

ABSTRACT

Title of Dissertation:

**REDOING GENDER, REDOING
FAMILY: A MIXED-METHODS
EXAMINATION OF FAMILY
COMPLEXITY AND GENDER
HETEROGENEITY AMONG
TRANSGENDER FAMILIES**

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Scholars have documented that considerable health disparities exist between transgender persons and the general population. A growing research base suggests that the family environment of trans individuals—i.e., the social climate within one’s family—can have a significant influence on the population’s health and wellbeing. Despite the substantiated relationship between the family environment of transgender people and their health, there are three identifiable gaps in the literature that warrant further research. First, no known quantitative studies have considered trans family environments beyond those that are accepting and rejecting, or how such family environments might be differently related to the population’s mental and physical health. Second, though scholars are increasingly recognizing the existence of gender heterogeneity within the trans population, it remains unknown if the health and family

environment vary for trans persons of different gender identities. A third gap exists within the nascent literature on individuals with nonbinary gender identities in which there is an absence of studies examining the experiences of their family members.

The three papers that comprise this mixed-methods dissertation respond to the aforementioned gaps in the literature. The first two studies analyze quantitative survey data collected from transgender adults ($N=873$); study three analyzes qualitative interview data collected from the parents of adult children with nonbinary gender identities ($N=14$). Study one examines family environment heterogeneity and tests its association with mental and physical health. Study two assesses variation in mental health, physical health, and family environment as a function of having a binary vs. a nonbinary gender identity. Study three uncovers how parents of nonbinary adult children make sense of their child's gender and the developmental processes that occur in doing so. Taken together, findings from this dissertation offer important implications for healthcare providers, clinicians, and intervention efforts aimed at improving the health of transgender populations.

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EXAMINATION OF FAMILY COMPLEXITY AND GENDER
HETEROGENEITY AMONG TRANSGENDER FAMILIES

by

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Chapter 1: Introduction

Statement of the Problem

Interest in studying transgender individuals¹ has increased substantially over the past decade, reflecting their growing visibility in public discourse and popular culture (Kuvallanka, Weiner, Munroe, Goldberg, & Gardner, 2017; Tebbe, Moradi, & Budge, 2016). Indeed, more than half of all scholarly publications on transgender identities has been published since 2010 (Moradi et al., 2016). With this visibility has come the increased recognition that many appreciable physical and mental health disparities exist between trans people and the general population. For example, data from the National Transgender Discrimination Survey (NTDS) suggests that more transgender Americans report being in current serious psychological distress and in poorer physical health than the general U.S. population (James et al., 2016b). Similarly, data from the 2014 Behavioral Risk Factor Surveillance System (BFRS) suggest that transgender adults have a higher prevalence of poor general, mental, and physical health compared to their non-transgender counterparts (Meyer, Brown, Herman, Reisner, & Bockting, 2017). Additionally, among a population-based sample of transgender youth, prevalence of suicidal ideation and substance use were higher than youth who were not transgender (Day, Fish, Perez-Brumer, Hatzenbuehler, & Russell, 2017; Perez-Brumer, Day, Russell, & Hatzenbuehler, 2017).

Growing scholarship on transgender health disparities explains them using iterations of minority stress theory (Meyer, 2003), whereby the population's poor health

¹ In this paper, "transgender" will be used to reference all individuals whose gender identities, whether binary or not, differ from their assigned sex at birth. Unless otherwise specified, the terms "trans" and "gender minority" will be used interchangeably with "transgender"

outcomes are thought to occur as a result of gender-minority-specific stress (e.g., identity-based discrimination, rejection, stigma, and violence; Bockting et al., 2013; James et al., 2016a; 2016b; Testa et al., 2012; Testa, Habarth, Peta, Balsam, & Bockting, 2015; Timmins, Rimes, & Rahman, 2017). One form of trans-specific minority stress can emanate from a family's response to gender variance. Reflecting the research on lesbian, gay, and bisexual (LGB) people, an emerging body of empirical evidence highlights the role of the family in influencing the mental and physical health of transgender individuals (Bariola et al., 2015; Grossman, D'Augelli, & Salter, 2006; Ryan, Huebner, Diaz, & Sanchez, 2009; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Simons, Schrager, Clark, Belzer, & Olson, 2013). For example, family rejection and rejecting behaviors (e.g., verbal and physical abuse) have been associated with suicidal ideation, anxiety, depression, and sexual risk-taking (Budge, Adelson, & Howard, 2014; Grossman & D'Augelli, 2007; Yadegarfar, Meinhold-Bergmann, & Ho, 2014), and increased family acceptance has been found to predict lower levels of depression and risk-taking behaviors among trans people (Bockting et al., 2013; Simons et al., 2013).

While it seems clear that family relationships are associated with the health and wellbeing of transgender individuals, much remains unknown about their family environment. Informed by the complexities inherent to both family relationships and to gender identity (Catalpa & McGuire, 2018), three problematic areas within the trans-family literature are identifiable:

First, scholarship on the family environment of trans people has historically been conceptualized using an 'acceptance-rejection' approach, wherein trans persons report their families as *either* accepting or rejecting of their gender—the former facilitating

improved health and wellbeing outcomes for the transgender population and the latter exacerbating them (e.g., Bockting et al., 2013; Grossman & D'Augelli, 2007; Yadergarfard et al., 2014). Increasingly, however, scholars are critiquing this binary conceptualization as it reduces the complexity of families' reactions to their child's gender variance to a dichotomy of acceptance *or* rejection (e.g., Coolhart, Ritenour, & Grodzinski, 2018; McGuire & Catalpa, 2017; Whalig, 2014), insinuating that the two behaviors are mutually exclusive. Recent data challenges this assumed exclusivity: families' accepting and rejecting behaviors of their child's gender variance can co-occur, change over time, and/or be understood by trans youth as contradictory (McGuire & Catalpa, 2017; Catalpa & McGuire, 2018). Indeed, without a more comprehensive and nuanced understanding of transgender adults' family environment—the social climate within a given family unit—those families' experiences remain “...reduced to a singular, fixed, and dichotomized” concept (Catalpa & McGuire, 2018, p.10).

In response, scholars are beginning to re-conceptualize transgender family environments through alternative frameworks beyond the assumed ‘acceptance/rejection’ approach, one of which is ambiguous loss (Boss, 1999; 2006). Within a framework of ambiguous loss, both trans individuals and their cisgender family members are thought to experience unclear and unverified losses which preclude the opportunity for resolution (Catalpa & McGuire, 2018; Coolhart, Ritenour, & Grodzinski, 2018; McGuire, Catalpa, Lacey, & Kuvalanka, 2016a; McGuire, Kuvalanka, Catalpa, & Toomey, 2016b; Norwood, 2013a; Whalig, 2014). While these contributions have expanded our understanding—and more accurately reflected the reality of—transgender family relationships by decentering the ‘either/or’ dichotomy of acceptance and rejection, they

comprise only theoretical and qualitative papers. What the current literature lacks is a quantitative exploration of the various family environments of trans individuals beyond the absolutes of the acceptance-rejection binary.

Second, backed by the cisnormative assumption that only two sexes and two genders exist (i.e., male and female; Bauer et al., 2009), transgender persons are often thought of as having the gender “opposite” to the one they were assigned at birth. However, recent developments in the scholarship on trans individuals highlights the prevalence of gender heterogeneity within the population (e.g., Cruz, 2014; Goldberg & Kuvalanka, 2018; Kubler, Nussbaum, & Mustanski, 2018; Singh, 2016; Tebbe, Moradi, & Budge, 2016). Data from the 2015 National Transgender Discrimination Survey suggests that over one-third (35%) of transgender individuals identify as nonbinary (James et al., 2016a; Matsuno & Budge, 2017); in other words, the majority of trans adults do not identify as male (33%) or female (31%). Accordingly, trans scholars are encouraging future research to reflect these data by providing adequate examination of the gender diversity among transgender people (e.g., Connell, 2010; Catalpa & McGuire, 2018). To date, however, studies addressing the gender heterogeneity within the trans population are limited (see Motmans, Nieder, & Bouman, 2019; Matsuno & Budge, 2017), and far fewer have considered the associations between having a binary vs. a nonbinary gender identity, the family environments, and the health of trans individuals. Given the pervasive promotion of the gender binary across and within most societal institutions— especially families (McGuire et al., 2016b)—there is reason to believe that both the family environment and health of trans adults may differ as a function of having a binary vs. a nonbinary gender identity.

Third, within the nascent literature on individuals with nonbinary gender identities, there is an absence of studies examining the experiences of their families. This noticeable void contrasts with extant research sampling family members of binary trans adults, findings from which highlight the complexity of these families' responses to their binary trans loved ones. For example, Norwood (2013b) performed interviews with parents, (ex-)spouses, and siblings of transgender persons to better understand their intrapersonal meaning-making processes. She identified four coping mechanisms family members use in response to a transgender loved one: (1) replacement, to see their family member as completely different; (2) revision, to see a change only in their physical appearance; (3) evolution, to conceptualize a trans loved one as an "updated version;" and (4) removal, to forgo gender constraints and see their family member for the person they are.

Norwood's (2013a; 2013b) sample comprised 37 relatives of "trans-identified" persons, all but two of whom spoke of family members who were female-to-male (FTM) or male-to-female (MTF); no specific attention was given to the two participants with a genderqueer or nonbinary (GQNB) loved one, including the ways in which their meaning-making and developmental processes may differ from participants with a trans relative who identifies with a binary gender identity. There is reason to believe their familial experience may be different from that of their binary transgender counterparts because of pervasive assumptions that only two sexes and two genders exists—male and female (e.g., cisnormativity; Bauer et al., 2009). Thus, a switch from one to the other may be easier to grasp than a change to something they cannot label or understand, such as in the case of a child who does not identify as either male or female (a gender truth regime;

Rahilly, 2015). In an effort to bolster the empirical investigation of the family environment of trans adults, it is prudent to assess the development and experiences of parents of children who identify with a nonbinary gender identity.

Thus, the present study seeks to address the three aforementioned shortcomings in the literature on the family relationships, health, and wellbeing of transgender individuals.

Each of the three papers considers different aspects of the family environment of trans adults, two from trans adults' perspectives, and one from the parents of GQNB individuals. The first two studies are based on secondary data analyses of quantitative data collected by McGuire and Fish (2018); the final paper analyzed qualitative data from interviews with parents of adults with nonbinary gender identities.

The first paper seeks to challenge the identified shortcoming in our understanding of the family environment of transgender adults—i.e., the acceptance/rejection dichotomy by identifying profiles of family environments among gender minority adults. To do so, I employ latent profile analysis (LPA), a process which allows for profiles to emerge that incorporate combined experiences of acceptance and rejection, in addition to ones of ambiguity. Such a method is limitedly used with queer populations, and can uniquely “characterize multidimensional, interdependent, and mutually-constructed...experiences” (Fish & Russel, 2018, p.19). Once identified, I consider the extent to which each latent profile predicts respondents' health and wellbeing.

Using the same data set, the second paper responds to critiques of the assumed gender homogeneity within the transgender population by exploring if, and to what extent, membership in the family environments identified in the first paper varies as a

function of having a binary vs. a nonbinary gender identity. The paper also considers if health differences exists between trans adults with binary vs. nonbinary gender identities. Finally, I test the moderating effects of paper one's latent profiles of family environment on relationship between gender identity and health.

The third paper seeks to (1) understand how the parents of adults who identify with a nonbinary gender identity (e.g., genderqueer) make sense of their child's gender identity and expression; (2) identify the developmental course of these parents' negotiation and understanding of their child's nonbinary gender identity; and (3) assess resilience and coping strategies used by parents of GQNB people. One-on-one semi-structured interviews with either one or both parents were recorded and transcribed verbatim; the collected data was analyzed using inductive thematic analysis (Braun & Clark, 2006).

As research on the family environment of trans adults is understudied and nascent, I chose to use a mixed-methods design to execute the current project. Mixing quantitative and qualitative methodologies allows scholars to leverage the strengths of each: findings from quantitative analyses possess a unique power in their generalizability, whereas qualitative methods offer a depth of understanding unattainable in quantitative analyses that can inform and/or provide variation to the variables and relationships of interest. Using both methodologies provided a more comprehensive and nuanced understanding of the mechanisms, interpretations, and contextual factors relating to my area of inquiry that would otherwise be absent from a study using only one. Accordingly, findings from this multimodal investigation of transgender families informs future research by pointing out gaps in the current literature, making evidence-based

recommendations for clinicians working with trans people and their families, and informing intervention efforts aimed at improving the lives of trans individuals and their family members.

Clarifying Terminology & Key Concepts

Prior to presenting this dissertation's theoretical framework and reviewing the literature on transgender persons and their families, it is important to first clarify trans-related terminology and delineate several key concepts that form the foundation of this project. Relevant terms include:

Sex assigned at birth: the assignment and classification of people as male, female, or intersex, assigned at birth often based on physical anatomy (Trans Student Educational Resources (TSER), 2017).

Gender identity: one's internal sense of being male, female, neither of these, both, or other gender(s). For transgender people, their sex assigned at birth and their gender identity are not the same (TSER, 2017).

Gender expression: the physical manifestation of one's gender identity through clothing, hairstyle, voice, body shape, etc. (typically referred to as masculine or feminine). Many transgender people seek to make their gender expression (how they look) match their gender identity (who they are), rather than their sex assigned at birth (TSER, 2017).

Family positions: the title given to family members based on relations to other family members (e.g., sister, brother, mother, father, daughter, son, aunt, grandson, etc.).

Family roles: the concurrent patterns of behavior by which individuals fulfill family functions and needs. Expectations for each family role are often informed by

broader social discourses, primary among which is gender (Epstein et al., 1993).

Examples of familial roles include breadwinner, homemaker, caregiver, nurturer, decision-maker, social manager, etc.

Family environment: broadly, family environment refers to the social climate within a given family unit. According to Landesman, Jaccard, & Gunderson (1991), the family environment refers to the overt behaviors, strategies, resources, and the lived experiences of each family members. It includes both the “physical and behavioral features of the environment, as well as the subjective experiences and emotions of family members” (p.67).

Transgender/trans/gender minority: I will use the three terms synonymously and interchangeably to reference all individuals whose gender identities and expressions, whether binary or not, differ from their assigned sex at birth and/or the binary cultural conceptualizations of gender associated with that sex. Unless otherwise noted, these three terms encompass transgender individuals with both binary and nonbinary gender identities².

Binary trans: The term “binary trans” will be used to specifically reference transgender persons with binary gender identities. This include (trans) females who were born into male bodies and thus assigned male at birth but consider themselves females and live their lives as such, and (trans) men who were born into female bodies and thus assigned female at birth but live as males and consider themselves male (Stryker, 2008).

² It should be noted that “gender minority” is distinct from the more prevalent “sexual minority,” a term used to reference individuals with sexual identities other than heterosexual (i.e., lesbian, gay, bisexual, pansexual, queer). In contrast, “gender minority,” refers to individuals whose gender identities and/or expressions are incongruent with traditional, societal, or cultural norms of gender (National Institutes of Health, 2016)

Common binary gender identities include, but are not limited to, transgender, trans, male/female, transmale/transfemale, and transman/transwoman.

Nonbinary/genderqueer/NBGQ: The term “nonbinary” will be used interchangeably with “genderqueer” and the acronym “NBGQ” to reference a spectrum of individuals whose gender identities fall between or outside binary “male” and “female” identities. Such persons can experience themselves as a man and woman simultaneously (e.g., intergender, adrogyne), as a man or a woman at distinct times (e.g., bigender, genderfluid), and/or without any gender (e.g., agender, neutrois) (Budge, 2017; Diamond et al., 2011; Matsuno & Budge, 2017). The terms to describe nonbinary gender identities are many and evolving (e.g., Kuper, Nussbaum, & Mustanski, 2012).

Cisnormativity: Cisnormativity is a pervasive ideology that endorses the assumptions that (a) there are only two genders, (b) gender identity is determined by biological sex, and (c) one’s gender ascribes them to specific familial roles (Bauer et al., 2009; Kuvalanka, Allen, Munroe, Goldberg, & Weiner, 2018). This pervasive ideology provides a base from which this pre- or perinatal binary assignment “steeps” the infant in binary gender expectations, constructed and perpetuated by families, schools, and institutions (Matsuno & Budge, 2017; p.117). Scholars have identified the family as the “primary context” in which cisnormativity is enforced, reproduced, and maintained (McGuire et al., 2016b, p.61). Throughout this paper and elsewhere, the term “cisgender” refers to individuals whose gender is congruent with the sex they were assigned at birth.

Theory

This dissertation is guided by a combined framework of queer and trans family theories (Allen & Mendez, 2018; McGuire et al., 2016b; Oswald, Blume, & Marks, 2005)

and ambiguous loss theory (Boss, 1999; 2016; McGuire et al., 2016a). This pairing best situates my inquiry into gender heterogeneity and family complexity among transgender adults and their families. For the first two papers, minority stress theory (Hendricks & Testa, 2012; Meyer, 2003; Testa et al., 2015) helps provide a rationale for the associations between trans persons' family environments and their health and wellbeing; for the third, it conceptualizes potential minority-specific stress the parents of NGGQ adults experience.

Queer & Trans Family Theories

The essence of queer theory is its ability to challenge and upend assumptions; to subvert what is perceived as *normal*. Distinct from other standpoint theories, a queer framework “interrogate(s), complicate(s), and destabilize(s)” the categories constructed and reified by social and political discourses, ones that restrict and silence complex human experiences that exist outside of them (Alexander, 2017; Smith & Shin, 2015, p.461). The origins of queer theory (e.g., Jagose, 1996) specifically questioned the binary ontological categories of sexuality (e.g., homosexual vs. heterosexual) and gender (i.e., male/masculine vs. female/feminine), centering queer theory's critique on heteronormativity and its pervasiveness. Broadly, heteronormativity is the traditionally unquestioned ideology that heterosexuality is assumed and normal and all other sexualities are deviant (e.g., Crawley & Broad, 2008).

Within family science, queer theory first emerged in the 2005 edition of *The Sourcebook of Family Theory & Research* (Bengtson, Acock, Allen, Dilworth-Anderson, & Klein). In it, Oswald, Blume, & Marks (2005) published a seminal chapter that proposed an expanded and family-specific redefinition of heteronormativity. Their model

posited that heteronormativity is an ideological composite of three inseparable binaries: the sexuality binary, the gender binary, and the family binary. Each of the heteronormativity binaries privilege one type of sexuality, gender, and family, and relegates all others as unnatural, deviant, or pseudo; every individual or family exists at either one end of the binary or the other. For example, the sexuality binary distinguishes “natural” (heterosexuality) and “unnatural” (homosexuality, bisexuality, pansexuality, etc.) sexualities, and the gender binary ascribes privilege and normalcy to “real” genders (masculine men, feminine women) and consigns those who do not conform to gender stereotypes as gender “deviants” at the opposite end of the binary. Similarly, the family binary privileges “genuine” families—those that are biologically, consanguineously, and legally related—and assumes all other family formations (e.g., gay/lesbian families, chosen families, cohabiting families) as “pseudo.” Thus, Oswald and colleagues define heteronormativity as “an ideology that promotes gender conventionality, heterosexuality, and family traditionalism as the correct way for people to be” (p.143). When individuals and families challenge and resist heteronormativity’s three binaries, they are engaging in a *queering process* that create *complex* sexualities, genders, and families.

Over a decade after Oswald, Blume, & Marks’ chapter was published (2005), McGuire et al., (2016b) sought to extend how family scholars question heteronormative assumptions about the family. Specifically, they highlight how the presence of a transgender person within a family unit may also distinctly challenge cisnormativity: the assumption that there are only two genders, that gender identity is determined by biological sex, and that gender ascribes them to specific familial roles (Bauer et al., 2009; Kuvalanka et al., 2018). Therefore, the presence of a trans person in a family informs

how their family members “stretch and expand” their understanding of gender, sexuality, and family (McGuire et al., 2016b, p.61).

Taken together with Oswald et al.’s queer family theory (2005), McGuire and colleagues’ trans*family theory (2016b) offers a unique framework among extant family theories to understand both trans persons’ familial experiences and the experiences of their family members. Inherently, transgender individuals challenge one or more cisnormative assumptions that sex and gender are congruent, and that gender is immutable: they are *undoing* and *queering* pervasive conceptualizations of gender (Oswald et al., 2005). Due to the interrelatedness and inseparability of the three heteronormative binaries, the gender complexities trans persons may reveal in families also complicate how they and their family members understand family membership and roles (i.e., complex families; Allen & Mendez, 2018; Oswald et al., 2005). Thus, the current study is best framed by queer family theories to uncover the “required remapping” of gender identity development that trans persons and their families undergo (Catalpa & McGuire, 2018, p.3). Additionally, as a standpoint theory (Alexander, 2017), queer theory exposes and elevate historically marginalized and unheard voices. This will be particularly useful in the third study as the marginalized perspectives/voices of parents of nonbinary trans adults are largely absent from the current literature.

Ambiguous Loss

Coined in the 1980s, ambiguous loss theory had made an indelible mark on the field of family studies and, more broadly, the social sciences (see Boss, 2016). Within the framework, families are thought to be both physical and psychological entities and ambiguous loss occurs when one is “lost” and the other remains. Indeed, ambiguous loss

was introduced to help families explain two phenomena. The first, known as Type I loss, conceptualizes the stress a family experiences when a family member is psychologically present but physically absent, such as during the deployment of a family member in the military (e.g., Huebner, Mancini, Wilcox, Grass, & Grass, 2007), or in the case of missing children (e.g., Favel & Boss, 1992). The second—Type II loss—refers to the stress a family experiences when one of its members is physically present but psychologically absent, such as in the case of a family member with dementia (e.g., Caron, Boss, & Mortimer, 1999), or with a traumatic brain injury (Kretzer, Mills, & Marwitz, 2016). Boss (2016) conceptualized ambiguous loss as “the most stressful type of loss because it defies resolution,” preventing the achievement of closure or finality, characteristic of more conventional losses (p.274). By being unable to move wholly toward either hope or mourning, individuals experiencing ambiguous loss describe persistent and prolonged feelings of grief, and boundary ambiguity: a lack of clarity of who is in or out of the family (Boss, 2006; 2016).

Increasingly, ambiguous loss is being applied to and used to frame the scholarship on transgender families. McGuire, Catalpa, Lacey & Kuvalanka (2016a) proposed a theoretical model to understand gender transitions in families using fundamental tenets of ambiguous loss theory. The authors suggest that pervasive and enduring gendered beliefs—namely, that there are only two genders, that one’s natal sex and gender identity are congruent and invariable, and that one’s gender consigns them to specific familial roles—manifest in parents’ gendered expectations for their children (i.e., cisnormativity; Bauer et al., 2009). When a trans family member discloses their gender identity and expression to their parents, these expectations, which includes cisnormative and

heteronormative visions for their child's future, can be upended or distorted; the individual that the parents assumed their child to be, is, in some ways, lost (Coolhart, Ritenour, & Grodzinski, 2018; Norwood, 2012; 2013a; 2013b; Whalig, 2014).

According to Whalig (2014), losses experienced by the parents of transgender children manifest as both Types of ambiguous loss—a phenomenon she designated with the term *dual ambiguous loss*. For such parents, Type I loss (psychological presence-physical absence) manifests whereby a child's physical appearance as a certain gender may be changed, lost, or made absent, but their personality and familial relationships may remain unchanged. Simultaneously, Type II ambiguous loss (psychological absence-physical presence) is also present in that the parents of a trans child “still have a child, but that child's psychological existence *as a certain gender* is significantly changed and may be perceived as no longer there” (Whalig, 2014, p.12).

McGuire and colleagues (2016a) describe parents' ambiguous loss as manifesting not only in response to a trans child's gender, but also in response to changes in the parent-child relationship—what the authors identify as *relational rupture*. Responses to a trans child's gender can result in behaviors that are physically rejecting (e.g., kicked out of the house) or psychologically rejecting (e.g., decreased intimacy and emotional support). While such behaviors result in ambiguous loss experienced by the trans child (see Catalpa & McGuire, 2018), parents' experience of ambiguous loss due to *relational rupture* can manifest in mourning their own behaviors that they did not anticipate engaging in with their child (e.g., kicking a child out of the house; decreasing intimacy with child, etc.).

As stated, what ambiguous loss had offered transgender family researchers is a way to conceptualize families beyond either accepting or rejecting of a trans loved one's gender identity. In the small but developing literature, scholars have embraced this alternate framework in empirical work with trans individuals (Catalpa & McGuire, 2018) and their family members (Coolhart et al., 2018; Norwood, 2013a; 2013b). However, extant empirical research using ambiguous loss as a framework to study transgender families has largely been applied to transgender individuals who transition to the "opposite" gender on the binary (e.g., a natal male who identifies as a transwoman). Potential ambiguous losses sustained within such a family include, for example, the absence of a son—and a future groom—but the presence of a daughter (and a future bride) for the parents, and withdrawal of emotional support but continued financial support for the transgender child (relational ambiguity; Catalpa & McGuire, 2018; Coolhart et al., 2018; Norwood, 2013a). According to McGuire and colleagues, what an ambiguous loss perspective offers future work with transgender families is "a framework for naming other ambiguous losses experiences when family members do or do not conform to gender role expectations" (2016a, p.382). In light of the increasing gender diversity among the transgender population beyond binary identities (e.g., Matsuno & Budge, 2017), more and more trans persons and their families will need to reconsider not only the cisnormative assumptions of sex-gender congruency and gender constancy but now also the assumption that there are only two genders: male and female. Additionally, both trans individuals and their families may face additional ambiguity in losing family positions and family roles (e.g., loss of a son), but not having one to replace it with, such as in the case of binary-identified gender minorities (e.g., presence of a daughter). For the

current study, ambiguous loss offers a framework to understand additional, and/or more complex ambiguous loss for nonbinary persons and their family members (McGuire et al., 2016a).

A Contextual Queer-Ambiguous Loss Framework

Within their application of ambiguous loss for trans families, McGuire and colleagues (2016a) assert that the meanings family members make regarding a trans loved one are affected by the context(s) in which families are situated. Though the pervasive binary and immutable understanding of gender contribute to difficult experiences of trans persons and their family members writ large, certain socio-cultural and/or socio-religious communities “...may actively promote absolute expectation of gender expressions and roles” (p.382). In light of certain subcultures’ heightened emphasis on traditional conceptualizations of gender, the authors highlight how context has significant power in influencing families’ interpretations of their trans family member’s gender identity.

McGuire et al.’s (2016a) recognition of context and its influence on trans families mirrors a growing criticism of queer theory, in that it does little to theorize contextual differences within the heteronormative constructs of gender, sexuality, and family (i.e., race, class, culture; Berkowitz, 2009; Johnson, 2005). For example, Johnson (2005) identified the ways in which queer theory is “...often unable to accommodate the issues faced by gays and lesbians of color who come from ‘raced’ communities... [queer] homogenizes, erases our differences” (p.127). In response to these critiques within family studies, Allen & Mendez (2018) offered a “more contextual, intersectional queer model... to understand the increasingly visible diversity of families” (p.73). To do so,

they situate the gender, sexuality, and family binaries identified by Oswald, Bloom, & Marks (2005) within five contextual spheres—race, class, ability, ethnicity, and nationality—each of which provides distinct experiences and influences the lives of the families within them. The authors emphasize: “...to consider a queer family, or any family, only in terms of sexuality, gender, and family....is to inadequately consider it” (Allen & Mendez, 2018, p.76). In line with their model and directions for its application, the current study attempts to uncover the queering processes within transgender families specifically with regard to the “myriad other social locations” our respondents inherently occupy (p.78). In papers one and two, we test for associations between our outcomes of interest and the sample’s key demographic information. In the third paper, Allen & Mendez’s (2018) model offers a guide in understanding the influence of participants’ (privileged) race, class, and ethnicity on the family processes under inquiry.

