*, *4*(5), 337–344. https://doi.org/10.1089/lgbt.2016.0117

Sommantico, M., & Parrello, S. (2022). Internalized stigma, adult attachment, relationship satisfaction, and depression in Italian gay and bisexual men: The mediating role of emotion regulation. *Journal of Gay and Lesbian Mental Health*, *26*(2), 158–175. https://doi.org/10.1080/19359705.2021.1913463

Steele, L. S., Daley, A., Curling, D., Gibson, M. F., Green, D. C., Williams, C. C., & Ross, L. E. (2017). LGBT Identity, Untreated Depression, and Unmet Need for Mental Health Services by Sexual Minority Women and Trans-Identified People. *Https://Home.Liebertpub.Com/Jwh*, *26*(2), 116–127. https://doi.org/10.1089/JWH.2015.5677

Storms, M. D. (1980). Theories of Sexual Orientation. In *Journal of Personality and Social Psychology* (Vol. 38, Issue 5).

Su, Y., & Zheng, L. (2023). Stability and Change in Asexuality: Relationship Between Sexual/Romantic Attraction and Sexual Desire. *Journal of Sex Research*, *60*(2), 231–241. https://doi.org/10.1080/00224499.2022.2045889/SUPPL_FILE/HJSR_A_2045889_SM9269.DOCX

Sundrud, J. (2011). *Performing Asexuality through Narratives of Sexual Identity*. https://doi.org/10.31979/etd.4bkg-gysx

Swan, J. D. (2018). Models and measures of sexual orientation. In *Bisexuality: Theories, Research, and Recommendations for the Invisible Sexuality* (pp. 19–36). Springer International Publishing. https://doi.org/10.1007/978-3-319-71535-3_2

Szoko, N., Sequeira, G. M., Coulter, R. W. S., Kobey, J., Ridenour, E., Burnett, O., & Kidd, K. M. (2023). Sexual Orientation Among Gender Diverse Youth. *Journal of Adolescent Health*, *72*(1), 153–155. https://doi.org/10.1016/J.JADOHEALTH.2022.08.016

Takšić, V., Mohorić, T., & Duran, M. (2009). Emotional skills and competence questionnaire (ESCQ) as a self-report measure of emotional intelligence. *Horizons of Psychology*, *18*(3), 7–21.

Tan, K., Treharne, G. J., Ellis, S. J., Schmidt, J. M., & Veale, J. F. (2019). Gender Minority Stress: A Critical Review. *Https://Doi.Org/10.1080/00918369.2019.1591789*, *67*(10), 1471–1489. https://doi.org/10.1080/00918369.2019.1591789

Tan, R. K. J., Low, T. Q. Y., Le, D., Tan, A., Tyler, A., Tan, C., Kwok, C., Banerjee, S., Cook, A. R., & Wong, M. L. (2021). Experienced Homophobia and Suicide among Young Gay, Bisexual, Transgender, and Queer Men in Singapore: Exploring the Mediating Role of Depression Severity, Self-Esteem, and Outness in the Pink Carpet y Cohort Study. *LGBT Health*, *8*(5), 349–358. https://doi.org/10.1089/LGBT.2020.0323/ASSET/IMAGES/LARGE/LGBT.2020.0323_FIGURE2.JPEG

The World Health Organization. (2020). *WHO Guidelines on Translation Process of translation and adaptation of instruments*. https://www.who.int/tools/whoqol/whoqol-bref/docs/default-source/publishing-policies/whoqol-100-guidelines/translation-methodology

Thelwall, M., Abdullah, A., & Fairclough, R. (2022). Researching women and men 1996–2020: Is androcentrism still dominant? *Quantitative Science Studies*, *3*(1), 244–264. https://doi.org/10.1162/QSS_A_00173

Thomeer, M. B., & Reczek, C. (2016). Happiness and Sexual Minority Status. *ARCHIVES OF SEXUAL BEHAVIOR*, *45*(7), 1745–1758. https://doi.org/10.1007/s10508-016-0737-z

