

Association of sexual minority status, gender nonconformity with childhood victimization and adulthood depressive symptoms: A path analysis

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Abstract

Background: Sexual minority status and childhood gender nonconformity have been associated with elevated risks of childhood adversities and poorer mental health.

Objective: To explore how abuse and bullying explain the disparities in the associations of sexual minority status and childhood gender nonconformity with adulthood depressive symptoms in men.

Participants and Setting: We conducted a cross-sectional study using a self-report questionnaire among Chinese adult men (18-35 years) who were identified as heterosexual ($n=873$) and sexual minority ($n=858$) in Guangzhou from 2017 to 2019.

Methods: Structural equation modeling (SEM) were conducted for path analysis.

Results: The levels of exposure to childhood maltreatment were higher in sexual minorities than in straight men, and sexual minority status predicted an increased risk of depressive symptoms via childhood maltreatment (indirect effect: $\beta=0.026$, $p=0.004$). Meanwhile, childhood gender nonconformity predicted higher depressive symptoms via both family (indirect effect: $\beta=0.042$, $p<0.001$) and school (indirect effect: $\beta=0.028$, $p<0.001$) victimization, and there was a direct effect ($\beta=0.154$, $p<0.001$) of gender nonconformity on depressive symptoms.

Conclusion: Sexual minority status and gender nonconformity are indicators of men's increased risk of childhood victimization and adulthood depressive symptoms. As a result, intervention based on both family and school dimensions needs to be developed.

Key words: sexual minority; childhood maltreatment; bullying; depressive symptoms; gender nonconformity

1. Introduction

Sexual minority men have reported a higher prevalence of family maltreatment during childhood, especially sexual abuse, and a higher prevalence of school bullying than straight men (Friedman et al., 2011; McGeough & Sterzing, 2018; Xu & Zheng, 2015; Zou & Andersen, 2015). Some studies have suggested that children who had disclosed their same-sex orientation to their family members could be targeted for physical and verbal abuse (D'Augelli, Hershberger, & Pilkington, 1998). In China, homosexuality was regarded as a kind of “hooliganism” until the law was removed in 1997. Also, homosexuality was classified as a sexual disorder until it was eliminated from the Chinese Classification of Mental Disorders (CCMD) in 2001 (Wu, 2003). Nonetheless, diagnosis of “ego-dystonic sexual orientation” was still retained in CCMD, and unfortunately, nearly 6% of Chinese sexual minorities reported that they had been recommended by their mental health care providers to receive conversion therapy (Suen & Chan, 2020). Besides, some traditional

customs, such as the filial piety, which values the continuation of family strain, may lead to some negative attitudes toward sexual minorities (Kwok & Wu, 2015). As a result, sexual minority men in China have been living in a heterosexism environment over the last decades, while few studies have investigated their childhood victimization experiences and the potential long-lasting mental health effects compared to straight men.

Individuals whose gender expression does not align with their biological sex are termed “gender nonconforming” (Zucker et al., 2006). Evidence has revealed that sexual minority individuals are disproportionately gender nonconforming in childhood (Jones, Robinson, Oginni, Rahman, & Rimes, 2017), which may lead to poorer parent-children relationships (Alanko et al., 2011). Individuals who are more gender nonconforming tend to report more childhood traumas, such as prejudice, discrimination (Gordon & Meyer, 2007), and abuse and violence committed by both family members (Andrea L. Roberts, Margaret Rosario, Heather L. Corliss, Karestan C. Koenen, & S. Bryn Austin, 2012) and peers (Gordon et al., 2018). The higher risk of family victimization for sexual minorities could be partly explained by gender nonconformity because parents may be abusive to attempt to control the gender expression of their children (Baams, 2018). Also, gender nonconformity in childhood has been associated with increased risks of parental rejection (Landolt, Bartholomew, Saffrey, Oram, & Perlman, 2004) and negative rating of parental relationships (Alanko et al., 2009).

