

The Relationship Between Family Acceptance-Rejection and Transgender Youth Psychosocial Functioning

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Objective: Transgender youth have a high risk of adverse mental health outcomes. Family acceptance may play a protective role in transgender youth's psychosocial adjustment; however, studies have largely examined acceptance independent from gender identity, averaged across family members, and in extreme examples (i.e., high acceptance or high rejection). Grounded in interpersonal acceptance-rejection theory, this study documents transgender youth's experiences of family acceptance-rejection across family members, including siblings, and investigates the relationship between family acceptance-rejection and youth psychosocial functioning. **Method:** Fifty-four youth completed psychosocial questionnaires, and youth and caregivers completed semistructured clinical interviews, which were coded for family acceptance-rejection. Analyses examined associations between acceptance-rejection and psychosocial variables. **Results:** Lower primary caregiver past acceptance predicted increased youth depressive/anxiety symptoms/internalizing problems. Higher secondary caregiver indifference predicted increased youth depressive symptoms. Lower sibling acceptance predicted increased youth suicidal ideation. **Conclusions:** Findings demonstrate that family acceptance-rejection plays an important role in the psychosocial adjustment of transgender youth. New to the existing literature are the findings that caregiver indifference and sibling acceptance are associated with mental health outcomes.

Implications for Impact Statement

Family acceptance and rejection play an important role in the adjustment of transgender youth. It is imperative for providers to evaluate acceptance and rejection across family members and to work with families to foster supportive relationships.

Keywords: transgender youth, acceptance, rejection, family, siblings

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Transgender adolescents have a high risk of adverse mental health outcomes (e.g., [Reisner et al., 2015](#)). Research has found that they frequently exhibit more depressive symptoms, anxiety, and suicidal ideation than their cisgender peers (e.g., [Reisner et al., 2015](#)). Yet other transgender youth do not endorse mental health difficulties (e.g., [Edwards-Leeper, Feldman, Lash, Shumer, & Tishelman, 2017](#)). A more comprehensive understanding of the factors that influence transgender youth's psychosocial functioning is necessary to inform assessment and interventions, with the ultimate goal of alleviating distress and fostering resilience for this high-risk population.

Growing evidence suggests that family factors may play a crucial role in the psychosocial adjustment of transgender youth. Transgender youth who report better family communication also report less severe depressive symptoms, fewer anxiety symptoms, and better self-esteem, as do transgender youth who report greater family satisfaction ([Katz-Wise, Ehrensaft, Veters, Forcier, & Austin, 2018](#)). Transgender youth with higher family connectedness have better overall mental health and are less likely to engage in self-harm or attempt suicide ([Veale, Peter, Travers, & Saewyc, 2017](#)). Parental support is associated with higher life satisfaction, better mental health, and fewer depressive symptoms in transgender youth (e.g., [Simons, Schrager, Clark, Belzer, & Olson, 2013](#)), and parents report that prepubescent youth who are supported to socially transition have normative levels of depression and only slightly elevated levels of anxiety ([Olson, Durwood, DeMeules, & McLaughlin, 2016](#)). However, a large percentage of transgender youth experience family rejection or lack of support, linked with negative mental health outcomes, such as self-harm and suicidality (e.g., [Grossman & D'Augelli, 2007](#)).

Studies examining the relationship between family factors and transgender youth mental health provide important first steps, but have methodological limitations. Research has largely studied family factors (e.g., support, communication) as general constructs (e.g., [Katz-Wise et al., 2018](#)) assessed with family subscales of measures that are intended for use with the general population. Such measures assess overall domains of family functioning, rather than domains in relation to the transgen-

der youth's gender identity. Several researchers have sought to assess gender-specific family support or acceptance; however, methodological limitations remain. One such study asked transgender adolescents to rank their family's gender-related support on a Likert scale from "not at all supportive" to "extremely supportive" ([Travers et al., 2012](#)). An inherent limitation to this assessment approach, however, is that it asks youth to assign global ratings of family support. In fact, transgender youth may experience differing levels of support from individual family members, similar to the finding that parents of LGB youth often have different reactions to learning about their child's sexuality ([Perrin et al., 2004](#)). Additionally, research on how family acceptance influences youth mental health has primarily focused on extreme examples (e.g., adolescents who report having "extremely supportive" families; [Travers et al., 2012](#)), rather than the co-occurring accepting and rejecting behaviors taking place as a family adjusts to a youth's affirmed gender identity ([Hidalgo, Chen, Garofalo, & Forbes, 2017](#)). Research with transgender youth supports the pre-existing theory that family acceptance and rejection are separate constructs ([Khaleque & Ali, 2017](#)) that can occur simultaneously (e.g., parents can support youth's gender transition and worry about how youth's gender identity will affect the family's image; [Hidalgo et al., 2017](#)).