Minority Stress Theory

Meyer’s minority stress theory (2003) conceptualizes the social stress specific to lesbian, gay, and bisexual (LGB) people and how it negatively impacts their mental health. The theory was monumental in de-pathologizing sexual minorities as inherently unwell and instead offered a framework that underscored the “stigma, prejudice, and discrimination that create a stressful social environment that leads to mental health problems” among the population (p.675). Indeed, minority stress is the theory most often used to drive research surrounding the mental and physical health of LGB people (IOM, 2011); as of early 2018, according to Google Scholar, Meyer’s (2003) article has been cited over 5,100 times. The theory outlines two categories of stressors that increase distress and worsen mental health among the LGB population: (1) distal/external

stressors, which include direct experiences of sexuality-related discrimination, rejection, and violence, and (2) proximal/internal stressors, which makes reference to the internalized experience of being LGB, such as internalized fear and mistrust of others, negative attributions about one's sexual minority status (i.e., internalized homophobia), and stress associated with concealing one's sexual identity. The model also offers factors that have the potential to attenuate the effects of LGB-specific minority stress, such as social and emotional support from other sexual minorities, identity pride, and a sense of community belonging (Meyer, 2003).

Though initially delineated for LGB individuals, minority stress theory has been extrapolated to also theorize the social stress specific to trans people and how it negatively influences their mental health. Namely, Hendricks and Testa (2012) adapted Meyer's (2003) seminal minority stress model and translated it to reflect the distinct experiences of trans people. The authors delineate the ways in which LGB-specific minority stress processes are both similar to and, in some ways, different from, those of gender minorities. Both populations similarly experience external stressors in the form of explicit experiences of discrimination, and internal stressors through fear of mistreatment by others and internalized homo or transphobia. Transgender individuals, however, may experience additional and distinct forms of external stressors, such as being unable to access legal documents or use public restrooms that reflect their gender identity and/or experiencing nonaffirmation: a term used to describe when trans persons' "internal sense of gender identity is not affirmed by others" (e.g., a transman being referred to as "ma'am"; Testa et al., 2015, p.66). Likewise, transgender individuals also navigate concealment of their identity (an internal stressor) differently than do non-transgender

LGB people due to the heavy reliance of physical characteristics to both express one's own gender and understand others' (e.g., body size and type, hair length and style). Further, gender expression is informed by many overlapping and sometimes uncontrollable phenomena, such as genetics, age of transition, access to transition-related healthcare, resources to purchase accessories involved in social transition, and the desired transition outcome (i.e., not all trans-identified persons desire to "fully" transition; Matsuno & Budge, 2017). Thus, concealing a trans identity is different from, and often more challenging than, concealing a lesbian, gay, or bisexual identity.

What a trans-specific minority theory lends the current study is a justification to consider the relationships between gender identity, family environment, and the health and wellbeing among gender minorities. The ways in which a trans person's family reacts to and makes sense of their loved one's gender identity renders the family environment as either a minority stressor or a coping mechanism, or some combination of both. In the first study, the associations between profiles of family environment and health and wellbeing are tested; in the second, the associations between having a binary vs. a nonbinary gender identity and (1) family environment, (2) physical health, and (3) mental health will be assessed. Additionally, the moderating potential of one's family environment will be considered on the relationship between gender identity and health.

Chapter 2: Review of the Literature

Transgender Health & Wellbeing

An increasing body of empirical research indicates that transgender people experience considerable physical and mental health disparities compared to the general population. According to data from the 2015 National Transgender Discrimination Survey (NTDS), the largest survey on transgender adults in the U.S. ($N=27,715$), 39% of transgender Americans experience serious psychological distress, a rate more than 8 times higher than that of the general population (5%; James et al., 2016a). When asked to rate their current physical health, 22% of survey respondents rated theirs as “fair” or “poor” compared to 18% of the general U.S. population (James et al., 2016b). Data elsewhere substantiates the presence of health disparities among the transgender population. For example, Meyer et al. (2017) identified prevalence rates of various general, mental, and physical health outcomes among a probability sample of trans persons using data from the 2014 Behavioral Risk Factor Surveillance System (BRFS; $n=151,456$). Compared to cisgender people, transgender individuals had a higher prevalence of poor general health (odds ratio [OR]=1.7) and history myocardial infarction (OR=1.74). They reported more days per month of both poor physical and poor mental health, including days when physical or mental health impairments limited them from normal daily activities (Meyer et al., 2017).

Data from studies of suicide suggest that gender minorities, compared to their cisgender counterparts, experience significantly higher levels of suicidality, suicide attempts, and suicide risk (Wolford-Clevenger, Canoon, Flores, Smith, & Stuart, 2017). Studies using convenience samples drawn from online or physical transgender

communities suggest that 18-45% of transgender adults have attempted suicide in their lifetime, a rate 4-9 times higher than that of the general population (4.6%) (e.g., Goldblum et al., 2012; Grossman & D'Augelli, 2007; James et al., 2016b). Data from the National Transgender Discrimination Survey mentioned previously indicate that 40% of transgender Americans have attempted suicide in their lifetime, and 7% have attempted suicide in the past year, nearly 12 times the rate in the general population (James et al., 2016a).

Among a representative, population-based sample of high school students, prevalence of past-year suicidal ideation among transgender participants was twice as high as the prevalence among both cisgender and LGB-identified cisgender participants; trans students had a nearly three times higher odds of past-year suicidal ideation than cisgender students (OR=2.99) (Perez-Bumer et al., 2017). In another study using data from the same sample of high school students, Day and colleagues (2017) identified similar transgender-cisgender disparities with respect to substance use. Prevalence rates of lifetime use of alcohol, cigarettes, and marijuana were markedly higher among transgender youth (1.5, 2.7, and 1.9 times higher, respectively). Analogous disparities were also evident in past 30-day alcohol use (3.2 times higher), cigarette use (4.2 times higher), marijuana use (2.5 times higher), other illicit drug use (4.8 times higher), and polysubstance use (4 times higher) between the transgender and cisgender subpopulations. Additionally, transgender participants reported a younger age of onset for each of the 5 substance outcomes measured—alcohol, cigarettes, marijuana, other illicit substances, and polysubstance— than did their cisgender peers (Day et al., 2017).

Disparities also manifest for trans people in healthcare access and healthcare settings. In findings from Meyer and colleagues' (2017) analyses of 2014 BRFSS data, more transgender than cisgender participants lacked both insurance coverage and a regular health care provider, and transgender participants were more likely to be unable to afford a needed healthcare visit. The National Transgender Discrimination Survey data on trans-related healthcare indicates that 1 in 4 trans respondents who sought coverage for hormone therapy in the past year were denied, and nearly 2 in 3 who sought coverage for transition-related surgery in the past year were denied (James et al., 2016a). Recently, qualitative findings from a small sample of genderqueer/nonbinary (GQNB) young adults highlight their experiences of bias and insensitive care from healthcare providers, and their feelings of disrespect, frustration, and misunderstanding while receiving needed healthcare (James, LeBlanc, & Bockting, 2018). Participants described receiving care that was rooted in a binary transgender perspective and thus inappropriate for their needs. Feeling pressured to conform to a binary healthcare protocol, some participants feigned a binary identity while in the healthcare setting, modified what was prescribed for them, or chose to forgo healthcare all together (James et al., 2018). These data stand alongside extant research that suggests trans individuals who desire and receive hormone therapy and/or transition-related surgery report a significantly higher quality of life than those who desire but do not receive the same medical interventions (Newfield, Hart, Dibble, & Kohler, 2006; van de Grift et al., 2017).

Overall, this research demonstrates the poorer social, economic, and health outcomes transgender persons experience compared to their cisgender counterparts (e.g., James et al., 2016b; Reisner et al., 2016). Indeed, in 2016, the National Institutes of

Health formally designated gender minorities a health disparity population for research purposes.

Minority Stress and the Family-Health Association

Historically, efforts to explain trans (and sexual minority) health disparities pathologized transgender individuals as innately disordered, backed by the 1980 introduction of *Gender Identity Disorder* (GIS)³ in the third *Diagnostic and Statistical Manual of Mental Disorders* (Drescher, 2014). Since then, the majority of trans scholarship has rejected the anachronistic ‘pathology narrative’ (e.g., Shumer, 2018) and instead use Meyer’s (2003) minority stress theory as the primary explanation for the health disparities among gender minorities, whereby the poor outcomes among the population are thought to occur as a result of identity-based stigma and systematic marginalization (e.g., Bockting et al., 2013; Sevelius, 2013; Shumer, 2018; Testa et al., 2015; 2017). Though stigma is increasingly identified as the root of minority stress and the poor health outcomes of gender minorities, scholarship on their social environments remains scant and underdeveloped (Catalpa & McGuire, 2018; Dierckx, Motmans, Mortelmans, & T’sjoen, 2016). As the family unit remains the first and primary social support network for humans, perception of one’s family environment among the trans population may have substantial implications for their health and wellbeing.

Findings from the transgender-family literature support this reality. For example, perceived family rejection is associated with attempted suicide, suicidal ideation, substance misuse, depression, and homelessness among transgender youth and adults (Grossman & D’Augelli, 2007; Mustanski & Liu, 2013; Ryan et al., 2009; Yadegarfar,

³ In the most recent DSM (DSM-V; APA, 2013), GIS was replaced with *Gender Dysphoria* (GD)

Meinhold-Bergmann, & Ho, 2014). In their 2014 study, Yadegarfar et al. sampled 260 transgender and cisgender young adults to assess differences on measures of family rejection, social isolation, loneliness, depression, suicidal thinking, and sexual risk behaviors. Multivariate analyses indicated that transgender participants reported significantly higher levels of each outcome variable than did their cisgender counterparts; for both subgroups, family rejection was a positive and significant predictor of depression. Descriptive findings from the study's 6-item family rejection measure suggest that trans youth experience more physical punishment, financial deprivation, exclusion from family activities, ejection from the house, and social deprivation (Yadegarfar et al., 2014).

Accompanying the aforementioned family rejection research is scholarship highlighting the inverse association: family acceptance is positively associated with and predicts various health outcomes. For example, higher levels of perceived family support were associated with lower levels of both depression and anxiety among trans adults (Budge et al., 2014; Tebbe & Moradi, 2016), and with higher life satisfaction, lower perceived burden of being transgender, and fewer depressive symptoms among trans youth (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Simons, Schrager, Clark, Belzer, & Olson, 2013).

In two separate studies among transgender adults, supportive family environments negatively predicted psychological distress. Framed by minority stress theory, Bockting and colleagues (2013) evaluated the relationship between experiences of stigma and mental health among an online sample of transgender persons ($n=1,093$) and assessed the potential moderating effect of "resilience indicators" on those relationships

(e.g., family support; “how supportive do you feel your family of origin is regarding your transgender identity?”). While family support did not moderate the relationship between stigma and psychological distress, results indicated that family support was negatively associated psychological distress. Similar findings are reflected in research done with a sample of Australian transgender adults ($n=169$; Bariola et al., 2015). The authors likewise sought to identify independent factors associated with psychological distress and resilience, respectively, among gender minorities. In the univariate analyses, participants’ reported ability to turn to their family for emotional support (“For emotional support, would you turn to your biological family? Yes/No”) was negatively associated with psychological distress and positively associated with resilience. In multivariate analysis, feeling unable to turn to one’s family for emotional support was a strong positive predictor of psychological distress among the transgender sample (Bariola et al., 2015). Indeed, the family can act as a protective factor against mental and physical health disparities among the population (Giovani et al., 2018; Klein & Golub, 2016): recent scholars have highlighted that the association between gender dysphoria and psychological functioning is “largely mediated” by the social intolerance of family and peers towards non-traditional gender identities and expressions (Giovani et al., 2018, p.61; Shumer, 2018).

While this body of research highlights the influence of trans people’s families on their health and wellbeing, it has been limited by measures of family environments that reflect its binary ‘acceptance-rejection’ conceptualization. In light of recent empirical scholarship critiquing this approach as reductionistic (McGuire & Catalpa, 2018), it is imperative to deepen the investigation of gender minorities’ family environments: such

an effort could contribute to achieving improved health outcomes among gender minorities (National Institutes of Health, 2016).

Family Environments of Gender Minorities

Early Theories & Approaches

Mirroring the aforementioned literature highlighting the family-health relationship among gender minorities, research attempting to document the experiences of transgender persons and their families has historically relied on a rejection-acceptance model (e.g., “Would you turn to your family for support? Yes or No,” “I get the emotional help and support I need from my parents” with Likert scale response from 1-5”) (Bariola et al., 2015; Grossman & D’Augelli, 2007; Simons et al., 2013). Binary in nature and thus simpler to assess and measure, this conceptualization insinuates parents either accept or reject a child’s gender variance, the former being associated with positive health and wellbeing outcomes (e.g., less depression; reduced sexual risk taking; less suicidality; Bariola et al., 2015; Ryan et al., 2010; Simons et al., 2013; Yadegardfard et al., 2013) and the latter being associated with negative ones (depression, anxiety; suicide; Grossman & D’Augelli, 2007; Grossman, D’Augelli, & Salter, 2006; Ryan et al., 2009).

While straightforward to understand and pragmatic for large-scale survey research, recent scholars have critiqued the dichotomous acceptance-rejection model as parsimonious and reductionist, one which “reifies a false binary of experience” (Catalpa & McGuire, 2018, p.3), and otherwise misrepresents the complex, temporal and dynamic realities of family relationships. Conceptualizing familial responses to a trans member as absolutes is limiting in that it obfuscates the potential for familial reactions that may exist between, or include the co-occurrence of both, acceptance and rejection (McGuire et al.,

2016a). Accordingly, a nascent body of scholarship has responded to this critique, forgoing reliance on the mutually exclusive acceptance-rejection approach and instead considering trans individuals and their families' experiences within a framework of Boss's (1999; 2006; 2016) ambiguous loss theory (i.e., Catalpa & McGuire, 2018; Coolhart, Ritenour, & Grodzinski, 2018; McGuire, et al., 2016a; Norwood, 2013a).

Prior to the recent recognition of ambiguous loss in the familial relationships of trans persons, a small number of stage models of gender transition in families had been offered in the clinical literature. Largely using case examples, these models accessed and highlighted the emotional processes family members undergo in learning of a trans loved ones' gender identity. For example, Emerson & Rosenfeld (1996) offered a stage model of grief akin to Kubler-Ross's (1969) model of grief for death and dying, which consisted of denial, anger, bargaining, depression, and acceptance. Ellis & Erikson (2002) also offered a stage model reflective of the grieving process, which included such emotions as shock and denial, anger and loss, coping, intrapersonal change, and acceptance. Prominently, in her 2004 book, Lev suggested a less pathologizing understanding of these families' emotional processes by offering a model with four stages: disclosure, turmoil, negotiation, and finding balance. While these models were fundamental in exposing the parsimony inherent in binary conceptualizations of family reactions to gender transition, they were not informed by empirical research. Further, while each of these models frame loss as part of families' developmental process in learning of a transgender loved one, they posit a finality to the loss, as do the models of grief on which they are based (Coolhart et al., 2018). What these clinical models lack beyond empirical backing is

recognition of loss without necessary resolution, what Boss (1999) identified as ambiguous loss.

Ambiguous Loss in Transgender Families

The small empirical literature on ambiguous loss and trans families is largely comprised of studies analyzing data from family members of gender minorities. In three separate publications, Norwood analyzed data from public online postings of trans people and their family members (2012) and from her own interviews with family members of trans individuals (2013a; 2013b). Analyses from the publicly-available online postings (2012) identified three types of dialectical struggle in family members' attempts at meaning-making when learning of a transgender loved one: (1) presence vs. absence, in which family members grieved the loss of their sibling/child/partner when their trans loved one transitioned, though that person was not, in fact, gone; (2) sameness vs. difference, which refers to the struggle of family members in conceptualizing their trans sibling/partner/parent as the same or different, post-transition; and (3) self vs. other, alluding to the struggle between families' desire to unconditionally support their trans member and being unable to do so because of religious beliefs, personal-emotional issues, or a lack of understanding (Norwood, 2012). Findings from her interviews with the parents, siblings, and partners of trans adults (2013a; 2013b) suggest those family members make sense of their transgender loved ones' gender transition as either a replacement, revision, evolution, or a removal. Regardless of the type of sense-making, however, family members grieved a loss related to their loved one's gender (e.g., gendered expectations for their future, gendered nature of their prior relationship, etc.; Norwood, 2013a). Other ambiguous loss analyses centering the experiences of parents of

older trans children include Coolhart and colleagues' (2018) qualitative study, in which they interviewed six parents of female-to-male (FTM) young adults. Findings underscored parents' experiences of ambiguous loss in several ways, including grief, a loss of dreams (e.g., no longer a "mother of the bride"), and a living death, a phenomenon in which parents reported having a living child, but not the child they had before: "...it felt like the child they once had was now deceased" (Coolhart, Ritenour, & Grodzinski, 2018, p.35).

One aspect that remains overlooked in the developing trans family/ambiguous loss literature is a more nuanced approach to understanding transgender *individuals'* experiences of their families. To date, two known exceptions exist. First, in their 2016 paper, McGuire and colleagues theorize how ambiguous loss is a suitable and defensible framework not only to conceptualize the parents' perspective of trans children, but also those of the trans family members themselves. The authors posit that akin to parents' experiences of ambiguous loss, "from the perspectives of trans persons, family members may become physically absent (e.g., unwilling to interact) or psychologically absent (e.g., ignoring or denying the gender transition)" (p. 374); they underscore the "incongruent experience" of trans people navigating inconsistent messages of psychological presence and absence, and physical presence and absence. Examples of the former include parents who iterate both accepting and rejection statements (e.g., "I love you but do not love your transgender status"); examples of the latter include ability to be present in some contexts, but not others (e.g., allowed to live in the family house but excluded from major or extended family events; McGuire et al., 2016a).

The trans perspectives of ambiguous loss delineated in McGuire and colleagues' article are reflected in a recent empirical study, in which qualitative data was collected from transgender youth (N=90; age range=15-26 years) about their perceptions of complex parental reactions to their gender variance (Catalpa & McGuire, 2018). Ethnographic content analysis (ECA; Altheide, 1987) identified three types of family boundary ambiguity in trans youth's perceptions of their family environment: (1) relationship ambiguity, (2) identity ambiguity, and (3) structural ambiguity. Relationship ambiguity, which was present in the majority of participants' interviews (81%), was both parent- and youth-initiated, and included such behaviors as ignoring gender variance, displaying ambivalence, and withdrawing emotional support (parent-initiated), or acting insubordinate and pulling away from the family (youth-induced); it "illuminated murky parent-child relationship marked by stress, conflict, and relational rupture" (p.11). The second ambiguity (73%), identity ambiguity, refers to youth's psychological distress in disassociating from their gender identity and expressions, which manifested in "hybridizing" or "suppressing" certain aspects of their gender identity in an effort to conserve family relationships. Structural ambiguity, which was present in roughly half of participant narratives (47%), refers to physical breaks between parent(s) and child, such as being kicked out (parent-induced) or leaving (youth-induced) the family home and removal of financial support. Taken together, transgender youth's narratives highlighted their parents' complex and inconsistent reactions to their gender identity and expression, and how youth managed them: some by constraining gender authenticity or subjecting to ambiguity to prevent family breaks, others choosing relational rupture to maintain or embrace their gender authenticity.

Arguably, what Catalpa & McGuire's (2018) empirical investigation broadly underscores is the complex reality of trans youth's family relationships in light of their parents' verbal and behavioral reactions to their gender. The authors identified the ambiguity, uncertainty, and the co-occurrence and variability of both accepting and rejecting behaviors that manifests in trans youth's familial relationships, a dynamic that reflects the "complicated amalgamation" of parental reactions to trans youth's gender identity and expression in extant studies (e.g., rejection, support, ambiguity, grief; Grossman & D'Augelli, 2007; Simons et al., 2013; Whalig, 2013; Norwood, 2013b).

Transgender Gender Heterogeneity

As the scholarship on the transgender experience within the family develops, it is becoming increasingly evident that substantial gender diversity exists among those subsumed under the broad transgender umbrella (e.g., Kubler, Nussbaum, & Mustanski, 2018; Singh, 2016; Tebbe, Moradi, & Budge, 2016). This gender heterogeneity is manifest, in part, by the "large, growing, and perhaps unlimited" number of terms used to describe persons with nonbinary gender identities (Marshall, 2017, p.10), ones that defy traditional and pervasive gender categorizations. Indeed, data from the NTDS suggest over a third (35%) of the transgender population identified with a nonbinary gender identity, more than identified as either a transgender man or a transgender woman (James et al., 2016a; Joel, Tarrasch, Berman, Mukamel, & Ziv, 2013). Recognizing this demographic reality and the complexity of gender and its development (Bockting, 2014; Catalpa & McGuire, 2018; Polderman et al., 2018), scholars are critiquing the tendency to assume the transgender experience as homogenous—a practice which obfuscates potential variation within the population—and are thus encouraging adequate recognition

to and examination of heterogeneous gender experiences within the transgender population (e.g., Connell, 2010; Darwin, 2020; Diamond, Pardo, & Butterworth, 2011). Indeed, Singh (2016) asserts that research on trans persons “is quite needed to move beyond.... a trans “homogenous” identity” (p.1058). The increasingly identified need to consider gender heterogeneity in future transgender scholarship is important due to the pervasiveness of the gender binary.

The Gender Binary & The Transgender Population

Binary gender identification is omnipresent in the vast majority of the world. After most births, medical professionals, midwives, and/or doulas typically⁴ consign infants to one of two sex categories (male or female; West & Zimmerman, 1987) based solely on inspection of external genitalia (Polderman et al., 2018). Cisnormativity, or the assumption that individuals’ biological sex and gender identity are congruent and unalterable (Bauer et al., 2009; Kuvalanka et al., 2018), provides a base from which this pre- or peri-natal binary assignment “steeps” the infant in binary gender expectations (Matsuno & Budge, 2017; p.117). These expectations are constructed and perpetuated by families, schools, and institutions, extending the pervasiveness of cisnormativity throughout the life course (Lorber, 1995). Accordingly, individuals who defy this pervasive ideology are also defying historical, institutional, and interpersonal norms that pathologize their existence. Transgender scholars recognize that genderqueer people, “must navigate a world in which there is little allotment for their identities” (Budge et al., 2014, p.97)—certain mundane tasks often overlooked by those who conform to the

⁴ According to Polderman and colleagues (2018), in some medical and/or cultural contexts, an infant may not be assigned to one of the two traditional sex categories if born with genitalia that do not entirely resemble our collective understanding of “male” and “female” biologies.

gender binary are inherently problematic for nonbinary individuals, such as using a public restroom, selecting a gender on identity documents and other paperwork, and being misnamed or misgendered (Budge, Tebbe, & Howard, 2010). Furthermore, similar to other identities existing outside socially-constructed binaries (e.g., bisexuality; Ross, Dobinson & Eady, 2010), GQNB people may find it necessary to justify their gender identity and expression, explain the complexity of gender, and/or defend one's ability to identify as neither a man or a woman (Matsuno & Budge, 2017).

Though they comprise more of the transgender population than do transmen and transwomen, what we know about GQNB persons—in general, and in relation to binary trans persons—is extremely limited. The nascent literature seeking to differentiate transgender individuals with binary and non-binary gender identities suggests that, compared to binary transgender people, GQNB individuals are more likely to report serious psychological distress (James et al., 2016b); higher levels of anxiety, depression, and low self-esteem (Thorne et al., 2018); higher rates of lifetime suicide attempts and non-suicidal self-injury (Clark et al., 2018; James et al., 2016b; Lefover, Boyd-Rogers, Sprague, & Janis, 2019); higher levels of substance use (Clark et al., 2018; Klein & Golub, 2016); and poorer health (Streed, McCarthy, & Haas, 2018). Additionally, GQNB people are more likely to have negative experiences with law enforcement and are twice as likely to report a negative experience seeking legal services than binary transgender persons (James et al., 2016b). Demographic differences between GQNB and the binary transgender people also exist: for example, in a non-clinical sample of 415 transgender adults, individuals comprising the GQNB subsample were younger, less likely to be

employed, resided in more urban areas, and accessed fewer trans-related healthcare services than their binary counterparts (Koehler et al., 2018).

While these reports suggest differences on certain health, psychosocial, and demographic outcomes between binary and GQNB people, findings elsewhere are inconsistent with, and at times, contradict, these data. In several studies assessing if health disparities between the two groups exists, no differences were found in their quality of life, physical health, or psychological health (Bradford & Catalpa, 2019; Fish, Catalpa, & McGuire, 2017; Jones, Pierre Boumann, Haycraft, & Arcelus, 2019). These findings are juxtaposed to the aforementioned research findings suggesting GQNB persons have poorer health outcomes than do their binary counterparts. More puzzling, however, is literature suggesting the reverse. For example, Rimes, Goodship, Ussher, Baker, and West (2017) found that nonbinary respondents reported more life satisfaction and were less likely to have ever attempted suicide than their binary counterparts. In other such studies, GQNB participants had higher psychological functioning (Jones et al., 2019) and reported lower levels of minority stress (Fish, Catalpa, & McGuire, 2017) than binary participants.

In sum, little research has considered the gender and/or health heterogeneity among the transgender population and, among what has been found, inconsistencies exist. Indeed, in a recent systematic review of the literature on the health of GQNB people, Scandurra and colleagues (2019) concluded that the research findings related to health differences between binary and nonbinary trans people are “inconsistent and mixed” (p.8). Further inquiry is warranted to explore the health implications of intra-group gender diversity among transgender adults. Further, no known research has explicitly

examined if, and to what extent, gender heterogeneity among trans adults is associated with their family environment, or the social climate within their families of origin. Justification for considering the relationship between binary vs. nonbinary gender identification and the family environment of trans adults is backed by findings—or the absence of findings—from the relevant scholarship. To date, very few (<5) known published studies have investigated the familial experiences of nonbinary trans persons, or potential differences in family environments as a factor of binary vs. nonbinary gender identification. Klein & Golub (2016), who analyzed data from the 2015 National Transgender Discrimination Survey, discovered that adults with binary gender identities were more likely to experience moderate or high levels of family rejection than individuals with nonbinary identities. In the NTDS full report, the only family-related finding by gender identity suggests that fewer transgender adults with nonbinary gender identities experience family rejection than do those with binary identities (32% to 59%; James et al., 2016b). Dissimilarly, Bradford & Catalpa (2019) observed— using data from an online nonprobability sample—that binary transgender participants reported higher family support than did nonbinary respondents, but this relationship was only marginally significant ($0.1 > p > 0.05$).

In the few remaining studies in the trans-family literature, GQNB individuals' experiences are not distinguished from those of their binary counterparts. For example, as mentioned earlier, Norwood (2012) collected data from postings to online transgender discussion forums by transgender persons and “those who consider themselves spouses/partners and family members” of transgender persons (p.81). However, she

provided no information regarding her participants' gender identities beyond distinguishing them as transgender.

The Gender Binary & The Families of Transgender Individuals

In addition to investigating trans persons' perspectives of their families with respect to gender identification (i.e., binary vs. nonbinary; Darwin, 2020; Klein & Golub, 2016), there is reason to investigate the same phenomenon from the perspective of the family members. This inquiry is justified, in part, by the aforementioned realities of cisnormativity and the gender binary.

