FACULDADE DE MEDICINA
UNIVERSIDADE D
COIMBRA

MESTRADO INTEGRADO EM MEDICINA – TRABALHO FINAL

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COPING WITH SUICIDE: HOW CAN DISTRESS TOLERANCE AND PSYCHOLOGICAL FLEXIBILITY HELP TRANS PEOPLE

ARTIGO CIENTÍFICO ORIGINAL

ÁREA CIENTÍFICA DE PSICOLOGIA MÉDICA

Trabalho realizado sob a orientação de:

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ABRIL/2022

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ABBREVIATIONS

MSM, Minority Stress Model

GMSM, Gender Minority Stress Model

WHO, World Health Organization

INE, National Statistics Institute

DT, Distress tolerance

PF, Psychological flexibility

PI, Psychological inflexibility

ACT, Acceptance and Commitment Therapy

CHUC, Coimbra Hospital and University Centre

FMUC, Faculty of Medicine of the University of Coimbra

URGUS, Genitourinary and Sexual Reconstruction Unit

CompACT, Comprehensive Assessment of Acceptance and Commitment Therapy Processes

DTS-S, Distress Tolerance Scale – Simons

DASS-21, Depression Anxiety Stress Scales

SS, Suicidality Scale

SPSS, Statistical Package for the Social Science

VIF, Variance Inflation Factors

ABSTRACT

Introduction: Trans people tend to exhibit high levels of suicidal behaviors, which are mostly associated with minority stress experiences they suffer in their daily lives. Psychological processes such as distress tolerance and psychological flexibility may play a protective role in transgender people's suicidality. In this study, the first aim of this study was to explore and characterize variables related to the transition process, mental health and suicide in Portuguese trans people. The second aim was to examine if distress tolerance and psychological flexibility could have a positive effect on suicidality in trans people.

Method: The sample was composed of 104 Portuguese trans people aged between 18 and 66 years (M=25.48; SD=8.44). Around 42% identified as man, 34% as non-binary and 23% as woman. Participants completed online self-report questionnaires which were advertised on social networks, and within LGBTQI^{+}-related Portuguese institutions and the Genitourinary and Sexual Reconstruction Unit (URGUS) of the Coimbra Hospital and University Centre (CHUC). Data were analysed through SPSS.

Results: Participants majority had already started one of the phases of the transition process (social, hormonal and/or physical). About 39% of participants reported a clinical diagnosis of mental illness. Around 63% of individuals reported having in the past a suicide plan and 33% had a suicide attempt. People who had not yet started the hormonal transition, but who wanted to do it, showed significant values of depression, hopelessness and suicidality compared to individuals who had already completed this phase of the process. Distress tolerance and psychological flexibility presented negative and moderate correlations with suicidality and depression, and a positive and moderate correlation with each other. In the first step of the hierarchical regression conducted, depression explained 56% of suicidality. In the second step, distress tolerance with depression explained 60% of suicidality. In the third step, the three components of psychological flexibility were also included and a significant model explained 63% of suicidality ($F(5,98)=35.99$, $p<.001$). Alongside with depression, only behavioral awareness (psychological flexibility component) had significant predictive effect.

Discussion: These findings suggest that being in contact with the present moment and with one’s own internal experience, even when difficult, might be essential to reduce the tendency to commit suicide in this population.

Conclusions: Psychotherapeutic interventions with trans people should promote psychological flexibility, especially working and exploring the present moment awareness, in order to decrease suicidality.

Keywords: Trans people, Distress tolerance, Psychological flexibility, Suicidal behavior

RESUMO

Introdução: As pessoas trans apresentam altos níveis de comportamentos suicidários, principalmente relacionados às experiências de stresse que sofrem diariamente nas suas vidas associadas ao seu *status* minoritário. Processos psicológicos como tolerância emocional ao sofrimento e flexibilidade psicológica podem desempenhar um papel protetor na suicidalidade das pessoas trans. Neste estudo, o primeiro objetivo foi explorar e caracterizar as variáveis relacionadas com o processo de transição, saúde mental e suicídio em pessoas trans portuguesas. O segundo objetivo foi examinar se a tolerância emocional ao sofrimento e a flexibilidade psicológica poderiam ter um efeito positivo na suicidalidade das pessoas trans.

Métodos: A amostra foi composta por 104 pessoas trans portuguesas com idades compreendidas entre os 18 e os 66 anos (M=25,48; DP=8,44). Aproximadamente 42% identificaram-se como homem, 34% como não-binário e 23% como mulher. Os participantes preencheram questionários de autorrelato online que foram publicados nas redes sociais, instituições portuguesas relacionadas com comunidade LGBTQI^{+} e na Unidade de Reconstrução Génito-Urinária e Sexual do Centro Hospitalar e Universitário de Coimbra. Os dados foram analisados através do SPSS.

Resultados: A maioria dos participantes já tinham iniciado uma das fases do processo de transição (social, hormonal e/ou física). Aproximadamente 39% dos participantes referiram ter diagnóstico de doença mental. Cerca de 63% relataram ter, no passado, um plano suicida e 33% tentaram o suicídio. Pessoas que ainda não tinham começado a transição hormonal, mas que o desejavam, apresentaram valores significativos de depressão, desesperança e suicídio, em comparação com indivíduos que já tinham terminado esta fase. A tolerância emocional ao sofrimento e flexibilidade psicológica apresentaram correlações negativas e moderadas com o suicídio e a depressão, e uma correlação positiva e moderada entre si. Na primeira etapa da regressão hierárquica realizada, a depressão explicou 56% da suicidalidade. A segunda etapa, a tolerância emocional ao sofrimento e a depressão explicaram 60% da suicidalidade. Na terceira etapa, as três componentes da flexibilidade psicológica também foram incluídas e um modelo significativo explicou 63% da suicidalidade ($F(5,98)=35,99$, $p<0,001$). Juntamente com a depressão, apenas a consciência comportamental (componente da flexibilidade psicológica) teve um efeito preditivo significativo.

Discussão: Os dados sugerem que estar em contato com o momento presente e com a própria experiência interna, mesmo perante dificuldades, pode ser essencial para reduzir os comportamentos suicidários na população trans.

Conclusões: Intervenções psicoterapêuticas com pessoas trans devem promover a flexibilidade psicológica, principalmente trabalhando e explorando a consciência do momento presente, a fim de diminuir a suicidalidade.

Palavras-chave: Pessoas trans, Tolerância emocional ao sofrimento, Flexibilidade psicológica, Comportamento Suicidário

1. INTRODUCTION

Transgender, or trans, is an umbrella term for people who have a gender identity, experience and/or behaviour that differs from the sex assigned at birth (McCann & Brown, 2017). This spectrum of identities and experiences encompasses individuals who intend to change their primary and/or secondary sexual characteristics through gender transition process, because they do not identify with the sex assigned at birth, and gender diverse individuals that do not fit the male-female binary gender categorization (Kia et al., 2021; McCann et al., 2021). The transition process may include a legal name and gender change, as well as dressing and grooming differently (social transition), hormone therapy (medical transition), and/or genital or non-genital surgery (physical transition) (Dickey et al., 2022).

In recent decades, the trans community has raised increasing interest and attention among the scientific community and society in general, regarding human rights, social inclusion, health, and well-being. However, trans people continue to report episodes of discrimination, violence, marginalization, and social isolation, which combined with less support from peers and family, make them more vulnerable. It has been consistently proven across studies that these adverse factors have a negative impact affecting their mental health and quality of life In this context, several studies have shown that trans people exhibit increased levels of depression, anxiety, post-traumatic stress disorder, body image dissatisfaction and feelings of rejection (Chen et al., 2020; McCann & Brown, 2017). Being trans is also associated with greater alcohol and drugs abuse, increased prevalence of infectious diseases, and increased risk of self-injurious and suicidal behaviours (Chen et al., 2020).

The Minority Stress Model (MSM) is one of the most important theories to understand the impact that discrimination has on mental and physical health of individuals belonging to minority groups (Meyer et al., 2015; Tebbe & Moradi, 2016). Meyer (2003) adapted the MSM for sexual minorities. According to this theory, sexual minorities experience a set of social and individual stressors, prejudice, and discrimination as a result of their high sociocultural prejudice and discrimination, which expose them to more psychological stress and fewer coping resources. This model describes two general processes by which sexual minorities experience minority stress: (a) distal stressors, which address to the minority group where the individual belongs and not directly to the person (e.g., discrimination, social rejection or violence) and (b) proximal stressors, which have a direct effect on the person and their identity (e.g., fear of rejection, internalized homophobia and sexual identity occultation) (Meyer et al., 2015; Staples et al., 2017).

To understand the impact of discrimination on trans individuals' mental health , the Gender Minority Stress Model (GMSM) was developed, which resulted from an adaptation of the MSM to this population (Hendricks & Testa, 2012; Testa et al., 2015). According to the GMSM, trans people experience a variety of social and emotional stressors, including violence, stigma and discrimination, which together increase vulnerability to physical and mental health problems, with impact on their quality of life (Hendricks & Testa, 2012; Inderbinen et al., 2021; Jäggi et al., 2018). The model describes as distal stressors gender-based discrimination, rejection, victimization and gender identity non-affirmation; and as proximal stressors negative expectations, internalized transphobia and non-disclosure of gender identity (Hendricks & Testa, 2012; Tan et al., 2019). This model also identifies two resilience factors that can minimize the negative effects of stigmatization, namely pride in their gender identity and connection to the trans community (Hendricks & Testa, 2012).

The cumulative effect of minority stress on trans people's daily lives is directly related to negative mental health outcomes, such as depression (Chen et al., 2020; McCann & Brown, 2017). Accordingly, studies showed that 1:2 transgender people are diagnosed with anxiety and depression, compared to 1:5 in the general population (Herman et al., 2019; McCann et al., 2021). This model also identifies two resilience factors that can minimize the negative effects of stigmatization, namely pride in their gender identity and connection to the trans community (Jäggi et al., 2018; Pellicane & Ciesla, 2022).

The cumulative effect of minority stress on trans people's daily lives is directly related to negative mental health outcomes (Chen et al., 2020; McCann & Brown, 2017). Accordingly, studies showed high prevalence of psychiatric disorders in trans people, particularly depression and anxiety (Herman et al., 2019; McCann et al., 2021). This fact is justified by the effect of minority stress associated with gender on the mental health and psychological well-being of trans people, in which proximal stressors have a stronger relationship with depression and distal stressors with anxiety (Reisner et al., 2015; Tebbe & Moradi, 2016; Witcomb et al., 2018).

Taken together, the negative effects of stressors on trans people's mental health can lead to suicide (Kia et al., 2021; Meyer et al., 2015). Suicide is a multidimensional phenomenon that results from the interaction of biological, psychological, cognitive, and social factors. Suicidal behaviour is described as a *continuum*, which goes from passive suicidal ideation (general thoughts about death), active suicidal ideation (conception and elaboration of the suicidal plan), going through the suicide attempt (non-fatal, self-directed, potentially harmful behaviour with the intention of dying) to suicide (fatal and self-directed behaviour with the intent to die) (Bridge et al., 2006; Klonsky & May, 2015; Matos-Gonçalves et al., 2015). Suicidal ideation and attempted suicide are a sign of severe emotional distress and strong predictors

of suicide. Approximately 9% of the world's adult population has considered committing suicide, and according to the World Health Organization (WHO), the global age-standardized annual suicide rate is 10.5/100,000 population (Nock & Mendes, 2008; WHO, 2014). In Portugal, according to data from the National Statistics Institute (INE) of 2019, the suicide mortality rate was 9.7/100,000 inhabitants, with males committing more suicide than females (INE, 2021).

The trans population has a higher rate of suicidal ideation and suicide attempts when compared to the general population, which might be related to the gender minority stress, physical violence and psychological pain they suffer (Adams & Vincent, 2019; Hendricks & Testa, 2012). In fact, evidence shows that 47% of trans people present suicidal ideation and 27% have attempted suicide (Adams & Vincent, 2019). Evidence shows that attempted suicide was reported in 26% of trans women and in 30% of trans men (Hendricks & Testa, 2012). In Portugal, a few studies have explored suicidal behavior in the trans population. However, a quantitative study, carried out in 2019, with a sample of 114 trans individuals, evaluated the suicidal and self-injurious behaviours in the Portuguese population. According to Cintra (2019) trans population had high levels of suicidal ideation, suicidal behaviours, and psychological pain, but reduced values of self-harm behaviours. Sociodemographic variables, such as age, body changes and experience of risk behaviours, influenced the onset of psychological suffering and suicidal behaviours (Cintra, 2019).