Interpersonal acceptance-rejection theory (IPARTheory) provides an evidence-based framework ([Khaleque & Ali, 2017](#)) through which to address these limitations and examine the relationship between transgender youth's co-occurring experiences of family acceptance and rejection, and their psychosocial functioning. IPARTheory suggests that the psychological adjustment of children is influenced by their perception of being accepted or rejected by their parents, siblings, or other attachment figures ([Rohner & Lansford, 2017](#)). Research across diverse samples demonstrates that family acceptance and rejection account for approximately 26% of the variability in youth mental health outcomes ([Khaleque & Ali, 2017](#)). Professionals in the field have highlighted the applicability of IPARTheory to LGB populations ([Fuller, 2017](#)). Recent research highlights the importance of understanding transgender youth's experiences of both acceptance and rejection ([Hidalgo et al.,](#)

2017), however, IPARTheory has not yet been applied to this population.

Previous IPARTheory-informed research demonstrates that individuals classify their perceptions of acceptance-rejection into four domains: warmth, hostility, indifference, and undifferentiated rejection (Rohner & Lansford, 2017). Warmth refers to the quality of the relationship between the individual and their family member, which can be expressed physically, verbally, or symbolically (Rohner & Lansford, 2017). Family members of transgender youth likely demonstrate warmth in the same ways as family members of cisgender youth (e.g., hugs), as well as ways that are specifically related to the youth's gender identity (e.g., using preferred pronouns). The other domains capture the youth's perception of how rejecting their family member is. Rejection occurs when family members are angry or hurtful (hostility) or appear uninterested (indifference), or sometimes youth feel rejected in the absence of clear rejecting behaviors (undifferentiated rejection). Past research on transgender youth has documented rejecting family behaviors (e.g., abuse; James et al., 2016), which through an IPARTheory lens would be classified as hostility; however, research has not yet examined transgender youth's experiences of indifference (e.g., lack of caregiver involvement in gender-related issues) or undifferentiated rejection (e.g., youth feels rejected despite caregiver acting in a supportive way).

In the general population, youth's experiences of acceptance-rejection by each of their family members (e.g., mother, father, and siblings) have been shown to differentially contribute to youth's psychological adjustment (Rohner, Varan, & Koberstein, 2013), highlighting the importance of understanding transgender youth's experiences of acceptance-rejection from siblings, in addition to parents. Transgender youth's sibling relationships have received limited attention in research. Siblings of transgender youth are in general more accepting of gender nonconformity than children without a transgender sibling (Olson & Gülgöz, 2018); however, research has not yet investigated how accepting they are specifically toward their own transgender sibling, or how sibling acceptance influences transgender youth mental health. In LGBT young adults, greater sibling acceptance of the LGBT individual's sexual behavior is related to closer sibling relationships (Toomey

& Richardson, 2009), possibly suggesting that how accepting the sibling is influences the closeness of the relationship. In the general population, close sibling relationships are related to positive mental health outcomes, and increased ability to cope with a lack of parental support (Milevsky, 2005), emphasizing the need for an expanded focus on transgender youth's sibling relationships.