Most families assume and expect their loved ones to be cisgender: namely, to have congruence between their gender identity and expression, and the sex assigned to them at birth. As previously stated, the family is a “primary context” in which cisnormativity—the assumption that there are only two genders, that gender identity is determined by biological sex, and that one's gender ascribes them to specific familial roles—is enforced, reproduced, and maintained (Bauer et al., 2009; Kuvalanka et al., 2018; McGuire et al., 2016b, p.61). Thus, transgender individuals, both binary and not, challenge the assumed congruence between assigned sex and gender identity. However, a distinction arises in considering the two other components of cisnormativity: that there are only two genders and that one's gender ascribes them to specific familial roles. Nonbinary trans persons, in contrast to their binary counterparts, uniquely challenge the gender binary, whereby their social and/or medical transition does not resolve in becoming the “other” of two genders (Elkins & King, 1999). Indeed, GQNB adults are less likely than binary transgender adults to seek transition-related healthcare services (Koehler et al., 2018). Though family members of binary trans adults undergo their own

challenges and meaning (re-)making processes in learning of their trans relative's authentic gender identity (e.g., Norwood, 2012; Coolhart et al., 2018), they are not inherently required to challenge the ubiquitous binary and essentialist notions of gender. As McGuire and colleagues (2016b) assert, they are "...not necessarily predispose[d] to critically examine constructs of gender or shift their view on how it should be expressed." Indeed, the authors add: "Living off the gender binary may challenge family members and others to critically examine the imbedded nature of gender binaries in human societies (p.62-63). In other words, binary transgender adults in many ways reinforce the gender binary whereas nonbinary trans persons may challenge it. However, the implications of this reality within the context of the family remain unknown.

Further, considering the gendered nature of family identities (i.e., mother, father, son, daughter), a trans identity requires a renegotiation of cisnormative expectations for that person's familial positions and roles. For example, the parents of an adult transman who was assigned female at birth are challenged to reconsider their assumed daughter as a son, and/or mourn the loss of how they may have expected to become grandparents in the future. Such examples are reflected in the literature on binary trans persons (e.g., Coolhart et al., 2018), and, in the case of the latter example, in the extant literature on gay and lesbian children (e.g., Chrisler, 2017). While these challenging processes are empirically supported, the process among nonbinary adults' families, which may manifest differently, remains unknown. For example, if an assigned-female and assumed daughter comes out as genderqueer and uses they/them pronouns, what positions(s) in the family do they now hold? Though no longer a "daughter," they are concurrently neither a son. Adults with a nonbinary gender identity, different from binary trans persons,

uniquely challenge previously un-challenged aspects of cisnormativity within their families (McGuire et al., 2016b). Yet, the experiences of such individuals' family members are largely absent from the literature.

Nearly all the published data on family members of gender minority adults reflects those of family members of binary-identified transgender loved ones. As mentioned, in two separate publications, Norwood (2013a; 2013b) analyzed interview data collected from 37 "family members of trans-identified persons" (2013a, p.158). In her first analysis (2013a), Norwood sought to, and discovered, how cisgender family members make sense of their trans loved one's gender identity: some did so by pathologizing it as a medical condition, others as a lifestyle choice. In her second (2013b), Norwood uncovered the aspects of a person's transition that inform their family members' struggle surrounding it. Findings suggest family members are challenged by their essentialist beliefs about gender, and, as a result, a way to conceptualize the transition; they do so as a replacement, an evolution, or a removal (Norwood, 2013b). In both of these studies, the author specified two of her 37 participants were relatives of individuals who identified as genderqueer; the others were relatives of female-to-male (FTM; 19) or male-to-female (MTF; 16) binary trans persons. Two of Norwood's (2013a; 2013b) 37 family member participants were relatives of a genderqueer person; however, no distinctions were made in her studies' findings between those relatives and ones with binary trans family members.

Only one known published empirical study exists reporting the experiences of the family members of a nonbinary trans person: a 25-year retrospective autoethnography of a single family with an adult child with a nonbinary gender identification (Marcus,

Marcus, Yaxte, & Marcus, 2015). The authors—two cisgender parents, one cisgender adult child, and one GQNB adult child—describe their own experiences with gender complexity within their family. The parents articulated their difficulty in understanding their GQNB child, Sara's, pleas to "accept me for who I am, whether or not I am easy to describe" (p.802). They attributed their challenge in comprehending her gender to the "satisfactory alignment" between their own gender identities and their biological sexes, in addition to the substantive gap in public awareness of the phenomenological reality of gender, or the understanding that gender is experienced in a variety of ways far beyond the male-female binary. This lack of knowledge, clarity, and "available options" for nonbinary individuals created the parents' inability to achieve finality, something they describe wanting:

"Over the years, we watched ourselves manifest nearly every possible irrational coping mechanism available as we accompanied Sara on her search: from denial to premature certainty as she declared her transgender identity, wanting to believe that such declarations would provide closure, and thereby relief, to us all."

While unique in their methodologies, Marcus and colleagues' (2015) autoethnography offers the perspective of only a single dyad of parents of a gender nonbinary adult; further, both parents are academic psychoanalysts and thus may be more self-reflective and tolerant than the population at large. While the parents talk of the difficulties they had in re-conceptualizing their essentialist views of gender when Sara came out as nonbinary, they did little to discuss nuances of their developmental process in challenging and reconfiguring their previous gender understanding.

What is increasingly evident in this literature is the absence of studies sampling, and thus exposing the experiences of, parents of nonbinary transgender adults. This is particularly important considering the recently acknowledged gender heterogeneity within the trans population. Additionally, as the number of trans-identified persons in the U.S. continues to rise (Herman, Flores, Brown, Wilson & Conron, 2017), the family members associated with those individuals are likewise increasing considerably (Coolhart et al., 2018; Dierckx et al., 2016); however, knowledge of their unique challenges, experiences, and resiliencies remain limited.

Chapter 3: Study One

Gap 1, Study 1: Family Complexity

In recognizing the complexity inherent in familial relationships and the gender diversity within the transgender population, a nascent but resounding literature asserts that the family environment cannot be conceptualized as a dichotomy of acceptance *or* rejection. In response, recent scholars have expanded our understanding of trans persons' family environments (e.g., ambiguous loss; Catalpa & McGuire, 2018; Coolhart, Ritenour, & Grodzinski, 2018; Norwood, 2013a; 2013b). Findings from this empirical literature include trans young adults' experience of multifaceted ambiguity—relational, identity, and structural—as they navigate their gender transitions and their familial relationships (i.e., Catalpa & McGuire, 2018), which substantiates that the binary acceptance-rejection framework “....cannot be reduced to a singular, fixed, or dichotomized experience of parental acceptance or parental rejection” (p.100).

One manifestation of the efforts to extend the rejection-support family dichotomy was the creation of *The Family Gender Environment Scale* (FEG), a measure to quantitatively assess the family environment of trans people (McGuire & Catalpa, 2017; McGuire & Fish, 2018; see [Appendix A](#)). The instrument's design was informed by findings from qualitative and quantitative research performed by the instrument's authors and their collaborators to measure respondents' gender-related experiences with their family-of-origin currently. While the instrument's validation is ongoing, initial validation analyses suggests it has strong psychometric properties across its 39 items (McGuire & Fish, 2018). Among a sample of trans-identified individuals, hierarchical confirmatory factor analysis (CFA) with oblimin rotation yielded six factors with favorable factor

loadings [$\chi^2(696, N=234) = 1873.91$; $p < .001$]; RMSEA = .084, CFI = .913, SRMR = .060]: (1) Family Inclusion ($\lambda = .662-.883$), (2) Explicit Care ($\lambda = .770-.802$), (3) Acceptance & Support ($\lambda = .592-.833$), (4) Active Barriers ($\lambda = .673-.809$), (5) Morally Wrong ($\lambda = .668-.813$), and (6) Disaffirm Gender ($\lambda = .715-.839$) (McGuire & Fish, 2018). What the new scale affords this burgeoning area of research is the ability to understand the complexity of transgender adults' extant family environments beyond those relegated to a binary of acceptance *or* rejection. This is particularly important as the empirical base of the family environment among this population is scant, which includes the absence of any quantitative assessments of the family environment of trans adults. Further, it remains unknown if types of familial environments are associated with the health and wellbeing of transgender people.

Latent Profile Analysis

To achieve a deeper understanding of trans persons' family environments, I employed Latent Profile Analysis (LPA). Distinct from traditional variable-centered approaches, LPA is a person-centered approach that seeks to identify latent subgroups (or profiles) of individuals who share a similar constellation of experiences (Lanza & Rhoades, 2013; Nylund, Asparouhov, & Muthén, 2007). In an effort to contribute to the noted gaps in the literature and our collective understanding of trans families, the current study will employ LPA to uncover potentially distinct types of family environments for trans adults using the six subscales of the FGE as the LPA's measured variable indicators. Such a methodology will provide a more holistic and contextualized understanding of the trans persons' family experiences, and, by examining the profiles' associations with health and wellbeing, a way to identify which types of family

environments pose the greatest risk for trans individuals' negative health outcomes. Additionally, Fish and Russell (2018) have identified latent class and latent profile analyses as “untapped methods” in the study of queer families. In encouraging researchers to employ such methods, the authors highlight LPA's advantageous ability to “model profiles that characterize multidimensional, interdependent, and mutually constructed identities and experiences in context” (p.19). It is these types of family classes I seek to model in the current study and their associations with the health and wellbeing of trans adults.

Therefore, the current study is guided by two research questions:

- 1) Do latent profiles characterized by types/styles of family-of-origin environments exist among transgender adults?
- 2) How are the latent profiles of family environment associated with measures of health and wellbeing among transgender adults?

Methods

Objectives

The purpose of Study 1 is two-fold: (1) to identify latent profiles of family-of-origin environments among a sample of transgender adults; and (2) to test the associations between the identified profiles and health outcomes.

Data & Procedures

The data used for this study are from a larger survey conducted in 2018 which sought to understand the lives of trans individuals over the age of 18. Specifically, survey questions utilized in the current study asked about participants' demographic information, family environment, genderqueer identity, experiences of minority stress, mental and physical health, and quality of life. To participate, respondents had to (1) identify as transgender ("I am trans with a binary identity, e.g., trans man, trans woman, mtf, ftm" or "I am trans with a nonbinary identity, e.g., nonbinary, genderqueer, agender, greygender, neutrois, gender fluid"); and (2) be at least 18 years old. As the survey was administered only once, the data are cross-sectional.

The original survey data were collected through Amazon's Mechanical Turk (MTurk) program ($N=875$). MTurk is an internet marketplace crowdsourcing initiative designed for work that requires human intelligence. "Employers" post individual, self-contained Human Intelligence Tasks (HITs) which workers can accept to complete and, upon finishing, receive payment. HITs are typically simple tasks that are best suited for human completion, such as transcribing recordings, comparing product images, and completing online forms. Due to MTurk's ability to recruit large numbers of participants

in a short amount of time, researchers are increasingly recognizing MTurk as a fruitful avenue for data collection (Casler Bickel, & Hackett, 2013).

Though MTurk is a relatively new interface for survey research, its validity has been tested and supported within the psychological literature. For example, Casler and colleagues (2013) compared the responses of their study participants recruited from MTurk to those recruited through other forms of social media. While MTurk respondents were more racially and socioeconomically diverse, results from the study's test—an object selection and categorization task—between the MTurk and non-Mturk respondents were nearly identical. Buhrmester, Kwang, and Gosling (2011) likewise identified greater demographic diversity among their MTurk sample compared to other internet samples; they also highlighted MTurk's capability for rapid and inexpensive recruitment which, the authors asserted, produces reliable and high-quality data.

Measures

Family Gender Environment Subscales (independent variables): Latent profiles of family gender environment were determined using the six subscales of *The Family Gender Environment Scale* (FGE; McGuire & Catalpa, 2017; McGuire & Fish, 2018). The instrument instructs respondents to “think about your family of origin currently” and contains 39 items, each of which is scored from 0 (“never”) to 4 (“all the time”). The six subscales, used as the indicators for the latent profile analysis, include: (1) family inclusion; (2) explicit care; (3) acceptance & support; (4) active barriers; (5) morally wrong; and (6) disaffirm gender. Broadly, factors 1-3 reflect supportive family environments and 4-6 reflect rejecting ones. The full questionnaire can be found in

[Appendix A](#). Among the study's sample, Cronbach's alpha for the six subscales were .89, .92, .92, .93, .94, and .91, respectively.

Subscale items were averaged to produce a mean score for each subscale (range = 0-4). If a respondent completed 60% or more of the items on a given subscale, a mean score was calculated from the available data. Subscale means ranged from 1.68 (SD = 1.16) to 2.26 (SD = 1.00) and are included in [Table 2](#).

Mental health (*dependent variable*). Participants' mental health was measured using the psychological health subscale from the World Health Organization's (WHO) Quality of Life-BREF Scale (WHOQOL-BREF), an international and cross-cultural assessment of an individual's subjective quality of life. The WHOQOL-BREF, a shortened version of its 100-question predecessor, contains 26 questions that assess four broad domains: physical health, psychological health, social relationships, and environment. The psychological health subscale, which comprises six questions, assesses, for example, positive and negative feelings, self-esteem, and ways of thinking, (Skevington, Lotfy, & O'Connell, 2003). Higher scores on the psychological health domain on the WHOQOL-BREF corresponds to higher levels of mental health. Internal consistency of the psychological health domain ranges from .79 to .81 (Harper & Power, 1998; Skevington, Lotfy, & O'Connell, 2003). Mean scores were calculated for all respondents who provided valid data for 4 of the 6 items on the mental health subscale. The sample's mean score was 2.45 (SD = 0.78).

Physical health (*dependent variable*). Participants' physical health was measured using the physical health subscale from the World Health Organization's (WHO) Quality of Life-BREF Scale (WHOQOL-BREF). The physical health subscale includes seven

questions that assess phenomena such as energy and fatigue, medication dependency, and pain and discomfort (Skevington, Lotfy, & O’Connell, 2003). Items are scored on a 5-point scale, ranging from 0 (“none at all,” “never,” “very poor,” or “very dissatisfied”) to 4 (“extremely,” “always,” “very good,” or “very satisfied”). Higher scores on the physical health domain reflects higher levels physical health. Studies have found the WHOQOL-BREF scale, including the physical health subscale, to exhibit strong and reliable psychometric properties (e.g., $\alpha_{\text{physical health}} = .84$; Harper & Power, 1998; $\alpha_{\text{physical health}} = .82$; Skevington, Lotfy, & O’Connell, 2003). Mean scores were calculated for all respondents who provided valid data for at least 5 of the 7 items on the physical health subscale. The sample’s mean score was 2.51 (SD = 0.72).

Covariates. Eight socio-demographic variables were included as covariates in our analyses: (1) sexual orientation; (2) natal sex; (3) age; (4) annual individual income; (5) education; (6) childhood familial religiosity; (7) nativity; and (8) race/ethnicity. The sample’s descriptive statistics of these covariates are included in [Table 1](#).

Sexual orientation was assessed via the question: “What best describes your sexual identity?” (Lesbian [reference], Gay, Bisexual, Queer, Straight/heterosexual, Asexual, Pansexual, and Other) and *natal sex* was measured using the item, “What sex were you assigned at birth?” (Female [reference], Male, and Intersex). *Age*, *annual income*, and *education* were each measured ordinally: *age* from “under 18” (1) through “65-74” (7); *annual income* from “\$0 - \$9,999 “(1) to “\$150,000 and above” (12); and *education*, from “high school or less” (0) to “graduate degree” (5). *Childhood familial religiosity* was assessed using the item: “I would describe my childhood religious upbringing as devout”. Responses ranged from “no, not at all” (1) to “yes, very devout”

(4) with higher scores conveying higher levels of family devoutness. *Immigrant status* was a binary outcome measured by the item, “Do you live in the country you were born?” (1=not an immigrant; 2=immigrant). Finally, *race/ethnicity* was assessed via the item, “What best describes your ethnic background?” for which participants could “check all that apply”: (1) White/Caucasian, (2) Black/African American; (3) African-born; (4) Hispanic/Latino, Caribbean; (5) American Indian/Alaskan Native; and (6) Asian/Pacific Islander.

Analyses

We estimated latent profiles of family environments using the six subscale indicators of the Family Gender Environment (FGE; McGuire & Fish, 2018) in Mplus version 8.2 (Muthén & Muthén, 1998-2017). Missing data were accounted for using full-information maximum likelihood estimation (FIML), a defensible strategy given that missing data were likely missing completely at random (MCAR; e.g., a respondent unintentionally skipped a survey item) or missing at random (MAR; e.g., AMAB respondents might have been less likely to complete the mental health WHO-QOL subscale) (de Leeuw & Hox, 2008; Enders, 2010). Respondents who had at least one of the six FGE subscale mean scores/LPA indicators were included in analyses. Of the 875 respondents, all but two had at least one subscale score on the FGE; it was these 873 that were included in the analysis ($N=873$). Sample demographic information is presented in [Table 1](#). Two-thirds of respondents reported a non-binary gender identity ($n=586$; 67%) and more than 60% were assigned male at birth ($n=526$). Eight in 10 respondents were between 18 and 34 years old ($n=704$), 85% had completed at least some secondary education ($n=715$), and 3% were immigrants ($n=26$). The sample reported an average

income between \$30,000 and \$49,999 during the last fiscal year and more than 60% of respondents rated their upbringing as “somewhat devout” or “very devout” ($n=634$; 61.2%). Half of respondents identified as White only ($n=479$), one third (31%; $n=271$) as “Spanish, Latinx, or Hispanic,” 15% as “Black/African American” ($n=131$), and 7.2% selected more than one ethnic group ($n=63$).

To determine a model with the optimal number of profiles, we followed the criteria outlined by Collins & Lanza (2010) and Masyn (2013). We began by fitting a one-profile model and added additional profiles in successive models up to 10 through an iterative process. For each model, we noted and compared several statistical criteria of relative fit: (1) the Akaike information criterion (AIC; Akaike, 1987), (2) the Bayesian information criterion (BIC; Schwarz, 1978), (3) the sample-adjusted Bayesian information criterion (SABIC; Sclove, 1987), (4) the bootstrapped likelihood ratio test (BLRT; McLachlan & Peel, 2000), and (5) the Lo-Mendell-Rubin adjusted likelihood ratio test (LMR; Lo, Mendell, & Rubin, 2001). Lower values of the AIC, BIC, and SABIC denote better data-model fit. The BLRT and LMR, which both compare and evaluate the fit of a model with k profiles to a model with $k - 1$ profiles, indicate improved model fit when the corresponding p -value is statistically significant. Thus, when a $p > .05$, the previous model with one less class shows better model fit than the $k + 1$ model. Additionally, we evaluated the posterior probabilities associated with models’ profiles, which allowed us to assess classification accuracy. Generally, high posterior probabilities ($< .70$) are an indicator of clearly defined profiles (Stanley, Kellermanns, & Zellweger, 2017). Finally, beyond the statistical outputs, we examined the characteristics

of each profile and considered the extent to which they were interpretable to the theory and research question(s) surrounding the analysis.

After model estimation, we sought to test the relationships between our sample's sociodemographic characteristics and their corresponding profile membership. We did this using the classify-analyze (CA) approach (e.g., Wang, Hendricks, & Bandeen-Roche, 2005) whereby we regressed the imputed profile membership variables on the sociodemographic variables in a separate multinomial linear regression. While the CA method does not account for profile classification error (Asparouhov & Muthén, 2014), it allowed us to induce FIML, a technique incompatible with auxiliary variables, and thus analyze a larger sample than the one we could with 3-step process⁵. Finally, to test associations between latent profiles of family gender environment and health outcomes, we regressed physical health and mental health (respectively) on the identified latent profiles of family gender environment, adjusting for sociodemographic covariates.

Results

Latent Profile Analysis

The purpose of this study was to (1) identify latent profiles of family-of-origin environments among transgender adults, and (2) to test the associations between the identified profiles and (a) mental health and (b) physical health.

Following the criteria outline by Collins & Lanza (2010) and Masyn (2013), we identified a 5-profile model to best represent our data. Complete comparisons of model fit statistics are presented in [Table 3](#). Although the AIC, BIC, and SABIC decreased with

⁵ To corroborate our decision, we ran the same analysis using R3STEP, the findings from which were analogous to those found using the classify-analyze approach.

each successive model, the difference was noticeably smaller between the 5- and 6-profile model than between the first four. Additionally, the p -value of the Lo-Mendell-Rubin adjusted likelihood ratio test, which was $\leq .0001$ for the first five models, became statistically non-significant in the 6-profile model, suggesting the 5-profile model exhibits better fit than the 6-profile model (Lo, Mendell, & Rubin, 2001). Penultimately, within the 5-profile model, we noted both large posterior probabilities (>0.94) and high entropy (0.94); no other model had higher model entropy. Finally, we considered the theoretical interpretability of the 5-profile model, paying a particularly scrutinizing eye to the comparable interpretability of the two adjacent models. It was unanimous among the study authors that the 5-profile model's theoretical interpretability was more salient and more defensible than both the 4-profile and the 6-profile model. Of note, the BLRT remained significant through all 10 models, which suggests that none of the models better fit the data than the one subsequent to it, including the 5-profile model. However, we defend our selection of the 5-profile model to best fit our data because the BLRT was the only indicator of the seven we used to determine optimal model fit that did *not* support our decision; the other six—AIC, BIC, SABIC, LMR, posterior probabilities, and theoretical interpretability—did.

Below, we provide brief descriptions of each profile and their assigned name. Profile names were selected based on the relative and absolute values of profile indicators, distinctive juxtapositions between profiles, and extant theory on the family gender environment of trans persons. A graphic depiction of the means for each profiles ([Figure 1](#)) and a table of the model's posterior probabilities ([Table 4](#)) are included below.

Profile 1: Disengaged. Roughly 20% of our sample ($n=174$) was assigned membership in the Profile 1 (“*disengaged*”), which was characterized by low mean values of all supportive (family inclusion, explicit care, acceptance & support) and unsupportive (active barriers, morally wrong, disaffirm gender) subscales (range: 0.38/4 - 1.4/4).

Profile 2: Embracing & affirming. Participants in Profile 2 ($n=123$; 14.1%; “*embracing & affirming*”) reported high scores on family inclusion, explicit care, and acceptance & support and low scores on active barriers, morally wrong, and disaffirm gender.

Profile 3: Repudiating. Juxtaposed to Profile 2, Profile 3 (“*repudiating*”) was characterized by participants with high scores on active barriers, morally wrong, and disaffirm gender and low scores on family inclusion, explicit care, and acceptance & support ($n=84$; 9.7%), and was the profile with the smallest membership.

Profile 4: Moderate family ambiguity (MFA). Respondents in Profile 4 reported near-identical scores on all six indicators (range: 2.0/4 - 2.2/4). As a result, we named this profile *moderate family ambiguity*. With 259 participants assigned to Profile 4, it was the profile with the largest membership ($n=259$; 29.7%)

Profile 5: High family ambiguity (HFA). The fifth profile was characterized by near-identical scores that were slightly higher than those in Profile 4. Thus, we refer to Profile 5 as *high family ambiguity* ($n=233$; 26.7%).

Socio-Demographic Characteristics Associated with Profile Membership

We regressed the latent profile membership on the sample’s sociodemographic characteristics in a multinomial linear regression using the classify-analyze (CA)

approach (e.g., Asparouhov & Muthén, 2014; Wang et al., 2005). The CA approach was used so that respondents were not listwise-deleted for those who had missing data on the covariates. Additionally, the CA approach is a particularly viable method in analyzing latent profile models with high entropy (Clark & Muthén, 2009), a characteristic of our identified 5-profile model (0.94).

We noted significant relationships between sociodemographic characteristics and assigned class membership, which are presented in [Table 5](#). To maximize statistical power and generalizability, a decision was made to drop any covariate with $n < 5$ respondents in a given profile. This included four *sexuality* dummy variables (straight/heterosexual, asexual, pansexual, other), intersex, and nativity. Respondents who were assigned male at birth (compared to those assigned female) were more likely to be assigned membership in the *mild family ambiguity* (MFA) and/or the *high family ambiguity* (HFA) profile than in *embracing & affirming* (OR_{MFA} : 1.73; 95% CI: [1.09-2.75]; OR_{HFA} : 1.76; 95% CI: [1.05-2.95]). Those with higher levels of education were more likely to be in *high family ambiguity* than in *embracing & affirming* (OR: 1.82; 95% CI: [1.40-2.39]), and participants who reported higher annual individual incomes were less likely to be assigned to the *disengaged* and/or the *repudiating* profile than to *embracing & affirming* (OR_{P1} : 0.88; 95% CI: [0.80-0.98]; OR_{P3} : 0.79; 95% CI: [0.69-0.91]). Additionally, respondents with more devout upbringings were roughly 1.5 times more likely to be placed in *repudiating* (P3) and *moderate family ambiguity* (P4), and 2.67 times more likely to be placed in *high family ambiguity* (P5), than in *embracing & affirming* (OR_{P3} : 1.59; 95% CI: [1.15-2.18]; OR_{P4} : 1.40; 95% CI: [1.12-1.76]; OR_{P5} : 2.67; 95% CI: [2.00-3.55]).

Associations between Latent Profile Membership and Mental and Physical Health

Results from our distal linear regressions are included in [Table 6](#). Overall, profile membership was predictive of both mental health and physical health. In the mental health model, membership in *disengaged*, *repudiating*, *mild family ambiguity*, and *high family ambiguity* relative to *embracing & affirming* were each negatively associated with mental health ($b_{P1} = -0.26$; $b_{P3} = -0.29$; $b_{P4} = -0.42$; $b_{P5} = -0.44$; all $p < .01$). Profile membership explained an additional 10% of the variance in mental health beyond that explained by the covariates ($\Delta R^2 = 0.10$). Similar results were found with regard to respondents' physical health: profile membership in each profile relative to *embracing & affirming* was negatively associated with physical health ($b_{P1} = -0.22$; $b_{P3} = -0.31$; $b_{P4} = -0.51$; $b_{P5} = -0.38$; all $p = .000$). After adjusting for covariates, profile membership explained an additional 15.6% of the variance in physical health.

Post-hoc Analyses

To help inform profile interpretation, a decision was made to compare the profiles on levels of mental health and physical health. We performed multi-group comparisons with model constraints in Mplus using full-information maximum likelihood estimation to assess mean differences in health outcomes between profiles, controlling for covariates. Results indicated that significant differences between profiles exist for both health outcomes ($\chi^2_{\text{mental}}(70, N = 873) = 139.3, p = .0000$; $\chi^2_{\text{physical}}(70, N = 873) = 135.7, p = .0000$). Examination of the between-group comparisons revealed that participants assigned membership in (a) Profile 2 (*embracing & affirming*) reported significantly higher scores of both mental health and physical health than those assigned to all other profiles; (b) Profile 1 (*disengaged*) reported significantly higher scores than those

assigned in Profiles 3, 4, or 5; and (c) Profile 4 (*mild family ambiguity*) reported significantly lower scores for both mental and physical health than those in Profile 5 (*high family ambiguity*). There were no significant differences in either health outcome between those assigned to Profile 3 (*repudiating*) and to those assigned to Profile 4 or to Profile 5. Complete results are included in [Table 7](#).

Discussion

Historically, scholars have conceptualized the family environment of gender minorities as a dialectic of acceptance or rejection, whereby family members either accept or reject their loved one's gender identity or expression. However, budding evidence suggests that this extant and widely-assumed understanding of the family is flawed: families' accepting and rejecting behaviors in response to a loved one's gender variance can co-occur and/or be perceived as contradictory or ambiguous (Catalpa & McGuire, 2018; Coolhart, Ritenour, & Grodzinski, 2018). To assess for such family heterogeneity, the first aim of the current study was to identify latent profiles of family environments among trans persons. The need for this investigation is particularly glaring as the small literature on transgender family environments comprises only qualitative and theoretical papers. We sought to fill this gap by quantitatively examining the complexity of transgender adults' family environments beyond those constricted to the acceptance/rejection binary.