Suicidal behaviors in the trans population might be associated with various gender minority stressors that these individuals feel and experience daily (Pellicane & Ciesla, 2022; Tebbe & Moradi, 2016; Wolford-Clevenger et al., 2018). Distal stressors of gender-based violence, discrimination, rejection, lack of social support and non-identity affirmation (e.g., McNeil et al., 2017; Staples et al., 2017; Testa et al., 2017) and proximal stressors such as internalized transphobia, non-disclosure of gender identity, and negative expectation and proximal stressors such as internalized transphobia, non-disclosure of gender identity, and negative expectations (e.g., Perez-Brumer et al., 2015; Testa et al., 2017; Trujillo et al., 2017) are mainly associated with suicidal ideation. On the other hand, victimization by physical, sexual and verbal violence (Bailey et al., 2014; Grossman & D'Augelli, 2007; Herman et al., 2019; Wolford-Clevenger et al., 2018), non-suicidal self-injurious behaviors (Staples et al., 2017; Wolford-Clevenger et al., 2018), substance abuse (Adams & Vincent, 2019; Bailey et al., 2014; Bridge et al., 2006) and proximal stressors such as low self-esteem and transphobia (Adams & Vincent, 2019; Flynn & Bhambhani, 2021; Wolford-Clevenger et al., 2018) are positively related to the suicide attempt.

Despite the risk factors that enhance the possibility of suicidal behaviour, several protective factors mitigate the adverse effect of the GMSM processes on the mental health of

transgender people, including suicidal ideation and attempted suicide (Kia et al., 2021; Tebbe & Moradi, 2016). Studies identified as protective factors of suicidality in the trans population: social, family and peer support, a sense of belonging to the community, resilience, the existence of a school and work environment that protects gender minorities, representation in the media and pride in identity (Adams & Vincent, 2019; Kia et al., 2021; Poštuvan et al., 2019).

The effect of the gender transition process on the suicidality and mental health of the population is not clear. Some studies indicate that the stress associated with the transition process can affect health and increase suicidal behaviors. Higher levels of distress related to feelings of rejection, lack of social support, discrimination in health environments, financial costs and job discrimination during the transition may be associated with a negative impact on mental (Budge et al., 2013; Rood et al., 2015). On the other hand, other studies suggest that the transition process has contributed to a reduction in the levels of depression and suicidal behavior in trans people, because it allows, for example, a gender expression that is congruent with the perceived gender, greater identity affirmation and a support and integration in the trans community (Dickey et al., 2022; Jäggi et al., 2018).

These experiences, together, contribute to the emergence of psychological pain in trans people, a clinical indicator associated with intense negative feelings of guilt, shame and hopelessness, being a predictor of suicidal ideation and trigger for suicidal behaviors appearing (Wolford-Clevenger et al., 2018).

In order to modify and reduce the effects of negative stressors on the life and mental health of trans people, it is also important to identify and understand psychological processes that can contribute to tackle suicide-related phenomena in this population. Distress tolerance (DT) is defined as the individual's ability to persist while experiencing adverse and negative emotional, cognitive and physical distress states. It is associated with psychological adjustment, resilience, better physical and mental health, and self-care (B. S. Russell et al., 2019). DT is affected by individual differences in experiencing emotions, attention or even the assessment of physical or emotional pain (Basharpoor et al., 2021). Individuals who have lower levels of DT experience distress as unbearable and believe that they are unable to cope with negative experiences in their lives (Anestis & Joiner, 2012; Daughters et al., 2017; Lass & Winer, 2020; Nock & Mendes, 2008). Some studies have shown that low distress tolerance is associated with long-term physical and psychological harm such as drugs and alcohol abuse, binge eating, risky sexual behaviors, depressive symptoms, non-suicidal self-injurious behaviors, and suicidality (Anestis & Joiner, 2012; Lass & Winer, 2020).

Psychological flexibility (PF) is another way of managing the effect of social and individual stressors on psychological well-being. PF is defined as an individual's ability to accept, to cope with and adjust to difficult thoughts, emotions and situations, staying in the

present moment and moving in a values-based pattern of behavior (S. C. Hayes et al., 2017; Kroska et al., 2020; Tindle & Moustafa, 2021). It includes six components: acceptance, self as context, cognitive defusion, being present, contact with values and committed action (Francis et al., 2016; S. C. Hayes et al., 2017). According to Francis et al. (2016) these six components can be grouped into three: openness to experience, behavioral awareness and valued action.

Behavioral awareness is defined as paying attention to one's internal experiences, context and behavior (Francis et al., 2016; Hayes et al., 2013). This concept wants to integrate the process of "self-awareness and perspective taking" established by Hayes et al. (2011) which, in turn, brings together two of the six sub-processes of psychological flexibility, "present moment awareness" and "self-as-context" (Hayes et al., 2006). An individual being in contact with present moment/mindfulness means being aware of one's own internal experience (thoughts, bodily sensations and feelings) and feel the experiences with curiosity, openness and acceptance (Arch & Craske, 2006; Francis et al., 2016; Schmelefske et al., 2020). Regarding the self-as-context construct, it can be interpreted as a posture of observation and detachment in relation to the self, where the self is felt "here and now", while self-related thoughts and emotions are experienced "there and then" (Carvalho et al., 2021; Hayes et al., 2006). Self-as-context is often thought of as an extension of contact with present moment/mindfulness, allowing individuals to focus on a lasting and stable sense of self, able to adopt a more flexible perspective of self (Godbee & Kangas, 2020).

PF has a protective effect against negative emotions and thoughts, and it is fundamental to the psychological well-being of individuals (Doorley et al., 2020). Studies suggest that PF is positively related to mindfulness (Baer et al., 2006) and that high levels of PF are associated with lower levels of depression (Bond & Bunce, 2000; Masuda et al., 2011), anxiety (Kashdan et al., 2006), emotional distress (Masuda et al., 2011; Tindle & Moustafa, 2021), and suicide (Krafft et al., 2019; McCracken et al., 2018). The opposite of PF is psychological inflexibility (PI) which is a rigid pattern of behavior that seeks to persistently avoid aversive internal and external events, interfering with the engagement in personally valued actions (Levin et al., 2014). The Acceptance and Commitment Therapy (ACT) is a transdiagnostic cognitive-behavioral intervention that promotes FP as an essential tool for human adaptation and well-being, reducing PI (Doorley et al., 2020; Francis et al., 2016).

Some researchers have studied the relationship between PF and psychological distress and stressors associated with the GMSM in the trans population. Lloyd et al. (2019) conducted a study with trans people in England in which they found that PI was positively associated with internalized transphobia and non-disclosure of identity. This study also concluded that PI mediated and strengthened the relationships between gender identity discrimination and depression, anxiety, and stress (Lloyd et al., 2019). More recently, Flynn &

Bhambhani (2021) investigated the relationship between internalized transphobia and non-disclosure of identity with PF/PI in trans individuals, with life satisfaction as an outcome variable. According to the authors, internalized transphobia and non-disclosure of gender identity are negatively associated with PF and positively correlated with PI. The results showed that in subjects with higher levels of PF, the relationship between internalized transphobia and life satisfaction was weaker. In this way, FP facilitates and allows trans people to behave more authentically and according to their gender identity, reducing the impact that oppressive internalized gender norms have on their behavior and actions. On the other hand, higher levels of PI are associated with a negative relationship between internalized gender norms and life satisfaction. Regarding non-disclosure of gender identity, the results suggest that individuals with higher PF have a lower relationship between non-disclosure of gender identity and life satisfaction. For Flynn & Bhambhani (2021), PF can control the effect of proximal stressors of trans people on life satisfaction, highlighting that FP-based interventions can be effective in the psychological well-being of the trans population.

The first aim of this study was to explore and characterize variables related to the transition process, mental health and suicide in Portuguese trans people. The second aim was to examine if distress tolerance and psychological flexibility could have a positive effect on suicidality in trans people. We hypothesize that both distress tolerance and psychological flexibility will have a significant effect on trans people's suicidality.

2. METHOD

2.1. Participants

Our sample was composed of 104 individuals from the Portuguese population who identified as trans, aged between 18 and 66 years old (*M* = 25.48, *SD* = 8.44). Of these, the sex assigned at birth was female for 71.2% and male for 28.8%. Regarding gender identity, 42.2% identified as man, 33.7% as non-binary and 23.1% as woman. Around 46% of the participants had changed their name and gender on their identification card. As for sexual orientation, 27.9% of the participants considered themselves heterosexual, 22.1% bisexual, 21.2% pansexual, 15.4% lesbian and 4.8% gay.

Regarding professional status, 45.2% were students, 34.6% workers and 9.6% were unemployed. Around 50% had a university degree and the great majority (61.5%) considered themselves to have a medium socioeconomic status.

The sample represents the different regions of Portugal, with 38.5% of participants residing in Lisbon and Vale do Tejo, 31.7% in the Central region, 22.1% in the North, 2.9% in the South and 4.8% in the Autonomous Regions of Madeira and Azores.

The sociodemographic characteristics are summarized in Table 1.

Table 1. *Sociodemographic Characteristics of Study Participants (*N=*104)*

	N	%
Sex assigned at birth		
Female	74	71.2
Male	30	28.8
Intersex	-	-
Gender identity		
Woman	24	23.1
Man	44	42.2
Non-binary	34	32.7
Agender	1	1
Other	1	1
Sexual orientation		
Lesbian	16	15.4
Gay	5	4.8
Bisexual	23	22.1
Heterosexual	29	27.9
Pansexual	22	21.2
Asexual	4	3.8
Other	5	4.8
Civil status		

Single	93	89.5
Married	4	3.8
Divorced	3	2.9
Unmarried couples	4	3.8
Employment status		
Student	47	45.2
Worker	36	34.6
Worker and student	10	9.6
Unemployed	10	9.6
Retired	1	1
Educational categories		
High school or less	52	50
Bachelor	5	4.8
Graduation	35	33.6
Master	11	10.6
Doctoral	1	1
Socioeconomic Status		
Very low	5	4.8
Low	28	26.9
Medium	64	61.5
High	6	5.8
Very high	1	1

2.2. Procedures

The current study was approved by the Ethics Committee of the Coimbra Hospital and University Centre (CHUC) and the Faculty of Medicine of the University of Coimbra (FMUC). Participants were recruited between May and November 2021, through an online questionnaire (appendix I) created on the Google Forms platform. The first page summarized the nature and objectives of the study, the inclusion criteria (age above 18 and identifying as a trans person) and assured the voluntary, anonymous, and confidential participation. Participants provided informed consent and accepted to participate in the study by clicking on “Proceed” to continue the questionnaire. Then, they completed a set of self-report questionnaires. Typical survey completion time was 30 minutes. In order to increase the online recruitment of participants, the study was presented in the Psychiatry consultations of the Genitourinary and Sexual Reconstruction Unit (URGUS) of the CHUC and released in the Instagram and Facebook. Trans and LGBTQI+ Portuguese associations/communities (e.g., ILGA, TransMissão and Casa Qui) were also contacted via email to share the study with their members through their communication platforms and social networks. The study was also disseminated through the online platforms of national newspapers and media sites.

2.3. Materials

Demographic questionnaire and background questions

The demographic questionnaire had 22 questions that assessed participants' basic demographic information including age, sex assigned at birth, gender identity, sexual orientation, educational level, employment status, socioeconomic status, and residence. Background questions were about the gender transition process - social (change gender expression and/or name), medical/hormonal (hormone therapy) and surgical/physical (genital and non-genital surgeries) - diagnosis of mental illness and suicide-related questions.

Comprehensive Assessment of Acceptance and Commitment Therapy Processes (CompACT; Francis et al., 2016; Portuguese version by Trindade et al., 2021).

The CompACT is a 23-item self-report measure that assesses psychological flexibility through three subscales: behavioural awareness (BA) (e.g., “I do jobs or tasks automatically. Without being aware of what I’m doing”); valued action (VA) (e.g., “I can keep going with something when it’s important to me”) and openness to experience (OE) (e.g., “One of my big goals is to be free from painful emotions”). The questionnaire has a 7-point Likert scale (0 = *Strongly disagree* to 6 = *Strongly agree*). Higher scores on the scale mean greater psychological flexibility. In the original study, this self-report scale demonstrated excellent internal consistency for the total scale (α = .91) and for each subscale (BA α = .87; VA α =.90 and OE α =.90) (Francis et al., 2016). The Portuguese version of CompACT questionnaire has only 18 items and presents good psychometric properties on the total scale (α = 0.84) and subscales (BA α = .87; VA α = .86 and OE α = .77) (Trindade et al., 2021). In the current study, the Cronbach's alpha of CompACT subscales was OE α =69; BA α = .89 and VA α =.86.