Building on Hidalgo et al.'s work documenting that transgender youth often experience both acceptance and rejection in their families (Hidalgo et al., 2017), the current preliminary study sought to advance our knowledge by evaluating whether these experiences of acceptance and rejection fit the specific domains outlined in IPARTheory (Rohner & Lansford, 2017), vary across family members, and are associated with youth's psychosocial functioning. In accordance with this goal, a coding system grounded in IPARTheory's domains of acceptance-rejection and informed by transgender-focused research and input from experts in the field, was designed to gather information on family acceptance-rejection from preexisting diagnostic interview summaries conducted with transgender youth and their caregivers. Clinical information collected with this coding system was then used to explore our research questions. Specifically, this exploratory research was designed to 1) document youth's experiences of family acceptance-rejection for a cohort of transgender youth presenting for treatment at a pediatric gender clinic, 2) examine the relationship between family acceptance-rejection and youth-reported psychosocial functioning, focusing specifically on individual family members' levels of acceptance-rejection and specific domains of acceptance-rejection, and 3) determine the relative contribution of these specific types of family acceptance-rejection to youth psychosocial functioning. This preliminary study was designed to inform future research by identifying aspects of family acceptance-rejection that may be relevant to psychological adjustment in transgender youth.

Method

Participants

Participants included 54 youth who presented at the Gender Management Service (GeMS) program at Boston Children's Hospital, a pedi-

atric gender clinic housed in an academic medical center, for psychological assessment prior to receiving possible puberty blocker or gender-affirming hormonal intervention. Participants included 30 self-identified transgender females (assigned male at birth but affirm a female identity) and 24 self-identified transgender males (assigned female at birth but affirm a male identity); none identified as nonbinary. Participants were 8.9 to 17.9 years old ($M = 14.6$, $SD = 2.4$). Each participant was accompanied by at least one caregiver.

Procedures

A chart review was conducted to gather data on family demographics, family acceptance and rejection, and youth psychosocial functioning. Data were collected for clinical purposes during standard of care (i.e., comprehensive, psychosocial) evaluations that took place from 2007 to 2011 in an interdisciplinary gender clinic serving transgender youth. The goal of the comprehensive evaluation was to better understand the youth's gender identity and related factors (e.g., mental health concerns, family dynamics). During these evaluations, participants and caregivers completed a battery of standardized psychosocial and gender questionnaires and participated in semistructured clinical interviews, completed by a single staff psychologist. The evaluation protocol remained consistent over this 4-year time period, and thus the same general approach to the evaluation was used for all participants.

In the clinical interview, the psychologist assessed family and developmental history, gender history, family support, family attitudes about the youth's gender, abuse/trauma, and family stressors (see Tishelman et al., 2015, for a more detailed description of clinical interviews). Time was spent alone with the youth and parents in order to fully understand all perspectives. Child and parent reports were synthesized so both perspectives were represented. Following the evaluations, the psychologist wrote a comprehensive report including a summary of information obtained in the clinical interview, questionnaire findings, and overall clinical impressions/recommendations. For the present study, data from youth self-report questionnaires were utilized to assess youth psychosocial functioning (Children's Depression In-

ventory, Revised Children's Manifest Anxiety Scale 1st Edition, and Youth Self Report). Data from interview summaries were entered into an acceptance-rejection coding system developed by the authors (see below), and scores from that coding system were used to assess family acceptance and rejection. Relevant family demographic information was also collected from interview summaries. Institutional Review Board approval was obtained to conduct this research.

Family acceptance-rejection coding system.

The family acceptance-rejection coding system (see [online supplemental materials](#)) was developed by the authors for the purpose of this preliminary study, grounded in IPARTheory (Rohner & Lansford, 2017) and informed by transgender-focused research and input from experts in the field. An initial coding system was developed by the first author and then revised in a collaborative process over the course of multiple meetings with the research team, which included two psychologists with expertise in transgender youth and family systems. The coding system was developed to assign individual ratings of acceptance-rejection for transgender youth's primary caregivers, secondary caregivers, and closest-in-age siblings based on information collected in the clinical interviews. Primary caregivers were defined as the caregiver who assumed the most responsibility in caring for the transgender youth (e.g., brought them to medical appointments, looked after them at home). Primary and secondary caregivers were assigned ratings on each of the four domains of acceptance-rejection: warmth, hostility, indifference, and undifferentiated rejection (Rohner & Lansford, 2017). Additionally, to capture caregivers' acceptance-rejection related specifically to the transgender youth's gender identity, caregivers were assigned ratings for past gender acceptance and current gender acceptance. Together, each caregiver received six ratings of acceptance-rejection. Coders used data from interview summaries to assign caregivers a rating based on family report of acceptance-rejection relative to each domain (i.e., 0 = *no*, 1 = *somewhat or sometimes*, 2 = *yes*). Examples for each domain were included as a part of the coding system to ensure reliability between coders, such as "wants youth to be safe and happy" for the warmth domain, "reacted in a supportive way when youth first ex-