Number and Types of Family Environments

Our LPA yielded five profiles of trans family environments. Guided by the model-selection specifications delineated by Collins & Lanza (2010) and Masyn (2013), a 5-profile model best fit our data. Profile 1 (*disengaged*), in which roughly 20% of our

sample were assigned membership, was characterized by low scores on all accepting and rejecting LPA indicators (0.4-1.4 out of 4). Profile 2 (*embracing and affirming*) and Profile 3 (*repudiating*) were the profiles with the smallest memberships, with 14.1% of the sample belonging to the former and 9.7% to the latter. Respondents in Profile 2 reported high scores on the “accepting” FES subscales and low scores on the “rejecting” ones; those assigned to Profile 3 reported the reverse. The remainder of our sample (~60%) was assigned membership into one of two profiles—*moderate family ambiguity* (Profile 4) or *high family ambiguity* (Profile 5)—which were distinguishable by near-identical scores on the three “accepting” and the three “rejecting” measured variable indicators (~2 out of 4 for *moderate family ambiguity* and ~3 out of 4 for *high*). This finding provides quantifiable evidence to dispute the claim that families of trans persons are either accepting *or* rejecting of their trans family members; our data supports the identified ambiguity among the families of transgender people (e.g., Catalpa & McGuire, 2018).

In addition to the quantitative identification of ambiguous family environments, our analyses indicated that the majority of respondents were assigned membership into an ambiguous family profile. Seemingly, family ambiguity not only exists in the trans population, but is the most prevalent experience in their families. These results validate the utility of ambiguous loss in capturing the experiences of trans people and their familial relationships, informing applied aspects of working with trans people and their families (McGuire et al., 2016a). Mental and physical healthcare providers working with transgender people and their families would benefit from addressing both the experience of support and those of rejection simultaneously as a way to effectively improve the

health and wellbeing of a designated health disparities population (National Institutes of Health, 2016).

Relationships Between Sociodemographic Variables & Family Environment

As part of our analyses, we noted significant associations between sociodemographic variables and respondents' assigned membership to one of the five identified profiles of family environment. Several such associations are of interest. First, compared to natal females, natal males were more likely to be assigned membership to *moderate family ambiguity* or *high family ambiguity* than to *accepting & affirming*. This finding supports previous research suggesting that families respond in less accepting ways to males exhibiting gender variance than to females. For example, in her seminal work on parents' responses to gender nonconformity, Kane (2006) identified that while most parents welcomed, and in some cases celebrated, their daughters' nonconformity, their responses to gender nonconforming behaviors exhibited by their sons were more complex. Parents' acceptance of their sons' nonconformity was limited to a small number of stereotypically feminine tendencies—namely, domestic skills, nurturance, and empathy—whereas their responses other transgressions of normative or hegemonic masculinity ranged from reticence to overt hostility. Thus, it seems reasonable that the family environment of respondents who were assigned male at birth would be comparatively ambiguous relative to those who were assigned female. Second, compared to those who identified as Black/African American, respondents who identified as Latinx were over four times more likely to be placed in *high family ambiguity* than in *accepting & affirming*. This result reflects extant research findings suggesting that, although there is increasing egalitarianism within Latinx cultures and families, rigid gendered expectation

persist (Cauce & Domenech-Rodriguez, 2002). It therefore seems prudent for those working with trans persons and/or their families in Latinx communities to be mindful of how cultural gender rigidity may challenge efforts in helping families become more affirming of their trans loved one's gender. Clinical interventions aimed at creating meaning in the face of loss associated with transgender identities in families (e.g., McGuire et al., 2016a) may be particularly beneficial for families from cultures emphasizing binary and rigid gender scripts.

Finally, trans respondents with higher incomes were less likely to be assigned membership in *disengaged* and *repudiating* than in *accepting and affirming*. At first glance, this finding might seem to suggest that poor families are inherently more transphobic and thus more likely to reject their trans loved one than are middle-class families. However, recent findings from research on LGBTQ youth homelessness suggests otherwise. In his ethnography of, and interviews with, homeless queer youth, Robinson (2018) critiques the assumption that poor families are inherently less tolerant of transgender persons: his scholarship highlights how the familial instability produced by poverty is what the trans youth in his study perceived as rejection of their gender identity, and not any heightened family rejection inherent in such families. As such, we echo Robinson's (2018) recommendations for policy solutions aimed at increasing family acceptance to account for the structural limitations of poverty, given trans persons in low-income families—as evidenced by the current study's findings—are more likely to experience family rejection or disengagement.

The Relationship Between Family Environment Profiles and Health

The second aim of the current study was to examine the associations between the identified profiles of family environment and our sample's mental and physical health. While a substantive body of empirical research has underscored the strong relationship between transgender family environments and various health outcomes people (e.g., Gower et al., 2018), to our knowledge, no published studies exist that have tested the transgender family-health relationship beyond family environments designated as “accepting” or “rejecting.” Results from our distal regression analyses indicated that membership in each family environment relative to Profile 2 (*embracing & affirming*)—*disengaged*, *repudiating*, *mild family ambiguity*, and *high family ambiguity*—was negatively associated with mental health and physical health, respectively. In part, these findings substantiate the well-established relationship between family rejection and negative health outcomes among gender minorities: membership in the *repudiating* family profile, which was characterized by high scores on the three “rejection” indicators, was negatively associated with both mental and physical health (e.g., Bradford & Catalpa, 2019; Puckett, Matsuno, Dyar, Mustanski, & Newcomb, 2019).

To access a more meaningful interpretation of the family environment-health relationship, we performed mean comparisons with model constraints in a post-hoc analysis to identify significant differences in mental and physical health by profile membership. Two results, which were consistent across both health outcomes, are noteworthy. First, participants who were assigned membership in Profile 3 did not differ from those assigned membership in Profile 4 or Profile 5. In other words, trans adults whose family environments were classified as *repudiating* did not report statistically

different health outcomes than those classified as *moderate family ambiguity* or *high family ambiguity*. While our earlier analyses support the positive association between an embracing and affirming family environment and health, and the inverse relationship for family repudiation, this finding seems to suggest that having a family that is solely rejecting is not the only harmful family environment for trans adults. It appears that family ambiguity, at both moderate and high levels, is comparably adverse for the health and wellbeing of transgender persons. Second, while there were no significant differences between the ambiguous and repudiating family environments, there were differences between *disengaged* and (a) the two *family ambiguity* profiles, and *disengaged* and (b) the *repudiating* profile. Respondents assigned membership in *disengaged* reported better mental and physical health, respectively, than those assigned membership in the latter three. What this finding suggests is that distancing—or disengaging—from one’s family environment may be better for the health of trans adults than experiencing ambiguity or outright rejection from it.

Implications

The first of these findings (i.e., similar health outcomes between ambiguous and rejecting family environments) corroborates past research highlighting the association between uncertain/unstable intimate relationships and negative mental health outcomes among gays and lesbians (depression, anxiety; Monk, Ogolsky, & Oswald, 2018), and extends it to a sample of transgender persons. Additionally, it prompts an important considering for clinicians and providers: if ambiguity is, in fact, similarly harmful to the health of trans persons in their family environments than is repudiation, clinical intervention programming aimed at decreasing family rejection as a way to enhance the

health of sexual and gender minorities (e.g., Huebner, Rullo, Thoma, McGarrity, & Mackenzie, 2013) might be made more efficacious by also targeting family and relational ambiguity. To do so, Boss (2006) emphasizes the importance of resiliency as a way to combat experiences of relational ambiguity. To help foster resilience, Boss (2006) encourages clinicians not to focus on resolving or tolerating ambiguity but instead helping clients “live comfortably” with it (p.48). According to McGuire et al. (2016a), one effective way in which this comfort and subsequent resilience can be achieved is through advocacy. Thus, clinicians working with trans persons may find therapy efficacious by connecting their clients to transgender advocacy efforts and encouraging their participation in it.

The second aforementioned finding—i.e., *disengaged* is better for health than both *family ambiguity* and *repudiating*—indicates that trans adults whose families are either ambiguous or rejecting and continue to seek acceptance from them fare worse than those who may distance themselves from such environments. It is possible that the distancing itself may be the mechanism through which the improved health is achieved; it may also occur in conjunction with those trans adults successfully obtaining the acceptance, affirmation, and validation of their gender from other family-like systems (e.g., McGuire et al., 2016b; Testa et al., 2015). Indeed, forming “chosen families” and “families-of-choice” is a common tactic undertaken by queer people, particularly by those who are a racial minority, to form family-like networks other than their families-of-origin (Weston, 1991). Perchance, the trans adults in our sample forwent attempts to garner support from their family-of-origin and instead found it from a “family” elsewhere. Clinically, helping trans persons disengage from their families-of-origin—

and/or find familial acceptance from other families—may be a more effective method for improving their health than is trying to work towards acceptance of familial ambiguity, as was recommended with the first finding, above. These findings may present a dilemma for mental health providers who assume that keeping families connected is always a valuable goal. Taken together, we encourage providers to carefully determine whether attempts towards achieving comfort with family ambiguity or attempts at family disengagement would prove more beneficial for trans adults' health and wellbeing.

Limitations

The current study has several strengths that defend its contribution to the literature, including the utility of a large sample of transgender and GQNB adults, which provided us ample statistical power to execute our analyses. In their review of the health research on GQNB individuals, Scandurra et al. (2019) identified the scarcity of studies with large sample sizes and encourage future researchers to employ them. We acknowledge MTurk's efficacy in recruiting large and diverse samples (Casler et al., 2013), particularly among hard-to-reach populations, such as those recruited for the current study (Smith, Sabat, Martinez, Weaver, & Xu, 2015). Additionally, given the absence of quantitative studies on the family environment of trans persons, our study fills this gap in the literature and responds to scholars' recent calls for quantitative research on this population. To our knowledge, ours is the first to quantitatively identify family environments among a sample of trans adults beyond those of acceptance and rejection. Furthermore, by considering the relationships between the identified family environments and health, our investigation also responds to Catalpa & McGuire's (2018) specific appeal for future transgender research to test associations between family ambiguity and

health outcomes. Finally, the decision to employ latent profile analysis was not only useful in identifying the diversity of trans family environments, but—given its designation as an “untapped method” in research on queer families (Fish & Russell, 2018) —also offers a needed and novel application of this technique in a study on transgender families.

Alongside these unique contributions, our study must also be considered with recognition to its limitations. The cross-sectional nature of our data precludes the possibility of drawing causal inferences among the variables and relationships investigated. We encourage the use of longitudinal data and methodologies in future research to bypass this shortcoming and to enable more causal conclusions in answering such research questions. Likewise, the nature of our data also limits the generalizability of our findings, none of which should be assumed to exist among all transgender persons. Among our sample, the majority of respondents were young (80% were under 35 years old), assigned male at birth (60.5%), and highly educated (67% had at least a bachelor’s degree); about twice as many identified with a nonbinary gender than with a binary one. While the age and gender composition of our sample may be reflective of the transgender population writ large (James et al., 2016a), other demographic realities are not (i.e., education, sex assigned at birth). Furthermore, our sample had relatively high scores of both mental and physical health and reported higher scores for the three “accepting” subscales of the FGES than for the “rejecting” ones. While we tried to bypass the shortcomings inherent in non-probability sampling designs by recruiting participants through an online marketplace (MTurk) and not through involvement in the LGBT community (Meyer & Wilson, 2009), it is plausible that our findings reflect a selection

bias, whereby the trans adults who participated in the present study reported better health and more accepting family outcomes than current population-level data would suggest (James et al., 2016a). One possible explanation for the inconsistency between our sample's higher health scores and those of the population include the presence of known protective factors (i.e., high level of education and household incomes). Along with our colleagues, we acknowledge the immense challenge in utilizing probability sampling designs with SGMs (Meyer & Wilson, 2009; Scandurra et al., 2019). Nevertheless, we encourage future scholars to employ research methods that control for such selection biases by recruiting on multiple platforms, for longer periods of time, and combining datasets to harness a fuller range of transgender family experiences.

Finally, we acknowledge one shortcoming in variable measurement. The survey investigators chose to assess respondents' race/ethnicity with the following item: "What best describes your ethnic background? Check all that apply," with 12 possible responses plus a 13th in which respondents were instructed to "Please write in as needed." The first 12 items included: (1) White/Caucasian, (2) Black/African American; (3) African-born; (4) Hispanic/Latino, Caribbean; (5) American Indian/Alaskan Native; (6) Asian – East Asian; (7) Asian – Central Asian; (8) Asian – South Asian; (9) Asian – Southeast Asian; (10) Pacific Islander; (11) Arab or Middle Eastern; and (12) Mixed race. While the same question has been used in published studies elsewhere (e.g., McGuire, Beek, Catalpa, & Steensma, 2018), it is problematic in several ways. The most notable shortcoming in the survey item is the conflation of race and ethnicity, two constructs which, while distinct, are often not clearly delineated. For example, though the item asks respondents to select their "ethnic background," several of the response options are overtly racial (e.g., "mixed

race”, “White/Caucasian”); one response item—“African-born”—suggests a continental nativity and not a race or an ethnicity. The potential conflation of race and ethnicity, though not inherently problematic, often can be, in that it limits the ability to capture the respondents’ positionality within racialized systems of power and oppression (Allen & Mendez, 2018). Consequently, we were unable to assess potential racial differences in family environments and their relationships with health outcomes, though extant research suggests differences exist in the familial experiences and wellbeing of differently-raced SGMs (e.g., Ryan et al., 2009). We implore future research to assess survey participants’ race and ethnicity separately.

Conclusion

Informed by ambiguous loss, queer, and trans family theories (Allen & Mendez, 2018; Boss, 2016; McGuire et al., 2016a; 2016b), the current paper is the first known study to quantitatively examine the family environments of transgender adults beyond those demarcated as “accepting” or “rejecting.” This binary, traditional, and assumedly dialectical understanding of families’ reaction to gender variance has recently been challenged by a small but growing body of qualitative research (e.g., Catalpa & McGuire, 2018; Coolhart et al., 2018; Norwood, 2013a). We sought to identify the range of transgender family environments using Latent Profile Analysis (Aim 1), and, in light of the established association between family environments and health of SGMs (e.g., Simons et al., 2013), to examine the relationships between different types and two health outcomes (Aim 2).

Our findings highlight the ambiguity present in trans persons’ family environments and the prevalence of it among the population. Results from our distal

regression models indicated that membership in any family profile relative to *embracing and affirming* was a negative predictor of both mental and physical health. Post-hoc analyses revealed the similarly detrimental effects of being placed in a “family ambiguity” profile than in the one characterized as *repudiating* on trans persons health. Taken together, the incidence of ambiguity in the families trans persons and its deleterious effect on their health suggests coordinated efforts focused on either (a) promoting comfort with ambiguity vis-à-vis resilience, and/or (b) encouraging disengagement from their families-of-origin, may be effective and attenuating the population’s health disparities. Those working with trans people and their family members should undertake such coordinated efforts: mental health providers, healthcare practitioners, school employees, intervention scientists, community leaders, and others. To date, no known clinical interventions have been formulated, let alone tested, that target treating the effects of ambiguity within trans families. Given the prevalence, this seems like a ripe avenue for future scholarship and clinical practice as a way to improve the health and wellbeing of transgender individuals, their families, and the communities in which they reside.

Tables & Figures

Table 1. Descriptive statistics of study participants ($N = 873$)

| Characteristic | n | % | Mean (SD) |
|---------------------------------|-----|------|-------------|
| Sexual orientation | | | |
| Lesbian | 85 | 9.7 | |
| Gay | 129 | 14.8 | |
| Bisexual | 281 | 32.2 | |
| Queer | 121 | 13.9 | |
| Straight/heterosexual | 110 | 12.6 | |
| Asexual | 48 | 5.5 | |
| Pansexual | 80 | 9.2 | |
| Other | 19 | 2.2 | |
| Natal Sex | | | |
| Female | 321 | 36.9 | |
| Male | 526 | 60.5 | |
| Intersex | 16 | 1.8 | |
| Age (1-7) | | | 3.14 (.81) |
| Under 18 | 0 | 0.0 | |
| 18-24 | 130 | 14.9 | |
| 25-34 | 573 | 65.5 | |
| 35-44 | 115 | 13.1 | |
| 45-54 | 40 | 4.6 | |
| 55-64 | 14 | 1.6 | |
| 65-74 | 3 | 0.3 | |
| Annual individual income (1-12) | | | 4.86 (2.68) |
| Less than \$10,000 | 110 | 11.5 | |
| \$10,000 to \$19,999 | 87 | 10.0 | |
| \$20,000 to \$29,999 | 106 | 12.1 | |
| \$30,000 to \$39,999 | 135 | 15.5 | |
| \$40,000 to \$49,999 | 121 | 13.9 | |
| \$50,000 to \$59,999 | 97 | 11.1 | |
| \$60,000 to \$69,999 | 75 | 8.6 | |
| \$70,000 to \$79,999 | 62 | 7.1 | |
| \$80,000 to \$89,999 | 42 | 4.8 | |
| \$90,000 to \$99,999 | 14 | 1.6 | |
| \$100,000 to \$149,999 | 25 | 2.9 | |
| \$150,000 or more | 9 | 1.0 | |

Table 1., cont'd

| | | | |
|--------------------------------------|-----|------|-------------|
| Education (0-4) | | | 2.61 (1.14) |
| High school or less | 88 | 10.1 | |
| GED | 36 | 4.1 | |
| Associate's or technical degree | 162 | 18.6 | |
| Bachelor's degree | 422 | 48.6 | |
| Graduate degree | 161 | 18.5 | |
| Childhood familial religiosity (1-4) | | | 2.68 (1.03) |
| Not at all devout | 152 | 17.4 | |
| Not really devout | 186 | 21.3 | |
| Somewhat devout | 321 | 36.8 | |
| Very devout | 213 | 24.4 | |
| Immigrant | | | |
| No | 843 | 97.0 | |
| Yes | 26 | 3.0 | |
| Gender identity | | | |
| Binary | 289 | 33.0 | |
| Nonbinary | 586 | 67.0 | |
| Race/Ethnicity | | | |
| White, non-Latinx | 479 | 54.9 | |
| Spanish, Latinx, or Hispanic | 271 | 30.9 | |
| Black/African American | 131 | 15.0 | |
| Asian/Pacific Islander | 52 | 5.9 | |
| American Indian | 17 | 1.9 | |
| Selected more than one ethnic group | 63 | 7.2 | |

Table 2. Descriptive statistics of study variables ($N = 873$)

| Variable (<i>range</i>) | Mean | SD |
|-----------------------------------------------------|------|------|
| FGE subscale scores/latent profile indicators (0-4) | | |
| Family inclusion | 2.06 | 1.09 |
| Explicit care | 1.86 | 1.21 |
| Acceptance & support | 2.26 | 1.00 |
| Active barriers | 1.68 | 1.16 |
| Morally wrong, MW | 1.81 | 1.17 |
| Disaffirm gender, DG | 1.85 | 1.18 |
| Mental Health (0-4) | 2.45 | 0.78 |
| Physical health (0-4) | 2.51 | 0.72 |

Table 3. Model fit statistics for latent profile analysis of family environment ($N = 873$)

| | AIC | BIC | SABIC | LMR p | BLRT _(K, K-1) | Entropy |
|------------|-------|-------|-------|---------|--------------------------|---------|
| 1-profile | 16511 | 16568 | 16530 | -- | -- | -- |
| 2-profile | 14487 | 14577 | 14517 | 0.0000 | -8244* | 0.93 |
| 3-profile | 13487 | 13611 | 13529 | 0.0000 | -7224* | 0.91 |
| 4-profile | 12893 | 13051 | 12946 | 0.0001 | -6718* | 0.91 |
| 5-profile | 12161 | 12352 | 12225 | 0.0000 | -6414* | 0.935 |
| 6-profile | 11916 | 12140 | 11991 | 0.0207 | -6041* | 0.93 |
| 7-profile | 11827 | 12085 | 11913 | 0.1112 | -5910* | 0.91 |
| 8-profile | 11656 | 11947 | 11753 | 0.2282 | -5818* | 0.928 |
| 9-profile | 11526 | 11850 | 11634 | 0.2339 | -5757* | 0.924 |
| 10-profile | 11448 | 11806 | 11568 | 0.3820 | -5694* | 0.926 |

* $p < 0.0001$

Table 4. Posterior probabilities associated with each profile ($N = 873$)

| Profile | $n(\%)$ | % | 1 | 2 | 3 | 4 | 5 |
|---------|---------|-------|--------------|--------------|--------------|--------------|--------------|
| 1 | 174 | 19.9% | 0.965 | 0.015 | 0.009 | 0.010 | 0.000 |
| 2 | 123 | 14.1% | 0.018 | 0.966 | 0.000 | 0.026 | 0.000 |
| 3 | 84 | 9.6% | 0.020 | 0.000 | 0.952 | 0.027 | 0.000 |
| 4 | 259 | 29.7% | 0.005 | 0.008 | 0.008 | 0.949 | 0.030 |
| 5 | 233 | 26.7% | 0.000 | 0.000 | 0.000 | 0.030 | 0.970 |

P1 = profile 1, *disengaged*; P2 = profile 2; *embracing & affirming*; P3 = profile 3, *repudiating*; P4 = profile 4, *moderate family ambiguity*; P5 = profile 5, *high family ambiguity*

Table 5. Significant associations between baseline sociodemographic characteristics and latent profile membership ($N = 873$)

| | P1 ¹ | | P3 ¹ | | P4 ¹ | | P5 ¹ | |
|-------------------------|------------------|-----------------------------|------------------|------------------------------|------------------|------------------------------|------------------|------------------------------|
| | <i>b</i> (SE) | OR [95% CI] | <i>B</i> (SE) | OR [95% CI] | <i>b</i> (SE) | OR [95% CI] | <i>b</i> (SE) | OR [95% CI] |
| Gay ² | - | - | - | - | - | - | - | - |
| Bisexual ² | - | - | - | - | - | - | - | - |
| Queer ² | - | - | - | - | - | - | - | - |
| Natal Male ³ | - | - | - | - | 0.55 (0.24) | 1.73* [1.09-2.75] | 0.56 (0.27) | 1.76* [1.05-2.95] |
| Age | - | - | - | - | - | - | - | - |
| Income | -0.12 (0.05) | 0.88* [0.80-0.98] | -0.24 (0.07) | 0.79** [0.69-0.91] | - | - | - | - |
| Education | - | - | - | - | - | - | 0.60 (0.14) | 1.82** [1.40-2.39] |
| Devoutness | - | - | 0.46 (0.16) | 1.59** [1.15-2.18] | 0.34 (0.12) | 1.40** [1.12-1.76] | 0.98 (0.15) | 2.67** [2.00-3.55] |
| Nonbinary | - | - | - | - | - | - | - | - |
| White ⁴ | - | - | - | - | - | - | - | - |
| Latinx ⁴ | - | - | - | - | - | - | 1.40 (0.43) | 4.06** [1.74-9.45] |

¹ Relative to *embracing & affirming* (P2); P1 = profile 1, *disengaged*; P3 = profile 3, *repudiating*; P4 = profile 4, *moderate family ambiguity*; P5 = profile 5, *high family ambiguity*

² Reference group is lesbian; ³ Reference group is natal female; ⁴ Reference group is Black/African American
*: $p < .05$; **: $p < .01$

Table 6. Results from linear regressions of health outcomes on profile membership ($N = 873$)

| | <u>Mental Health</u> | | | <u>Physical Health</u> | | |
|-------------------------------------|----------------------|------|----------|------------------------|------|----------|
| | β | SE | <i>p</i> | β | SE | <i>p</i> |
| Profile 1: Disengaged ^a | -0.26 | 0.04 | <.001 | -0.22 | 0.04 | <.001 |
| Profile 3: Repudiating ^a | -0.29 | 0.04 | <.001 | -0.31 | 0.04 | <.001 |
| Profile 4: MFA ^a | -0.42 | 0.04 | <.001 | -0.51 | 0.04 | <.001 |
| Profile 5: HFA ^a | -0.44 | 0.05 | .004 | -0.38 | 0.05 | <.001 |

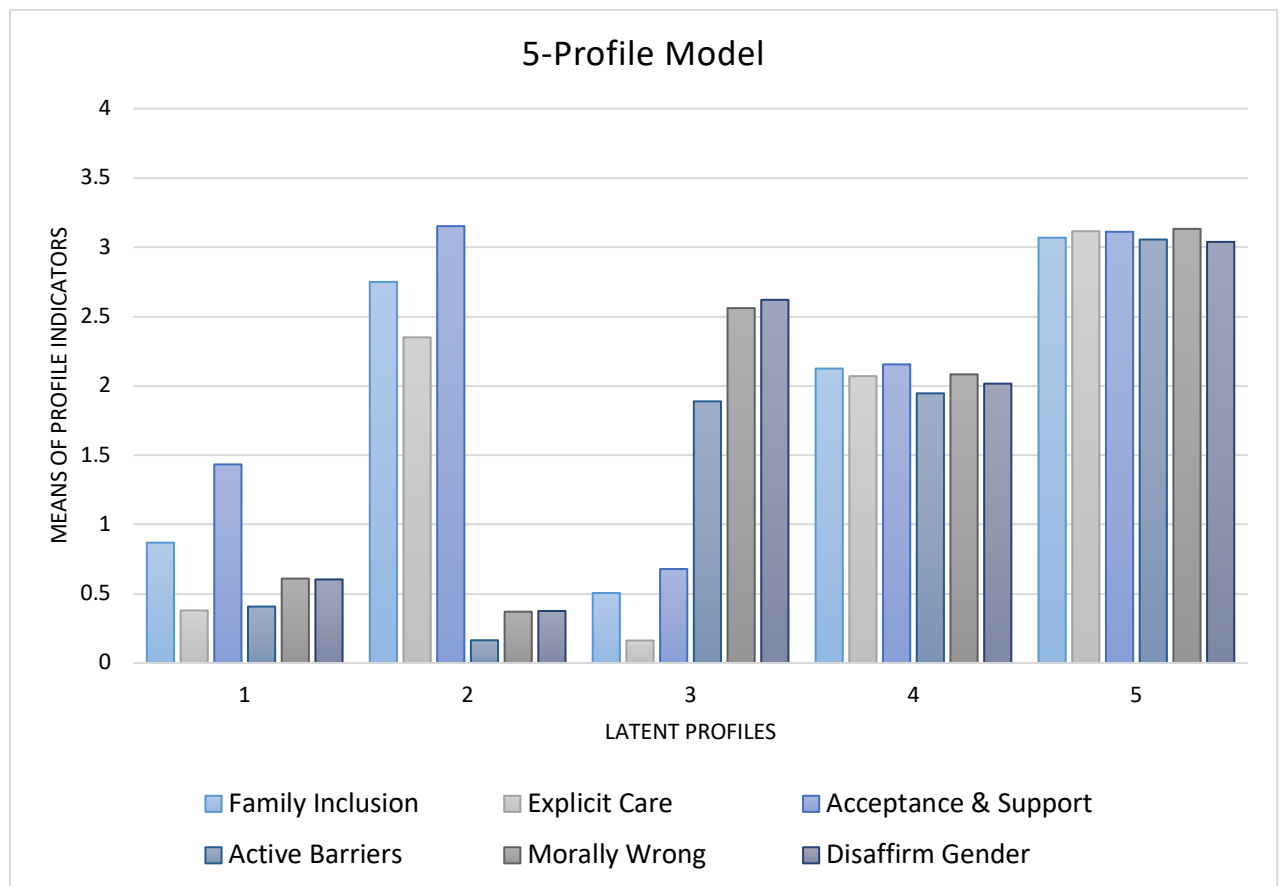
^a*Embracing & affirming* (Profile 2) is reference group

Table 7. Post-hoc comparisons of profile means of mental and physical health, controlling for covariates ($N = 873$)

| | <u>Mental Health</u> | <u>Physical Health</u> |
|----------------------------------|----------------------|------------------------|
| Profile 1: Disengaged | 2.30 | 2.33 |
| Profile 2: Embracing & Affirming | 2.49 | 2.76 |
| Profile 3: Repudiating | 1.65 ^{a,b} | 1.90 ^{a,b} |
| Profile 4: MFA | 1.75 ^a | 1.90 ^a |
| Profile 5: HFA | 1.94 ^b | 2.09 ^b |

^{a,b} Superscript letters represent results of our mean comparison with model constraints. Means with the same superscript letter did not significant differ from one another. All other means differed significantly

Figure 1. Means of latent profiles in the 5-profile model ($N=873$)



Chapter 4: Study Two

Gap 2, Study 2: Transgender Gender Heterogeneity

Within the developing literature examining differences between binary and nonbinary persons, there is a continued absence of understanding if differences exist between the family environments of these two sub-populations. However, there is reason to believe the family environment of trans adults may vary as a function of having a binary or a nonbinary gender identity. One justification for this hypothesized association is the phenomena of cisnormativity, in which a binary form of gender is explicitly and implicitly endorsed across and within institutions, and continuously reified via interactions between people (Lorber, 1995; West & Zimmerman, 1987). However, little research has considered potential variations in the families of binary vs. nonbinary trans persons. As such, it remains unknown the extent to which the binary nature of gender identity influences the familial experiences of the trans individual. This is an important and timely avenue of future research as increasing data suggest many individuals within the trans population identify as genderqueer/nonbinary (GQNB) (James et al., 2016; Kuper et al., 2012; Matsuno & Budge, 2017), and findings from the few reports on binary vs. nonbinary differences in health and family outcomes of gender minorities are inconsistent and, at times, contradictory (Bradford & Catalpa, 2019; Fish et al., 2017; James et al., 2016a; 2016b; Jones et al., 2019; Scandurra et al., 2019). This need is further substantiated by the identified health disparities among the trans population's and the considerable research highlighting the positive association between meaningful family relationships and improved health and wellbeing (e.g., Klein & Golub, 2016). In an attempt to bolster efforts aimed at improving the health of this heterogenous population,

we seek to discern if having a binary gender identity among the trans population may contribute to potential variations in their health and family environment.