Distress Tolerance Scale – Simons (DTS-S; Simons & Gaher, 2005; Portuguese version by Lucena-Santos et al., 2013).

The Portuguese version of DTS-S is a 15-item questionnaire that assesses tolerance to suffering through two types of items: one related to the perceived ability to tolerate emotional distress (e.g., “I can’t handle feeling distressed or upset”) and another related to emotion regulation to alleviate distress (e.g., “When I feel distressed or upset, I must do something Regulation about it immediately”). Each question is answered using a 5-point Likert scale (1 = *Strongly disagree* to 5 = *Strongly agree*). On this scale, higher scores mean greater tolerance for suffering. The original version had an alpha coefficient of .89 after two-factor extraction (Simons & Gaher, 2005). In the Portuguese version, two factors were extracted and an internal

consistency of .85 was obtained for the total scale (Lucena-Santos et al., 2013). In this study, Cronbach's alpha was .90.

Depression Anxiety Stress Scales (DASS-21Lovibond & Lovibond, 1995; Portuguese version by Pais-Ribeiro et al., 2007)

The DASS-21 is a 21-item scale that assesses three dimensions of psychological symptoms experienced in the week prior to the assessment: anxiety (e.g., “I felt scared without any good reason”), depression (e.g., “I was unable to become enthusiastic about anything”) and stress (e.g., “I felt that I was using a lot of nervous energy”). Each subscale consists of 7 items evaluated using a 4-point Likert scale (0 = *Did not apply to me at all* to 3 = *True most of the time*). The scores on the anxiety, depression and stress scales are calculated by a sum of the respective items. The higher the score on each dimension, the higher the levels of anxiety, depression, and stress. The original version of DASS showed good internal consistency with α = .91 for depression, α = .81 for anxiety and α = .89 for stress (Lovibond & Lovibond, 1995). In the Portuguese version, the results were similar, with a Cronbach’s coefficient of .74 for the anxiety subscale, .85 for the depression, and .81 for the stress (Pais-Ribeiro et al., 2007). In this study, the depression scale presented Cronbach’s alpha of .94.

Suicidality Scale (SS; Castilho et al., 2019)

The SS consists of 11 items and aim to assess the propensity to commit suicide through two dimensions: hopelessness (e.g., “There are times when I wish I had never been born”) and cognitions about death/suicide (e.g., There are times when I wish I had never been born). Hopelessness is measured through 7 items and cognitions about death/suicide are measured with 4 items. The 11 items are evaluated using a 4-point Likert scale (0 = *never happens to me*; 3 = *happens to me all the time*). A total score is calculated by a sum of all items and subscales’ scores are obtained by a total of the respective items. The SS had a very good internal consistency for the total score with a Cronbach coefficient of .94. The subscales had a α = .91 for hopelessness and α = .89 for cognitions about death (Castilho et al., 2019). In the current study, Cronbach's alpha for the total scale was .95, hopelessness subscale was .92 and cognitions about death/suicide subscale was .90.

2.4. Data Analyses

The current study had a cross-sectional design and data were analysed in the Statistical Package for the Social Science (SPSS, version 22; SPSS Inc, Chicago, IL, USA) and Process Macro (A. F. Hayes, 2018).

The internal consistency of the scales presented in this study were examined through the *Cronbach's'* alphas. We used the reference values of Field et al., 2013: α value lower than .60 is considered inadmissible, between .60 and .70 is weak, between .70 and .80 is reasonable, between .80 and .90 is good and above .90 is very good.

Normality of data was examined with the Kolmogorov-Smirnoff test and analysing skewness and kurtosis values (Kline, 2011). Descriptive statistics and frequencies were calculated to examine the characteristics of the sample. Pearson's correlations were conducted to analyse the association between variables. According to Dancey & Reidy, 2017, correlation coefficients between .10 and .39 are considered weak; between .40 and .69 moderate; and above .70 considered strong. Comparisons between two groups were performed using independent samples' t-test for groups with $n > 30$ and Mann–Whitney U **test** for groups with $n < 30$.

Exploratory analyses were conducted to understand the predictors of suicidality in this study population. A hierarchical regression was conducted to examine the predictive effect of distress tolerance and psychological flexibility on suicidality. The independence of the errors was analysed and validated through the Durbin–Watson value (acceptable values < 2.5). Regarding multicollinearity or singularity amongst the variables, Variance Inflation Factors (VIF) indicate the absence of β estimation problems when < 5 (Kline, 2011).

3. RESULTS

3.1 Preliminary analysis

According to the Kolmogorov-Smirnov test, the DTS-S and SS scores followed a normal distribution. The same did not happen to the CompACT subscales and DASS-21 ($p > .05$). However, considering the reference values for skewness and kurtosis (Sk < 3 and Ku < 8; Kline, 2011), the normality of data was assumed. To examine outliers, we used the diagram of extremes and quartiles (boxplot). Four outliers were eliminated.

Regarding the hierarchical regression, homogeneity (normal probability plot) and residual independence were assured considering the Durbin-Watson statistic (<2.5) and VIF values under the recommended 5 (ranging between 1.00 and 2.82).

3.2. Trans people's mental health, suicide, and transition phase

We questioned participants regarding their transition phase at a social, hormonal and physical level, with the majority having made their social transition (Table 2).

Table 2. Frequencies regarding status and intent to pursue transition (N=104)

	Social Transition		**Hormonal Transition**		**Physical Transition**	
	N	%	N	%	N	%
Perspective about intent/state of transition process						
I do not intend to do it	3	2.9	19	18.3	9	8.7
I have not initiated it, but I intend to	15	14.4	30	28.8	64	61.5
I already initiated, but I haven't completed it yet	27	26	23	22.1	22	21.2
I have done	59	56.7	32	38.8	9	8.7

About mental health, 30% reported using psychiatric medication daily and approximately 39% reported a clinical diagnosis of mental illness. Of these, 29% had a diagnosis of depression, 20% of anxiety, 37% had both (depression and anxiety), and 14% reported having other mental disorder (e.g., autism, bipolar disorder, obsessive-compulsive disorder).

About suicide, 63% of individuals reported having in the past a suicide plan and 33% had a suicide attempt. About 14% attempted suicide once, 10% attempted twice and 10% attempted suicide three times or more. Approximately 8% of individuals who attempted suicide required hospitalization.

3.3. Comparison between different transition states

We conducted a linear regression to understand if the phase of the transition process predicted suicidality, however, transition (regardless of which – social, hormonal or physical), did not had a predictive role in the suicidality scale.

Thus, we separated people who had already transitioned and people who want to transition but have not started yet, and we found significant differences regarding hopelessness and depression levels. Mann-Whitney independent test differences was used to compare trans people regarding their social transition status, comparing people who wish to transition but still have not started and people who already finished the transition, and significant differences were found regarding depression levels, $U(N_{\text{have not started transition, but wants to}}=15, N_{\text{finished transition}}=59)= 274.00$, $z= -2.27$, $p <.023$. No significant differences on the suicidality total score and subscales were observed. Using the same test to compare physical transition status, only 9 people reported having finished their transition, and they were compared with people who had not started yet (n = 64), and no significant differences were found (regarding depression, suicidality total scale or subscales).

When comparing according to the hormonal stage of transition we used a t-student test to compare both groups ($n \geq 30$), and significant differences regarding suicidality total score, hopelessness and depression levels were found, with people that have not started the process presenting higher means (Table 3).

Table 3. Differences between Trans people that already made hormonal transition and who did not, using independent sample *t* test differences (N = 62).

	Hormonal Transition					
	Have not started transition, but wants to		Finished Transition			
	(n = 30)		(n = 32)			
	M	*SD*	*M*	*SD*	*t*	*p*
Suicidality (SS)	16.07	9.24	10.88	8.22	2.34	.023*
Hopelessness	11.30	6.56	7.25	5.70	2.60	.012*
Cognitions about death/suicide	4.77	3.21	3.63	3.07	1.43	.157
Depression (DASS-21)	11.47	5.31	7.38	5.72	2.92	.005*

Note. *p < .05; SS = Suicidality Scale; DASS-21 = Depression Anxiety Stress Scales

3.4 Correlations

In order to explore the association between variables, Pearson product-moment correlations were conducted (Table 4). Distress tolerance showed a negative and moderate correlation with suicidality ($r = -.64$, $p < .001$) and depression ($r = -.63$, $p < .001$), and a positive and moderate correlation with the psychological flexibility subscales (openness to experience, behavioral awareness and valued action). Suicidality had a moderate and negative correlation with behavioral awareness ($r = -.60$, $p < .001$) and valued action ($r = -.43$, $p < .001$) and, as expected, a positive and strong correlation with depression ($r = .75$, $p < .001$). Examining the psychological flexibility subscales, it was found that openness to experience presented a positive and weak correlation with behavioral awareness (r = .39, $p < .001$). On the contrary, openness to experience and valued action were not related. Additionally, behavioral awareness presented a positive and moderate correlation with valued action ($r = .43$, $p < .001$). All psychological flexibility subscales had a negative and moderate correlation with depression (ranging between -.44 and -.50, $p < .001$).

Table 3. Pearson correlations between the variables in study ($N = 104$).

Variables	1	2	3	4	5	**6**
1. Distress Tolerance (DTS-S)	1					
2. Suicidality (SS)	-.64**	1				
3. Openness to Experience (CompACT)	.64**	-.35**	1			
4. Behavioral Awareness (CompACT)	.58**	-.60**	.39**	1		
5. Valued Action (CompACT)	.30**	-.43**	-.03**	.43**	1	
6. Depression (DASS-21)	-.63**	.75**	-.50**	-.50**	-.44**	1

Note. **$p < .001$; DTS-S = Distress Tolerance Scale – Simons; SS = Suicidality Scale; CompACT = Comprehensive Assessment of Acceptance and Commitment Therapy Processes; DASS-21 = Depression Anxiety Stress Scales

3.5 Hierarchical regression analysis

A hierarchical regression to predict suicide behaviours in trans people is presented in Table 3. In the first step, depression was entered as the only independent variable. The model was significant ($F_{(1,102)} = 129.31$, $p < .001$) and depression ($\beta = .75$, $p < .001$) explained 56% of suicidality variance. In the second step, distress tolerance was included ($\beta = -.28$, $p < .001$) which, together with depression, explained 60% of suicidality. This model was also significant ($F_{(2,101)} = 78.10$, $p < .001$). Lastly, in the third step, the three components of psychological

flexibility (openness to experience, behavioral awareness and valued action) were also included and a significant model explained 63% of suicidality ($F_{(5,98)}$ = 35.99, p < .001). Depression maintained a significant predictive effect (β = .49, p < .001), followed by behavioral awareness (β = -.23, p = .006), which was the only psychological flexibility component with a significant predictive effect in the model. Distress tolerance, openness to experience and valued action were not significant predictors of trans people suicidality.

Table 5. Hierarchical regression predicting suicidality of trans people (N = 104).

Variables	R^2	R^2 adjusted	R^2 change	F change	B	β	VIF
Model 1	.56	.56	.56	129.31**			
Depression (DASS-21)					1.17	.75**	1.00
Model 2	.61	.60	.05	12.42**			
Depression (DASS-21)					0.98	.57**	1.64
Distress Tolerance (DTS-S)					-0.20	-.28**	1.64
Model 3	.65	.63	.04	3.72*			
Depression (DASS-21)					.77	.49**	1.89
Distress Tolerance (DTS-S)					-.14	-.20	2.82
Openness to Experience (CompACT)					.03	.26	1.91
Behavioral Awareness (CompACT)					-0.28	-.23*	1.74
Valued Action (CompACT)					-0.06	-.06	1.47

Note. *p < .05; **p < .001; DASS-21 = Depression Anxiety Stress Scales; DTS-S = Distress Tolerance Scale – Simons; CompACT = Comprehensive Assessment of Acceptance and Commitment Therapy Processes

4. DISCUSSION

Several international studies report a high incidence of suicidal ideation and suicide attempt in the trans population, demonstrating a positive association with psychiatric comorbidity, namely depression and anxiety (Adams & Vincent, 2019; McNeil et al., 2017; Wolford-Clevenger et al., 2018). The process of gender transition often plays an important role in reducing the levels of psychiatric illness and suicidality in trans people. However, due to the complexity and duration of this process, its positive effect takes time and is insufficient, and an aggravation of some of the social and individual stressors in trans people has been reported during transition (Bailey et al., 2014; Dickey et al., 2022; Haimson & Veinot, 2020). Other psychological processes, such as distress tolerance and psychological flexibility, may have a protective effect in suicidality, since they increase the individual's ability to deal with psychological suffering and with various risk factors that make them vulnerable to adopt suicidal behaviors (Anestis & Joiner, 2012; Bryan et al., 2015; Kyron et al., 2022; Masuda et al., 2011). However, the effect of these two variables on the suicidal behavior of trans people is still unknown. Therefore, in this study we aimed to characterize the variables related to the transition process, mental health and suicide behavior in the Portuguese trans population, and to explore the predictive effect of distress tolerance (DT) and psychological flexibility (PF) on suicidality in trans people.