In terms of school victimization, research has indicated that adolescents experience

bullying related to their gender nonconformity, independent of sexual orientation (Gordon et al., 2018). Gender nonconforming men were more frequently perceived as gay than gender conforming ones (Johnson & Ghavami, 2011). This subtle cognitive tendency related to gender stereotypes may explain the elevated risk of bullying victimization among gender nonconforming adolescents, which often contains homophobia elements (Wyss, 2004). A study in Taiwan found that early identification of minority sexual orientation and gender role nonconformity were associated with bullying victimization among gay and bisexual men (Wang, Hsiao, & Yen, 2019). However, few studies in mainland China have focused on the relationship of sexual orientation and gender expression with different types of childhood victimization. It is important to fill the gap of unequal treatment among this unprotected minority population in China and find an effect target of sexual orientation and gender expression for interventions.

Sexual minority men who have experienced childhood emotional, physical and sexual abuse, and bullying reported higher rates of depressive symptoms than non-victim sexual minority men (Charak, Villarreal, Schmitz, Hirai, & Ford, 2019; Wang et al., 2018), and sexual minority men are at an elevated risk of depressive symptoms in contrast to heterosexuals (Lucassen, Stasiak, Samra, Frampton, & Merry, 2017). Depressive symptoms may affect health and well-being throughout adulthood and can predict major depression, suicidal behavior, anxiety disorders, and substance misuse (McLeod, Horwood, & Fergusson, 2016) , so identifying risk factors that could explain sexual orientation

disparities in depressive symptoms and optimizing prevention targets among sexual minorities at an early age is particularly vital. In the general population, the link of maltreatment and bullying victimization with mental health problems has been documented (Chandan et al., 2019; Evans-Lacko et al., 2017; Lereya, Copeland, Costello, & Wolke, 2015). For sexual minorities, according to the minority stress theory, sexual minority youths who had experienced stressful events (i.e., being the victim of violence) during their development process may anticipate these stressors and internalize the negative thoughts, and therefore were more vulnerable to have mental health problems in adulthood (Meyer, 1995). In China, research has revealed the critical role of minority stressors in mental health problems among men who have sex with men (MSM) population (Sun, Pachankis, Li, & Operario, 2020). Sexual minority-specific victimization has been confirmed to be a mediator of the effect of sexual minority status on depressive symptoms (Burton, Marshal, Chisolm, Sucato, & Friedman, 2013). However, few studies have shown whether the higher rates of childhood abuse and bullying victimization among sexual minorities could explain their higher risks of having depressive symptoms in comparison with straight men.

Additionally, possibly because of increased exposure to these stressors, gender nonconformity in childhood has been associated with a series of mental health problems in adulthood, such as depression, anxiety symptoms, suicidality, etc. (Guss, Shumer, & Katz-Wise, 2015; Lowry et al., 2018; Andrea L. Roberts et al., 2012; A. L. Roberts, M. Rosario, H. L. Corliss, K. C. Koenen, & S. B. Austin, 2012). A recent study based on the minority

stress theory depicted that childhood gender nonconformity predicted psychological distress through prejudice events and victimization among sexual minorities (Timmins, Rimes, & Rahman, 2020). Study has also revealed that childhood maltreatment and bullying victimization accounted for the increased rates of depressive symptoms in gender nonconforming youth in comparison with their gender conforming peers (Roberts, Rosario, Slopen, Calzo, & Austin, 2013).

Therefore, we hypothesize that the possible greater exposure to childhood victimization experienced by Chinese sexual minority men may contribute to their more severe depressive symptoms in adulthood compared with heterosexuals, and gender nonconformity would partially account for these adverse outcomes.

2. Methods

2.1. Participants and data collection

This study was conducted in Guangzhou, China, and the data were collected from July 2017 to June 2019. Because the sexual minority population is relatively hidden, all the gay and bisexual participants as well as their heterosexual counterparts were recruited from the visitors of AIDS control and prevention departments in Center for Disease Control and Prevention (CDC) in Yuexiu District and Tianhe District. The inclusion criteria were as

follows: 1) adult Chinese males aged between 18 and 35 years; 2) voluntary participation with written informed consent. The exclusion criterion were: 1) having self-reported AIDS or HIV infection; 2) having a history of severe physical or psychiatric disorders.