pressed feelings about affirmed gender” for the past acceptance domain, “uses youth’s preferred name/ pronouns” for the current acceptance domain, “yells at youth for gender non-conforming behavior” for the hostility domain, and “won’t talk to youth about gender related issues” for the indifference domain. For these domains, if youth and caregiver report were consistent with an acceptance-rejection domain, then a “yes” rating was assigned; if youth and caregiver report were inconsistent with a domain then a “no” rating was assigned (e.g., neither youth nor caregiver reported family hostility or aggression); and if youth and caregiver provided examples of both “yes” and “no” (e.g., caregiver allows youth to dress in masculine clothing, but does not use preferred pronouns), then a “somewhat/sometimes” rating was assigned. For the undifferentiated rejection domain, a “yes” rating was assigned if youth reported often feeling like their caregiver did not love/care about/accept them, without being able to provide specific examples of caregiver rejection, and a “somewhat/sometimes” rating was assigned if they reported sometimes feeling this way.

Although asking about family acceptance and rejection was included in all of the clinical interviews, the depth in which youth and caregivers were queried about sibling relationships varied some from patient to patient, largely due to the clinical focus of the interviews, which were time-limited because of the structure of clinic. Due to more limited information about sibling relationships in the interview summaries, sibling acceptance-rejection was not assessed in the same depth as caregiver acceptance-rejection. Rather, siblings were assigned an overall rating of gender-related acceptance-rejection (i.e., sibling acceptance), ranging from low to high (i.e., 0 = *low*, 1 = *medium*, 2 = *high*). “Low” ratings were assigned to interview summaries with only negative examples (e.g., cold, hostile, indifferent), “medium” ratings were assigned to interviews with both positive and negative examples, and “high” ratings were assigned to interviews with only positive examples (e.g., warm, accepting). For clinical interviews that contained information about multiple siblings, data regarding closest-in-age siblings were used for analyses. Relationships with closest-in-age siblings were often described in the most detail.

The coding team was made up of one master’s-level clinical psychology doctoral student (the first author) and one undergraduate-level psychology student. The first author oriented the undergraduate student to the acceptance-rejection coding system (e.g., domains of acceptance-rejection, differentiating between “yes,” “somewhat/sometimes,” and “no” ratings), followed by reviewing two scored case examples. Next, the undergraduate student independently assigned ratings for two cases, which were then checked by the first author with discussion of any uncertainties and questions. Following training, the undergraduate student demonstrated a strong understanding of how to apply the coding system and served as the primary coder for the remaining families ($n = 50$). The first author served as the reliability coder, and double coded a random sample (13 families, 26%), which was then compared to ensure interrater reliability. Weekly meetings were held throughout the coding process to discuss application of the coding system and to resolve disagreements that arose in assigning ratings. Reliability scores (number of consistent ratings divided by number of total ratings) demonstrated high interrater reliability (89% agreement). Consensus was reached on all ratings prior to data analysis.

Family demographics. Relevant family demographic information was collected from interview summaries (see [online supplemental materials](#) for details). All transgender youth had a primary caregiver ($N = 54$), and 96% of youth had a secondary caregiver ($n = 52$). The majority (79.6%) of primary caregivers were biological mothers, and the majority (66.7%) of secondary caregivers were biological fathers. Eighty-seven percent of transgender youth had a sibling ($n = 47$). Siblings ranged from 4 to 27 years old ($M = 15.5$, $SD = 4.9$). Fifty percent of siblings shared the transgender youth’s assigned sex at birth, and 35% shared the transgender youth’s affirmed gender (i.e., the gender with which they self-identified). Gender data were not documented for 15% of siblings. Family race, ethnicity, and socioeconomic status were unavailable; however, as previously reported ([Edwards-Leeper et al., 2017](#)), it can be assumed that the majority of families were White and middle-class or above.