Regarding the transition process, our results showed that most participants (56.7%) had already made their social transition and that 2.9% had no intention to do it. The social transition, which may include the legal change of name and/or gender, can be seen as the transgender experience of coming out, often being the first step to start the medical and/or surgical transition process, as well as a way of the person to socially assert their identity and feel more identified and integrated in the trans community (Haimson & Veinot, 2020; Turban & Keuroghlian, 2018).

In the physical transition, normally associated with sex reassignment surgery, 8.7% of participants had already completed the process. These results suggest that the same phenomena described in other studies might also reflect in our sample, with low numbers of transsexuals with complete physical transition being associated with individual factors, such as fear of surgical procedures and possible complications, poor final results of the surgery in the aesthetics of the body and changes in their social (Bustos et al., 2021; Fitzgibbons, 2015). Additionally, other external factors may also contribute to these results, namely those associated with health care, such as long waiting times for surgeries or economic difficulties to pay for the surgeries, but also social factors, such as non-validation of gender identity after surgery, increased discrimination and loss of family or friendship relationships (Bustos et al.,

2021; Fitzgibbons, 2015; Rodrigues et al., 2020), with more than half of Portuguese trans people reporting social and organizational barriers as the main obstacles (Cintra, 2019). Our results also indicated a high percentage of participants (61.5%) reporting that, even though they had not started the process, they wanted to do it. This fact is in agreement with the study by Weinforth et al. (2019) , which showed an increase in demand for sex reassignment surgery in recent years, due to its effects on mental health, sexuality and life satisfaction.

In our study, the medical/hormonal transition was the phase of the transition process that more people reporting they were not interested in doing it (18.3%). This result may suggest fear about the safety of hormones and health effects, such as the onset of metabolic disorders, changes in body weight or infertility (Aldridge et al., 2021; Baker et al., 2021), but also in the fact that it causes the masculinization or feminization of the body, thus increasing discrimination and social rejection (Baker et al., 2021; Giovanardi et al., 2019). However, more than 60% of participants were at this stage of the process or had already completed it, demonstrating it is still a needed change for most trans people, contributing to achieve a social image that correspond to their identity and how they see themselves (Baker et al., 2021; Turban & Keuroghlian, 2018).

In our study, the results on mental illness aligned with these data, with 29% of participants reporting a diagnosis of depression, 20% of anxiety, and 37% of both. Additionally, 14% reported the presence of other mental illnesses such as obsessive-compulsive disorder, bipolar disorder, eating disorder or post-traumatic stress disorder, also described in other studies as being associated with this population (Chen et al., 2020; Perez-Brumer et al., 2015; Reisner et al., 2015), with 30% of participants reporting taking prescribed psychiatric medication.

Our results regarding suicidal behavior in trans people corroborated the high incidence reported in international data (Reisner et al., 2015), verifying that 63% of participants had in the past a suicide plan and 33% had at least one suicide attempt across their life span. Suicidal behaviors in trans people have been associated with the experiences of minority gender-related stress that this population experience in their daily lives (Pellicane & Ciesla, 2022; Tebbe & Moradi, 2016; Wolford-Clevenger et al., 2018). Distal stressors (e.g., gender-based discrimination, rejection, or gender identity non-affirmation) and proximal stressors (e.g., negative expectations, internalized transphobia, or non-disclosure of gender identity) may explain the results obtained in this study and alert to the emergence of psychological pain in trans people, a predictor of suicidal ideation and trigger for appearing suicidal behaviors (Wolford-Clevenger et al., 2018).

We explored the predictive role of the stage of transition in suicidality, revealing no apparent significant explanation. This fact contradicts the data of some studies that indicate

the transition process has an impact on reducing the levels of suicidal ideation and suicide attempt among trans people, highlighting the important role of social transition and gender reassignment in improving quality of life and psychological well-being (Bailey et al., 2014; Dickey et al., 2022). In our study, most participants had already finished some stages or were undergoing the transition process and, therefore, this might have diluted the impact of the transition process in suicidal behavior. Furthermore, we found significant differences in suicidality and depression between people who had not started their transition process (but wanted to), and people who had already finished their process.

Regarding social transition, significant differences were found between groups on depression, with a higher average of depression in people who have not started transition, but without differences in suicidality. Our results with regard to depression were in line with other studies, which indicated that those who have made the social transition have reduced levels of psychiatric illnesses, in particular depression (Haimson & Veinot, 2020; Russell et al., 2018). When considering physical transition, the differences between the two groups had no significant differences in depression or suicidality, however, only 10 per cent of the participants had finished their transition, thus the comparison might need more people in both stages to give a clearer picture of the underlying differences. Some studies have, however, linked the physical transition to a reduction in levels of depression and suicidal behaviors, since there is an increase in levels related to the satisfaction and quality of life of trans people when completed (Dickey et al., 2022; Weinforth et al., 2019).

Regarding the hormonal transition state, significant differences were found between groups, with the group of people who want to transition but have not started yet revealing higher averages with regard to depressive symptoms, suicidality, and hopelessness in particular. The results followed the direction of previous studies, where it is mentioned that trans people who intend to make the transition process, but are not undergoing hormonal treatment, present negative results in their mental health, with higher levels of depression, anxiety, self-harming and suicidal behaviors (Bailey et al., 2014; Weinforth et al., 2019). According Witcomb et al. (2018), before taking hormone treatment trans people have a four times greater risk of developing depression compared to a control group of the general population. With regards to suicide, studies show that those who are undergoing or have already finished hormone treatment have a reduction in levels of suicidality, because trans people observe physical changes in the body that match their gender identity, allowing a greater affirmation of identity and an increase in quality and satisfaction with life (Bailey et al., 2014; Baker et al., 2021; Tucker et al., 2018).

However, it is worth noting, in the case of our study, that the hopelessness subscale of suicidality proved to be significant in people who had not started transition, but want to. This

result might be suggestive of negative expectations for the future and lack of motivation, factors that define hopelessness (De Berardis et al., 2020; Pettorruso et al., 2020). Likewise, the fact that these trans people do not progress in their transition process, starting and completing hormonal treatment, leads to negative perception about themselves and demotivation, which lead to psychological distress and pain (Klonsky & May, 2015). Together, these factors contribute to the onset of depressive symptoms and an increased risk of suicidal ideation.

The correlational study showed that DT and PF (openness to experience, behavioral awareness and valued action) had a moderate and negative correlation with suicidality and depression, supporting previous research (Anestis & Joiner, 2012; Bryan et al., 2015; Kratovic et al., 2020; McCracken et al., 2018), and a positive and moderate correlation with each other. Thus, the data suggested that high levels of DT and PF are associated with lower levels of suicidality and depression. This means that individuals with greater ability to persist and tolerate an aversive emotional state while experiencing adversity and that can be in contact with the present moment, fully aware of emotions and thoughts, and that, according to the context, persist or change the pursuit of personal goals and values, experience less depression and less suicidal behavior.

Our statistical analysis evidenced that depression, distress tolerance and the three components of PF explained 63% of suicidality variance, with depression and behavioral awareness exhibiting the most relevant and significant role in the model.

Trans people being in contact with present moment/mindfulness means being aware of one's own internal experience (thoughts, bodily sensations and feelings) which experiencing in the present moment and looking at those experiences with curiosity, openness and acceptance (Arch & Craske, 2006; Francis et al., 2016; Schmelefske et al., 2020). This concept is contrary to “automatic pilot”, according to which the individual acts with unconscious intention and without sensory perception of the experiencing moment (S. C. Hayes et al., 2011).

According to the theoretical framework of behavioural awareness (Francis et al., 2016) it makes sense that this variable plays an important role in a positive psychological adjustment, because by being aware of the experiences they are currently experiencing and keeping their focus in the present moment, trans people create effective ways of combating psychological distress associated with the past and the future, namely, being able to view and assess current stressors and experiences as transient and contextual events that will change over time. Likewise, mindful trans people have a greater ability to track and identify, inside themselves the growth of feelings of psychological distress and, thus, develop adaptation mechanisms or search professional help to overcome their problems. Having problem-solving skills and a regulated stress response, trans people might then be able to buffer distress and not engage

in suicidal behaviors that often, which at times might seem as the only escape from emotional pain (Aguiar et al., 2021; Chesin et al., 2016; Schmelefske et al., 2020). Some studies also indicate that being mindful have contributed to the reduction of depressive symptoms, which lead to major depressive disorder which is one of the main psychiatric illnesses that affect trans individuals, and consequently reduce the risk of suicidal ideation (Aguiar et al., 2021; Schmelefske et al., 2020).

In our study, the self-as-context construct, when encompassed in behavioral awareness, and this having a predictive effect on suicidality, allows us to consider that trans individuals, by looking at their "here and now" self, can have mechanisms that manage feelings of hopelessness and psychological distress that can lead to suicidal behavior. In trans people, much of their psychological suffering comes from the fact that they are not who they would like to be in that moment and are not seen by others as they feel and would like to be seen. By looking at the self as a context and having the security of knowing who they are and do not let the way people see them define themselves, might contribute to prevent them from falling into hopelessness and have the feeling that they will never be seen as the person they would like to be. Awareness, tolerance of emotional pain and non-judgement contribute to prevent suicide ideation.

Our hypothesis suggested that DT and PF had a significant effect on trans people's suicidality. According to our results, only PF, in particular behavioral awareness, revealed a positive role potentially behaving as a protective factor concerning suicidality in trans people. For this reason, Acceptance and Commitment Therapy (ACT), as transdiagnostic psychotherapy that targets psychological flexibility as the primary goal through acceptance-focused interventions, mindfulness and behavior change, may have a role to play in accompanying trans people (Hayes et al., 2006). By developing behavioral awareness during ACT sessions, it is possible to stimulate the "present moment awareness" and "self-as-context" constructs so that individuals are able to respond more effectively to difficult situations, making them not only better prepared to deal with future challenges, but also to lessen the impact of these experiences on their lives and decrease the tendency to think about ending own life (Hayes et al., 2006).

The present study has some limitations. Its cross-sectional design limits causality inference and thus the results should be read in the light of those limitations. For future research, it is recommended to carry out studies with a longitudinal and prospective design, to test causality hypotheses. Another limitation is the use of only self-report measures, which encompasses greater subjectivity, as well as greater probability of socially desirable responses and even the avoidance of items and constructs that the scales measure. On the other hand, the fact that the data were collected during the SARS-CoV-2/COVID-19 pandemic period may

have led to some bias in the responses, since trans people have increased their social isolation related to gender discrimination, with a social isolation imposed by the rules to contain the pandemic spread. Some studies have positively associated the social isolation caused by the COVID-19 pandemic with increased rates of depression and suicidality in trans people (Burgess et al., 2021; Kidd et al., 2021).

Future studies could include other measures (e.g., clinical interviews) and exploration of other variables related to suicidality in trans people, such as discrimination or social support. It is also suggested to carry out studies that relate the different stages of the transition process with suicidality and life satisfaction in trans people.

However, the current study raises significant points and relevant information with possible clinical implications. Our results emphasize the need to implement interventions capable of working and exploring the present moment awareness and mindfulness skills among trans people, as a possible way to prevent suicide in this population. Additionally, it opens an opportunity to create guidelines that can contribute to a better intervention by mental health professionals who work with trans people.

ACKNOWLEDGMENTS

To my supervisor, Professor Dr. António Macedo, and my co-supervisor, Dr. Susana Renca, for the opportunity to undertake this study and for their thoughtful comments and recommendations on this dissertation. Special thanks to Dr. Julieta Azevedo, for her extensive knowledge and great support throughout the different phases of this study. To Dr. Diogo Carreiras for his time dedicated to this study and enthusiasm. And to Dr. Sara Magano for her collaboration.

I want to thank the participation of the Trans and LGBTQI+ Portuguese associations/communities that get involved on dissemination of this study and to all trans people who voluntarily participated in the survey.

My biggest thanks to my parents and brother, for their unconditional support throughout these years, and to Elvira, my aunt and elementary school teacher, who always supported and encouraged me in the dream of medicine.