On weekdays, one to three participants simultaneously answered self-reported questionnaires, depending on the number of visitors who met the criteria. Well-trained investigators including the researchers in our research group and our cooperative health workers in CDC took turns to conduct the survey. After giving the instruction, the investigator would wait for the participants to complete their questionnaires and explain the items if the participants had any confusion. Throughout the survey, investigators were not allowed to read the content of the responses. Ultimately, 1731 respondents completed the questionnaires.

2.2 Ethical statement

This work followed the Declaration of Helsinki and received approval from the Institutional Review Board of the School of Public Health of Sun Yat-sen University (Guo et al., 2017; Zhou et al., 2015). All the respondents had signed a written voluntary informed consent form before the survey started, and the survey was anonymous for confidential reasons.

2.3 Measurement and instruments

2.3.1. Sexual minority status

Sexual orientation was assessed with the following statement and question: “There are all sorts of people with different sexual orientations who together make the world diverse. What do you think your sexual orientation is?” Response options range from “(1) exclusively straight” to “(7) exclusively gay” with an additional option “(8) others or unsure.” Respondents who reported being “exclusively straight” were categorized as “heterosexual (coded as 0),” those who reported being “exclusively gay” were categorized as “gay,” and the rest of the respondents who chose answers ranging from “predominantly straight, only incidentally gay” to “predominantly gay, only incidentally straight” were categorized as “bisexual.” According to the definition from the American Psychological Association (APA), sexual minority men (coded as 1) include male individuals who identify as gay or bisexual (Lowry et al., 2018). Those who chose “others or unsure” (37 men, 2.1% of all the participants) were excluded from further statistical analysis, because we mainly focused on gay, bisexual and straight men in this study.

2.3.2. Childhood gender nonconformity

Childhood gender expression was assessed by asking: “When you were a child (from

birth to 12 years of age), how did you feel about your appearance, style or behavior?” The five response options range from “1) very masculine” to “5) very feminine.” The respondents were categorized as “masculine” (very and somewhat masculine), “equally masculine and feminine,” and “feminine” (very and somewhat feminine) for the descriptive statistics (Lowry et al., 2018; Wylie, Corliss, Boulanger, Prokop, & Austin, 2010). According to the definition from the APA, the respondents were further categorized as “gender conforming” (masculine) and “gender nonconforming” (feminine or equally masculine and feminine) (Lowry et al., 2018).

2.3.3. Childhood maltreatment

Childhood family emotional, physical and sexual maltreatment was assessed using the corresponding subscales of the Childhood Trauma Questionnaire (CTQ) (Bernstein et al., 2003). In comparison with interview methods, the CTQ have dimensional scales assessing different types of childhood maltreatment (before 16 years old), and each subscale is based on five questions about childhood experiences. The items in CTQ are rated on a Likert-type scale, and the response options range from never happened (1 point) to always happened (5 points), so the scores vary along continuous dimensions, including duration, frequency, and severity (Bernstein et al., 2003). For the emotional abuse items, an example question is, “In my childhood, some family members called me stupid, lazy, or ugly”. For the physical abuse items, an example is, “In my childhood, some family members left me

bruises or scars by beating.” For the sexual abuse items, an example is, “In my childhood, someone threatened me to make me do something sexual with him/her.” The scores for each subscale range from 5 to 25, and higher scores represent more severe abuse.

2.3.4. Bullying victimization

Childhood school bullying was assessed by asking: “At school, have you ever been bullied, for example, being hit or kicked, made fun of or insulted, isolated, blackmailed, etc.?” The response options were as follows: “1) never,” “2) occasionally,” “3) sometimes,” “4) often” and “5) always.” Respondents who reported being sometimes to always bullied were categorized as bullying victims.

2.3.5. Depressive symptoms

Depressive symptoms in the past week were evaluated using the 20-item Center for Epidemiological Studies Depression (CES-D, the Chinese version) scale (Radloff, 1977). The items are graded on a scale from 0 (never) to 3 (5 to 7 days per week), and four items are reverse-coded. The total scores of CES-D range from 0 to 60, and higher scores suggest stronger depressive symptoms (Zhang et al., 2015).

2.3.6. Covariates

Sociodemographic characteristics included the participants’ age, educational level and

monthly income. Educational level was assessed by asking, “What is your educational background?” The 9-level response options range from “never went to school” to “Ph. D degree.” Income was assessed by asking, “What is your monthly income (¥)?” The 6-level response options range from “no fixed income” to “more than 10000.”