Measures

Behavioral functioning. Transgender youth completed the Youth Self Report (YSR; Achenbach, 1991), a 113-item, self-report measure of youth (ages 11–18) internalizing and externalizing symptoms, and functioning. Two critical items, “deliberately harms self or attempts suicide” and “thinks about killing self,” were separately coded due to the high risk for self-harm and suicidal ideation in this population, however, only “thinks about killing self” was retained for analyses due to the small percentage of youth that reported self-harm ($n = 4$). YSR scores were converted to T scores and normed by age and gender assigned at birth. The YSR is a widely used measure and has good convergent and divergent validity, and test–retest reliability (Achenbach, Dumenci, & Rescorla, 2001). Cronbach’s alpha, measuring internal consistency, was 0.88.

Depression. Youth completed the Children’s Depression Inventory: Child Version (CDI; Kovacs, 1992), a 27-item, youth (ages 7–17) self-report measure of depressive symptoms. The CDI produces a total score, with higher scores indicating higher levels of depressive symptoms. Scores for this measure were normed by age and gender assigned at birth. The CDI has been found to have good internal consistency, test–retest reliability, and construct validity (Kovacs, 1992; Sitarenios & Kovacs, 1999). Cronbach’s alpha was 0.90 for the CDI.

Anxiety. Transgender youth completed the Revised Children’s Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978), a 37-item, youth (ages 6–19) self-report measure of anxiety. Total Anxiety raw scores were converted to T scores. The RCMAS has been used widely to assess child anxiety and has good test–retest reliability and convergent, divergent, and construct validity, (Wisniewski, Genshaft, Mulick, & Coury, 1987). Cronbach’s alpha was 0.91.

Data Analysis

Preliminary analyses examined skew and kurtosis of acceptance-rejection ratings. Due to the non-normal distribution of acceptance-rejection ratings, nonparametric tests were utilized for subsequent analyses. Spearman correlations examined associations between psychosocial variables

(i.e., YSR, CDI, and RCMAS) and possible covariates, including youth’s age and gender identity. Neither were significantly associated with any psychosocial variables.

In accordance with Aim 1, acceptance-rejection ratings were summarized using frequencies and percentages, and differences in primary and secondary caregivers’ ratings were assessed using 2-tailed, Wilcoxon signed-ranks test. In accordance with Aim 2, Spearman correlations were used to assess the association between acceptance-rejection ratings (e.g., primary caregiver current acceptance) and psychosocial variables (e.g., depressive symptoms). In accordance with Aim 3, acceptance-rejection ratings associated with psychosocial variables in the Spearman correlations were then entered into linear or logistic regression analyses to determine each rating’s unique contribution in predicting each psychosocial variable. Specifically, linear regressions were used for continuous variables (i.e., depression symptoms, anxiety symptoms, internalizing problems, and externalizing problems), and a logistic regression was used for the binary outcome variable of suicidal ideation. Bonferroni cutoffs were used in all analyses to account for multiple hypothesis testing (Armstrong, 2014).

Results

Aim 1: Document Family Acceptance-Rejection

Interview summaries contained data that were consistent with each IPARTheory domain. See [online supplemental materials](#) for common themes in data that were captured using the coding system under each domain, as well as a full summary of primary and secondary caregivers’ acceptance-rejection ratings. Primary and secondary caregivers did not differ significantly ($Z = -1.23, p = .22$) on past acceptance. However, primary caregivers demonstrated significantly higher current acceptance ($Z = -2.64, p = .008$), significantly higher warmth ($Z = -3.39, p = .001$), and significantly lower hostility than secondary caregivers ($Z = -2.12, p = .03$). There were no significant differences between primary and secondary caregivers’ indifference ($Z = -1.84, p = .07$) or undifferentiated rejection ($Z = -1.84, p = .07$). Variable acceptance

levels were noted for siblings regarding the transgender youth’s gender, with 8.6% ($n = 3$) showing low acceptance/high rejection, 28.6% ($n = 10$) showing mixed acceptance and rejection, and 62.9% ($n = 22$) showing high acceptance/low rejection.