Thus, the current study will consider the following three research questions:

- 1) To what extent does a binary vs. a non-binary gender identity predict the (a) mental health and (b) physical health of trans adults?
- 2) To what extent does a binary vs. a non-binary gender identity predict the family environment of trans adults?
- 3) Do profiles of family environment moderate the relationship between (a) gender identity and mental health and (b) gender identity and physical health?

Methods

Objective

The purpose of Study 2 is to assess the extent to which gender identity predicts trans individuals' (1) family environment, (2) physical health, and (3) mental health; it will also assess the extent to which family environment moderates the relationship between gender identity and the two health outcomes.

Data & Procedures

Data used for this study are from a larger survey conducted in 2018 which sought to understand the lives of trans individuals over the age of 18; specifically, questions asked about participants' demographic information, family environment, genderqueer identity, experiences of minority stress, mental and physical health, and quality of life. To participate, respondents had to (1) identify as transgender ("Do you identify as transgender?" "Yes, I am trans"); and (2) be at least 18 years old. As the survey was administered only once, the data from it are cross-sectional.

The original survey data were collected through Amazon's Mechanical Turk (MTurk) program ($N = 875$). MTurk is an internet marketplace crowdsourcing initiative designed for work that requires human intelligence. "Employers" post individual, self-contained Human Intelligence Tasks (HITs) which workers can accept to complete and, upon finishing, receive payment. HITs are typically simple tasks that are best suited for human completion, such as transcribing recordings, comparing product images, and completing online forms. Due to MTurk's ability to recruit large numbers of participants in a short amount of time, researchers are increasingly recognizing MTurk as a fruitful avenue for data collection (Casler Bickel, & Hackett, 2013).

Though MTurk is a relatively new interface for survey research, its validity has been tested and supported within the psychological literature. For example, Casler and colleagues (2013) compared the responses of their study participants recruited from MTurk to those recruited through other forms of social media. While MTurk respondents were more racially and socioeconomically diverse, results from the study's test—an object selection and categorization task—between the MTurk and non-Mturk respondents were nearly identical. Buhrmester, Kwang, and Gosling (2011) likewise identified greater demographic diversity among their MTurk sample compared to other internet samples; they also highlighted MTurk's capability for rapid and inexpensive recruitment which, the authors asserted, produces reliable and high-quality data.

Measures

Nonbinary Gender Identity (NBGI) (*independent variable*). We created a dichotomous *nonbinary gender identity* (NBGI) variable (0=binary; 1=nonbinary) by comparing responses to the questions about sex assigned at birth and gender identity ("What best describes your gender identity?"). Participants who endorsed a nonbinary identity on the item, "What best describes your gender identity?" were marked as "nonbinary", and those who picked "transgender man", "transgender woman", "man", or "woman" that was the reverse from their response to the question, "What was your sex assigned at birth?", were marked as "binary." For the respondents who marked a sex assigned at birth and gender that matched, four other variables—"genderfluid", "transscreener", "gender_perf_gq", and "gqi_nb"—were used to assess whether

participants endorsed a nonbinary identity at any point during the survey. If they did, they were marked as nonbinary; if they did not, as binary⁶.

Mental health (*dependent variable*). Participants' mental health was measured using the psychological health subscale from the World Health Organization's (WHO) Quality of Life-BREF Scale (WHOQOL-BREF), an international and cross-cultural assessment of an individual's subjective quality of life. The WHOQOL-BREF, a shortened version of its 100-question predecessor, contains 26 questions that assess four broad domains: physical health, psychological health, social relationships, and environment. The psychological health subscale, which comprises six questions, assesses, for example, positive and negative feelings, self-esteem, and ways of thinking, (Skevington, Lotfy, & O'Connell, 2003). Higher scores on the psychological health domain on the WHOQOL-BREF corresponds to higher levels of mental health. Internal consistency of the psychological health domain ranges from .79 to .81 (Harper & Power, 1998; Skevington, Lotfy, & O'Connell, 2003). Mean scores were calculated for all respondents who provided valid data for 4 of the 6 items on the mental health subscale. The sample's mean score was 2.45 (SD = 0.78).

Physical health (*dependent variable*). Participants' physical health was measured using the physical health subscale from the World Health Organization's (WHO) Quality of Life-BREF Scale (WHOQOL-BREF). The physical health subscale includes seven questions that assess phenomena such as energy and fatigue, medication dependency, and pain and discomfort (Skevington, Lotfy, & O'Connell, 2003). Items are scored on a 5-

⁶We recognize that reporting a sex assigned at birth (SAAB) and gender identity that (seemingly) match could be understood by some as antithetical to a transgender identity. We include justifications for our sampling decision in the Discussion, including the complexities of transgender identification and the challenges of gender identity measurement.

point scale, ranging from 0 (“none at all,” “never,” “very poor,” or “very dissatisfied”) to 4 (“extremely,” “always,” “very good,” or “very satisfied”). Higher scores on the physical health domain reflects higher levels physical health. Studies have found the WHOQOL-BREF scale, including the physical health subscale, to exhibit strong and reliable psychometric properties (e.g., $\alpha_{\text{physical health}} = .84$; Harper & Power, 1998; $\alpha_{\text{physical health}} = .82$; Skevington, Lotfy, & O’Connell, 2003). Mean scores were calculated for all respondents who completed provided valid data for at least 5 of the 7 items on the physical health subscale. The sample’s mean score was 2.51 (SD = 0.72).

Latent profiles of family environment (*dependent variables*). We used the five latent profiles of family environment identified in the previous study, which were estimated using the 6 subscales of *The Family Gender Environment Scale* (FGE; McGuire & Fish, 2018). The FGE asks respondent to rate the quality of their experiences with their family-of-origin within the past year; items are scored from 0 (“never”) to 4 (“all the time”). The five-profile model was selected using the decision criteria outlined by Collins & Lanza (2010) and Masyn (2013): relative to the other models, the 5-profile model had low AIC, BIC, and SABIC scores, high entropy (0.94), large posterior probabilities (>0.94), and had a significant p-value in the Lo-Mendell-Rubin adjusted likelihood ratio test (Lo, Mendell, & Rubin, 2001). We named the five profiles by evaluating the relative and absolute mean values of their indicators: *disengaged*, *embracing & affirming*, *repudiating*, *moderate family ambiguity*, and *high family ambiguity*. In the current study, each of the 5 latent profiles were coded dichotomously (1=“profile membership”; 0=“no profile membership”) as outcome and moderating variables, respectively, in separate models. The reference Profile is Profile 2, *embracing*

& affirming, a decision made using extant theoretical and empirical scholarship on the associations between an accepting family environment and positive health outcomes for both sexual and gender minorities (e.g., Bariola et al., 2015; Bockting et al., 2013; Budge et al., 2014; Giovani et al., 2018; Ryan et al., 2010; Tebbe & Moradi, 2016).

Covariates. Eight socio-demographic variables were included as covariates in the regression analyses: (1) sexual orientation; (2) natal sex; (3) age; (4) annual income; (5) education; (6) childhood familial religiosity; (7) nativity; and (8) race/ethnicity. The sample's descriptive statistics of these covariates are included in [Table 1](#).

Analyses

Prior to answering our research questions, we tested for multicollinearity among the study variables by assessing variables' (1) bivariate correlations and (2) Variable Inflation Factors (VIFs). If a correlation between two variables was $>.25$, and/or if a variable presents with a $VIF >5$, a theoretically-defensible decision will be made regarding if any variable(s) need to be removed from the proposed models (O'Brien, 2007; Vatcheva, Lee, McCormick, & Rahbar, 2016).

To answer the first research question, we ran two linear regressions: one of mental health, and one of physical health, on NBGI, controlling for sociodemographic variables. To answer the second question, we then ran a multinomial logistic regression regressing profile membership on NBGI. For both the linear and multinomial logistic regressions, demographic variables were entered into step 1 and each outcome—mental health, physical health, and family environment profile membership—was entered into step 2. To answer the third question, we performed a comparison of NBGI x profile membership means across each profile for both health outcomes. All analyses were conducted using

Mplus version 8.2; missing data were accounted for using full-information maximum likelihood estimation (FIML) given they were likely either missing completely at random (MCAR) or missing or at random (MAR) (de Leeuw & Hox, 2008; Enders, 2010)

Results

Tests indicated minimal multicollinearity among the study's independent variables, NBGI and the five dichotomous profile variables (VIF; range: 1.011 - 1.39). As a result, all study variables were included in the subsequent analyses. Bivariate correlations are included in [Table 8](#).

Associations Between Gender Identity and Mental Health, Physical Health, and Profile Membership

The first two research questions were: (1) *To what extent does a binary vs. a non-binary gender identity predict the (a) mental health; (b) physical health of trans adults?* and (2) *to what extent does a binary vs. a non-binary gender identity predict the family environment of trans adults?* After adjusting for socio-demographic information, results from regressing mental health and physical health (respectively) on NBGI suggested that having a binary vs. a nonbinary identity did not predict either mental or physical health ($b_{\text{mentalH}} = -0.03$; $p_{\text{mentalH}} > .05$; $b_{\text{physicalH}} = -0.02$; $p_{\text{physicalH}} > .05$). Similarly, results from the multinomial logistic regression (RQ 2) indicated that, after adjusting for covariates, nonbinary respondents were no more or less likely than binary respondents to be assigned membership to any of the profiles than to *embracing & affirming* (P2) ($OR_{P1} = 1.66$; 95% CI: [0.99-2.78]; $OR_{P3} = 1.34$; 95% CI: [0.70-2.32]; $OR_{P4} = 0.94$; 95% CI: [0.59-1.51]; $OR_{P5} = 0.91$; 95% CI: [0.54-1.54]; all $p > .05$).

Tests of Latent Profile Membership Moderation

To answer our third research question—*do family environment profiles moderate the relationships between gender identity and the two health outcomes?*—we performed a comparison of the NBGI x family environment means across the profiles for mental health and physical health, respectively, controlling for covariates. Results are included in [Table 9](#). Comparisons of mean interaction scores for mental health indicated that Profile 1 (*disengaged*) differed significantly from the mean of Profiles 2 (*embracing & affirming*), 3 (*repudiating*), 4 (*mild family ambiguity*), and 5 (*high family ambiguity*), whereby the mean mental health in Profile 1 was significantly less than that of Profile 2 and significantly more than that of Profiles 3, 4, and 5. Similarly, in comparisons of mean interaction scores for physical health, Profile 1 (*disengaged*) differed significantly from the mean of each of the other four profiles: the physical health mean of Profile 1 was significantly less than Profile 2 and significantly more than Profiles 3, 4, and 5.

Discussion

In our first of three research aims in the current study, we sought to assess the extent to which having a binary vs. a non-binary gender identity predicted the (a) mental health and (b) physical health of trans adults. Findings from the few published studies testing for health disparities between the binary and nonbinary subpopulations remain inconclusive, whereby some suggest differences do exist and others suggest they do not (see Scandurra et al., 2019). In light of population-level data which indicates the largest proportion of the transgender population identifies as nonbinary (James et al., 2016a; 2016b), we sought to help alleviate some of the stated inconsistencies in health findings

between binary and GQNB trans adults by examining potential variation in the two groups' family environments.

Gender Identity & Health

Results from regressing mental and physical health on gender identity (respectively) indicated that, after controlling for covariates, transgender participants' health did not vary as a function of having a binary vs. a nonbinary gender identity. Accordingly, it seems possible that, at least on outcomes of physical health and mental health, binary and nonbinary subgroups have similar outcomes. Our findings substantiate recently published empirical work indicating an analogous phenomenon, whereby binary transgender respondents and those with nonbinary gender identities were indistinguishable on outcomes of satisfaction with, and quality of, life (Bradford & Catalpa, 2018; Jones et al., 2019). However, it is important to note that while our results are supportive of these findings, they simultaneously contradict others: specifically, those suggesting that nonbinary trans persons have better health outcomes than their binary counterparts (e.g., Rimes et al., 2017) and those that suggest the reverse (e.g., Lefover et al., 2019). Consequently, the identified contradictions in the small literature on the health GQNB persons persist.

Taken together, one conspicuous question arises: what contributes to the ensuing inconsistency in health findings between transgender persons with binary vs. nonbinary gender identities? In other words, why do some studies find health differences between the two groups and others do not—and for those that do, why do some report better health among GQNB trans people and others among those who are binary?

Our reading of the literature indicates that the only theoretical rationales offered in the transgender-health scholarship—namely, minority stress theory (MST; Hendricks & Testa, 2012; Meyer, 2003; Testa et al., 2015)—would suggest the presence of health disparities between NBGQ trans persons and their binary counterparts, whereby the former has poorer health outcomes than the latter as a result of additional and unique minority stressors they experience from individuals and institutions within their environment. Indeed, Leftover et al. (2019) used minority stress theory to frame their study in which they identified worse health outcomes among their GQNB sample than their binary sample. Relatedly, while it does not theorize the presence or absence of health disparities specifically, transnormativity (Johnson, 2016) likewise suggests social differences to exist between binary and nonbinary transgender persons. The framework posits that trans individuals with binary gender identities and expressions inherently align themselves with hegemonic gender categories. In so doing, they obtain certain power and privileges that are unavailable to those existing outside the gender binary and its hegemonic categorizations of ‘male’ and ‘female’ (Allen & Mendez, 2018; Bradford & Catalpa, 2019).

Little theoretical rationale has been offered to explain the reverse gender identity health disparity ($\text{health}_{\text{nonbinary}} > \text{health}_{\text{binary}}$). Resilience has been identified among the trans population and is understood to result from developed coping mechanisms and support networks in response to discrimination, invalidation, and other stressors (e.g., Bowling, Baldwin, & Schnarrs, 2019; Budge et al., 2014; Grossman, D’Augelli, & Frank, 2011; Hendricks & Testa, 2012; Jessamyn, Schoebel, & Chloe, 2019). However, assuming resilience as the mechanism through which we can explain better health among

nonbinary trans persons than binary trans persons, why would the former experience comparatively “more” resilience than the latter? One possible explanation is that nonbinary people, different from binary trans peoples, challenge the first and most pervasive tenet of cisnormativity, which states that only two genders exists (Bauer et al., 2009; Kuvalanka et al., 2018). Given the extent to which nonbinary persons encounter this invalidating reality both institutionally and interpersonally (Matsuno & Budge, 2017), perhaps they have more opportunity to exhibit resilience than do their binary trans counterparts. To date and to our knowledge, however, this question remains unanswered. In an effort to obtain a more comprehensive understanding of the contested intra-population health disparities, we encourage future empirical and theoretical scholarship to consider potential variations in resilience among binary and nonbinary trans persons and the implications of those variations for the groups’ health and wellbeing.

Gender Identity & Family Environment

In our second research endeavor, we sought to examine the relationships between gender identity and profiles of family environments of trans adults. To date, only two known studies have been published that considered differences in family environment between transgender adults with binary and those with nonbinary gender identities (Bradford & Catalpa, 2019; Klein & Golub, 2016). Given this dearth of a relevant research base, the identified need to move beyond the acceptance-rejection family binary, and the role of family environments in either protecting or exacerbating the health of SGMs, we tested the associations between gender identity and profiles of family environments.

Results from our multinomial logistic regressions indicated that nonbinary respondents were no more or less likely to be assigned membership in a family environment profile relative to *embracing & affirming*. In other words, binary and nonbinary respondents were equally likely to be in any of the five family environments. This finding diverges from those in the two aforementioned studies: Klein & Golub, 2016 and Bradford & Catalpa, 2019). The first, which analyzed data from the 2015 NTDS, discovered that binary respondents were more likely to report family rejection than were nonbinary respondents (Klein & Golub, 2016). The second, which used an online convenience sample, found the reverse, whereby binary transgender participants reported higher family support than did nonbinary respondents, though this relationship was only marginally significant ($0.1 > p > 0.05$; Bradford & Catalpa, 2019). Both sets of authors offered explanations for their findings. Klein & Golub (2016) posit that nonbinary adults might choose to express their gender more ambiguously around family members as a way to generate more tolerance and/or reduce disapproval. Explaining a dissimilar finding, Bradford & Catalpa (2019) suggest that nonbinary trans adults conceptualize gender differently than do their families, resulting in relational tension due to the absence of a shared framework to understand gender—something binary trans adults do not experience. Given we did not find any difference in family environment membership between binary and nonbinary trans adults, we cannot offer empirical support for either of these hypotheses. What our findings do offer, however, is the analytical implementation of a measure of family environment that goes beyond the ones used by family scholars that are confined to measuring families as either ‘supportive’ or ‘rejecting.’ We implore family scholars to approach future studies of transgender families

with a multidimensional conceptualization of family environment, which, we assert, will more effectively uncover gender-binary-based differences or similarities in trans persons' families. With this knowledge obtained, more nuanced interventions can be generated to more effectively guide providers working with the families to enhance the population's health and wellbeing.

Family Environment Moderation

Our third and final aim for the current study was to determine if, and to what extent, profiles of family environment moderate the relationship between gender identity and health among trans adults. Results from our comparisons across profiles indicated that profile membership did, in fact, moderate the gender-health relationships for mental health and physical health, respectively. Comparisons of mean interaction scores indicated that Profile 1 (*disengaged*) differed significantly from the other four mean interaction scores for both health outcomes. Practically, this means that binary trans respondents had better mental and physical health when assigned membership to *disengaged* relative to *repudiating*, *moderate family ambiguity*, and *high family ambiguity profiles* and worse relative to *embracing & affirming*; nonbinary respondents did not.

To best interpret these findings, we contextualize them with one identified in the first paper, whereby respondents who had *disengaged* family environments reported relatively better health than those with *ambiguous and rejecting* family profiles. There, we suggested that this may occur because of supportive, non-consanguineous family relationships transgender persons are known to form, especially if their families-of-origin are not fully accepting of their gender (McGuire et al., 2016b; Testa et al., 2015; Westin, 1991). It is possible that nonbinary trans persons, who do not conform to transnormativity

which privileges binary transgender identities (Johnson, 2016) may not have as strong an affiliation with the transgender community, or may derive less social benefit from engaging with it, than do binary trans persons (Bradford & Catalpa, 2019). Because we did not assess transgender community engagement in the current study, we cannot confirm this empirically. Future studies would benefit from assessing transgender community engagement to ascertain the potentially different experiences nonbinary trans persons have with it as compared to those with binary gender identities.

Strengths & Limitations

In their review of the NBGQ health disparities literature, Scandurra and colleagues (2019) offer four explanations for the mixed results they identified: (1) the use of cross-sectional data; recruitment of (2) small and (3) non-probability samples of NBGQ persons; and (4) sampling from and within LGBT environments. In attempting to bypass these shortcomings in the current study, we sought to—and did—accumulate a large sample of trans adults ($n=873$), the majority of whom were nonbinary (67%). Additionally, by leveraging the marketplace crowdsourcing initiative, MTurk, for recruitment, participants were sampled outside of LGBT environments (e.g., community centers) which enabled us to access trans people who are not instinctively affiliated with LGBT communities. As Scandurra et al. (2019) remark, this is an important consideration given that those affiliated with the LGBT community, who tend to be over-sampled in queer research, may methodically differ from those that do (Bradford & Catalpa, 2019; Meyer & Wilson, 2009).

While we were able to address two of the identified shortcomings, we were unable to overcome the others: the use of cross-sectional data and a non-probability

sampling design. Indeed, each of these realities is a drawback of the present study and limits both the generalizability of our findings and the causality of any of the relationships we examined. We emphasize the challenges inherent in obtaining precise population estimates and resulting probability samples of nonbinary persons, and the need to overcome this substantive limitation in future research. Sampling biases are longstanding difficulties within research on LGBT people and families (Fish & Russell, 2018; Meyer & Wilson, 2009). Thus, future queer scholarship would particularly benefit from undertaking methods to limit these biases, such as combining rigorous datasets or using findings from extant research with non-probability samples to approximate population patterns (Scandurra et al., 2019). Additionally, our sample was mostly White, young, and educated. Though we controlled for the potential effects of these demographic realities in our analyses, the variables of interest must be considered in light of them. With respect to one of the guiding theoretical frameworks of this study—Allen & Mendez’s (2018) intersectional queer family theory—it is plausible that lack of health disparities between binary and nonbinary trans persons identified in the current study can be better explained by other social locations those individuals occupy (e.g., race, class, ability, ethnicity, nationality; Allen & Mendez, 2018). In line with recent scholars (e.g., Monro, 2019), we underscore the need for more intersectional scholarship on gender minority people. This is a particularly compelling not only to better understand the health of these populations, but in part due to the varying understandings of gender across cultural groups (Bauer, Braimoh, Scheim, & Dharma, 2017).

Lastly, our findings are not impervious to the effects of a potential response bias among our sample. Of particular concern are respondents who may have purposefully

misrepresented themselves on the screener question assessing transgender identity (“Are you transgender?” “Yes, I am transgender” or “No, I am cisgender”). While we could not definitively protect against such misrepresentation, it seems unlikely given the length of our survey and the relatively small honorarium (\$2) respondents received at survey completion. It is our hope that the combination of these two realities limited the extent to which non-trans persons would have been incentivized to fill out the survey dishonestly.

The Challenge(s) in Measuring Gender Identity and Assessing Transgender Identification

It would be remiss not to acknowledge the potential influence of variable measurement on the current study’s findings; specifically, how we chose to operationalize nonbinary gender identity. In seeking to be transparent in how we arrived at this operationalization, we describe the process below.

Based on other items in the survey, we created a new dichotomous variable—“nonbinary”—in which participants were coded as either having a (0) binary or a (1) nonbinary gender identity. At survey creation, participant eligibility was assessed via the question: “Are you transgender?” with only two possible responses: (1) “Yes, I am transgender (including nonbinary and genderqueer identities)” or (2) “No, I am cisgender.” During later waves of data collection, however, a third response option was added to the screener question, whereby respondents could now select either (1) “Yes, I am trans with a binary identity,” (2) “Yes, I am trans with a nonbinary gender identity,” or (3) “No, I am cisgender.” While the altered screener question allowed the researchers to differentiate later respondents as “binary” and “nonbinary,” it did not allow them to use that stratification method for the majority of the sample recruited with the initial question.

Consequently, we found ourselves needing a unified protocol for categorizing all participants as having either a binary or a nonbinary identity, and one that was scientifically sound.

To do so, we compared the responses of two items: (1) “What sex were you assigned at birth (SAAB)?” and (2) “What best describes your gender identity?”. The gender question included 11 response items, four of which we considered “binary” and the remainder as “nonbinary.” Any respondent who endorsed a nonbinary identity on the gender variable were coded as “nonbinary” and those who picked a binary identity (“trans man,” “trans woman,” “man,” or “woman”) that was opposite from their SAAB were coded as “binary.” However, this method was not fully comprehensive as a number of participants’ responses to the two questions matched: they selected a sex assigned at birth that corresponded to their gender identity (e.g., assigned male at birth and a gender identity of “man” or “trans man”). To account for those who reported this anomalous response pattern, we checked their responses to four other survey items to see if they endorsed a nonbinary identity at any point on the survey. If they did, they were coded as “nonbinary”; if they did not, as “binary.”

We recognize that reporting a sex assigned at birth (SAAB) and gender identity that (seemingly) match could be understood by some as antithetical to a transgender identity. However, we elected to include data from those who reported congruent SAABs and gender identities for two reasons. First, all respondents self-identified as transgender, which we ascertained from our screener question: “Do you identify as transgender?” Those who answered, “No, I am cisgender” were not granted access to the survey; those who answered “Yes, I am transgender” were. Second, from our professional experience

researching trans people and reviews of the relevant literature, there are complexities inherent in trans identification and thus in efforts to systematically recruit transgender people (Bauer et al., 2017; Davidson, 2007; Tate, Ledbetter, & Youssef, 2013). These complexities, in part, are due to the multi-dimensionality of gender among SGM populations (e.g., Levitt, 2019; McGuire et al., 2018), and different ways in which binary and nonbinary trans people relate to various constructs of gender (Catalpa et al., 2019). For example, it has been noted that GQNB individuals may not consider themselves transgender or identify as such (APA & NASP, 2015), and some even reject a trans identity (Davidson, 2007). With respect to our trans respondents who reported a sex assigned at birth and gender identity that match, this may have included those who (1) continue to identify with their gender assigned at birth until a certain point in their transitions; (2) are genderfluid, and who may, at the time of data collection, experience (and thus report) a felt sense of gender that reflects the one they were assigned at birth; and/or (3) use one gender identity when interacting with the world but use a different one in their own understanding of their gender (Levitt, 2019).

Reflecting the aforementioned complexity related to trans identification, contention exists over best practices in measuring gender identity. Indeed, Fraser (2018) emphasizes that “there is, to date, no 'gold standard' measure of gender identity for use in quantitative research. Rather, the use of each measure of gender identity comes with its own advantages and disadvantages (p.353). Diverging from a prior recommendation to use two-question method in assessing gender identity (Tate, Ledbetter, & Youssef, 2013), Bradford & Catalpa (2019) advocate for a four-question approach, assessing respondents’ (1) transgender community membership, (2) SAAB, (3) gender identity through an open-

ended question [“Please describe your gender identity”], and (4) gender identity through a forced-choice designation: “If you had a choice, which of the following is closest to your gender identity?” [trans man, trans women, nonbinary or genderqueer]. While we, as do Bradford & Catalpa (2019), support the use of a forced-choice gender identity designation to bypass the shortcomings in classifying open-ended gender identity responses as ‘binary’ or ‘nonbinary,’ we contend this is not sufficient. As was the case in our survey, some participants selected “man” or “woman” in response to “What best describes your gender identity?” with a corresponding SAAB, but then reported later in the survey that they identified as “genderfluid” (they also identified themselves as “transgender” to complete the survey). Using only the first question to distinguish binary vs. nonbinary respondents would discount the reported fluidity of this person’s gender, potentially muddling analyses in which said respondent is assumed to have a binary gender identity.