2.4. Statistical analysis

Categorical data were described as the number and proportion for the descriptive statistics, and the differences among straight and sexual minority men were tested by Chi-square tests. Continuous data were reported in the form of the mean $\pm$ standard deviation (*SD*), and the differences were tested by independent sample t-tests. Structural equation modeling (SEM) was conducted to determine the associations between interested variables and whether the hypothesized intermediary variables could account for such associations by indirect effects. In SEM, childhood maltreatment were included as a latent variable and were estimated by the corresponding CTQ scores of the emotional, physical, and sexual abuse subscales, which would maintain the important variance in responses. Because the occurrence and extent of childhood victimization and depressive symptoms among the participants could not be assumed to be normally distributed, the bootstrap method was employed (Tofighi, 2019). Standardized path coefficients (β) for both the direct and indirect effects were estimated using 2000 bootstrap samples, and the model adjusted for age, educational level and income. The chi-square test, comparative fit index (CFI), root mean

square error of approximation (RMSEA), and standardized root mean square residual (SRMR) were employed to indicate the adequacy of the model fit (Garver & Mentzer, 1999; L.-t. Hu & Bentler, 1998; Schermelleh-Engel, Moosbrugger, & Müller, 2003). Generally, the values of $CFI \geq 0.90$, $RMSEA \leq 0.08$, and $SRMR \leq 0.08$ were considered as a satisfactory model fit (L. t. Hu & Bentler, 1999). The parameter estimates of direct and indirect effects of each pathway with 95% confidence intervals (CI) are shown in Table 3. All data were calculated using SPSS version 24.0 and Mplus version 7.4, and a two-tailed p -value <0.05 was considered statistically significant.

3. Results

3.1. Descriptive statistics

Sociodemographic characteristics, childhood adverse experiences and adulthood depressive symptoms among respondents are shown in Table 1. In total, 873 respondents were identified as heterosexual, and 858 respondents were identified as sexual minorities. The Chi-square test results showed significant differences in age and income but no significant difference in educational level between the two groups of participants. For gender expression in childhood, 58.7% of the sexual minority respondents were identified as gender nonconforming, whereas only 9.6% of the straight respondents were identified

as gender nonconforming. With respect to childhood maltreatment, the mean scores of the three types of abuse were all higher in the sexual minority respondents than in heterosexual respondents. In terms of school bullying, higher proportions of sexual minority men than straight men had experienced bullying (23.3% vs. 13.2%). When comparing the gender expression disparities in victimization among heterosexual and sexual minority groups (Supplementary table 1), sexual minority men with nonconforming gender expression were more likely to be the victims of emotional abuse, sexual abuse and bullying in contrast to those with conforming gender expression ($p<0.05$). However, the differences of victimization were not significant among straight men with different gender expression. With respect to depressive symptoms, the mean CES-D scale scores for sexual minority respondents were significantly higher than that for straight respondents (Table 1).

3.2. Correlations

Table 2 shows the correlations between the variables of interest and demographics. Except for the three demographical variables, the variables of interests were all positively correlated with each other ($p<0.01$). Sexual minority status and childhood gender nonconformity were correlated with emotional, physical and sexual abuse and bullying victimization, and higher scores of depressive symptoms. In addition, each kind of victimization was correlated with depressive symptoms.

3.3. Path analyses

Figure 1 shows the path analysis results, and Table 3 shows the estimates with 95% CIs in the SEM. The model fit was satisfied, with a χ^2 (20) of 131.955 ($p < 0.001$), a CFI of 0.936, an RMSEA of 0.060 (95% CI=0.050-0.070; $p = 0.042$), and an SRMR of 0.039. The relationship between sexual minority status and depressive symptoms could be explained by the mediating effects of family maltreatment (indirect effect: $\beta = 0.026$, $p = 0.004$). However, sexual minority status failed to properly predict victimization of school bullying ($p > 0.05$) when simultaneously included the item of gender nonconformity into the model. In addition, childhood gender nonconformity could significantly predict depressive symptoms through both direct and indirect effects, suggesting that gender nonconformity is an extra risk factor for a higher score of depressive symptoms in sexual minorities. The relationship between childhood gender nonconformity and depressive symptoms could be explained by the mediating effect of family maltreatment (indirect effect: $\beta = 0.042$, $p < 0.001$) and school bullying (indirect effect: $\beta = 0.028$, $p < 0.001$).