Aim 2: Evaluate Bivariate Associations Between Family Acceptance-Rejection and Youth Psychosocial Functioning

Associations between caregivers’ and siblings’ acceptance-rejection ratings and youth psychosocial variables are presented in Table 1. After applying Bonferroni corrections, primary caregivers’ past acceptance was significantly negatively correlated with youth depressive symptoms, $r = -.38, p = .009$, anxiety symptoms, $r = -.37, p < .009$, and internalizing problems, $r = -.46, p = .002$. Secondary caregivers’ indifference was significantly positively correlated with youth depressive symptoms, $r = .38, p = .008$, and marginally positively correlated with youth anxiety symptoms, $r = .35, p = .013$. Siblings’ acceptance was negatively correlated with youth externalizing problems, $r = -.52, p = .004$, and suicidal ideation, $r = -.51, p = .005$.

Aim 3: Assess Variance in Psychosocial Variables Explained by Family Acceptance-Rejection

Regression analyses determined the relative variance in youth psychosocial variables accounted for by each predictor significantly associated with psychosocial variables in Spearman correlations. Linear regressions were used for depressive symptoms, anxiety symptoms, internalizing problems, and externalizing problems (see Table 2). Primary caregivers’ past acceptance ($\beta = -.31, p = .02$) and secondary caregivers’ indifference ($\beta = .46, p = .001$) significantly and independently predicted youth depressive symptoms, accounting for 31% of the variance. Primary caregivers’ past acceptance ($\beta = -.34, p = .01$) and secondary caregivers’ indifference ($\beta = .37, p = .006$) significantly and independently predicted youth anxiety symptoms, accounting for 26% of the variance. Primary caregivers’ past acceptance ($\beta = -.41, p = .007$) significantly predicted internalizing problems, accounting for 17% of the variance. Sibling acceptance did not significantly predict youth externalizing problems. A logistic regression determined the effect of sib-

Table 1
Family Acceptance-Rejection Correlations

| Family acceptance-rejection ratings | Depressive symptoms (CDI) | Anxiety symptoms (RCMAS) | Internalizing problems (YSR) | Externalizing problems (YSR) | Thinks suicide (YSR) |
|-------------------------------------|----------------------------|----------------------------|------------------------------|------------------------------|----------------------------|
| Primary caregiver | | | | | |
| Current acceptance | -.02 ($N = 51$) | .07 ($N = 53$) | .08 ($N = 46$) | -.06 ($N = 46$) | -.02 ($N = 47$) |
| Past acceptance | -.38** ($N = 47$) | -.37** ($N = 49$) | -.46** ($N = 42$) | -.28 ($N = 42$) | .01 ($N = 43$) |
| Warmth | -.24 ($N = 51$) | -.11 ($N = 53$) | -.14 ($N = 46$) | -.11 ($N = 46$) | -.07 ($N = 47$) |
| Hostility | .02 ($N = 51$) | -.22 ($N = 53$) | -.05 ($N = 46$) | -.14 ($N = 46$) | -.08 ($N = 47$) |
| Indifference | -.09 ($N = 51$) | -.13 ($N = 53$) | -.09 ($N = 46$) | .10 ($N = 46$) | -.08 ($N = 47$) |
| Undifferentiated rejection | .18 ($N = 51$) | .01 ($N = 53$) | .13 ($N = 46$) | .05 ($N = 46$) | .13 ($N = 47$) |
| Secondary caregiver | | | | | |
| Current acceptance | -.04 ($N = 49$) | .08 ($N = 51$) | .14 ($N = 44$) | -.06 ($N = 44$) | .02 ($N = 45$) |
| Past acceptance | -.05 ($N = 45$) | -.13 ($N = 47$) | -.11 ($N = 40$) | -.04 ($N = 40$) | .02 ($N = 41$) |
| Warmth | -.15 ($N = 49$) | -.04 ($N = 51$) | -.01 ($N = 44$) | -.03 ($N = 44$) | -.03 ($N = 45$) |
| Hostility | -.19 ($N = 49$) | -.30 ($N = 51$) | -.20 ($N = 44$) | -.20 ($N = 44$) | -.21 ($N = 45$) |
| Indifference | .38** ($N = 49$) | .35* ($N = 51$) | .19 ($N = 44$) | .32 ($N = 44$) | .21 ($N = 45$) |
| Undifferentiated rejection | .13 ($N = 49$) | .01 ($N = 51$) | .06 ($N = 44$) | -.01 ($N = 44$) | .11 ($N = 45$) |
| Sibling | | | | | |
| Acceptance | -.31 ($N = 32$) | -.09 ($N = 34$) | -.13 ($N = 28$) | -.52** ($N = 28$) | -.51** ($N = 29$) |

Note. A Bonferroni cutoff of .01 was used to account for multiple hypothesis testing. Bold text indicates a statistically significant correlation with a p -value less than .01 or a marginally significant correlation with a p -value equal to .013. * $p = .013$ (marginally significant). ** $p < .01$.