Lastly, my thanks to my friends, who shared these academic years with me, and to Henrique, for his presence and support.

REFERENCES

Adams, N. J., & Vincent, B. (2019). Suicidal Thoughts and Behaviors Among Transgender Adults in Relation to Education, Ethnicity, and Income: A Systematic Review. *Transgender Health*, *4*(1), 226–246. https://doi.org/10.1089/trgh.2019.0009

Aguiar, K. R. de, Bilhalva, J. B., Cabelleira, M. D., Guimarães, G. O., Madureira, T., Agako, A., Souza, M. S. de, & Souza, L. D. de M. (2021). The impact of mindfulness on suicidal behavior: a systematic review. *Trends in Psychiatry and Psychotherapy*. https://doi.org/10.47626/2237-6089-2021-0316

Aldridge, Z., Patel, S., Guo, B., Nixon, E., Pierre Bouman, W., Witcomb, G. L., & Arcelus, J. (2021). Long-term effect of gender-affirming hormone treatment on depression and anxiety symptoms in transgender people: A prospective cohort study. *Andrology*, *9*(6), 1808–1816. https://doi.org/10.1111/ANDR.12884

Anestis, M. D., & Joiner, T. E. (2012). Behaviorally-indexed distress tolerance and suicidality. *Journal of Psychiatric Research*, *46*(6), 703–707. https://doi.org/10.1016/J.JPSYCHIRES.2012.02.015

Arch, J. J., & Craske, M. G. (2006). Mechanisms of mindfulness: Emotion regulation following a focused breathing induction. *Behaviour Research and Therapy*, *44*(12), 1849–1858. https://doi.org/10.1016/J.BRAT.2005.12.007

Baer, R. A., Smith, G. T., Hopkins, J., Krietemeyer, J., & Toney, L. (2006). Using self-report assessment methods to explore facets of mindfulness. *Assessment*, *13*(1), 27–45. https://doi.org/10.1177/1073191105283504

Bailey, L., J. Ellis, S., & McNeil, J. (2014). Suicide risk in the UK trans population and the role of gender transition in decreasing suicidal ideation and suicide attempt. *Mental Health Review Journal*, *19*(4), 209–220. https://doi.org/10.1108/MHRJ-05-2014-0015

Baker, K. E., Wilson, L. M., Sharma, R., Dukhanin, V., McArthur, K., & Robinson, K. A. (2021). Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review. *Journal of the Endocrine Society*, *5*(4). https://doi.org/10.1210/JENDSO/BVAB011

Basharpoor, S., Mowlaie, M., & Sarafrazi, L. (2021). The Relationships of Distress Tolerance, Self-compassion to Posttraumatic Growth, the Mediating Role of Cognitive Fusion. *Https://Doi.Org/10.1080/10926771.2019.1711279*, *30*(1), 70–81. https://doi.org/10.1080/10926771.2019.1711279

Bond, F. W., & Bunce, D. (2000). Mediators of change in emotion-focused and problem-focused worksite stress management interventions. *Journal of Occupational Health Psychology*, *5*(1), 156–163. https://doi.org/10.1037//1076-8998.5.1.156

Bridge, J. A., Goldstein, T. R., & Brent, D. A. (2006). Adolescent suicide and suicidal behavior. *Journal of Child Psychology and Psychiatry*, *47*(3), 372–394. https://doi.org/10.1111/j.1469-7610.2006.01615.x

Bryan, C. J., Ray-Sannerud, B., & Heron, E. A. (2015). Psychological flexibility as a dimension of resilience for posttraumatic stress, depression, and risk for suicidal ideation among Air Force personnel. *Journal of Contextual Behavioral Science*, *4*(4), 263–268. https://doi.org/10.1016/J.JCBS.2015.10.002

Budge, S. L., Adelson, J. L., & Howard, K. A. S. (2013). Anxiety and depression in transgender individuals: the roles of transition status, loss, social support, and coping. *Journal of Consulting and Clinical Psychology*, *81*(3), 545–557. https://doi.org/10.1037/A0031774

Burgess, C. M., Batchelder, A. W., Sloan, C. A., Ieong, M., & Streed, C. G. (2021). Impact of the COVID-19 pandemic on transgender and gender diverse health care. *The Lancet. Diabetes & Endocrinology*, *9*(11), 729. https://doi.org/10.1016/S2213-8587(21)00266-7

Bustos, V. P., Bustos, S. S., Mascaro, A., Del Corral, G., Forte, A. J., Ciudad, P., Kim, E. A., Langstein, H. N., & Manrique, O. J. (2021). Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence. *Plastic and Reconstructive Surgery - Global Open*. https://doi.org/10.1097/GOX.0000000000003477

Castilho, P., Carreiras., D., & Pinto, A. (2019). The Suicidality Scale: Development of a new instrument to assess the tendency to commit suicide. *Manuscrito Submetido*.

Chen, Y., Chen, S., Arayasirikul, S., Wilson, E., McFarland, W., Lu, J., Chen, Y., & Yan, H. (2020). A cross-sectional study of mental health, suicidal ideation and suicide attempt among transgender women in Jiangsu province, China. *Journal of Affective Disorders*, *277*, 869–874. https://doi.org/10.1016/j.jad.2020.09.002

Chesin, M., Interian, A., Kline, A., Benjamin-Phillips, C., Latorre, M., & Stanley, B. (2016). Reviewing Mindfulness-Based Interventions for Suicidal Behavior. *Archives of Suicide Research : Official Journal of the International Academy for Suicide Research*, *20*(4), 507–527. https://doi.org/10.1080/13811118.2016.1162244

Cintra, S. C. Z. (2019). *Comportamentos suicidários e autolesivos na população trans* [Universidade Lusíada de Lisboa]. http://repositorio.ulusiada.pt/bitstream/11067/4762/2/mpc_sara_cintra_dissertacao.pdf

Dancey, C., & Reidy, J. (2017). *Statistics Without Maths for Psychology* (7th ed.). Pearson Education.

Daughters, S. B., Ross, T. J., Bell, R. P., Yi, J. Y., Ryan, J., & Stein, E. A. (2017). Distress tolerance among substance users is associated with functional connectivity between prefrontal regions during a distress tolerance task. *Addiction Biology*, *22*(5), 1378–1390. https://doi.org/10.1111/ADB.12396

De Berardis, D., Olivieri, L., Rapini, G., Serroni, N., Fornaro, M., Valchera, A., Carano, A.,

Vellante, F., Bustini, M., Serafini, G., Pompili, M., Ventriglio, A., Perna, G., Fraticelli, S., Martinotti, G., & Di Giannantonio, M. (2020). Religious Coping, Hopelessness, and Suicide Ideation in Subjects with First-Episode Major Depression: An Exploratory Study in the Real World Clinical Practice. *Brain Sciences*, *10*(12), 1–12. https://doi.org/10.3390/BRAINSCI10120912

Dickey, lore m., Thomas, K., Andert, B., Ibarra, N., & Budge, S. L. (2022). The relationship between realization of transgender identity and transition processes with nonsuicidal self-injury in transgender populations. *Psychiatry Research*, *310*, 114332. https://doi.org/10.1016/J.PSYCHRES.2021.114332

Doorley, J. D., Goodman, F. R., Kelso, K. C., & Kashdan, T. B. (2020). Psychological flexibility: What we know, what we do not know, and what we think we know. *Social and Personality Psychology Compass*, *14*(12), 1–11. https://doi.org/10.1111/SPC3.12566

Field, A., Miles, J., & Field, Z. (2013). Discovering Statistics Using R. *International Statistical Review*, *81*(1), 169–170. https://doi.org/10.1111/insr.12011_21

Fitzgibbons, R. P. (2015). Transsexual attractions and sexual reassignment surgery: Risks and potential risks. *The Linacre Quarterly*, *82*(4), 337. https://doi.org/10.1080/00243639.2015.1125574

Flynn, M. K., & Bhambhani, Y. (2021). Internalized transphobia, nondisclosure of gender identity, and life satisfaction among transgender and non-binary adults: The moderating roles of psychological flexibility and inflexibility. *Journal of Contextual Behavioral Science*, *20*, 194–201. https://doi.org/10.1016/J.JCBS.2021.04.008

Francis, A. W., Dawson, D. L., & Golijani-Moghaddam, N. (2016). The development and validation of the Comprehensive assessment of Acceptance and Commitment Therapy processes (CompACT). *Journal of Contextual Behavioral Science*, *5*(3), 134–145. https://doi.org/10.1016/J.JCBS.2016.05.003

Giovanardi, G., Morales, P., Mirabella, M., Fortunato, A., Chianura, L., Speranza, A. M., & Lingiardi, V. (2019). Transition memories: experiences of trans adult women with hormone therapy and their beliefs on the usage of hormone blockers to suppress puberty. *Journal of Endocrinological Investigation*, *42*(10), 1231–1240. https://doi.org/10.1007/S40618-019-01045-2

Grossman, A. H., & D'Augelli, A. R. (2007). Transgender Youth and Life-Threatening Behaviors. *Suicide and Life-Threatening Behavior*, *37*(5), 527–537. https://doi.org/10.1521/suli.2007.37.5.527

Haimson, O. L., & Veinot, T. C. (2020). Coming Out to Doctors, Coming Out to "Everyone": Understanding the Average Sequence of Transgender Identity Disclosures Using Social Media Data. *Transgender Health*, *5*(3), 158. https://doi.org/10.1089/TRGH.2019.0045

Hayes, A. F. (2018). *Introduction to mediation, moderation, and conditional process analysis:*

A regression-based approach (2nd ed.). The Guilford Press.

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: model, processes and outcomes. *Behaviour Research and Therapy*, *44*(1), 1–25. https://doi.org/10.1016/J.BRAT.2005.06.006

Hayes, S. C., Strosahl, K., Wilson, K. G., Bissett, R. T., Pistorello, J., Toarmino, D., Polusny, M. A., Dykstra, T. A., Batten, S. V., Bergan, J., Stewart, S. H., Zvolensky, M. J., Eifert, G. H., Bond, F. W., Forsyth, J. P., Karekla, M., & Mccurry, S. M. (2017). Measuring experiential avoidance: A preliminary test of a working model. *The Psychological Record 2004 54:4*, *54*(4), 553–578. https://doi.org/10.1007/BF03395492

Hayes, S. C., Villatte, M., Levin, M. E., Hildebrandt, M. J., Levin, M., & Hildebrandt, M. (2011). Open, aware, and active: Contextual approaches as an emerging trend in the behavioral and cognitive therapies. *Annual Review of Clinical Psychology*, *7*(4), 141–168. https://doi.org/10.1146/annurev-clinpsy-032210-104449

Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the minority stress model. *Professional Psychology: Research and Practice*, *43*(5), 460–467. https://doi.org/10.1037/A0029597

Herman, J. L., Brown, T. N. T., & Haas, A. P. (2019). *Suicide Thoughts and Attempts Among Transgender Adults: Findings from the 2015 U.S. Transgender Survey*. https://escholarship.org/uc/item/1812g3hm

Inderbinen, M., Schaefer, K., Schneeberger, A., Gaab, J., & Garcia Nuñez, D. (2021). Relationship of Internalized Transnegativity and Protective Factors With Depression, Anxiety, Non-suicidal Self-Injury and Suicidal Tendency in Trans Populations: A Systematic Review. *Frontiers in Psychiatry*, *12*, 629. https://doi.org/10.3389/FPSYT.2021.636513/BIBTEX

INE. (2021). *Estatísticas demográficas – taxa de mortalidade padronizada.*

Jäggi, T., Jellestad, L., Corbisiero, S., Schaefer, D. J., Jenewein, J., Schneeberger, A., Kuhn, A., & Garcia Nuñez, D. (2018). Gender Minority Stress and Depressive Symptoms in Transitioned Swiss Transpersons. *BioMed Research International*, *2018*. https://doi.org/10.1155/2018/8639263

Kashdan, T. B., Barrios, V., Forsyth, J. P., & Steger, M. F. (2006). Experiential avoidance as a generalized psychological vulnerability: Comparisons with coping and emotion regulation strategies. *Behaviour Research and Therapy*, *44*(9), 1301–1320. https://doi.org/10.1016/J.BRAT.2005.10.003

Kia, H., MacKinnon, K. R., Abramovich, A., & Bonato, S. (2021). Peer support as a protective factor against suicide in trans populations: A scoping review. *Social Science & Medicine*, *279*. https://sci-

hub.se/https://www.sciencedirect.com/science/article/abs/pii/S0277953621003580?via%3Dihub

Kidd, J. D., Jackman, K. B., Barucco, R., Dworkin, J. D., Dolezal, C., Navalta, T. V., Belloir, J., & Bockting, W. O. (2021). Understanding the impact of the COVID-19 pandemic on the mental health of transgender and gender nonbinary individuals engaged in a longitudinal cohort study. *Journal of Homosexuality*, *68*(4), 592. https://doi.org/10.1080/00918369.2020.1868185

Kline, R. B. (2011). *Principles and practice of structural equation modeling* (3rd ed.). Guilford Press.