The ensuing contention surrounding gender identity measurement has implications for the current study and for future work with gender minority people. With respect to the former, it is possible that our classification of binary and nonbinary respondents, though executed with due recognition to the current empirical scholarship, may not accurately reflect how those very respondents would classify themselves. Thus, future research might benefit from allowing nonbinary persons to self-identify as such. However, as mentioned, not all nonbinary persons consider themselves transgender (Davidson, 2007). Accordingly, even with the addition of the option to self-identify as nonbinary, those who identify as nonbinary but not as transgender would be omitted from participating in a study recruiting “transgender persons.” Inquiry into potential

psychosocial differences between transgender vs. non-transgender nonbinary persons is an additional avenue of future research (see Bradford & Catalpa, 2019). All things considered, while scholarship on nonbinary persons has blossomed in the past decade (Motmans, Nieder, & Bouman, 2019), the need for a deeper understanding on nonbinary identities is striking. Future scholarship on nonbinary genders would bring additional clarity to these and other issues relating to nonbinary and/or transgender identities.

Considering our interest in uncovering the relationship between gender identity and the outcomes of interests, our findings may have differed if we performed analyses with a different operationalization of gender identity. The need for a far more accurate and nuanced understanding of gender identity—and its multifacetedness (McGuire et al., 2018)—is eminent. Filling that gap in knowledge will clarify not only the best methods to measure it, but, subsequently, a more accurate assessment of the lived experiences and health of gender minority populations.

Conclusion

The current study considered if having a binary vs. a nonbinary gender identity was differently associated with the (a) mental health, (b) physical health, and (c) family environment of transgender adults. We also assessed the moderating effect of family environment on the relationship between gender identity and health. Analyses revealed that no differences in mental or physical health existed as a function of having a binary vs. nonbinary gender identity. Similarly, binary respondents were no more or less likely to be assigned membership into one or more family environments. Findings from our moderation analyses were significant, whereby membership in a *disengages* family environment attenuated the relationship between gender identity and health for binary,

but not nonbinary, respondents. Findings contribute to the nascent but growing literature on the health and family of transgender persons and offer implications for clinicians, future research, and directions for gender identity measurement.

Tables

Table 8. Significant bivariate correlations among study variables (N=873)

| | NBGI | Profile Membership 1 | Profile Membership 2 | Profile Membership 3 | Profile Membership 4 | Profile Membership 5 |
|----------------------|-------|----------------------|----------------------|----------------------|----------------------|----------------------|
| NBGI | -- | | | | | |
| Profile Membership 1 | .083* | -- | | | | |
| Profile Membership 2 | | -.202** | -- | | | |
| Profile Membership 3 | | -.163** | -.132** | -- | | |
| Profile Membership 4 | | -.324** | -.263** | -.212** | -- | |
| Profile Membership 5 | | -.301** | -.244** | -.197** | -.392** | -- |

Table 9. Comparisons of intercept means, controlling for covariates (N = 873)

| | NBGI x Mental Health | NBGI x Physical Health |
|----------------------------------|-------------------------|-------------------------|
| Profile 1: Disengaged | 2.21 ^{a,b,c,d} | 2.60 ^{a,b,c,d} |
| Profile 2: Embracing & Affirming | 2.41 ^a | 2.75 ^a |
| Profile 3: Repudiating | 1.59 ^b | 1.73 ^b |
| Profile 4: MFA | 1.83 ^c | 1.92 ^c |
| Profile 5: HFA | 2.01 ^d | 2.02 ^d |

^{a,b,c,d} Superscript letters represent results of our mean comparison with model constraints. Means with the same superscript letter differed significantly from one another. All other means did not differ significantly

Chapter 5: Study Three

Gap 3, Study 3: Transgender Family Heterogeneity

The present study addresses several gaps in the current literature on the family environment of gender minority adults. First, the majority of the trans-family research has sampled young, often pre-pubescent transgender/gender nonconforming children and their families (e.g., Kuvalanka, Weiner, & Mahan, 2014; 2018; Pearlman, 2012; Rahilly, 2015), typically omitting any distinctions in findings between children asserting a binary vs. a nonbinary gender identity. Research performed with post-pubescent/adult trans children are far less common (Dierckx et al., 2016), and when parents and their adult trans children are studied, no distinctions are made between family members of binary and nonbinary persons (e.g., Norwood, 2013a; 2013b). This is a noteworthy shortcoming, as there is reason to believe their familial experiences may be different due to the pervasive assumption that only two sexes and two genders exists—male and female (e.g., cisnormativity; Bauer et al., 2009). Thus, a switch from one binary gender to the other may be easier to grasp than a change to something a parent cannot label or understand, such as in the case of a child who does not identify as either male or female (Rahilly, 2015).

What is absent from the literature, and what the current study endeavors to capture, is the experience of having an adult child who identifies as GQNB, and the developmental process undergirding it. Such an inquiry is particularly relevant considering the increasing diversity of gender identities and the ostensible absence of these families' experiences with gender complexity in the literature. Understanding how families negotiate such gender complexity can unearth both the stress and/or the

resilience these parents experience when witnessing a change in their child that they, perhaps, do not understand. Additionally, considering the literature that highlights the role of families in influencing the mental and physical health of transgender people (e.g., Bariola et al., 2015; Bocking et al., 2013; 2016), understanding how parents react to and negotiate nonbinary gender identities may help inform intervention efforts to bolster the health and wellbeing of transgender populations.

Phenomenology

To best understand the subjective realities of the parents of nonbinary adult children, we approached the current study phenomenologically. According to Daly (2007), research that is guided by phenomenology seeks to “investigate the lived experience of one or more individuals in relation to a phenomenon of interest” (p.97). Phenomenological inquiry focuses on a specific circumstance shared by all research subjects—i.e., having a child with a nonbinary gender identity—in order to understand and describe the meanings they make and subjectivities they have surrounding that phenomenon of interest (Creswell, 2007). Such a framework was ideal for the goal of the current study: to uncover how parents of children with nonbinary gender identities experience their child’s gender and how they come to understand it over time.

The present study will be guided by the following two research questions:

- 1) How do the parents of adult children with nonbinary gender identities make sense of, understand, and navigate their child’s gender identity?
- 2) What developmental processes occurred over time for the parents of adult children with nonbinary gender identities in their understanding of and experiences with their child’s gender?

Methods

Procedures

Data were collected from parents of adult children who identify with a nonbinary gender identity ($n=14$). Such identities include, but are not limited to, genderqueer, nonbinary, gender non-conforming, agender, pangender, and genderfluid (Bockting, 2014; Watson, Weldon, & Puhl, 2019). Participants were recruited purposively over the course of six months through social media, transgender family listservs, professional connections to the transgender community, and via snowball sampling; recruitment efforts were not limited to a particular geographic region and spanned the entire United States. To be eligible for participation, parents had to have a child who currently (1) identifies with a gender identity that is nonbinary (e.g., genderqueer); and (2) is over 18 years of age.

Interested respondents were instructed to contact the first author, who performed a screening interview over the phone to determine eligibility. For those who were eligible, the first author then scheduled an interview with each participant at a mutually convenient time. Participants were emailed a letter explaining the study and a consent form that was approved by the first and second authors' Institutional Review Board (IRB), each of whom signed and returned the consent form prior to their scheduled interview. The first author conducted all interviews either in-person or over-the-phone depending on the interviewees' preference, which was determined during the scheduling process. In-person interviews occurred either in participants' homes or in a secured office space at the first author's therapy practice; over-the-phone interviews were conducted from the same office space.

Interviews were semi-structured, guided by an open-ended, IRB-approved questionnaire. The 12-item interview instrument asked participants around three general topic areas: (a) demographics and family relationships, (b) knowledge of their child's gender and its development, and (c) how they make sense of and understand their child's gender identity over time. The complete questionnaire is included in [Appendix B](#). All interviews were conducted and recorded by the first author and were transcribed verbatim by the first author and a team of trained research assistants.

Sample

In response to recruitment efforts, 16 potential participants conveyed interest in partaking in the study, two of whom were deemed ineligible during the screening interview given the binary nature of their child's gender identity. Thus, the final sample included 14 parents of adult children with nonbinary gender identities. The majority of the sample was comprised of mothers ($n=12$)—two were fathers—and ranged in age from 50 to 70 years ($M = 58.2$). All 14 respondents identified as White and cisgender (female, $n=12$; male, $n=2$), 13 identified as heterosexual, and one identified as bisexual. Respondents were relatively educated, whereby all but one had earned at least a bachelor's degree. At the time of the interview, nine respondents were married, three were remarried, and two were legally separated. Twelve interviews in total were conducted with the 14 participants; in two of them, both parents participated.

The 14 participants in the sample were the biological parents of 12 nonbinary children, all of whom at the time of their parents' interviews were between 18 and 31 years of age ($M=22.1$). Nine of the children were identified by their parents as “nonbinary” (75%), two as “transmasculine,” and one as “genderfluid.” All but one child

was assigned female at birth (AFAB) and all were identified as White. Parents reported that eight of the children use “they/them” pronouns (67%), three use “he/him,” and one uses “she/hers.” Complete demographic information of study participants, including that of their nonbinary children, are included in [Table 10](#).

Data Analysis

Daly (2007) asserts that: “the starting point for any phenomenological analysis is the description of the lived experience that is provided by the participant” (p.219). Thus, throughout our analysis, we were first and foremost committed to elucidating the parents’ experience of having a nonbinary child as they described it to us. To do so, analysis of the collected data was guided by inductive thematic analysis (Braun & Clark, 2006), which began by familiarizing ourselves with the data. The first author conducted all the interviews, reviewed all the audiotapes, and transcribed half of them; additionally, prior to any formal coding process, both the first and second authors read through each transcript separately, all of which fostered their familiarity with the data. Subsequently, the first two authors read each transcript individually as a way to generate their own set of initial codes reflecting content relevant to parents’ experience of nonbinary gender identities. For example, one participant described “getting educated” about nonbinary genders from online sources in response to her child coming out, which was coded as *information-gathering*. With their own list of codes and content generated, the first two authors then met together to discuss their initial codes, identifying repetitiveness and similarity in what they had developed separately, and refining the list of common codes that they agreed to best represent the data. They then re-read the transcripts separately with the codes developed during their meeting to validate those codes, search for

connections between them, and identify broader themes that most accurately described participants' experience with their child's nonbinary gender identity. For example, the aforementioned code of *information-gathering* was aggregated with related codes under a larger theme of *attempts to understand nonbinary gender identities*. Finally, the authors met again to review, discuss, and define the themes they identified individually, and agreed upon final narrative that most accurately reflected the data.

Qualitative Integrity

We employed several strategies to ensure the qualitative integrity (Roy, Zvonkovic, Goldberg, Sharpe, & LaRossa, 2015) of the current study. For example, to ensure closeness-of-fit between our unit of observation and unit of analysis—the parents of children with nonbinary gender identities—we performed regular debriefing, which included triangulation (using multiple researchers to analyze the data and verify findings) which occurred through cross-verification of the codes generated from our data analysis (coding from multiple sources; Stanley & Slaterry, 2003). This helped us to retain our focus on the parents of nonbinary adults as in both our observation and our analysis. To buttress the credibility of our data, the semi-structured nature of the interviews allowed for member checking during data collection, whereby the interviewer invited the participant to evaluate, and verify, the accuracy of their words, and/or to clarify any potential misunderstandings about their lived experience during the interview dialogue (Krefting, 1991). Further, we prioritized exposing the data's "truth value" (Krefting, 1999, p.177) by using quotes from our participants' interviews as much as possible in formulating our codes and identifying our themes, which was also methodologically consistent with the phenomenological approach framing the study.

We likewise sought to achieve qualitative integrity through sampling richness, which is not by itself accomplished through “knowing how many individuals...are interviewed” (Roy et al., 2015; p.245). Thus, prior to recruitment, we did not specify a sample size and instead tailored our sampling methods to achieve the study’s overarching endeavor: to understand how parents experience and understand their child’s nonbinary gender identity. To do so, our recruitment criteria were exact, and were disseminated in spaces concentrated with our specific, hard-to-reach population. This yielded a homogenous sample of parents of adults with nonbinary gender as a way to “offer rich details of the daily experience” (p.253) of the understudied population—and the understudied phenomenon—of interest. Moreover, the number of participants in our final sample ($n=14$) reflects numeric guidelines for ideal sample sizes in phenomenological research endeavors (i.e., 15 ± 10 ; 5 to 25; Kvale, 1996; Polkinghorne, 1989).

Reflexivity & Positionality

Vital to both qualitative research methods and to queer/feminist theoretical frameworks is reflexivity on behalf of the researchers, including acknowledgment to the ways their own positionality and lived experiences may be different and/or similar from those of their participants. Indeed, feminist family scholars have underscored how “shared statuses” (Goldberg & Allen, 2015, p.9) can help establish rapport and augment the extent to which participants share their experiences with the researchers. The first author, who spearheaded the project, conducted all the interviews, and solely recruited and corresponded with research participants, identifies as White, cisgender, and queer, which were identities shared by all of the research participants and/or experienced vicariously through their experiences parenting a nonbinary child is a heteronormative

and cisnormative world (Allen & Mendez, 2018). Despite these shared statuses, the first author is not a parent, and not one to a child with a nonbinary gender identity. This reality limited the extent to which he could be considered an “insider” with the research subjects, particularly because the line of inquiry was centered around the experiences of being a parent. Thus, it was important for the first author to create a comfortable environment for study participants to limit any hesitation the participants may have during data collection. This was achieved, in part, by utilizing clinical skills as a licensed therapist to help ensure empathic connection with respondents and by engaging in regular communication with study participants both before and after the actual interviews. Additionally, with several participants, he disclosed his history of research, clinical, and advocacy work with gender minority people and their families, which helped develop and foster relationships with participants and increase their willingness to share their stories.

Though only the first author interacted didactically with research subjects, it was important for the data analysis to be performed not only by more than one person but by persons of different identities and/or positionalities. The second author, distinct from the first, is a cisgender heterosexual female and is a parent to two adult (cisgender) children. This explicit difference in lived experiences offered varied perspectives in the analysis, interpretation, and organization of the data, helping safeguard the data’s authenticity (Emerson, Fretz, & Shaw, 1997).

Results

The processes of understanding, managing, and coping with an adult child’s nonbinary gender are best described as ongoing, and shaped by the pervasiveness of cisnormativity (McGuire et al., 2016a). Our analyses revealed four broad themes that

captured the experiences of the 14 mothers and fathers in our sample who are the parents of adult children with nonbinary gender identities: (1) varied attempts to understand nonbinary gender; (2) emotional challenges; (3) a nonbinary “double-edged sword”; and (4) familial resilience.

Theme 1: Varied Attempts to Understand Nonbinary Gender

One of the central questions that guided the current study was: “How do the parents of children with nonbinary gender identities make sense of, or understand, their child’s gender?” Participants’ narratives suggested that there were several ways in which they came to understand nonbinary gender identities, if they came to understand them at all. Indeed, seven parents (50%), in response to the aforementioned question, explained that they do not, in fact, understand their child’s nonbinary gender identity. One participant (Lilly, 58) articulated that, “it’s almost like you have to accept [nonbinary gender] on faith, as opposed to fully [understanding it]”. Another participant (Jocelyn, 54), who said she cannot understand her child’s gender because “it is not me,” compared nonbinary gender identities to outer space: “I don’t really understand *space*, either, but, you know, I know it’s *there*, in this form– you know what I mean? [original emphases].” For those parents that did feel more confident in their understanding on nonbinary identities, as well as those working to understand, there were several identifiable methods they used to educate or inform themselves:

1.1: Educating One’s Self. The most common strategy, used by 10 of the 14 parents (71%), was to gather information. This included using the internet for both content (“I had to get on Google”; Tim, 57) and for online support (“I reached out to a Yahoo support group”; Julia, 50), seeking out local organizations for materials and group

meetings (i.e., PFLAG), reading books, attending workshops or nearby conferences, and contacting local medical and mental health providers. One parent (Samantha, 53), in her search for information about nonbinary identities online, described the strength of her desire to get informed: “I was, um, initially, just trying to be a *sponge*” [original emphasis]. These 10 participants were clear in the ways their information-seeking helped them understand their child’s nonbinary gender identity. For example, one mother (Julia, 50) associated her “realizing that gender truly is just a societal construct” with the “reading and research” she did soon after learning of her child’s nonbinary gender identity.

1.2: Phase Thinking. Eight parents (57%) described thinking, or assuming, that their child’s nonbinary gender identity was a transient phase of their development. This method of understanding their child’s gender typically happened soon after gender identity disclosure. Lilly (58), whose nonbinary child first came out as lesbian in high school, said in response to learning of her child’s gender identity: “I, at that point, quite frankly was thinking it was a phase...and that they were still a pretty little lesbian.” Similarly, other parents referenced “phases” their children had gone through previously, in describing how they thought being nonbinary might also be such a phase:

[My child] had been through a lot of different—I wanna say *phases*—um, you know, like, she went through....like, there was time where she really liked *rappers*, and then she, you know...she had her... phase where she had, um, only boyfriends of *color*, and, you know, I was like, ‘Okay, here’s just another *phase*,’ maybe... (Jocelyn, 54) [original emphases]

Half of the parents who articulated “phase-thinking” as a way to understand their child’s nonbinary gender not only thought of it as a temporary or transitional phase, but also hoped for it to be one. For example, immediately after her quote above, Jocelyn continued: “...And also *wishing* that it was a phase, and that it was gonna.... you know, blow over. That she’ll grow out of it.” In response to the question, “What was your reaction to learning of [your child’s] gender?”, Samantha (53), likewise recalled thinking, “Maybe it’s a phase and it will pass. I *hope* it’s a phase that will pass” [original emphasis].

1.3: Attempted Empathy. When first learning of their child’s nonbinary gender identity, over a quarter of respondents (29%) engaged in an introspective process in which they attempted to consider what it might feel like to be nonbinary; what we coded as *attempted empathy*. Isabelle (71) was one participant who identified this process in trying to understand her child’s nonbinary gender: “I would try to think, ‘Well, do *I* feel that?’” [original emphasis]. Similarly, Julia (50) described trying to put herself “in that place” which, for her, was “...to say, ‘Ok, alright, if they say they don’t always feel like a girl, has there ever been a point where I was like that?’ And so it was trying to relate it to something that I could grasp easier.” Edith (56), who’s nonbinary child told her, ‘I don’t feel comfortable in the girls’ room or the boys’ room,’ said she could “identify with that.” She went on to explain:

Because I was never a girly girl who, like, sat in the girls’ room and fixed their hair and stuff like that. If I came in and lots of girls were doing that, I was like, ‘I’m just gonna go to the bathroom and wash my hands and get out of here!’ You know? I didn’t feel *comfortable* around that. And I knew I wouldn’t feel

comfortable in the men's room either, so I could understand that [original emphasis]

What Edith's recollection exemplifies is an attempt to relate to their child's nonbinary gender empathically, from her own lived experience. Though none of the parents in our sample identified as nonbinary, some were able to—or at least attempted to—“get it” through analogous experiences of not fitting in, or ones in which they felt they diverged from hegemonic gender narratives.

1.4. Nonbinary as Androgyny? Akin to parents' attempts to understand nonbinary gender through empathy and personal reflections, four participants (29%) initially attempted to understand their child's gender through their knowledge of, and experience with, androgyny in earlier decades of their life. One parent (Lilly, 58) recalled that the first thing she asked her child when learning of their nonbinary gender was: “I said, ‘do you feel, like, androgynous?’.” Another parent, Janet (57), described: “I was like, ‘Okay, I *think* I understand that: not male, not female’...I mean, I grew up in the 60s and 70s, so *androgyny* was a big thing back then, so it's like, ‘Okay; yeah, I get the whole ‘androgyny’ thing’.” While none of the parents in our sample reported that their children identify as androgynous (or that they ever did), several leveraged their extant understanding of the term to make sense of their child's gender—the one historically associated with social movements of the 1960s, 70s, and 80s that challenged gender stereotypes and encouraged departure from traditional forms of masculinity and femininity.

Theme 2: Emotional Challenges

Throughout the course of their interviews, all 14 parents in our sample described experiencing certain emotions in reaction to their child's nonbinary identity and the implications they perceived for that identity over time—implications both for their children, and for themselves. These emotional challenges were organized under two broad emotional experiences: (1) fear/worry; and (2) loss/sadness. All 14 parents in the sample experienced the former (100%); more than half, the latter ($n=8$).

2.1: Fear/Worry. Every parent ($n=14$) in our sample described feelings of worry or fear in response to learning of their child's gender identity. This emotional experience was manifest as a fear that their child would (a) experience discrimination and be physically unsafe as a result of their gender; and (b) regret any biological intervention they may make.

For those parents who articulated a fear that their children would experience trans-related discrimination and harassment, several cited their own knowledge of transgender health disparities, such as Lilly (58), who emphasized that, “there’s a lot of statistics out there that are not very pretty,” and Julia (50), who justified her fear of discrimination “because trans people get beaten and murdered every day.” Other parents alluded to “a transphobic word” (Lydia, 52), or “being faced with hate” (Edith, 56), or “how people are gonna treat [my child]” (Ruben, 67). One father (Tim, 57) stated that his worry of his child experiencing discrimination exceeds any other concern he has surrounding his child's nonbinary gender identity. He clarified that “a feared discrimination is sort-of the *only* thing that really...*shakes* me” [original emphases].

Some parents made reference to the worsening political climate at the time of the interview in describing their fear of discrimination. Amy (63), for example, articulated that her “reaction when he came out was just concern for him. That, you know, that it’s pretty tough out there and it seems to be getting perhaps even tougher.” She continued:

I mean, I remember being terrified when he took the bus from Chicago to Ann Arbor and, you know he’d be using the men’s restrooms. And I’m thinking ‘Oh my gosh...’ You know, just afraid for him. That some nut case would decide that it was their business to get into his.

Amy’s worry for her child experiencing discrimination, and even physical danger, in a bathroom, specifically, as referenced in the quote above, was also shared by Danielle (57). In recalling her reaction to her child coming out as nonbinary, one of her fears included, “...whether or not they’re gonna get beaten up in a bathroom.” Danielle, also like Amy, referenced her concern with respect to the current political climate:

It is a very tense time in this country, and I was very worried about them going out into the world. I was worried about them and I was worried about the country... You know, they go into a women’s bathroom and people glare at them or tell them to leave or turn around and walk out. Or people, like, yell things sometimes at them on the street. I think each time it’s very hurtful, and to me it’s scary. Because, especially at a time when assholes are so emboldened in this country, and hate crimes are, you know, rampant. And so—it’s really a fear of the outside world.

Those parents who described fearing their child’s experiences of discrimination also made reference to their perceived consequences of it. Sometimes, this reference was

made in a general sense—e.g., “it’s gonna make [my child’s] life more difficult” (Elise, 61)—whereas at other times, it was more explicit. Specifically, four parents (29%) expressed a worry for how discrimination would impact their children’s professional futures, such as in the process of securing employment. This was a particular fear for Samantha (53), the only parent in our sample whose nonbinary child was assigned male at birth (AMAB). During her interview, she raised concern over how her child “...expresses themselves. You know, in a job interview. How’s that gonna go over?... So, I worry about employment, job opportunities, and who knows what other opportunities won’t be presented.” Akin to Samantha, Lydia (52) also expressed worry about the interview her child, Alix, would inevitably endure prior to being offered a job:

And so I think it’s hard, especially ‘cause Alix wants to pursue being a teacher. I think that’s really *hard*. And Alix is *fantastic* with kids, and Alix is a *great* teacher...one of Alix’s professors said Alix was, like, a *natural* teacher. Alix was probably one of the best students! And yet I do think it’s still *hard* to break the interview and the ‘these are my pronouns’ conversation... [original emphases]

For Lydia, her worry about Alix needing to clarify their nonbinary pronouns during a job interview was exacerbated by their desired career path of becoming a high school teacher—which involves using a title, typically Mr. or Ms., both of which are gendered and are incongruent with Alix’s gender identity. Indeed, Lydia indicated that during the previous year, when Alix worked in a high school, the students referred to them using the title “Miss,” an experience that, according to Alix, “really started to chafe them.”

The second way in which participants described feeling worried or fearful was with respect to their child making “alterations” to their physical body. Exactly half of our sample ($n=7$) made reference to this emotional experience when discussing the biological and physiological interventions their nonbinary children had (or had not) undertaken. Unanimously, these parents—all of whom were mothers—were worried about (what they perceived as) the permanence and/or irreversibility of biological interventions, and, as a result the regret their children might feel in later years.

Lilly (58) was vocal about the perceived irreversibility of biological changes to her child’s body. Referencing her child coming out as genderqueer, Lilly shared: “I didn’t think that it really mattered, as long as [they] weren’t making any biological changes to [their] body.” She continued:

I mean, you can be whatever you want to be as a gender in your head, but until you start changing your body in irreversible ways, it’s still something that can go back. Once you remove your chest, your chest is gone. It’s not coming back.

Janet (57), too, was worried about the permanence of potential biological interventions: worried that her child may, one day, want to reverse course on such interventions: “I *do* worry when there starts to be, you know, *permanent* physical changes to a body, and...you know, ten years from now, I don’t know if their feelings will be the same, so I’d be concerned about any kind of permanent physical alterations” [original emphases]. Amy (63) shared a similar sentiment, worrying her child would “really regret” his double mastectomy and hysterectomy: “I want him to be safe and I don’t in any way want to interfere with his very thoughtful consideration of how he wants to lead his life. But I don’t want him to find he’s done something to his body that he’s going to

really regret in five, ten, or twenty years.” Edith (56), whose nonbinary child elected to bind their chest, claimed to feel comfortable with the binding because it “put off this decision—the permanent stuff.” Danielle (57) also “preferred” her child to bind their chest because she didn’t want them to “make any rash moves.” During her interview, she recalled saying to her child things like, “You may regret it,” “There are other purposes for breasts,” and “Don’t you think you might want to pass?”

What became evident in these mothers’ narratives was their strong emotional reaction—one replete with worry—to their children making biological changes to their bodies or, in some cases, to the mere notion of it. Their worry was grounded in what they perceived as the permanence and irreversibility of biological or surgical interventions, and how their children might regret such decisions later in life.

2.2: Loss/Sadness. The eight participants ($n=57\%$) who described feelings of loss and sadness experienced them surrounding two general phenomena: (a) the (perceived) loss of a daughter; and (b) the (perceived) loss of future grandchildren. All eight participants who articulated these feelings were mothers of the nonbinary children in question—no father participant expressed them—and were all mothers to nonbinary children who were assigned female at birth (AFAB).

Lilly, Jocelyn, Isabelle, Sarah, and Edith all described having a strong desire for a daughter, either pre- or peri-partum. For some, the reason for their desire was identifiable (e.g., several miscarriages after having three sons but prior to giving birth to her AFAB child); for others, it was not. For example, Lilly (58) expressed that she “liked having a daughter in a big, big way. I mean, you know, it was sort of like one of those things where, you know, I always wanted to have a daughter.” She went on to explain:

If I had a son – yeah that’s all right, but I really wanted to have a girl. You know some people are just like that, you know, they have to have one. And so I remember at first how I knew...we had an amnio, and then they could actually—I guess it’s sophisticated enough that they could see little ovaries and stuff like that so, I was just so excited I thought I was gonna faint because I was just so excited. I wanted a daughter, right? And so, you know, it was kind of like, you know, the whole mourning of what you’re losing, right? I mean...yeah.