Thompson, H. M., Wojciak, A. S., & Cooley, M. E. (2016). Self-esteem: A mediator between peer relationships and behaviors of adolescents in foster care. *Children and Youth Services Review*, *66*, 109–116. https://doi.org/10.1016/j.childyouth.2016.05.003

Thomsen, C. (2021). *Visibility Interrupted: Rural Queer Life and the Politics of Unbecoming*. The University of Minnessota Press. https://books.google.es/books?hl=es&lr=&id=MVQ5EAAAQBAJ&oi=fnd&pg=PT4&dq=rural+queer+women&ots=80Szqb16Bw&sig=tQe0tpcEzjh1KqzLsqPu6hLTs7o#v=onepage&q=rural%20queer%20women&f=false

Tomar, A., Spadine, M. N., Graves-Boswell, T., & Wigfall, L. T. (2021). *COVID-19 among LGBTQ+ individuals living with HIV/AIDS: psycho-social challenges and care options*. *8*(2), 303–308. https://doi.org/10.3934/publichealth.2021023

Toomey, R. B., Ryan, C., Diaz, R. M., & Russell, S. T. (2017). Coping With Sexual Orientation–Related Minority Stress. *Journal of Homosexuality*, *8369*(April), 1–17. https://doi.org/10.1080/00918369.2017.1321888

Travis, M. (2019). The Vulnerability of Heterosexuality: Consent, Gender Deception and Embodiment. *Social and Legal Studies*, *28*(3), 303–326. https://doi.org/10.1177/0964663918773151

van Anders, S. M. (2015). Beyond Sexual Orientation: Integrating Gender/Sex and Diverse Sexualities via Sexual Configurations Theory. *ARCHIVES OF SEXUAL BEHAVIOR*, *44*(5), 1177–1213. https://doi.org/10.1007/s10508-015-0490-8

van den Brink, F., Vollmann, M., & van Weelie, S. (2019). Relationships Between Transgender Congruence, Gender Identity Rumination, and Self-Esteem in Transgender and Gender-Nonconforming Individuals. *Psychology of Sexual Orientation and Gender Diversity*. https://doi.org/10.1037/SGD0000357

Vázquez, C., Duque, A., & Hervás, G. (2013). Satisfaction with life scale in a representative sample of Spanish adults: Validation and normative data. *Spanish Journal of Psychology*, *16*(e82), 1–15. https://doi.org/10.1017/sjp.2013.82

Villarreal, L., Charak, R., Schmitz, R. M., Hsieh, C., & Ford, J. D. (2021). The relationship between sexual orientation outness, heterosexism, emotion dysregulation, and alcohol use among lesbian, gay, and bisexual emerging adults. *Journal of Gay and Lesbian Mental Health*, *25*(1), 94–115. https://doi.org/10.1080/19359705.2020.1809588

Vinces, J. M. (2016). *Adaptación de la escala de identidad para lesbianas, gays y bisexuales (LGBIS) en un grupo de lesbianas, gays y bisexuales del Perú*. Universidad de Lima.

Wahab Kassir, A. al, Willem, C., & Tortajada, I. (2022). Mi pluma es política: apropiaciones no occidentales del drag. In *Feminismos, violencias y redes sociales*. Peter Lang. https://doi.org/10.3726/b18689

Walls, N. E. (2008). Modern Heterosexism and Social Dominance Orientation: Do Subdomains of Heterosexism Function as Hierarchy-enhancing Legitimizing Myths? In T. G. Morrison & M. A. Morrison (Eds.), *The psychology of modern prejudice*. Nova Science Publishers.

Walton, M. T., Lykins, A. D., & Navjot Bhullar, •. (2016). Beyond Heterosexual, Bisexual, and Homosexual: A Diversity in Sexual Identity Expression. *Archives of Sexual Behavior*, *45*. https://doi.org/10.1007/s10508-016-0778-3

Watson, R. J., Grossman, A. H., & Russell, S. T. (2019). Sources of Social Support and Mental Health Among LGB Youth. *Youth & Society*, *51*(1), 30–48. https://doi.org/10.1177/0044118X16660110

West, C., & Zimmerman, D. H. (1987). Doing Gender. In *Gender and Society* (Vol. 1, Issue 2). http://www.jstor.org/about/terms.html.