4. Discussion

Depressive symptoms are regarded as one of today's most severe public health issues, and they can have wide-ranging and long-lasting negative effects on victims' physical, mental and behavioral health (Luk, Gilman, Haynie, & Simons-Morton, 2018). The high

prevalence of depressive symptoms among gay and bisexual individuals has been assumed as a result of the stigma, discrimination and victimization experienced by this minority group of people (Charak et al., 2019). Previous studies have indicated that victims of adverse childhood experiences, such as family maltreatment and school-based homophobic bullying, will have more severe depressive symptoms in emerging adulthood than non-victims (Austin, Herrick, & Proescholdbell, 2016; Tucker et al., 2016; Wang et al., 2018). In addition, studies based on the minority stress hypotheses have confirmed that childhood gender nonconformity was a significant risk factor for both adverse experiences and poor mental health in sexual minority population (Roberts et al., 2013).

In our study, we included sexual orientation and gender nonconformity simultaneously in the model, which allowed for the examination of disparities among sexual minority men while controlling for gender nonconformity. The results showed that sexual minority status positively predicted family abuse victimization, and men who were more feminine had a greater chance of being abused during childhood than those who were masculine, which is consistent with previous studies (Baams, 2018). In terms of school-based victimization, we found that men with gender nonconformity in their childhood were more likely to have experienced bullying by their peers, whereas sexual orientation performed more like a confounder, suggesting that the targeting of gender-nonconforming children at school may be one explanation for higher bullying prevalence among sexual minorities. Nevertheless, possibly because of the small number of gender nonconforming

heterosexual respondents, we couldn't find any significant difference in both family and school victimization among straight men with different gender expression.

The path analysis results of our study showed that family maltreatment could completely mediate the association between sexual minority status and disparities in depressive symptom, suggesting that family abuse experienced by sexual minority children may increase the risk of developing depressive symptoms in adulthood. Furthermore, both the direct and indirect effects of gender nonconformity on depressive symptoms were stronger than that of minority sexual orientation, suggesting that being gender nonconforming and being abused and bullied as a gender-nonconforming child could predominantly explain the disparities in depressive symptoms. The mechanisms by which childhood trauma would account for mental health problems in sexual minorities were mainly explained by minority stress theory (Meyer, 1995). Studies based on minority stress theory indicated that dysfunctional thoughts (Hart et al., 2018), expectations of rejection and rumination (Timmins et al., 2020) mediated the relationship of abuse and bullying with depressive symptoms among sexual minorities.

In the past decade, only five sexual minority-specific interventions for mental health or bullying were conducted worldwide and gained expected outcomes, including policy, family, computer, and online interventions (Coulter et al., 2019). Fortunately, there have been decreasing trends in school bullying victimization, and the disparities between sexual minorities and straight adolescents narrowed within the years (Tucker et al., 2016). In

China, despite the efforts of eliminating the unreasonable laws and diagnosis regarding sexual minorities during the last decades, the government officials and health workers only started to pay attention to gay and bisexual men in 2003 because of the AIDS epidemic (He & Detels, 2005). Given the adverse childhood experiences and the relevant poorer mental health, family and school interventions for sexual minorities, especially those who do not meet gender norms, are essential. School bullying prevention programs should also consider giving sexual and gender diversity education, which was absent in the past.

There are several limitations of this study. Firstly, because of the cross-sectional design of this study, the results cannot determine whether there is a causal relationship between childhood adversities and current depressive symptoms. Secondly, because the items of childhood gender expression, CTQ, and bullying victimization were asking about the experiences in childhood, the results would have been more convincing if the population was on children. However, it would be quite sensitive to recruit sexual minority children to participate this survey in China. Thirdly, our study did not examine the disparities of different types of non-heterosexual orientation compared with heterosexuals. Finally, since the study sites were in Guangzhou, China, the generalizability of this study to other countries is limited. Nevertheless, given the special context in China, the experiences of sexual minority youth might be unique, and policy makers should consider developing equal laws and policies that favor sexual minority and gender nonconforming individuals.