In the quote above, Lilly could not offer a tangible reason for her desire to have a daughter, but nonetheless felt its salience throughout her life, even before she was a mother. As a result, as she also referenced, she experienced a process of “mourning” what she was “losing” as she came to understand her child’s nonbinary gender identity. This loss, as she described it, occurred elsewhere in her life, too: “We do a mom’s lunch, a bunch of women from my church, and, you know, it’s just kind of...I mean, you know, [my nonbinary child] is not part of anything that’s ‘girl’ anymore....I couldn’t go with them anymore.”

Isabelle (71), distinct from Lilly, could clearly identify the reason why she had “been very interested in having a daughter”: her mother left her family when she was a young child and she thus wished to forge a satisfying relationship with her own AFAB child, Jo. Isabelle described her experience of loss as gradual, which was apparent in how she described her reaction when Jo came out as gay after previously coming out as bisexual, but before coming out as nonbinary:

...because we’re gonna be women and we’re gonna be with men and we can commiserate about how challenging it is to be with men, so...when she told me

that she's gay, I thought, 'oh, you're not gonna do that!' And I think I felt a little...a little bit on my own. I experienced it as a loss

She went on to share how the loss became magnified when Jo came out as nonbinary ("and when [Jo] came out as trans, that was much, much harder than anything before"), and when Jo shared their plans to have chest surgery ("not this beautiful body that I gave birth to! And the body that's like mine"). Isabelle, perhaps, articulated her loss most poignantly in a chapter she authored about her experience having a nonbinary child: "Perhaps [Jo's] necessary individuation and self-discovery, entailing disavowal of such a significant "sameness," felt like a potential rupture of the attachment bond, not just a difficult transition, but a traumatic loss."

Adjacent to these mothers' feelings of loss surrounding their desire for a daughter were identical feelings surrounding their desire for grandchildren. Specifically, the sadness/loss that some parents—some mothers—articulated was in response to what they assumed being nonbinary would implicate on their future grandparenthood. Amy (63), for example, shared that after her child received a hysterectomy, she "...was a little sad because having kids is gonna be way more complicated....I was sad that, you know, it would just be more complicated for him to have kids. And, you know, at this point we have no grandchildren...and there aren't any in sight!" Similarly, Sarah (60) shared that when her child, Harrison, came out to her as nonbinary, the first thought she had in response was: "'Hm. There goes my idea of ever having...of being a grandmother.' You know, I always thought that I'd be having grandkids."

One mother's grandparent-related feelings of loss included a reference to the wedding that she assumed would precede her child becoming a parent—and thus, her a

grandparent. When asked what she envisioned for her child as a young adult, Jocelyn (54) answered:

A wedding with a white gown, you know? At...30. Maybe not 20. But, just, you know, meeting a nice guy and settling down and...being a grandma and, you know, all those kinds of things. So, there's a lot of that kinda*loss* that happens [original emphasis].

Of note, the feelings of loss/sadness parents expressed in response to (what they perceived as) an altered grandparenthood emerged whether or not their children engaged in any biological intervention. Instead, it was the presence of certain assumptions about their child's stated gender identity that portended such feelings.

Theme 3: A Nonbinary “Double-Edged Sword”

What became evident in our participants' narratives is the ways in which being nonbinary—in some ways—generated additional and unique challenges for the parents in our sample; in other ways, it generated fewer. We coded this phenomenon, which emerged in all 14 interviews, as *a nonbinary “double-edged” sword*. Below, we delineate this theme as described by the participants.

3.1: What It Is—Nonbinary as More Difficult: As parents increased their understanding of nonbinary gender identities, several ($n=6$) had difficulty in conceptualizing their child as neither a man nor a woman. For example, with respect to her child's nonbinary gender identity, Lydia (52) said: “If you *believe* gender is a binary and you're saying you're *off* the binary then...something seems *very* wrong” [original emphases]. She continued:

I also don't like non-words. Like, it's hard to be a 'non-something.' Like, even an atheist believes in *something*, so telling me you're an atheist doesn't really *tell* me anything about you. So, my brain has a *hard* time with non-words" [original emphases]

Lydia's husband, Tim (57), who was another participant in our sample, shared a similar sentiment: "If you think about binary as 'you're a one or you're a zero,' it's an either-or and you're *not* 'either' or 'or.' So... where is that?"

Janet (57), whose AFAB nonbinary child, Kayden, came out to her within the previous six months, shared that Kayden recently "got a buzzcut" and started binding their chest. She conveyed her perspective on nonbinary gender: "It just feels like it's *erasing* a lot of things, but not really.... adding—or, not *replacing* it with anything, you know what I mean?" [original emphases]. Later in her interview, she referenced "erasing" again, in divulging what her child's nonbinary gender seems like to her:

'Non-binary' feels like a non-identity. I guess *that's* kind of that *erasing*. Like, if it was *binary* transgender, and they were replacing female with male, it's like, 'Okay, got that; I understand that,' you know. But, just choosing to be androgynous in the way they *dress* or whatever...I don't know. I feel like it's all very...it's all very unclear to me [original emphases].

Above, in describing the difficulty she experienced trying to conceptualize her child as nonbinary, Janet also makes an explicit comparison to trans individuals with binary gender identities, and the relative ease with which she could understand such a transition if her child were to be transgender with a binary gender identity. Several other parents ($n=4$) made reference to binary genders; specifically, how other people have

comparable ease understanding such identities. Samantha (53), for example, when describing some of the disadvantages she has experienced as the mother of a nonbinary child, said “...people want you to choose [genders]. I’ve had friends say it would be a lot easier if, you know.... I’ve had friends say, ‘I’m sorry, it’s just, it would be easier if it was ‘he’,’ You know?’” Danielle (57) was also explicit in articulating the comparable challenges people face in understanding nonbinary trans identities than they do understanding binary ones (“people try to understand nonbinary gender which I know is harder than even trans”). Citing knowledge she gleaned from attending support group sessions at her local PFLAG office, she said:

What’s hard about a nonbinary kid is that society doesn’t get it. And it’s not only that they don’t have the easy narrative, but that’s part of it. There’s people just starting to get, ‘Ok, you were born in the wrong body and now you’re gonna be in the right body,’ but nonbinary is like, ‘wait, wait, wait. What?’ [laughs] You know, like, how do you...how do you explain yourself, and how do people interact with you and how can that be?

Central to parents’ narratives about the unique difficulties in navigating their children’ nonbinary gender identities were difficulties in using terms for their children that were not gendered ($n=14$)—what we coded as, *terminology troubles*. Most often, this difficulty emerged in the need to use their child’s ‘they/them’ pronouns. In explaining their struggles with pronoun usage, some parents referenced their professional training—e.g., “as a writer, I’ve had trouble with the ‘they/them’ thing” (Edith, 56)—or their educational background, such as did Amy (63): “I was an English Lit major, I found that really hard to deal with...the ‘they/them’ ...you know. This is *not* the way we use these

pronouns!” [original emphasis]. Other parents, who did not reference their vocational expertise, cited their age. Elise (61), for example, articulated that: “For us, it’s just a grammatical thing! We’re just kind of old-school; it’s like, ‘That’s the plural! It’s really confusing! Come up with another pronoun!’.”

Several parents ($n=5$) expressed the *relative* difficulty of using they/them pronouns, whereby using those pronouns was more challenging than adapting pronouns for (binary) trans persons. These parents juxtaposed using they/them pronouns to first- or second-degree experiences of switching pronouns for (binary) trans people. Julia (50), who is the mother to a binary transgender son in addition to her nonbinary child, clarified that using them/them for her nonbinary child “...has been harder for me than switching to he/him for my son.” Similarly, Sarah (60) described her experience adapting new pronouns for one of her child’s (binary) transgender friends:

One of her good friends in college transitioned from female to male, and I had a *much* easier time with those pronouns, just because it’s not the plural... I just get *confused* every time I use the word ‘they’, because I think there’s somebody else I’m talking about [original emphases].

Terminology troubles emerged not only with respect to pronouns, but in parents’ attempts to devise terms to reference their nonbinary child ($n=3$). For example, Janet (57) admitted how “I *can’t* say ‘my daughter’” [original emphasis] to refer to her nonbinary child, Kayden. She continued:

I have a hard time... not just with the *pronouns*, but also, like... if I wanna say... I don’t wanna use the word ‘*children*’, because they’re not children. I can say ‘*adult* children’ but that sounds really peculiar in certain contexts. So... the natural

thing would be to say, ‘my *daughter*’, but...they’re *not* my daughter. [original emphases]

Janet, who is the mother to a cisgender female in addition to her AFAB nonbinary child, described what it has been like for her to reference her two children collectively in her social interactions:

They were always ‘my girls,’ you know? Like, it’s just—it’s such an easy thing to *say*. And, you know, I kind of liked...I liked *saying* it. ‘My girls.’ You know? If I had... if I had a *boy* and a girl, I don’t know what I would have done! I would have had to say, ‘my children,’ but again, ‘children’ feels... sometimes more *infantilizing*, like, ‘my girls’....it doesn’t sound quite as infantilizing as saying ‘my kids’ or ‘my children.’....And there’s just certain *contexts* where, you know, you sort of want to make it clear that you have *children* but they’re *adults*...but to say ‘adult children’ sounds just *so* stupid [original emphases]

Edith (56), whose child, Mako, identifies as transmasculine and uses he/him pronouns, explained how “it just doesn’t feel right to call him ‘my son’.” The conversation ensued:

Interviewer: I’m curious: does it feel the same to consider calling [Mako] “your daughter”?

Edith: It does! It doesn’t feel right. It doesn’t feel right anymore.

Interviewer: Daughter no longer feels right.

Emily: No.

Interviewer: Than what does?

Emily: My kid. I don’t know what I’m going to do when he’s not a teen and I can’t refer to him as “my teen”! Like, what do people call their nonbinary adult children?!

Interviewer: Mmmm.

Edith: My sister calls him her “nibling,” but I can’t do that because...he’s my kid!

Edith went on to recount her experience trying to reference her two children together; she has a second child, a cisgender male, in addition to Mako. She clarified that she, “usually says ‘I have two kids’,” but then lamented what sometimes happens to her next in conversation:

And then they ask if—and that’s been a hard question for a long time: ‘Do you have a son or a daughter?’, or... ‘what kind of kids do you have?’, or however people put it. And I feel like, you know, what difference does it make? I feel like I wanna say that, but it’s kind-of rude, you know [chuckle], like, it’s none of your business.

What is embedded throughout the narratives of our parent participants is a narrative of cisnormativity: the promotion of binary gender identities (McGuire et al., 2016b) and the subsequent erasure of ones that exist outside or within the hegemonic gender binary (Allen & Mendez, 2018)—as Edith (56), for example, shared: “this world...is so binary.” Without a shared understanding of nonbinary genders, and without the existence of inclusive terms and pronouns, these parents experienced unique challenges both intra- and inter-personally which, as some shared, would likely not be shared by parents of children with binary gender identities.

3.2: What It Is Not—Nonbinary as Less Difficult. While the anecdotes above illustrate the ways in which nonbinary genders generated additional challenges for the parents, there were separate and concurrent instances in which nonbinary genders produced fewer challenges for our participants. For the majority of these parents ($n=9$), what made nonbinary less challenging was some semblance of continuity from before

their child came out as nonbinary—as Samantha (53) put it, regarding her child, Morgan: “It’s just Morgan....with more stuff added on.”

Tim (57) expressed a comparable sentiment about his nonbinary child, whose physical appearance, to him, did not change much from before coming out to him as nonbinary: “They’re, like, ‘Okay, yay, I found a word!’ and that’s...*great*. It’s fine. But I don’t think there’s been a...a drastic *change*, so when they say, ‘I’m transgender,’ I’ll be like, ‘From *what?* To *what?*’” [original emphases]. Similarly, when Lilly’s (58) child came out to her as genderqueer, she recalled thinking: “Well, does it matter if you’re genderqueer? If you’re not doing anything about it? Not really.” She made a similar reference when discussing the potential for her child to experience discrimination: “...Nobody’s gonna discriminate against you if no one perceives you as trans anyway. Right? I mean, you walk around, and people think you’re a girl with short hair.”

Elise’s (61) nonbinary child, Emma, was the only child of the parents in our sample who did not change their pronouns from the ones they were assigned at birth. When Emma specified this to her mom, Elise responded, “Ok, so even better! I don’t have change too much!” Consequently, Elise went on to underscore how “there’s not much at all of a *practical* difference” in her life since Emma had come out to her as nonbinary. In her interview, which was just a few weeks post-disclosure, Elise told the interviewer that “...it doesn’t sound like I’ll be doing a whole lot different from whatever I’m doing now.”

In describing the reduced challenges their child’s nonbinary gender identity affords them, three parents (21%) drew explicit comparisons between their children’s gender identities and those of binary trans children. One instance in which this emerged was

when Lydia (52) admitted how she and her husband call their nonbinary child, Alix, “trans lite.” She coined this nickname, which she does not say in front of Alix, specifically when comparing her experience to that of parents of (binary) transgender children:

I mean, we have a trans community at church and people have gone through all *sorts* of transitions and Alix is like... Alix is nothing. Alix is still Alix. Alix doesn't have a deadname, Alix hasn't adopted another name, Alix is not undergoing any medical alterations, so... we call Alix 'trans lite' [original emphases]

Akin to Lydia, Danielle (57) also compared her experiences to those of parents who have trans children with binary gender identities, whom she met through her local PFLAG chapter:

I think a lot of parents [of binary trans kids] feel like they have to grieve for the child as they knew them to begin with and the gender that they were assigned at birth, and I have never had that. You know, there's not been a letting go of anything. It's the same person.

Danielle was thoughtful in articulating what she thinks would be different for her, specifically, if her child was trans with a binary gender identity. She shared that she “...would feel more of a loss of the person I know...because...I think when you can see the continuity in the person, then you don't feel the loss. It's the same person.” She continued:

...on the one hand, it seems easier for the rest of the world to accept a trans person, a binary person (even though it's not easy at all). For me, though, I feel

like nonbinary is easier because it's my kid and I can look at and talk to my kid and they're the same kid... it seems it would be much more dissonant for me to sort-of look at my kid and have them be a man.

The quotes from Danielle's interview, above, exemplify the double-edged nature of nonbinary gender identities. Though the world has difficulty understanding her child's nonbinary gender identity—and certainly more difficulty than it does understanding binary gender identities (i.e., cisnormativity)—she herself is able to experience a “continuity” of her child as she knew her pre-disclosure that, according to her, parents of binary trans children would not be able to do. For this reason, according to Danielle, it has been easy to accept her child's gender because “it's nonbinary, it's in the middle somewhere, it's still my kid.”

Theme 4: Familial Resilience

Every parent in our sample ($n=14$) exhibited resilience in the face of their child's nonbinary gender identity, and it was expressed in three consistently identifiable ways: (1) advocacy; (2) unconditional parenting; and (3) queer accordion families.

4.1: Advocacy. The majority of parents in our sample (71%) were advocates for their children with nonbinary gender identities. The breadth of parental advocacy varied within the sample: some parents, for example, became involved with diversity initiatives in their workplace (e.g., Tim, Samantha, Ruben) while others changed careers entirely to advocate for the community their children, and they themselves, were now a part of. Lilly (58) was one such parent. At the time of her interview, she was working towards a graduate degree in mental health counseling after a career as an attorney, a degree with which she “hope[s] to counsel trans families.” Additionally, prior to enrolling in her

graduate program, Lilly presented a workshop to parents of trans children and spoke at a regional gender conference. Indeed, in response to, “How has your life changed since becoming a parent of a nonbinary child?”, Lilly answered: “Well, I’m a trans advocate now.”

Isabelle (71) was another participant who altered her professional career in response to learning of her child’s nonbinary gender identity. Though she worked as a psychotherapist prior to her child’s coming out, she sought out trans-competent “training” in response, and now centers her clinical practice on trans-related issues. Isabelle described feeling a need to “lean into this” when she learned of her child’s nonbinary gender identity, and “looked for something [she] could do, get involved, volunteer.” For her, this process began by approaching a transgender pastor at a nearby church who directed her to the planning committee for the county’s Transgender Day of Remembrance event: “So, all of the sudden, I knew some trans people and I got used to identifying with gender pronouns and, I didn’t do much to help put that together but I gave people rides, I took notes.”

4.2: Unconditionality. A striking way in which the parents in our sample exhibited resilience was characterized by their stated commitment to support their children’s nonbinary gender identities unconditionally. This phenomenon was identifiable in six parent narratives (43%). Jocelyn (54), for example, recalled “trying to get on board as soon as possible” when her child, Koda, came out to her as nonbinary, because she “...just *knew* how important it was for them to be supported.” Later in her interview, she used an island analogy to describe her unconditional support of Koda’s

gender identity: “I am team Koda....and anybody who’s not on the team, they’re voted off the island!”

Samantha (53) was one of three parents who alluded to well-known suicide disparities between trans youth and their cisgender counterparts when explaining the motivation behind her unconditional support for her nonbinary child, Morgan. She asserted that “...the important thing is to be a *hundred* percent behind your kid...because, you know, if you’re not, and they, you know, are *gone*, you don’t get a second chance” [original emphases]. Julia (50), too, made explicit reference to trans suicide disparities: “I mean, looking at the suicide rates among trans people in particular, I’ve gotta do everything in my power to keep that from happening to my children. To keep my kids from walking that path.” She went on to delineate her own “unconditional” parenting philosophy:

For us, parenting is you love your kids no matter what. If my job as a parent is to help my children be who they are supposed to be, then I don’t get to decide who they’re supposed to be. Then it’s my job to help them figure it out and let them be that and support that journey and discovery and process for them. And not try and force it into my little box or what I think it should look like.

In the quote above, Julia makes reference to her “job” as a parent, a word that another parent (Elise, 67) also employed in describing her unconditional support of her nonbinary child: “I certainly felt, and still do to some extent, that my job is to advocate and support my kids.”

4.3. Queer Accordion Families. This subtheme, which emerged in 11 of the 14 interviews (79%), references both the expansion and contraction of our participants’

families. In response to their child's nonbinary gender identity, some lost family members while others gained new ones, which we coded as *queer accordion families*. The subtheme makes reference to Katherine Newman's (2012) "accordion family," a term she uses to describe the malleability of families when faced with the need to accommodate certain members—an indicator, she asserts, of the resilience of families.

The 11 interviews in which this subtheme emerged were replete with "contractions" in the parents' families—both immediate and extended—in response to learning of their children's nonbinary gender identities. Lydia (52) shared how "my world shrank really quick" while recounting the number of extended family members with whom she no longer speaks. Jocelyn (54) and Julia (50) also experienced contractions in their families in response to having a nonbinary child: Jocelyn's son and nephew, the brother and first cousin of her nonbinary child, "had an issue with it," both of whom scoffed at the existence of nonbinary gender identities and relegated them to "just the popular thing now." Julia, while referencing her parents (the grandparents of her nonbinary child) reported that "we don't talk to them at all 'cause they disowned us." However, soon thereafter, she went on to describe that despite this shrinking of her family, she also experienced it expanding in other ways:

I've met so many really, really wonderful young adults, because my house is a safe place. We lost my former family, but everyone else has been amazing. All my neighbors, my neighbors are chill, they're fine, they're just like, 'Yeah, whatever. We know your kids. Doesn't matter.' You know, it's like 'Ok, I might not be a grandma, I may not have biological grandchildren,' but, who cares. I've

got so many other ones. My family keeps growing. And I have so many more children than just the three biological ones, and it's really kind-of great.

The simultaneous contraction and expansion of Julia's family, as depicted in the quotes above, is emblematic of the queer accordion families common among the parents in our sample: their families both contracted and expanded in response to their children coming out as nonbinary.

The accordion nature of our parents' families did not just occur within their immediate and extended family members, but also with their proximal social networks. Several parents described contraction of these networks with respect to their friends, such as Jocelyn (54), who shared: "I even had one friend that was really *surprised* when I said, 'Oh...[my child] is non-binary,' and she's like, 'Oh, that's *bullshit*'" [original emphases]. Similarly, Isabelle (71) reported that when she told her best friend about her child's nonbinary gender identity, the friend responded: "Oh, I don't think that's a thing." Tim (57) had a similar experience on his social media platform: he shared how "there are friends who are just...*whup!* Unfriend them." However, as is characteristic of accordion families, the parents in our sample also experienced growth in their proximal social networks after learning of their child's nonbinary gender identity. For some, like Samantha (53), this expansion occurred vis-à-vis interactions with her local PFLAG chapter: "PFLAG has been a place I always turn to for terminology or descriptions...and we belong to a PFLAG support group that meets once a month and we've been going to that, as a new family." Edith (54), too, was one such parent who mentioned an expansion in her proximal social network after her child came out to her and to the world as nonbinary:

I'm finding I just attract people who have gender non-conforming kids—there are a lot out there—and I have *so* many colleagues who have kids who are trans or are gender non-conforming. So, it's becoming more of a connecting point for me.

New relationships. There was one relationship I have with a writer who I would not normally be friends with at all, just because we were in different circles, and we were in a meeting together and I showed a picture of [my child] at 15 and she looks at me and she said, 'We have to talk!'

Analogous to Newman's (2012) accordion families, the families of our participants experienced changes to the size of their families: immediate, extended, and -of-choice. The contractions and expansion of the queer families of the parents in our sample, as is the case with accordion families, was a resilient adaptation strategy exhibited by the parents of nonbinary children in our sample to include supportive members and exclude unsupportive ones.

Discussion

Our multiparticipant study is the first of its kind to focus its inquiry exclusively on the parents of adult children with nonbinary gender identities (≥ 18 years of age). Broadly, we sought to understand the lived experiences of such parents: how they make sense of their child's nonbinary gender identity, how they navigate the challenges cisnormativity imposes on nonbinary genders in families, and the developmental processes that occur in doing so. While there is a small literature sampling the family members of binary trans persons (e.g., Coolhart et al., 2018; Norwood, 2013a; 2013b), there is a near absence of empirical research on the families of nonbinary people. Further, given the pervasive exclusion of nonbinary gender identities within families (i.e., cisnormativity), there is

reasons to believe those family members may experience distinct challenges and/or resiliencies that the families of binary gender minority persons do not. Thus, we endeavored to uncover those experiences and to contribute to the barren knowledge base.

Major Research Questions

Our interview questionnaire was guided by two broad research questions, the first of which sought to understand how parents of children with nonbinary gender identities come to understand their child's gender. In retrospect, this question was based on an assumption that parents did, at the time of their interview, understand nonbinary gender identities. Our findings indicated otherwise: exactly half of the parents in our sample admitted to not really understanding nonbinary gender identities, some of whom said so even after they sought out information from various sources. The difficulty parents had in trying to understand gender that is nonbinary substantiates what was found in Marcus and colleagues' (2015) autoethnography—the one known empirical study reporting the experiences of a family with an NBGQ-identified member—whose three cisgender authors (mother, father, adult sibling) described how challenging it was for them to understand their GQNB family member's gender.

The second question guiding our interview schedule aimed to uncover the developmental processes that occurred for the parents in our sample navigating their children's nonbinary gender identities. Findings highlighted two such processes, the first involving emotions; the second, resiliencies. Parents reported two consistent emotional experiences in response to learning of their child's gender: fear/worry and loss/sadness. The emotions of loss/sadness, conveyed by the majority participants, was solely in response to the (perceived) loss of a daughter and/or of future grandchildren. These

perceived losses are common among parents of both sexual (e.g., Chrisler, 2017) and gender minorities (e.g., McGuire et al., 2016a). Specifically, Coolhart and colleagues (2018) refer to them using the terms “loss of dreams” and “loss of rites of passage,” such as the father of a trans man mourning the loss of being “the father of the bride” (p.35). Interestingly, the eight participants in the current study who expressed loss/sadness were all mothers, a phenomenon which also occurred in Coolhart and colleagues’ (2018) sample: all of the mothers in their sample, and none of the fathers, expressed feelings of loss. One possible explanation for this finding is the match between mothers and their AFAB children in natal sex, what Coolhart et al. (2018) refer to as “same-gender-identification” (p.39). Perhaps these feelings would arise in our father participants if their nonbinary children were AMAB and not AFAB. Future research would benefit from sampling such father-NBGQ child dyads to assess if this emotional experience mothers undergo for their AFAB nonbinary children is likewise shared by fathers for their AMAB ones.

Resilience was the second developmental process that parents exhibited in response to their children’s nonbinary gender identity, and one that all 14 participants articulated during their interviews. The finding reflects a key assumption of ambiguous loss theory which posits that families are naturally resilient and thus have the capacity to thrive in the face of unresolved ambiguity (Boss, 2007). In our study, parents of nonbinary children expressed resiliency by becoming advocates for their children in various ways, including making a career change at the age of 58, as was the case for one mother in our sample. This finding corroborates scholarship on the family members of (binary) trans persons which suggests that “doing” advocacy is a common practice

undertaken by the population (e.g., Kuvalanka et al., 2014). Indeed, McGuire and colleagues (2016b) assert that advocacy is “readily apparent” (p.70) in the research on families with a transgender member.

Parents also expressed resilience vis-à-vis unconditionality, whereby they were, or were committed to being, unconditionally supportive of their child and their gender identity. This findings conflicts with those identified in Norwood’s (2012) thematic analysis of online postings from the family members of (binary) trans people. In it, Norwood (2012) found that although the parents in her study “often talked about wanting to be unconditionally supportive of the transgender person...they struggled with actually doing so,” something she attributed to the parents’ “lack of understanding, religious or moral beliefs, or their own emotional issues” (p.86). Two possible explanations for this disparate finding include differences in the demographic backgrounds—namely, religious affiliation—between Norwood’s (2012) participants and ours. In our sample, while most parents conveyed a religious identity, none communicated any level of devoutness that might conflict with their unconditional support of their children’s nonbinary gender identities. A second explanation lies within the chronological context in which the two projects occurred: whereas we collected data between 2018 and 2019, the data Norwood (2012) analyzed were posted on or before October 1st, 2007. The increased acceptance of gender minority individuals nowadays relative to a decade ago may help explain this disparate finding, which aligns with one of the current study’s guiding theoretical frameworks: “considering changes in time also provides insight into what has changed....in the historical, social, and political contexts” (Allen & Mendez, 2018, p.78).

Cisnormativity, Families, & The Gender Binary

Our findings underscore how the experiences of parents with adult children with nonbinary gender identities are unequivocally colored by cisnormativity. As defined earlier in this paper, cisnormativity is the pervasive ideology that (a) there are only two genders, (b) gender identity is determined by biological sex, and (c) one's gender ascribes them to specific familial roles (Bauer et al., 2009; Kuvalanka et al., 2018). Of particular significance in the narratives of the parents in our sample was the first tenet of cisnormativity, which states that there are only two genders. This tenet was apparent throughout our findings.

For example, as mentioned, most parents in response to our first research question admitted they had difficulty understanding nonbinary gender identities. Many had difficulty conceiving their child as such: parents used phrases such as “a non-something” and “erasing a lot of things without adding” to describe their difficulty in imaging their child within their recently-gleaned framework of nonbinary gender. Some parents made a direct comparison to (binary) transgender persons, whereby they thought (binary) transgender identities “would be easier” to grasp than their child's nonbinary one, a comparison which was both conceived by the parents themselves and communicated to them from others. Unanimously, parents also struggled to use their children's nonbinary pronouns (i.e., they/them), and to coin new terms to reference their nonbinary child to others (e.g., son, daughter)—what we coded as *terminology troubles*. Each of these challenges are clear products of the first tenet of cisnormativity, that only two genders exist.