Williams, T., Connolly, J., Pepler, D., & Craig, W. (2005). Peer Victimization, Social Support, and Psychosocial Adjustment of Sexual Minority Adolescents. *Journal of Youth and Adolescence*, *34*(5), 471–482. https://doi.org/10.1007/s10964-005-7264-x

Wilson, K. (2022). LESBIAN EXPERIENCES OF THE CRIMINAL JUSTICE SYSTEM A Practitioner Perspective. *The Routledge Handbook of Women's Experiences of Criminal Justice*, 197–207. https://doi.org/10.4324/9781003202295-18/LESBIAN-EXPERIENCES-CRIMINAL-JUSTICE-SYSTEM-KATH-WILSON

Winderman, K., & Smith, N. G. (2019). Minority Stress and LGB-Inclusive Television Viewing Frequency Among LGB Adults: The Roles of Community Connectedness and Perceived Social Support. *Mass Communication and Society*, *22*(2), 248–269. https://doi.org/10.1080/15205436.2018.1504303

Winer, C., Carroll, M., Yang, Y., Linder, K., & Miles, B. (2022). "I Didn't Know Ace Was a Thing": Bisexuality and pansexuality as identity pathways in asexual identity formation. *Https://Doi.Org/10.1177/13634607221085485*. https://doi.org/10.1177/13634607221085485

Winter-Gray, T., & Hayfield, N. (2021). 'Can I be a kinky ace?': How asexual people negotiate their experiences of kinks and fetishes. *Psychology and Sexuality*, *12*(3), 163–179. https://doi.org/10.1080/19419899.2019.1679866

Witt, S. D. (1997). Parental influence on children's socialization to gender roles. *Adolescence*, *32*(126).

World Medical Association. (2013). World Medical Association Declaration of Helsinki: ethical principles for medical research involving human subjects. *Journal of American Medical Association (JAMA)*, *310*(20), 2191–2194.

Young, E. (2022). *Ace Voices: What it Means to Be Asexual, Aromantic, Demi or Grey-Ace* . Jessica Kingsley Publishers. https://books.google.es/books?hl=es&lr=&id=EzCXEAAAQBAJ&oi=fnd&pg=PP1&dq=ace+voices&ots=7yYm8sp6JJ&sig=7eTjgVSZcqZQdS0MUBVN2MP_exU#v=onepage&q=ace%20voices&f=false

Yule, M. A., Brotto, L. A., & Gorzalka, B. B. (2015). A validated measure of no sexual attraction: The asexuality identification scale. *Psychological Assessment*, *27*(1), 148–160. https://doi.org/10.1037/a0038196

Yule, M. A., Brotto, L. A., & Gorzalka, B. B. (2017). Human Asexuality: What Do We Know About a Lack of Sexual Attraction? *Current Sexual Health Reports*. https://doi.org/10.1007/s11930-017-0100-y

Zeeman, L., & Aranda, K. (2020). A Systematic Review of the Health and Healthcare Inequalities for People with Intersex Variance. *International Journal of Environmental Research and Public Health 2020, Vol. 17, Page 6533*, *17*(18), 6533. https://doi.org/10.3390/IJERPH17186533

Zheng, L., & Zheng, Y. (2016). Gender Nonconformity and Butch-Femme Identity among Lesbians in China. *Journal of Sex Research*, *53*(2), 186–193. https://doi.org/10.1080/00224499.2015.1058890

Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The Multidimensional Scale of Perceived Social Support. *Journal of Personality Assessment*, *52*(1), 30–41. https://doi.org/10.1207/S15327752JPA5201_2

Zosuls, K. M., Ruble, D. N., Tamis-LeMonda, C. S., Shrout, P. E., Bornstein, M. H., & Greulich, F. K. (2009). The Acquisition of Gender Labels in Infancy: Implications for Gender-Typed Play. *Developmental Psychology*, *45*(3), 688–701. https://doi.org/10.1037/A0014053