5. Conclusion

The higher risks of victimization experienced by sexual minority and gender-nonconforming individuals in their childhood might be one of the driving mechanisms underlying their higher rates of having depressive symptoms in adulthood. School health providers and pediatricians should consider screening abuse and bullying for this vulnerable population, especially as gender nonconformity seems to be more visible in comparison with the highly hidden sexual minority status. Meanwhile, early intervention to prevent or reduce depressive symptoms among sexual minorities is needed.

References

Table 1

Sociodemographic characteristics, childhood victimization, and depressive symptoms by sexual orientation.

Variables	Heterosexual (<i>n</i> =873)	Sexual minorities (<i>n</i> =858)	<i>t</i> / χ^2
Age			
18~23	252 (28.9)	341 (39.7)	22.8***
24~29	439 (50.3)	369 (43.0)	
30~35	182 (20.8)	148 (17.2)	
Sexual orientation			
Gay	-	331 (19.1)	-
Bisexual		527 (30.4)	
Childhood gender expression			
Masculine	726 (90.4)	313 (41.3)	434.6***
Equally masculine and feminine	72 (9.0)	287 (37.9)	
Feminine	5 (0.6)	157 (20.7)	
Educational level			
High school or lower	239 (27.4)	206 (24.0)	4.4
College or university	576 (66.1)	580 (67.6)	
Any postgraduate studies	56 (6.4)	72 (8.4)	
Income (per month, RMB)			
¥0~3000	232 (26.6)	285 (33.3)	9.5**
¥3001~5000	252 (28.9)	216 (25.2)	
¥5001~	388 (44.5)	355 (41.5)	
Emotional abuse score	6.37 (2.23)	7.14 (3.12)	-5.9***
Physical abuse score	5.82 (1.64)	6.33 (2.46)	-5.0***
Sexual abuse score	5.38 (1.09)	6.12 (2.03)	-9.4***
School bullying			
Never	352 (41.6)	271 (32.7)	32.3***
Occasionally	383 (45.2)	365 (44.0)	
Sometimes to always	112 (13.2)	193 (23.3)	
CES-D scale scores	13.71 (9.92)	15.39 (10.46)	-3.4**

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

Table 2

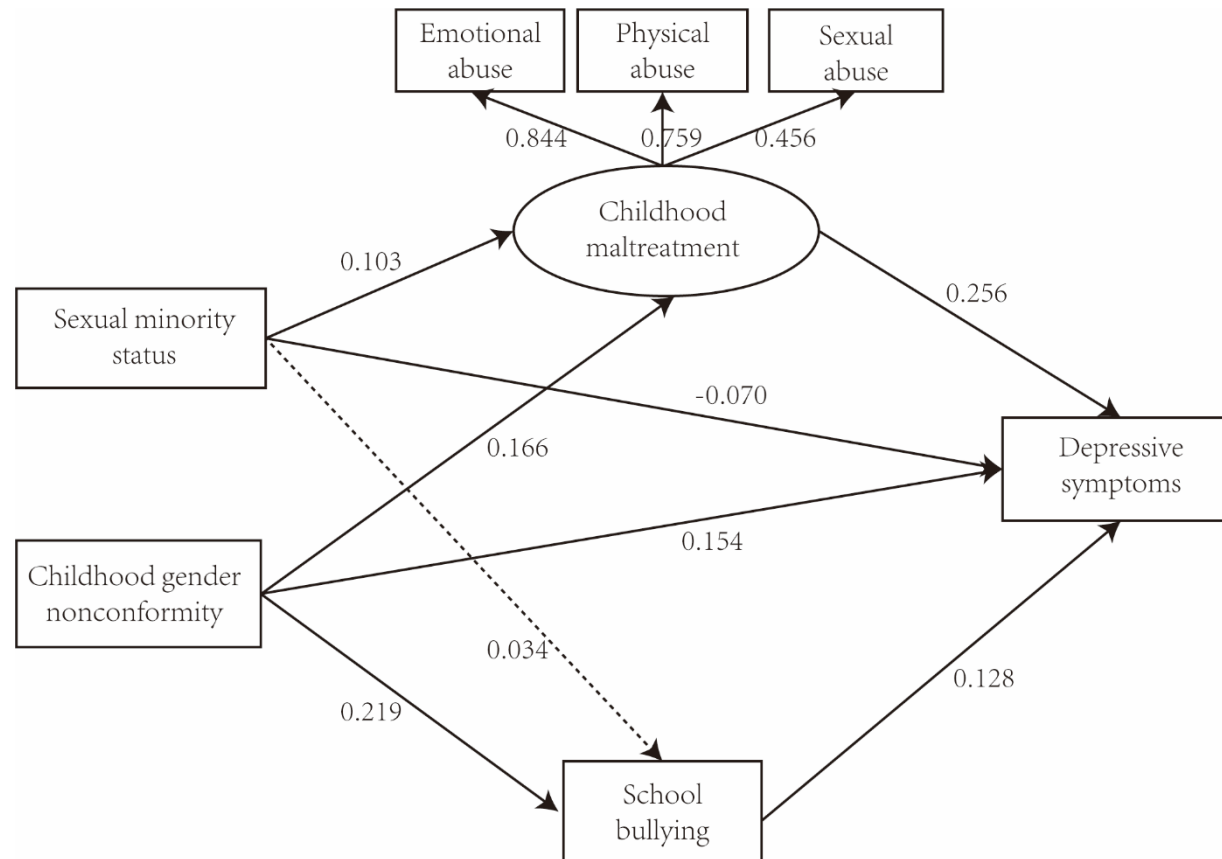
Correlations between variables of interest.