Importantly, while these challenges are ones many of our participants experienced, they are unique to the parents of nonbinary adult children: whereas parents of (binary) trans youth must face the challenges imposed by the second and third components of cisnormativity—that gender is biologically-determined and that gender ascribes certain familial roles— parents of nonbinary children are distinct in their need to also face those imposed by the first: that one two gender exist. McGuire and colleagues (2016b) highlight this sentiment:

“...[the] acceptance of a binary identified trans* family member (i.e., one who was assigned as a girl or woman but now identifies as a boy or man, and vice versa) simply requires a basic understanding of transsexuality as one variation of gender development and does not demand critical evaluation of the construct of gender as nonbinary” (p.62).

Our findings provide empirical evidence to this claim. While some parents engaged in the suggested “critical evaluation” of the gender binary, more simply encountered the aforementioned challenges in trying to understand a child who existed beyond it. In sum, the challenges conveyed by many of the participants in our study are ones (a) that exist because of the ubiquitous promotion of gender as a binary, and (b) that the parents of (binary) trans adult children would not experience.

In this way, the experiences of parents of nonbinary persons are distinct from those of binary trans persons. While recent developments increasingly highlight the existence of gender diversity and heterogeneity within the population of gender minority people (e.g., Goldberg & Kuvalanka, 2018; James et al., 2016a; Kubler, Nussbaum, & Mustanski, 2018; Singh, 2016), our findings suggest that differences also exists in their

families’—specifically, their parents’—experiences. As interest in studying gender minority people continues to increase (e.g., Tebbe et al., 2016), we encourage future researchers studying these populations and their families to be cautious in assuming homogeneity among them, particularly when using samples comprised of both binary trans and nonbinary people and their families.

Implications for Practice & Policy

In addition to this suggestion for future research, the distinction between the family members of binary trans people and their nonbinary counterparts has implications for practice and policy. The challenges experienced by parents of nonbinary children can help inform the clinical practice of therapists and other healthcare providers working with family members of nonbinary persons. Both Boss (2006) and McGuire et al. (2016a) highlight the importance of promoting resilience as an effective method of addressing ambiguity within transgender families. Specifically, they assert that resiliency in the face of ambiguity should be achieved through (1) meaning making, (2) revising attachments, and (3) redefining the self (for a detailed discussion of each, see McGuire et al., 2016a, p.380-1). Meaning-making, in particular, is a strategy emphasized by Boss (1996; 2006) and Norwood (2012; 2013b), which can be accomplished, in part, through advocacy, a method documented in other studies among parents of binary transgender children (e.g., Kuvalanka, Weiner, & Mahan, 2014). Advocacy, too, was a valuable method used by the parents in our sample in the face of learning of their child’s nonbinary gender identity. Providers would benefit from encouraging advocacy among the family members of nonbinary persons, including connecting them to resources and support communities that might catalyze such efforts.

For the other two recommended strategies to achieve resilience when faced with ambiguity, we encourage clinicians to promote dialectical thinking (both—and) as a way to change families’ “habits of thinking” around a loved one’s gender (McGuire et al., 2016a, p. 381). For example, being able to conceptualize a child as both a son and a daughter might facilitate a parents’ ability to retain a sense of sameness while also experiencing their nonbinary child’s transition. We recognize that, different from parents of binary trans person, this process necessitates the incorporation of a new gender schema, one that is not widely understood and accepted. Accordingly, providers working with the family members of nonbinary persons would benefit from including psychoeducation about nonbinary genders in their practice as a way to help facilitate parents’ cognitive understanding of gender beyond the cisnormative gender binary. For many of the participants in the current study, learning about nonbinary genders from available sources was a common—and helpful—strategy in efforts to understand their child’s gender. Above all else, we encourage clinicians to first listen to the parents of nonbinary adult children to assess the nature of their challenges in light of their child’s gender identity, as opposed to assuming their experience as uniform.

Finally, the identified distinctions between parents of nonbinary adult children in our sample and their binary counterparts in other studies call attention to how the unique challenges the parents of nonbinary children face are imposed on them by the continued promotion of two binary genders in the U.S. and in most Western cultures, both institutionally and interpersonally. As the number of gender minority individuals—and thus that of their family members—continues to rise (Herman et al., 2017), there is a strong need for recognition of genders that exist beyond the binary. Policies at all levels

of government that acknowledge the existence of nonbinary genders are structural ways to undo cisnormativity and affirm such persons and their families. For example, in the U.S., a growing number of states are enacting state-wide statutes that legally recognize nonbinary or third gender classifications on state identification documents, including birth certificates and driver's licenses. Currently, 14 states plus the District of Columbia have passed laws allowing residents to select "M, F, or X" on their driver's license; others intend to follow suit in the next several years (Movement Advancement Project, 2019). Relatedly, current "bathroom laws" in four states, nine metropolitan jurisdictions, and the District of Columbia require any public, single-occupancy restroom be available to any gender and explicitly designated as such (see, for example, Office of Human Rights, 2017).

In addition to providing legal recognition to individuals not identifying as either a man or a woman, these legislative initiatives challenge structural reification of the cisnormative gender binary and instead recognize the existence of nonbinary genders. Additionally, increased legal protections for nonbinary persons, such as those that allow for third-gender identification on legal documents, as well as anti-discrimination policies that include gender identity and expression (e.g., Equality Act, 2019) might help alleviate the documented anxiety, fear, and worry their loved ones experience, as did the parents in our study. Finally, at more regional levels of policy making, school curricula that are inclusive of LGBT people and families (Goldberg, 2017), and especially of diverse and nonbinary gender identities (Fischer, Bellinger, Horn, & Sullivan, 2017) would help increase public knowledge around nonbinary genders, reduce societal cisgenderism, and contribute to improving the lives of nonbinary youth and their families.

Strengths & Limitations

The current study has both several strengths and several limitations. Notably, it contributes to the scant literature on the experiences of parents of transgender adults: to our knowledge, it is the first multiparticipant study to specifically and exclusively sample the parents of adult children with nonbinary gender identities. We extend the work of Marcus and colleagues' family autoethnography (2015) by focusing on the experiences of parents whose child is nonbinary but doing so with data collected from multiple such families. Additionally, we recruited a uniform sample of the subpopulation of interest, all of whom shared the phenomenon at the center of our inquiry, which was ideally suited for our research goals, qualitative study design, and phenomenological approach (i.e., achieving qualitative integrity; Roy et al., 2015).

The homogeneity of our sample, though ideal for the nature of the project, simultaneously proved to be a limitation: what diversity of experience was potentially omitted by our relatively small and demographically consistent analytical sample? Future studies would benefit from parents who, unlike in the current study, are not all white, not all educated, and not all upper-middle class. Further, all of the parents that comprised the current study's sample were affirming and supportive of their child's gender. While this is an expected outcome given our chosen recruitment methods and the hard-to-reach nature of the population, it is undoubtedly also shortcoming. How might the experiences of parents who do not support or affirm their children's nonbinary gender identity diverge from those of the affirming parents in the current study? This is another potential direction of future research, and one we encourage future scholars of queer families to undertake.

As is true with most qualitative study designs, the findings from the current study cannot be generalized to the entire population of parents of adult children with nonbinary identities and should therefore not be assumed to be representative of all such families. To bypass this limitation, future investigations would benefit from recruiting larger samples and samples with more demographic diversity. Furthermore, the data analyzed for the present study were collected at a single point in time. While a shortcoming for many studies, the cross-sectional nature of the current study is particularly noteworthy considering how little is known about the nature of nonbinary gender identities and their development (for one recent example of such scholarship, see Bradford et al., 2019). Indeed, there was non-uniformity in the gender identity and expression of our participants' children, including the extent to which they physically and socially transitioned and whether or not they also identified as "trans." One way in which we attempted to control for such variation was by sampling parents whose children were adults; however, such variation was still apparent. To better understand the nature and the development of nonbinary gender identities—and that of the parents of such individuals—we encourage longitudinal studies to investigate these families' experiences over time.

Conclusion

In the current phenomenological study, we sought to uncover the lived experiences of the parents of adult children with nonbinary gender identities. Our study is backed by the noticeable absence of these families' experiences in the literature, cisnormativity's central assumption that only two genders exist (e.g., Bauer et al., 2009) and the increasing prevalence of nonbinary gender identities (e.g., James et al., 2016a;

Watson et al., 2019). Findings highlighted how parents made attempts to understand a gender schema they did not already possess and one not easily accessible; they also revealed the emotional processes and resiliency strategies parents expressed in response to having a child with a nonbinary gender identity. In addition to offering implications for practice and policy, our study highlights important distinctions among the families of gender minority people, informing future research with these populations.

Tables

Table 10. Participant & participant child demographic information (N=14)

| Participant | | | Participant's Child | | | |
|-------------|-----|-----------------|---------------------|-----------------|--------|-----------|
| Name | Age | Gender Identity | Age | Gender Identity | SAAB | Pronouns |
| Lilly | 58 | Female | 23 | Transmasculine | Female | They/them |
| Jocelyn | 54 | Female | 20 | Nonbinary | Female | They/them |
| Lydia | 52 | Female | 23 | Nonbinary | Female | They/them |
| Tim | 57 | Male | - | - | - | - |
| Julia | 50 | Female | 21 | Nonbinary | Female | They/them |
| Isabelle | 70 | Female | 31 | Nonbinary | Female | They/them |
| Janet | 57 | Female | 23 | Nonbinary | Female | They/them |
| Samantha | 53 | Female | 19 | Nonbinary | Male | They/them |
| Amy | 63 | Female | 24 | Genderfluid | Female | He/him |
| Ruben | 67 | Male | - | - | - | - |
| Edith | 56 | Female | 18 | Transmasculine | Female | He/him |
| Sarah | 60 | Female | 20 | Nonbinary | Female | He/him |
| Danielle | 57 | Female | 23 | Nonbinary | Female | They/them |
| Elise | 61 | Female | 20 | Nonbinary | Female | She/hers |

Note: Adjacent participants shaded in gray are married parents to one nonbinary child.

Note: To maintain participant anonymity, all names listed above are pseudonyms

Chapter 6: Concluding Discussion

The three studies comprising this dissertation critically examine the family environment of gender minority adults. By using data collected from both transgender adults and their parents, this mixed-methods project expands the scope of research on transgender families and contributes to the nascent literature. Studies one and two quantitatively assess family environment heterogeneity and its associations with gender identity, mental health, and physical health among transgender adults; study three qualitatively investigate how parents of adult children with nonbinary gender identities make sense of their child's gender. Below, I summarize the main findings from each study and discuss how the three studies, taken together, uniquely inform the field, policy, and practice.

Individual Contributions

The first study is backed by recent scholarship that critiques the assumption that families of transgender people are either accepting *or* rejecting of their loved one's gender variance. This small literature, comprised of qualitative or theoretical papers, suggests that families' accepting and rejecting behaviors can co-occur, change over time, and/or be understood by trans persons as contradictory (McGuire & Catalpa, 2017; Catalpa & McGuire, 2018). To move beyond the "singular, fixed, and dichotomized" acceptance-rejection binary (Catalpa & McGuire, 2018, p.10), and to more accurately capture the range of familial reactions to gender variance, we employed latent profile analysis (LPA) to identify different types of family environments among transgender adults.

Our analyses yielded five distinct profiles of transgender family environments: (1) *disengaged*, (2) *repudiating*, (3) *accepting & affirming*, (4) *moderate family ambiguity*, and (5) *high family ambiguity*. The majority of respondents (56%) were assigned membership into Profiles 4 or 5—the two “*family ambiguity*” profiles—which were characterized by equal scores of both accepting and rejecting behaviors. We then assessed the relationships between family environment and health, findings from which indicated that membership in any family profile other than *accepting & affirming* was negatively associated with both health outcomes. In a post-hoc analysis, which we performed to access a more meaningful interpretation of the family-health relationship, results indicated that participants who were assigned membership to Profile 3 (“*repudiating*”) did not report statistically different health outcomes than those assigned membership to Profile 4 (“*mild family ambiguity*”) or to Profile 5 (“*high family ambiguity*”). Taken together, findings from the first study (1) provide quantifiable evidence to support both the *presence* and the *prevalence* of family ambiguity in the families of transgender people, and (2) suggest that family ambiguity, at both moderate and high levels, is just as adverse for the health of transgender persons as is outright rejection.

Utilizing the profiles of family environment identified in the first study, the second study assessed the extent to which having a binary vs. a non-binary gender identity predicts the (a) family environment, (b) mental health, and (c) physical health of transgender adults. We also tested the moderating effect of family environment on the relationship between gender identity and both health outcomes. Findings revealed that, in the adjusted model controlling for demographic covariates, transgender participants’

family environment, mental health, and physical health did not vary as a function of having a binary vs. a nonbinary gender identity. Tests of family environment moderation were significant and indicated that binary trans respondents, but not those identified as nonbinary, had higher mental and physical health score when assigned membership to Profile 1 (“*disengaged*”). The second study’s close examination of the relationships between gender heterogeneity, family environment diversity, and health among transgender adults highlights the need for a more nuanced understanding of gender identity measurement as a way to more accurately assess their health, wellbeing, and familial experiences.

The third study differed from the previous two in two ways: first, it shifted the perspective from transgender adults to that of their parents, and second, it utilized qualitative data instead of the quantitative survey data used for the prior analyses. Through in-depth, semi-structured interviews, we asked the parents of adult children with nonbinary gender identities ($N=14$) how they come to understand their child’s gender. The need for the third study emerged from the near absence of these families’ experiences in the literature, and, given the pervasive assumption that only two sexes and two genders exist (e.g., cisnormativity; Bauer et al., 2009), it seemed likely that a transition from one binary gender to the other may be easier to comprehend than one that results in a gender that is not readily understood (McGuire et al., 2016b).

Using thematic content analysis (Braun & Clark, 2006), we identified four broad themes: (1) varied attempts to understand nonbinary gender; (2) emotional challenges; (3) a nonbinary “double-edged sword”; and (4) familial resilience. Results underscore the unique difficulty of having an adult child with a gender identity that does not exist within

the widely assumed and espoused gender binary, and the resilience these parents expressed in response. Two key takeaways from the third study is how the challenges experienced by the family members of nonbinary persons (1) exist because of the ubiquitous promotion of gender as a binary, and (b) are ones the parents of (binary) trans adult children would not encounter.

Each of the three studies provide a more comprehensive and nuanced picture of the family environment of gender minority people. The first study is novel in its heterogenous approach to transgender family environments, responding to recent critiques to move beyond the reductionistic acceptance-rejection dichotomy historically used to conceptualize family reactions to gender variance (e.g., Catalpa & McGuire, 2018). To our knowledge, it is also the first quantitative exploration of (a) transgender family environments beyond those measured as either acceptance or rejection; and (b) their relationship with health outcomes. The second study is timely in addressing the prevalence of nonbinary gender identities among the transgender population (e.g., Kubler, Nussbaum, & Mustanski, 2018) and assessing if living beyond cisnormativity's central, two-gender tenet (e.g., McGuire et al., 2016b) might differently inform those persons' health and family outcomes. The third study is the first known published study to capture the experiences of multiple parents of nonbinary adult children by qualitatively exploring how they come to understand their child's gender and uncovering the processes they undergo in doing so.

Taken Together: A Holistic Mosaic of this Dissertation's Implications

While interest in studying the transgender population continues to grow (Moradi et al., 2016), research on the family environment of transgender persons is comparably

scant—a noteworthy shortcoming due to the substantiated relationship between the family environment of trans people and their health and wellbeing (e.g., Bockting et al., 2013; Simons et al., 2013). Findings from this dissertation reinforce that relationship and add important nuance to the collective understanding of transgender family environments. This, in turn, offers myriad implications for practice, policy, and future research.

The prevalence of family ambiguity among transgender adults and its deleterious effect on their mental and physical health highlight the need to address this ambiguity as a way to help improve the health of the population. This is especially important given the relative detriment of family ambiguity on the mental and physical health of our participants: ambiguity was just as adverse for their health as was outright rejection. Thus, future clinical, prevention, and intervention endeavors should aim to increase resiliency among trans adults, something that can be achieved, for example, through trans advocacy efforts (Boss, 2006; McGuire et al., 2016a). Additionally, study one identified that *disengaged* family environments were healthier than both ambiguous and reupdating environments, suggesting that instead of continuing to obtain acceptance from ambiguous or rejecting families, trans adults might be better off distancing themselves from them. Thus, clinical efforts that facilitate such familial distancing might be equally helpful in improving the health of the population.

The data used in study one preclude us offering a better understanding of what, precisely, the family ambiguity identified in the two latent *family ambiguity* profiles reflects at the level of interpersonal interactions. However, findings from study three offer a glimpse as to what such family ambiguity may look like at such a micro level,

from both (1) the parents' and (2) the trans adults' perspective. First, parents experienced ambiguity in part by the limited knowledge available of nonbinary gender identities in public discourse, and the subsequent need to conceptualize their child as neither a man nor a woman—something foreign to the parents in our sample. What was consistent among the parents in study three, however, is that they were largely committed to being unconditionally accepting of their child and their gender identity: even families trying to be accepting and affirming struggled to do so, inhibited by their own experiences of ambiguity. What becomes clearer after combining these findings with those of study one is that even if parents' intentions are benevolent—even if they desire to be accepting and affirming—they still may struggle to behave in the ways that are optimal for their trans loved one's health. This reality, if true, offers implications for both (a) scale development and (b) family therapy. Future development of the parent version the *Family Gender Environment Scale* (McGuire & Fish, 2018) might benefit from including items that more precisely capture the confusion/ambiguity *and* the affirming intentions expressed by the parents in study three: a group of parents who wanted to be supportive but struggled to do so. Family therapists working with trans adult children and their parents might focus clinical interventions on helping trans persons distinguish parents' confusion from a perceived lack of acceptance, helping to re-create meaning around their parents' behaviors that might be read as unsupportive.

Combining the findings from the first study with those of the third not only begin to illuminate family ambiguity from the parents' perspective but also from that of their transgender (adult) child. For example, several of the parents in study three who were strong advocates for their NBGQ child were also the same parents who struggled to

understand NGBQ identities and encountered difficulties in using their child's chosen name and pronouns. Considering these concurrent—and seemingly contradictory—behaviors from the perspective of a trans young adult offers an initial glimpse of the very familial ambiguity that was prevalent among the trans respondents in studies one and two. Future studies that are able to empirically harness the perspectives of familial ambiguity from NGBQ persons will be able to validate the narratives of ambiguity that emerged in this dissertation's first and third studies. Future research would also benefit from determining which components of familial ambiguity are the ones that are the most deleterious to the poorer health of trans persons that exist within ambiguous family environments, as identified in study one.

The need for this dissertation was defended in part by the noted prevalence of nonbinary gender identities among the trans population (James et al., 2016a; Watson et al., 2019) and the inconsistencies in what is known about the health and the family environment of those who identify as nonbinary relative to their binary counterparts. Our findings substantiated the prevalence of nonbinary gender identities among the transgender population—twice as many participants in our sample identified as nonbinary—but they did not clarify the aforementioned inconsistencies: we found no significant differences in health or family environment between binary and nonbinary trans respondents. While this supports certain empirical findings (Bradford & Catalpa, 2019; Fish, Catalpa, & McGuire, 2017; Jones et al., 2019), it also contradicts others that suggest nonbinary trans persons have better health than binary ones (e.g., Rimes et al., 2017) and those that suggest they have worse (e.g., Lefover et al., 2019). This ensuing inconsistency points to two key avenues of future research. First, there is a need to

discern a “gold standard” for measuring gender identity, especially those that are nonbinary (Fraser, 2018, p.353). Inherently, this will necessitate obtaining a much better understanding of nonbinary gender identities than what currently exists in the literature, which is the second agenda item we recommend for future research. In so doing, scholars would benefit from understanding the development of nonbinary gender identities over time (Bradford et al., 2019), including nonbinary persons’ relationship to transgender identities (Darwin, 2020), as a way to create and validate a more accurate assessment of gender identity. The importance of these future research endeavors was substantiated by insight gleaned from the parents in the third study, whose narratives pointed to a nonuniformity in their children’s nonbinary gender identities. For example, parents described variability (a) in the physical changes their children were or were not making to their bodies and their appearance, (b) in whether or not their children also identified as transgender in addition to nonbinary, and (c) the development of their child’s nonbinary gender identity (e.g., if they previously identified as a different sexual or gender minority identity).

Finally, this dissertation points to the need for two distinct but related policy initiatives, both of which would benefit the health and wellbeing of non-cisgender populations and those of their family members. The first initiative should target the removal of policies that discriminate on the basis of gender identity and, conversely, aim to support those that include protections for it. Policies that restrict gender identity to an individual’s natal sex are structural barriers that contribute to the appreciable health disparities between transgender and cisgender people (e.g., National Institutes of Health, 2016). Passing legislation at all levels of policymaking—federal, state, and/or local—that

affirm and protect trans persons' gender identities may help reduce these health disparities. The second suggested policy initiative pertains to individuals with gender identities that are neither male nor female. Nonbinary gender identities are incompatible within the pervasive, cisnormative, two-gender framework of the western world, including that of the United States. Because nonbinary genders comprise a growing proportion of the transgender population (James et al., 2016a), it seems especially prudent to expand the collective understanding and acceptance of all genders. In addition to changes to school curricula that are inclusive of such gender identities (e.g., Fischer et al., 2017) and to the inclusion of nonbinary persons in film and media (e.g., Sam Smith, Asia Kate Dillon), policies that, at the very least, *allow* for the existence of identities might likewise contribute to improving the health of this population.

Appendices

Appendix A: The Family Gender Environment Scale (FGE)

Please think about your family-of-origin currently. Each statement below describes a particular aspect of your family environment. Please indicate how much you agree or disagree with each statement.

How often do members of your family...

| | Never | Once or twice | Sometimes | Frequently | All the time |
|--------------------------------------------------------------------------------------|-------|---------------|-----------|------------|--------------|
| Talk openly to you about your gender and gender roles? | 0 | 1 | 2 | 3 | 4 |
| Discuss and work through differences within the family about your gender expression? | 0 | 1 | 2 | 3 | 4 |
| Talk with your siblings about accepting your gender expression? | 0 | 1 | 2 | 3 | 4 |
| Talk with extended family about accepting your gender expression? | 0 | 1 | 2 | 3 | 4 |

| | | | | | |
|----------------------------------------------------------------------------|---|---|---|---|---|
| Give you information about gender role or transition? | 0 | 1 | 2 | 3 | 4 |
| Show you books, videos, or items that supported diverse gender expression? | 0 | 1 | 2 | 3 | 4 |
| Require that others treat you with respect? | 0 | 1 | 2 | 3 | 4 |
| Advocate for your safety, inclusion, or well-being outside the home? | 0 | 1 | 2 | 3 | 4 |
| Talk with teachers or school personnel to accept your gender expression? | 0 | 1 | 2 | 3 | 4 |

| | | | | | |
|-----------------------------------------------------------------------------------------|---|---|---|---|---|
| Invite openly LGBTQ+ friends to join family activities? | 0 | 1 | 2 | 3 | 4 |
| Accept your clothing or hairstyle, even though it might not be typical for your gender? | 0 | 1 | 2 | 3 | 4 |
| Make sure the family environment is supportive of your gender expression? | 0 | 1 | 2 | 3 | 4 |
| Appreciate and support your gender expression? | 0 | 1 | 2 | 3 | 4 |

| | | | | | |
|-----------------------------------------------------------------------|---|---|---|---|---|
| Disregard gender stereotypes about items (toys or clothes)? | 0 | 1 | 2 | 3 | 4 |
| Support you in using a different name or pronoun? | 0 | 1 | 2 | 3 | 4 |
| Purchase items to support your gender expression? | 0 | 1 | 2 | 3 | 4 |
| Allow you to dress in gender variant ways in the home? | 0 | 1 | 2 | 3 | 4 |
| Discuss your gender with a medical provider in a positive way? | 0 | 1 | 2 | 3 | 4 |
| Take you to a gender clinic or other supportive health care provider? | 0 | 1 | 2 | 3 | 4 |

| | | | | | |
|----------------------------------------------------------------------------------|---|---|---|---|---|
| Ridicule, tease, or call you names about your gender? | 0 | 1 | 2 | 3 | 4 |
| Hit or physically abuse you? | 0 | 1 | 2 | 3 | 4 |
| Not let you attend certain events/ activities because of your gender expression? | 0 | 1 | 2 | 3 | 4 |
| Make you feel “not normal” because of your gender expression? | 0 | 1 | 2 | 3 | 4 |
| Give you fewer opportunities than siblings because of your gender expression? | 0 | 1 | 2 | 3 | 4 |
| Talk negatively about you to others because of your gender expression? | 0 | 1 | 2 | 3 | 4 |
| Force secrecy about your gender expression because of your gender expression? | 0 | 1 | 2 | 3 | 4 |
| Express shame about your gender expression or identity? | 0 | 1 | 2 | 3 | 4 |

| | | | | | |
|------------------------------------------------------------------------|---|---|---|---|---|
| Tell you that others do not approve of cross gender expression? | 0 | 1 | 2 | 3 | 4 |
| Blame you for any mistreatment that you experienced? | 0 | 1 | 2 | 3 | 4 |
| Tell you that your behavior is a “sin?” | 0 | 1 | 2 | 3 | 4 |
| Tell you that your religion or your god does not approve? | 0 | 1 | 2 | 3 | 4 |
| Force you to meet with religious leaders about your gender expression? | 0 | 1 | 2 | 3 | 4 |

| | | | | | |
|--------------------------------------------------------------------------------|---|---|---|---|---|
| Force you to dress or behave in gender conforming ways? | 0 | 1 | 2 | 3 | 4 |
| Take you to see a medical provider who tried to change your gender expression? | 0 | 1 | 2 | 3 | 4 |
| Buy you items that push you into gender conformity? | 0 | 1 | 2 | 3 | 4 |
| Assume your gender expression was an act of defiance? | 0 | 1 | 2 | 3 | 4 |
| Tell you that you are not allowed to socially transition? | 0 | 1 | 2 | 3 | 4 |
| Treat your transgender desire as a phase? | 0 | 1 | 2 | 3 | 4 |
| Allow others to enforce gender conformity against you? | 0 | 1 | 2 | 3 | 4 |

Appendix B: Qualitative Study Interview Questionnaire

This open-ended interview questionnaire is intended to understand your experiences as a parent of an adult child who identifies with a nonbinary gender identity. It is guided by two overarching research questions: (1) How do the parents of adult children with nonbinary gender identities make sense of, understand, and navigate their child's gender identity? (2) What happened over time for the parents of adult children with nonbinary gender identities in understanding their child's gender?

- 1) Tell me about yourself.
 - a. How old are you?
 - b. What is your gender identity?
 - c. What is your race/ethnicity?
 - d. What is your highest level of education?
 - e. Your sexual orientation?
- 2) Tell me about your family.
 - a. Who is in it, and what is their relation to you?
 - b. How old is each member, and where/with whom does each member live?
- 3) I'd like to now direct our conversation about _____ (name of child who identifies as trans). What is your child's current gender identity/ies?
- 4) I'm interested in understanding your perspective of _____'s gender identity development. To your knowledge, what other gender and/or sexual identities has your child identified with over their life?
- 5) Tell me about their past and current gender identity/ies.
 - a. How did you come to know each of them (if more than one)?

- i. What was happening at those times in your life, your family's life, your child's life?
- 6) What was your reaction to each one (if more than one)?
 - a. How have your thoughts, reactions, and emotions evolved over time?
 - b. How have you made sense of their transition(s)?
- 7) How do you make sense of and understand your child's nonbinary gender identity?
- 8) In what ways has your child's gender identity influenced you? Your family? Your relationships?
- 9) How has your life changed? (minority stress)
- 10) What has been particularly challenging with regards to your child's gender identity and expression, over time? For you? For your child? For your family?
- 11) What are the benefits of having a child with a NBGQ gender identity?
- 12) What do you look forward to in your future? Your child's? Your family's?

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