Klonsky, E. D., & May, A. M. (2015). The three-step theory (3ST): A new theory of suicide rooted in the "ideation-to-action" framework. *International Journal of Cognitive Therapy*, *8*(2), 114–129. https://doi.org/10.1521/IJCT.2015.8.2.114

Krafft, J., Hicks, E. T., Mack, S. A., & Levin, M. E. (2019). Psychological Inflexibility Predicts Suicidality Over Time in College Students. *Suicide & Life-Threatening Behavior*, *49*(5), 1488–1496. https://doi.org/10.1111/SLTB.12533

Kratovic, L., Smith, L. J., & Vujanovic, A. A. (2020). PTSD Symptoms, Suicidal Ideation, and Suicide Risk in University Students: The Role of Distress Tolerance. *Https://Doi.Org/10.1080/10926771.2019.1709594*, *30*(1), 82–100. https://doi.org/10.1080/10926771.2019.1709594

Kroska, E. B., Roche, A. I., Adamowicz, J. L., & Stegall, M. S. (2020). Psychological flexibility in the context of COVID-19 adversity: Associations with distress. *Journal of Contextual Behavioral Science*, *18*, 28–33. https://doi.org/10.1016/j.jcbs.2020.07.011

Kyron, M. J., Hooke, G. R., Bryan, C. J., & Page, A. C. (2022). Distress tolerance as a moderator of the dynamic associations between interpersonal needs and suicidal thoughts. *Suicide and Life-Threatening Behavior*, *52*(1), 159–170. https://doi.org/10.1111/SLTB.12814

Lass, A. N. S., & Winer, E. S. (2020). Distress tolerance and symptoms of depression: A review and integration of literatures. *Clinical Psychology: Science and Practice*, *27*(3), e12336. https://doi.org/10.1111/CPSP.12336

Levin, M. E., MacLane, C., Daflos, S., Seeley, J. R., Hayes, S. C., Biglan, A., & Pistorello, J. (2014). Examining psychological inflexibility as a transdiagnostic process across psychological disorders. *Journal of Contextual Behavioral Science*, *3*(3), 155. https://doi.org/10.1016/J.JCBS.2014.06.003

Lloyd, J., Chalklin, V., & Bond, F. W. (2019). Psychological processes underlying the impact of gender-related discrimination on psychological distress in transgender and gender nonconforming people. *Journal of Counseling Psychology*, *66*(5). https://doi.org/10.1037/COU0000371

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

Lucena-Santos, P., Palmeira, L., Duarte, C., Oliveira, M., & Pinto-Gouveia, J. (2013). *Distress Tolerance Scale-Simons (DTS-S): Preliminary data for the Portuguese Version*.

Masuda, A., Anderson, P. L., Wendell, J. W., Chou, Y. Y., Price, M., & Feinstein, A. B. (2011). Psychological flexibility mediates the relations between self-concealment and negative psychological outcomes. *Personality and Individual Differences*, *50*(2), 243–247. https://doi.org/10.1016/J.PAID.2010.09.037

Matos-Gonçalves, A., Alberto, C., Sequeira, C., Carvalho Duarte, J., & Pinto De Freitas, P. (2015). Suicidal Ideation on Higher Education Students: Influence of Some Psychosocial Variables. *Archives of Psychiatric Nursing*. https://doi.org/10.1016/j.apnu.2015.08.005

McCann, E., & Brown, M. (2017). Vulnerability and Psychosocial Risk Factors Regarding People who Identify as Transgender. A Systematic Review of the Research Evidence. *Issues in Mental Health Nursing*. https://doi.org/10.1080/01612840.2017.1382623

McCann, E., Donohue, G., & Brown, M. (2021). Experiences and Perceptions of Trans and Gender Non-Binary People Regarding Their Psychosocial Support Needs: A Systematic Review of the Qualitative Research Evidence. *Int. J. Environ. Res. Public Health*, *18*. https://sci-hub.se/https://pubmed.ncbi.nlm.nih.gov/33806008/

McCracken, L. M., Patel, S., & Scott, W. (2018). The role of psychological flexibility in relation to suicidal thinking in chronic pain. *European Journal of Pain*, *22*(10), 1774–1781. https://doi.org/10.1002/EJP.1273

McNeil, J., Ellis, S. J., & Eccles, F. J. R. (2017). Suicide in trans populations: A systematic review of prevalence and correlates. *Psychology of Sexual Orientation and Gender Diversity*, *4*(3), 341–353. https://doi.org/10.1037/SGD0000235

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. https://doi.org/10.1037/0033-2909.129.5.674

Meyer, I. H., Frost, D. M., & Nezhad, S. (2015). Minority Stress and Suicide in Lesbians, Gay Men, and Bisexuals. In Peter Goldblum, Dorothy L. Espelage, Joyce Chu, & Bruce Bongar (Eds.), *Youth Suicide and Bullying* (pp. 177–188). Oxford University Press. https://doi.org/10.1093/MED:PSYCH/9780199950706.003.0015

Nock, M. K., & Mendes, W. B. (2008). Physiological arousal, distress tolerance, and social problem-solving deficits among adolescent self-injurers. *Journal of Consulting and Clinical Psychology*, *76*(1), 28–38. https://doi.org/10.1037/0022-006X.76.1.28

Pais-Ribeiro, J., Silva, I., Ferreira, T., Martins, A., Meneses, R., & Baltar, M. (2007). Validation

study of a Portuguese version of the Hospital Anxiety and Depression Scale. *Psychology, Health & Medicine*, *12*(2), 225–237. https://doi.org/10.1080/13548500500524088

Pellicane, M. J., & Ciesla, J. A. (2022). Associations between minority stress, depression, and suicidal ideation and attempts in transgender and gender diverse (TGD) individuals: Systematic review and meta-analysis. *Clinical Psychology Review*, *91*. https://doi.org/10.1016/J.CPR.2021.102113

Perez-Brumer, A., Hatzenbuehler, M. L., Oldenburg, C. E., & Bockting, W. (2015). Individual- and Structural-Level Risk Factors for Suicide Attempts Among Transgender Adults. *Https://Doi.Org/10.1080/08964289.2015.1028322*, *41*(3), 164–171. https://doi.org/10.1080/08964289.2015.1028322

Pettorruso, M., D'andrea, G., Martinotti, G., Cocciolillo, F., Miuli, A., Di Muzio, I., Collevecchio, R., Verrastro, V., De-Giorgio, F., Janiri, L., Di Giannantonio, M., Di Giuda, D., & Camardese, G. (2020). Hopelessness, Dissociative Symptoms, and Suicide Risk in Major Depressive Disorder: Clinical and Biological Correlates. *Brain Sciences*, *10*(8), 1–11. https://doi.org/10.3390/BRAINSCI10080519

Poštuvan, V., Podlogar, T., Zadravec Šedivy, N., & De Leo, D. (2019). Suicidal behaviour among sexual-minority youth: a review of the role of acceptance and support. In *The Lancet Child and Adolescent Health* (Vol. 3, Issue 3, pp. 190–198). Elsevier B.V. https://doi.org/10.1016/S2352-4642(18)30400-0

Reisner, S. L., Vetters, R., Leclerc, M., Zaslow, S., Wolfrum, S., Shumer, D., & Mimiaga, M. J. (2015). Mental Health of Transgender Youth in Care at an Adolescent Urban Community Health Center: A Matched Retrospective Cohort Study. *Journal of Adolescent Health*, *56*(3), 274–279. https://doi.org/10.1016/J.JADOHEALTH.2014.10.264

Rodrigues, J., Lemos, C., & Figueiredo, Z. (2020). Discriminação e Barreiras ao Acesso ao Serviço Nacional de Saúde Percecionados por Pessoas Trans. *Revista Portuguesa de Psiquiatria e Saúde Mental*, *6*(3), 98–108. https://doi.org/10.51338/rppsm.2020.v6.i3.152

Rood, B. A., Puckett, J. A., Pantalone, D. W., & Bradford, J. B. (2015). Predictors of Suicidal Ideation in a Statewide Sample of Transgender Individuals. *Https://Home.Liebertpub.Com/Lgbt*, *2*(3), 270–275. https://doi.org/10.1089/LGBT.2013.0048

Russell, B. S., Lincoln, C. R., & Starkweather, A. R. (2019). Distress Tolerance Intervention for Improving Self-Management of Chronic Conditions: A Systematic Review. *Journal of Holistic Nursing : Official Journal of the American Holistic Nurses' Association*, *37*(1), 74–86. https://doi.org/10.1177/0898010118777327

Russell, S. T., Pollitt, A. M., Li, G., & Grossman, A. H. (2018). Chosen Name Use Is Linked to Reduced Depressive Symptoms, Suicidal Ideation, and Suicidal Behavior Among Transgender Youth. *Journal of Adolescent Health*, *63*(4), 503–505.

https://doi.org/10.1016/J.JADOHEALTH.2018.02.003

Schmelefske, E., Per, M., Khoury, B., & Heath, N. (2020). The Effects of Mindfulness-Based Interventions on Suicide Outcomes: A Meta-Analysis. *Archives of Suicide Research : Official Journal of the International Academy for Suicide Research*. https://doi.org/10.1080/13811118.2020.1833796

Simons, J. S., & Gaher, R. M. (2005). The Distress Tolerance Scale: Development and Validation of a Self-Report Measure. *Motivation and Emotion 2005 29:2*, *29*(2), 83–102. https://doi.org/10.1007/S11031-005-7955-3

Simons, J. S., Simons, R. M., Grimm, K. J., Keith, J. A., & Stoltenberg, S. F. (2021). Affective dynamics among veterans: Associations with distress tolerance and posttraumatic stress symptoms. *Emotion*, *21*(4), 757–771. https://doi.org/10.1037/EMO0000745

Staples, J. M., Neilson, E. C., Bryan, A. E. B., & George, W. H. (2017). The Role of Distal Minority Stress and Internalized Transnegativity in Suicidal Ideation and Nonsuicidal Self-Injury Among Transgender Adults. *Https://Doi.Org/10.1080/00224499.2017.1393651*, *55*(4–5), 591–603. https://doi.org/10.1080/00224499.2017.1393651

Tan, K. K. H., 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

Tebbe, E. A., & Moradi, B. (2016). Suicide risk in trans populations: An application of minority stress theory. *Journal of Counseling Psychology*, *63*(5), 520–533. https://doi.org/10.1037/cou0000152

Testa, R. J., Habarth, J., Peta, J., Balsam, K., & Bockting, W. (2015). Development of the Gender Minority Stress and Resilience Measure. *Psychology of Sexual Orientation and Gender Diversity*, *2*(1), 65–77. https://doi.org/10.1037/SGD0000081

Testa, R. J., Michaels, M. S., Bliss, W., Rogers, M. L., Balsam, K. F., & Joiner, T. (2017). Suicidal ideation in transgender people: Gender minority stress and interpersonal theory factors. *Journal of Abnormal Psychology*, *126*(1), 125–136. https://doi.org/10.1037/ABN0000234

Tindle, R., & Moustafa, A. A. (2021). Psychological distress, social support, and psychological flexibility during COVID-19. *Mental Health Effects of COVID-19*, 89–101. https://doi.org/10.1016/B978-0-12-824289-6.00012-X

Trindade, I. A., Ferreira, N. B., Mendes, A. L., Ferreira, C., Dawson, D., & Golijani-Moghaddam, N. (2021). Comprehensive assessment of Acceptance and Commitment Therapy processes (CompACT): Measure refinement and study of measurement invariance across Portuguese and UK samples. *Journal of Contextual Behavioral Science*, *21*, 30–36. https://doi.org/10.1016/J.JCBS.2021.05.002

Trujillo, M. A., Perrin, P. B., Sutter, M., Tabaac, A., & Benotsch, E. G. (2017). The buffering

role of social support on the associations among discrimination, mental health, and suicidality in a transgender sample. *The International Journal of Transgenderism*, *18*(1), 39–52. https://doi.org/10.1080/15532739.2016.1247405

Tucker, R. P., Testa, R. J., Simpson, T. L., Shipherd, J. C., Blosnich, J. R., & Lehavot, K. (2018). Hormone therapy, gender affirmation surgery, and their association with recent suicidal ideation and depression symptoms in transgender veterans. *Psychological Medicine*, *48*(14), 2329–2336. https://doi.org/10.1017/S0033291717003853