Table 2
Multiple Regression: Variance in Depression and Anxiety Explained by Acceptance Variables

| Variable | Depressive symptoms (CDI) | | | Anxiety symptoms (RCMAS) | | | Internalizing symptoms (YSR) | | | Externalizing symptoms (YSR) | | |
|-----------------------------------|---------------------------|-----------------|---------|--------------------------|-----------------|---------|------------------------------|-----------------|---------|------------------------------|--------------|---------|
| | B (SE) | 95% CI | β | B (SE) | 95% CI | β | B (SE) | 95% CI | β | B (SE) | 95% CI | β |
| Primary caregiver past acceptance | -6.30 (2.62) | [-11.58, -1.02] | -.31* | -6.30 (2.62) | [-11.58, -1.02] | -.31* | -9.24 (5.25) | [-15.83, -2.66] | -.41* | | | |
| Secondary caregiver indifference | 9.55 (2.68) | [4.15, 14.95] | .46* | 9.55 (2.68) | [4.15, 14.95] | .46* | | | | | | |
| Sibling acceptance | | | | | | | | | | -4.64 (2.32) | [-9.40, .13] | -.31 |
| R ² | | .31 | | | .31 | | | .17 | | | .13 | |
| F | | 9.31* | | | 9.31* | | | 8.05* | | | 4.00 | |

Note. A Bonferroni cutoff of .025 was used to account for multiple hypothesis testing.
* $p < .025$.

ling acceptance on the likelihood of youth suicidal ideation. The model was significant, $\chi^2(1) = 4.6, p = .03$, explained 30% of the variance in suicidal ideation, and correctly classified 79.3% of cases. Increased sibling acceptance was associated with a decreased likelihood (OR = .2) of suicidal ideation.

Discussion

This preliminary study was designed to inform future research by identifying specific aspects of family acceptance and rejection that may be relevant to psychological adjustment in transgender youth. Findings provide further evidence that family acceptance and rejection play an important role in the psychosocial adjustment of transgender youth, and support the applicability of IPARTheory (Rohner & Lansford, 2017) to transgender youth. Generally, lower acceptance (in primary caregivers and siblings) and higher indifference (in secondary caregivers) were significantly related to negative psychosocial outcomes (e.g., depressive symptoms, anxiety symptoms, internalizing problems, externalizing problems) in transgender youth. New to the existing literature are the findings that caregiver indifference and sibling acceptance (independent of caregiver acceptance and rejection) are associated with mental health outcomes in transgender youth, supporting the need for a family systems approach to research and care.

The relationship between higher secondary caregiver indifference and increased transgender youth depressive and anxiety symptoms highlights the importance of considering not just extreme examples of acceptance and rejection but also subtler or more passive forms of rejection. Previous research on family rejection in transgender youth has primarily focused on behaviors consistent with the hostility domain of rejection (e.g., James et al., 2016), however, the current findings suggest that caregiver indifference may also negatively impact youth mental health. Caregivers express indifference through ignoring their child's gender identity, deferring to the other caregiver on gender-related decisions, not seeking out information to increase their own understanding of gender issues, and not helping their child to get their gender-related needs met. When transgender individuals experience family boundary ambigui-

ity (i.e., uncertainty about family membership, family relationships, and when/how to express their transgender identity), this can lead to psychological distress (Catalpa & McGuire, 2018), and caregiver indifference may trigger similar feelings of uncertainty and distress. Alternatively, when caregivers advocate for their child's gender-related rights, transgender youth perceive this as accepting (Hidalgo et al., 2017). Thus, clinicians may need to emphasize with caregivers the importance of active acceptance and engagement in proactive support, rather than passive neutrality. Appropriate clinical strategies may include psychoeducation on the potentially negative influence of caregiver indifference, motivational interviewing to encourage increased involvement, and collaborative brainstorming to identify ideas for caregiver involvement that are consistent with their values and current understanding/acceptance of youth's gender. In addition, direct therapeutic work with youth can help them further understand family dynamics, problem-solve, and develop adaptive coping skills, especially in the unfortunate circumstance when one or more caregivers are unavailable or not amenable to change.