	1	2	3	4	5	6	7	8	9	10
1 Age	1									
2 Educational level	-0.001	1								
3 Income	.415**	.063**	1							
4 Sexual minority status	-.101**	.056*	-.071**	1						
5 Gender nonconformity	-0.042	.083**	-0.037	.554**	1					
6 Emotional abuse	-.089**	-.097**	-0.041	.139**	.194**	1				
7 Physical abuse	-.075**	-.049*	-0.016	.121**	.124**	.646**	1			
8 Sexual abuse	-0.022	-0.031	.000	.220**	.227**	.365**	.358**	1		
9 School bullying	0.012	-.101**	-0.002	.154**	.240**	.331**	.272**	.191**	1	
10 depressive symptoms	-.050*	-.102**	-.078**	.082**	.201**	.298**	.210**	.204**	.253**	1
Range	18-35	1-9	1-6	0-1	1-5	5-22	5-21	5-23	1-5	0-60

Note: Pearson's correlation coefficients were presented. * $p < .05$; ** $p < .01$.

Figure 1

Structural equation model predicting depressive symptoms.



Note: All the estimates were standardized; the dashed lines indicate that the path coefficient is not significant ($p \geq 0.05$).

Table 3

Path analysis results.

Path	β	SE	95% CI		p-value
			lower	upper	
Direct effects					
Sexual minority status → Childhood maltreatment	0.103	0.034	0.039	0.170	0.002
Sexual minority status → School bullying	0.034	0.028	-0.020	0.087	0.225
Gender nonconformity → Childhood maltreatment	0.166	0.037	0.096	0.240	<0.001
Gender nonconformity → School bullying	0.219	0.031	0.159	0.279	<0.001
Childhood maltreatment → Depressive symptoms	0.256	0.032	0.192	0.321	<0.001
School bullying → Depressive symptoms	0.128	0.030	0.072	0.186	<0.001
Sexual minority status → Depressive symptoms	-0.070	0.029	-0.127	-0.010	0.017
Gender nonconformity → Depressive symptoms	0.154	0.031	0.096	0.214	<0.001
Indirect effects on depressive symptoms via childhood maltreatment					
Sexual minority status	0.026	0.009	0.010	0.046	0.004
Gender nonconformity	0.042	0.011	0.023	0.067	<0.001
Indirect effects on depressive symptoms via school bullying					
Sexual minority status	0.004	0.004	-0.002	0.013	0.261
Gender nonconformity	0.028	0.007	0.016	0.045	<0.001

Note: β , standardized path coefficient; *SE*, standard error; *CI*, confidence interval.

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