Turban, J. L., & Keuroghlian, A. S. (2018). Dynamic Gender Presentations: Understanding Transition and "De-Transition" Among Transgender Youth. *Journal of the American Academy of Child and Adolescent Psychiatry*, *57*(7), 451–453. https://doi.org/10.1016/J.JAAC.2018.03.016

Weinforth, G., Fakin, R., Giovanoli, P., & Nuñez, D. G. (2019). Quality of Life Following Male-To-Female Sex Reassignment Surgery. *Deutsches Ärzteblatt International*, *116*(15), 253. https://doi.org/10.3238/ARZTEBL.2019.0253

WHO. (2014). *Preventing Preventing suicide suicide A global imperative A global imperative*. www.who.int

Witcomb, G. L., Bouman, W. P., Claes, L., Brewin, N., Crawford, J. R., & Arcelus, J. (2018). Levels of depression in transgender people and its predictors: Results of a large matched control study with transgender people accessing clinical services. *Journal of Affective Disorders*, *235*, 308–315. https://doi.org/10.1016/J.JAD.2018.02.051

Wolford-Clevenger, C., Frantell, K., Smith, P. N., Flores, L. Y., & Stuart, G. L. (2018). Correlates of suicide ideation and behaviors among transgender people: A systematic review guided by ideation-to-action theory. *Clinical Psychology Review*, *63*, 93–105. https://doi.org/10.1016/J.CPR.2018.06.009

APPENDIX

Appendix I - Study Questionnaire

FACTORES PSICOSSOCIAIS ASSOCIADOS À IDEAÇÃO SUICIDA NA PESSOA TRANS: FATORES DE PROTEÇÃO E VULNERABILIDADE

Solicitamos a sua participação voluntária neste estudo intitulado "Fatores Psicossociais Associados à Ideação Suicida na Pessoa Trans: Fatores de Proteção e Vulnerabilidade", que vai decorrer no âmbito dos trabalhos finais do 6º ano do Mestrado Integrado em Medicina, em colaboração com o Instituto de Psicologia Médica da Faculdade de Medicina da Universidade de Coimbra, sob orientação do Prof Dr. António Macedo, e coorientação da Dra. Susana Renca, Dra. Sara Magano e Doutoranda Julieta Azevedo.

Este procedimento é chamado de Consentimento Informado e descreve a finalidade do estudo, os procedimentos, os possíveis benefícios e riscos. Este estudo foi aprovado pela Comissão de Ética da Faculdade Medicina da Universidade de Coimbra (FMUC), de modo a garantir a proteção dos direitos, segurança e bem-estar de todos/as os/as participantes incluídos/as e garantir prova pública dessa proteção.

Para participar neste estudo deverá ter mais de 18 anos e identificar-se como uma pessoa Trans. Se aceitar participar, iremos solicitar o preenchimento de um conjunto de questionários de autorresposta sobre a saúde mental, comportamentos e processos psicológicos, que pretende ajudar a compreender os fatores protetores e de vulnerabilidade inerentes à psicopatologia e mal-estar psicológico nas pessoas Trans. Não há respostas certas ou erradas. O preenchimento da bateria de questionários tem a duração aproximada de 20 minutos.

A sua participação vai contribuir para melhorar o conhecimento nesta área de investigação, contribuindo para a prevenção e intervenção psicológica e psiquiátrica nas pessoas Trans, através da compreensão dos fatores que contribuem para o desenvolvimento e/ou manutenção de mal-estar psicológico.

A participação é voluntária e é inteiramente livre de aceitar ou recusar participar neste estudo.

Iremos pedir-lhe que forneça 4 dígitos (os dois primeiros números correspondem aos dois últimos números do seu telemóvel/telefone e os outros aos últimos dois números do seu ano de nascimento), com o objetivo de saber se a mesma pessoa respondeu mais que uma vez ao questionário nos vários meios em que o mesmo está a ser disponibilizado.

Os seus registos manter-se-ão confidenciais e anonimizados, de acordo com os regulamentos e leis aplicáveis. As respostas não serão analisadas individualmente e os dados serão informatizados para podermos proceder ao seu tratamento estatístico. O prazo máximo de conservação dos dados do estudo é de 5 anos.

No caso de pretender eliminar/alterar as suas respostas, deve entrar em contacto com o responsável pelo tratamento dos dados, através do endereço de email indicado neste Consentimento Informado.

Ao submeter o questionário, confirma que tomou conhecimento das informações descritas no Consentimento Informado e que autoriza a sua participação no estudo.

Agradecemos a sua colaboração.

Se tiver perguntas relativas aos seus direitos como participante deste estudo, deve contactar:

Luís Miguel Martins.

E-mail: luismcomartins@gmail.com

☐ Li e aceito participar de forma voluntária neste estudo, tendo sido informado/a sobre os objetivos e procedimentos da investigação, permitindo o uso das minhas respostas para os fins referidos.

Tem mais de 18 anos?

Sim ☐

Não ☐

QUESTIONÁRIO

Por favor, leia com atenção cada uma das questões apresentadas.

Pedimos que responda ao questionário até ao fim. Não há respostas certas ou erradas.

A sua participação irá contribuir para melhorar o conhecimento nesta área de investigação.

Agradecemos a sua colaboração.

Por favor, introduza:

- Dois últimos dígitos do seu número de telemóvel/telefone __ __
- Dois últimos dígitos do seu ano de nascimento __ __

Identifica-se como uma pessoa Trans?

Sim ☐
Não ☐

1. **Idade:** _____

2. **Sexo à nascença:**

Feminino ☐
Masculino ☐
Intersexo ☐

3. **Identidade de género**:

Mulher ☐
Homem ☐
Não binário ☐
Outra: _____

4. **Orientação sexual:**

Lésbica ☐
Gay ☐
Bissexual ☐
Heterossexual ☐
Pansexual ☐
Assexual ☐
Outra: _____

5. **Em relação à possibilidade de um processo de transição, por favor indique?**

Transição	Já fiz	Já iniciei, mas ainda não completei	Ainda não iniciei, mas pretendo fazê-lo	Não pretendo fazer
Social (mudar a expressão de género e/ou nome)	☐	☐	☐	☐
Hormonal (fazer terapia hormonal)	☐	☐	☐	☐
Física/Cirúrgica (fazer operações/alterações físicas)	☐	☐	☐	☐

6. Alterou o nome próprio e sexo no Registo Civil?

Sim ☐
Não ☐

7. Se já realizou procedimentos cirúrgicos de reatribuição sexual, indique que alterações realizou:

_____

8. Tem algum diagnóstico clínico de doença física?

Sim ☐
Não ☐

9. Se respondeu "sim" à questão anterior, por favor indique qual:

_____

10. Tem algum diagnóstico clínico de doença psiquiátrica?

Sim ☐
Não ☐

11. Se respondeu "sim" à questão anterior, por favor indique qual:

_____

12. Com exceção da avaliação psicológica e psiquiátrica relacionada com o seu processo de transição, é acompanhado por (assinale todas as que se aplicam):

Psicólogo ☐

Psiquiatra ☐

Não se aplica ☐

12.1 Se sim, há quanto tempo e qual o motivo (caso tenha selecionado duas opções, especifique cada uma delas).

_____

_____

13. Toma medicação psiquiátrica?

Sim ☐
Não ☐

14. Estado civil:

Solteiro/a ☐
Casado/a ☐

Divorciado/a ☐
União de facto ☐
Viúvo/a ☐
Outra: _____

15. Tem, neste momento, algum relacionamento?

Sim ☐
Não ☐

16. Se sim, há quanto tempo?

_____

17. Considera-se uma pessoa religiosa?

Sim ☐
Não ☐

18. Se sim, qual?

_____

19. Residência:

Norte ☐
Centro ☐
Lisboa e Vale do Tejo ☐
Sul ☐
Ilhas ☐

20. Escolaridade:

Ensino Primário ☐
Ensino Básico ☐
Ensino Secundário ☐
Bacharelato ☐
Licenciatura ☐
Mestrado ☐
Doutoramento ☐
Outra: _____

21. Situação laboral:

Trabalhador/a ☐
Trabalhador/a e estudante ☐
Estudante ☐
Desempregado ☐
Outra: _____

22. Como considera a sua situação socioeconómica?

Muito baixa	☐
Baixa	☐
Média	☐
Alta	☐
Muito alta	☐

B. *OUTNESS INVENTORY*

(Mohr & Fassinger, 2000; Gato & Fointaine, 2014 – adaptação para Trans)

Por favor, utilize a seguinte escala para indicar em que medida as seguintes pessoas estão a par do facto de ser uma pessoa Trans. Tente responder a todos os itens, mas selecione 0 se não se aplicarem a si. Se algum item se referir a um grupo de pessoas (e.g. colegas de trabalho), indique como se sente em relação a esse grupo.

1 = Esta pessoa definitivamente NÃO sabe que sou Trans

2 = Esta pessoa poderá saber, mas NUNCA falamos disso

3 = Esta pessoa provavelmente sabe, mas NUNCA falamos sobre isso

4 = Esta pessoa provavelmente sabe, mas RARAMENTE falamos disso

5 = Esta pessoa sabe com toda a certeza, mas RARAMENTE falamos disso

6 = Esta pessoa sabe com toda a certeza a ÀS VEZES falamos disso

7 = Esta pessoa sabe com toda a certeza e falamos ABERTAMENTE disso

0 = Não aplicável à sua situação; esta pessoa ou grupo de pessoas não fazem parte da sua vida

01. Mãe	1	2	3	4	5	6	7	0
02. Pai	1	2	3	4	5	6	7	0
03. Irmãos/ãs	1	2	3	4	5	6	7	0
04. Família alargada/Parentes	1	2	3	4	5	6	7	0
05. Novos/as amigos/as heterossexuais	1	2	3	4	5	6	7	0
06. Colegas de trabalho	1	2	3	4	5	6	7	0

07. Chefe/s de trabalho	1	2	3	4	5	6	7	0
08. Membros da minha comunidade religiosa	1	2	3	4	5	6	7	0
09. Líderes da minha comunidade religiosa	1	2	3	4	5	6	7	0
10. Estranhos/Novos conhecimentos	1	2	3	4	5	6	7	0
11. Antigos/as amigos/as heterossexuais	1	2	3	4	5	6	7	0

C. ESCALA DE SATISFAÇÃO COM A VIDA (SWL)

(Diener E, Emmons RA, Larsen RJ, Griffin S., 1995; P.V. Laranjeira, C. 2009)

Este questionário pretende conhecer o que pensam as pessoas a respeito da sua vida. Responda sinceramente a todas as perguntas, conforme aquilo que verdadeiramente sente e não como gostaria de ser. Não há respostas boas nem más; todas são boas desde que sinceras.

Em todas as perguntas seguintes faça um círculo à volta do número que melhor corresponde ao seu caso, conforme a seguinte escala:

1	2	3	4	5
Discordo muito	Discordo um pouco	Não concordo nem discordo	Concordo um pouco	Concordo muito

1. A minha vida parece-se em quase tudo com o que eu desejaria que ela fosse.	1	2	3	4	5
2. As minhas condições de vida são muito boas.	1	2	3	4	5
3. Estou satisfeito com a minha vida.	1	2	3	4	5
4. Até agora tenho conseguido as coisas importantes da vida que eu desejaria.	1	2	3	4	5
5. Se pudesse recomeçar a minha vida, não mudaria quase nada.	1	2	3	4	5

D. COMPACT

(Francis, Dawson, Golijani-Moghaddam, 2016; Trindade et al., 2020)

Em baixo, encontrará uma lista de afirmações. Por favor, indique o seu grau de concordância com cada uma das afirmações, utilizando a seguinte escala.

Discordo Fortemente	**Discordo Moderadamente**	**Discordo Ligeiramente**	**Não concordo nem discordo**	**Concordo Ligeiramente**	**Concordo Moderadamente**	**Concordo Fortemente**
0	**1**	**2**	**3**	**4**	**5**	**6**

	1	2	3	4	5	6

1. Consigo identificar as coisas que são realmente importantes para a minha vida, e segui-las.

2. Um dos meus maiores objetivos é estar livre de emoções dolorosas.

3. Realizo atividades importantes para mim apressadamente e sem estar verdadeiramente atento/a ao que faço.

4. Tento manter-me ocupado/a para evitar ter alguns pensamentos e sentimentos.

5. Comporto-me de uma forma consistente com a maneira como quero viver a minha vida.

6. Faço escolhas baseando-me no que é importante para mim, mesmo quando isso me provoca tensão/stress.

7. Digo a mim mesmo/a que não deveria pensar da forma como penso (ou ter certos pensamentos).

8. Acho difícil manter-me focado/a no que está a acontecer no momento presente.

9. Comporto-me de acordo com os meus valores pessoais.

10. Evito intencionalmente certas situações que possam provocar pensamentos, sentimentos ou sensações difíceis.

11. Mesmo quando faço coisas que são importantes para mim, dou por mim a fazê-las sem prestar atenção (em piloto automático).

12. Faço coisas importantes e que têm significado para mim, mesmo quando acho que isso é difícil.

13. Esforço-me bastante para afastar sentimentos perturbadores ou difíceis.

14. Faço atividades ou tarefas automaticamente, sem estar atento/a ao que estou a fazer.

15. Sou capaz de seguir os meus planos a longo prazo, mesmo em alturas em que o progresso é lento.

16. Parece que funciono em "piloto automático", sem prestar muita atenção ao que estou a fazer.

17. Os meus valores de vida estão claramente refletidos no meu comportamento.

18. Consigo continuar ou prosseguir com uma atividade quando ela é importante para mim.

E. *DISTRESS TOLERANCE SCALE (*DTS-S)

(Lucena-Santos, Palmeira, Duarte, Oliveira, & Pinto-Gouveia, 2013)

Pense nos momentos que sente angústia ou mal-estar psicológico (não se sente bem, tem emoções desagradáveis/desconfortáveis como angústia, sofrimento ou dor emocional). Selecione a opção que melhor descreve as suas opiniões acerca de sentimentos de mal-estar psicológico e emocional, usando a seguinte escala de resposta:

Discordo Fortemente	**Discordo Moderadamente**	**Não concordo nem discordo**	**Concordo Moderadamente**	**Concordo Fortemente**
1	**2**	**3**	**4**	**5**

	1	2	3	4	5
1. Sentir angústia ou sentir-me perturbado/a é insuportável para mim.					
2. Quando eu me sinto mal ou perturbado/a, só consigo pensar em quão mal me sinto.					
3. Eu não consigo lidar com o meu mal-estar psicológico ou com sentir-me perturbado/a.					
4. Os meus sentimentos de mal-estar emocional são tão intensos que me dominam completamente.					
5. Não há nada pior do que sentir mal-estar psicológico/emocional.					
6. Consigo tolerar sentir mal-estar psicológico/emocional tanto como as outras pessoas.					
7. Sentir mal-estar psicológico ou sentir-me perturbado/a não é aceitável para mim.					
8. Faço qualquer coisa para evitar sentir-me mal ou perturbado/a.					
9. As outras pessoas parecem ser mais capazes de tolerar sentimentos de mal-estar ou sofrimento do que eu.					
10. Sentir angústia ou mal-estar psicológico/emocional é sempre um grande sacrifício para mim.					
11. Sinto vergonha de mim próprio/a quando me sinto mal (angústia e/ou perturbado/a)					
12. Os meus sentimentos de mal-estar psicológico/emocional assustam-me.					
13. Faço qualquer coisa para deixar de me sentir mal (em sofrimento psicológico).					
14. Quando eu me sinto mal (psicologicamente/emocionalmente) ou perturbado/a tenho de fazer alguma coisa acerca disso imediatamente.					

15. Quando me sinto mal (psicologicamente/emocionalmente) não consigo deixar de me concentrar em quão mau é sentir-me assim.					

F. ESCALA MULTIDIMENSIONAL DE SUPORTE SOCIAL PERCEBIDO (MSPSS)

(ZIMET, DAHLEM, ZIMET & FARLEY, 1988; TRADUÇÃO E ADAPTAÇÃO: CARVALHO, S., 2006)

Estamos interessados em avaliar o que pensa em relação às afirmações seguintes. Leia cuidadosamente cada uma das afirmações.

Utilizando a escala abaixo, indique como se sente acerca de cada uma delas assinalando a sua resposta.

	Discorda completamente	**Discorda fortemente**	**Discorda parcialmente**	**Não tem opinião**	**Concorda parcialmente**	**Concorda fortemente**	**Concorda completamente**
1. Há uma pessoa especial que se encontra próximo quando necessito.							
2. Há uma pessoa especial com quem posso partilhar as minhas alegrias e tristezas							
3. A minha família tenta ajudar-me verdadeiramente							
4. Tenho a ajuda emocional e o apoio que necessito da minha família							
5. Tenho uma pessoa que é verdadeiramente uma fonte de conforto para mim							
6. Os/As meus/minhas amigos/as realmente procuram ajudar-me							
7. Posso contar com os/as meus/minhas amigos/as quando algo corre mal							
8. Posso falar dos meus problemas com a minha família							

9. Tenho amigos/as com quem posso partilhar as minhas alegrias e tristezas							
10. Há uma pessoa especial na minha vida que se preocupa comos meus sentimentos							
11. A minha família esta disponível para me ajudar a tomar decisões							
12. Posso falar dos meus problemas com os/as meus/minhas amigos/as							

G. ESCALA DE ANSIEDADE, DEPRESSÃO E STRESS (EADS-21)

(Lovibond & Lovibond, 1995)

(Versão Portuguesa para adolescentes: Pais-Ribeiro, J.L., Honrado, A. & Leal, I.)

Por favor leia cada uma das afirmações abaixo e assinale 0, 1, 2 ou 3 para indicar quanto cada afirmação se aplicou a si **durante a semana passada.** Não há respostas certas ou erradas. Não leve muito tempo a indicar a sua resposta em cada afirmação. A classificação é a seguinte:

0	**1**	**2**	**3**
Não se aplicou nada a mim	Aplicou-se a mim algumas vezes	Aplicou-se a mim muitas vezes	Aplicou-se a mim a maior parte das vezes

1. Tive dificuldades em me acalmar	0	1	2	3
2. Senti a minha boca seca	0	1	2	3
3. Não consegui sentir nenhum sentimento positivo	0	1	2	3
4. Senti dificuldades em respirar	0	1	2	3
5. Tive dificuldade em tomar iniciativa para fazer coisas	0	1	2	3
6. Tive tendência a reagir em demasia em determinadas situações	0	1	2	3
7. Senti tremores (por ex., nas mãos)	0	1	2	3
8. Senti que estava a utilizar muita energia nervosa	0	1	2	3

9. Preocupei-me com situações em que podia entrar em pânico e fazer figura ridícula	0	1	2	3
10. Senti que não tinha nada a esperar do futuro	0	1	2	3
11. Dei por mim a ficar agitado/a	0	1	2	3
12. Senti dificuldade em me relaxar	0	1	2	3
13. Senti-me desanimado/a e melancólico/a	0	1	2	3
14. Estive intolerante em relação a qualquer coisa que me impedisse de terminar aquilo que estava a fazer	0	1	2	3
15. Senti-me quase a entrar em pânico	0	1	2	3
16. Não fui capaz de ter entusiasmo por nada	0	1	2	3
17. Senti que não tinha muito valor como pessoa	0	1	2	3
18. Senti que por vezes estava sensível	0	1	2	3
19. Senti alterações no meu coração sem fazer exercício físico	0	1	2	3
20. Senti-me assustado/a sem ter tido uma boa razão para isso	0	1	2	3
21. Senti que a vida não tinha sentido	0	1	2	3

H. ESCALA DE SUICIDALIDADE

(Castilho, Pinto & Carreiras, 2019)

Esta escala pretende avaliar pensamentos relacionados com a morte e suicídio. Estamos interessados em saber a frequência com que tem este tipo de pensamentos.

Por favor, leia atentamente cada uma das afirmações e assinale a opção que melhor se aplica a si de acordo com a escala abaixo fornecida:

Nunca me acontece	**Acontece-me algumas vezes**	**Acontece-me muitas vezes**	**Acontece-me sempre**
0	**1**	**2**	**3**

	0	1	2	3
1. Há alturas em que sinto que a minha vida não vale a pena.				
2. Há alturas em que penso que os outros estariam melhor se eu não estivesse presente.				
3. Há alturas em que penso que me quero matar.				
4. Há alturas em que desejo nunca ter nascido.				
5. Há alturas em que penso que não tenho futuro ou saída.				
6. Há alturas em que gostava simplesmente de desaparecer.				
7. Há alturas em que penso ser um fardo para os outros.				
8. Há alturas em que planeio o que quero fazer quando me matar.				
9. Há alturas em que penso na morte.				
10. Há alturas em que penso que ninguém se importa se estou vivo/a ou morto/a.				
11. Há alturas em que desejo estar morto/a.				

I. TENTATIVA DE SUICÍDIO

1. **Já alguma vez teve um plano para se matar?**

   Sim ☐
   Não ☐

2. **Já alguma vez tentou matar-se?**

   Sim ☐
   Não ☐

3. **Se respondeu "sim" na questão anterior, quantas vezes? _____**

4. **Se respondeu "sim" na questão 2, foi hospitalizado/a?**

   Sim ☐
   Não ☐

J. Escada de Discriminação Quotidiana (EDS-PT)

(Williams, Yu, Jackson, & Anderson, 1997; Freitas, Coimbra, Marturano, & Marie Fontaine, 2015; Seabra, Salvador, & Gato, 2019)

No seu dia-a-dia atual, por favor indique a frequência com que as seguintes situações ocorrem, devido ao facto de ser uma pessoa Trans:

Escala de resposta:

0 = Nunca

1 = Raramente (menos de 1 vez / ANO)

2 = Por vezes (algumas vezes / ANO)

3 = Algumas vezes (alguma vezes / MÊS)

4 = Muitas vezes (pelo menos 1 vez / SEMANA)

5 = Quase sempre (quase todos os DIAS)

01. Sou tratado/a com menos simpatia do que as outras pessoas _____

02. Sou tratado/a com menos respeito do que as outras pessoas _____

03. Em lojas, restaurantes ou noutros serviços sou menos bem atendido/a do que as outras pessoas _____

04. As pessoas agem como se pensassem que não sou inteligente _____

05. As pessoas agem como se tivessem medo de mim _____

06. As pessoas agem como se pensassem que sou desonesto/a _____

07. As pessoas agem como se fossem melhores do que eu _____

08. Chamam-me nomes ou insultam-me _____

09. Sou ameaçado/a ou provocado/a _____

10. As pessoas agem como se houvesse algo errado comigo _____

11. As pessoas tratam-me de forma negativa por acharem que pareço com uma pessoa do sexo oposto _____

Muito obrigado pela sua colaboração!

Appendix II - Psychology of Sexual Orientation and Gender Diversity: *submission guidelines*

Manuscript types

Psychology of Sexual Orientation and Gender Diversity® (PSOGD) accepts a variety of article types consistent with the journal's mission, including:

Standard articles containing a maximum of 7,500 words of text. These will be the most typical articles.

Longer, monograph-style articles containing a maximum of 12,000 words of text. These longer contributions will not be typical and to be considered, must provide a particularly enhanced coverage of the topic addressed.

This can take the form of:

- especially extensive literature review with a methodological critique and/or public policy implications explicated
- description of an interlocked series of research projects
- synthesis of material on sexual orientation and gender diversity with material from other aspects of psychology and/or other disciplines
- similarly extensive contributions

AUTHORS MUST OBTAIN PRIOR APPROVAL OF THE EDITOR PRIOR TO SUBMITTING THIS ARTICLE TYPE.

Brief reports are research-oriented and contain a maximum of 4,000 words of text.

Case studies are clinically/practice-oriented (including industrial/organization practice) and contain a maximum of 3,000 words of text. All ethical and risk management considerations regarding informed consent, confidentiality, and other relevant concerns must be addressed. Case studies must also situate the case in question in relevant theoretical, empirical, and methodological matrices.

Letters to the editor should be limited to 500 words. In unusual circumstances, the founding editor may allow a longer limit with the author.

Commentaries may address developments in the behavioral sciences and related fields, the legal system, national or world events, as these pertain to the content areas of PSOGD. These should be a maximum of 1000 words unless a longer length is allowed by the founding editor.

This list is not meant to be exclusive. Other article varieties may be accepted under unusual circumstances. However, authors must contact the editor prior to submission of any other article to discuss and get approval.

As a rule of thumb one double-spaced page of standard font and size text contains about 300 words. If submissions contain an unusually larger number of references for the article type and/or unusually large tables/charts/graphs, authors may be required to reduce these. "Words" refers to words and other symbols or characters.

Reference: *Psychology of Sexual Orientation and Gender Diversity*. (n.d.). Retrieved April 3, 2022, from https://www.apa.org/pubs/journals/SGD/index?tab=1