Although the relationships between transgender youth and their siblings have received limited attention in research, the observed association between lower sibling acceptance and increased youth suicidal ideation suggests that sibling relationships warrant additional focus. Some transgender youth report that discrimination can trigger negative or suicidal thoughts (e.g., worthlessness, lack of control) or the urge to engage self-injurious behavior as a way to cope (McDermott, Roen, & Piela, 2015). Transgender youth may experience similar feelings and urges in response to sibling rejection. This finding suggests that it may be important for therapeutic interventions to encompass all family members and that intervening to enhance sibling closeness and acceptance may prove to help buffer transgender youth from some mental health morbidities. Although warranting further investigation, speculatively, in a rejecting caregiver environment, the role of sibling acceptance may prove even more important. The scope of this paper did not allow an examination of sibling experiences and perspectives directly, and this can also provide a meaningful area for future empirical study.

Almost all transgender youth in the current sample had a primary caregiver that loved/cared about them (warmth domain). Importantly, at least one caregiver chose to take their child to a gender clinic for psychological evaluation at a time when medical intervention for transgender youth was not widely studied or widely available. Thus, these families likely differ from other families on factors related to treatment-seeking, and may be more likely to have at least one supportive caregiver in the home. Primary caregivers were rated significantly higher on warmth than secondary caregivers. This aligns with previous findings that in general populations, mothers tend to be higher in warmth than fathers (Putnick et al., 2012), as in the present study primary caregivers were primarily mothers and secondary caregivers were primarily fathers. Primary and secondary caregivers did not differ significantly on how accepting of the youth's gender identity they were in the past, however, primary caregivers demonstrated significantly higher current acceptance than secondary caregivers. These findings may suggest that primary and secondary caregivers approach parenting a transgender child in different ways, which could influence their acceptance over time.

Several limitations of the present study should be noted. This study did not examine similar factors in a control group of age-matched cisgender youth and therefore we do not know if our findings are specific to transgender youth or generalizable to all similar age adolescents. As previously observed, participants and their families may differ from the larger population of transgender youth due to the fact that at least one parent supported their effort to seek medical intervention at a gender clinic, perhaps reflecting greater family support than represented in the broader transgender youth community. Future research should be conducted with larger more diverse samples, given that family factors such as ethnicity, religious-affiliation, and socioeconomic status may influence family acceptance. Data were collected during a time-limited clinical appointment, and although the clinical interview followed a semistructured template, the purpose of the interview was entirely clinical in nature. In other words, the template was not designed as part of a research study and therefore the data collection did not follow a rigorous method-

ological research protocol, and may have changed in subtle ways over time from 2007 to 2011. In this study, time spent exploring the details of acceptance and rejection by each family member likely varied across patients/clinical interviews (e.g., the depth in which youth and caregivers were queried about sibling relationships varied from patient to patient). Although information about siblings was available, it was more limited than information related to caregiver acceptance. Additionally, the coding system was used solely for the purpose of this exploratory study, and is not a measure that has been tested for reliability or validity. This coding system relied on one psychologist's standard of care clinic interview summaries, which may have varied somewhat across participants and time. Although speculative, it is also possible that this psychologist held unknown implicit beliefs or assumptions that systematically impacted available clinical data, whether related to youth age, family SES, or racial, ethnic, gender or other matters. Nonetheless, the current preliminary findings can be used to inform the development of reliable and valid self-report measures of family member gender-related acceptance and rejection.

Findings provide further evidence that family acceptance-rejection plays an important role in the psychosocial adjustment of transgender youth, and support the need for increased clinical and research attention to less extreme examples of acceptance-rejection (e.g., indifference) across multiple family members (e.g., siblings). Future research should build upon these findings by systematically collecting data on transgender youth's relationships across family members in order to inform a more nuanced understanding of how family relationships serve as protective and risk factors. Continued research is needed to understand the cumulative impact of acceptance-rejection from multiple family members, the factors that influence sibling relationships (e.g., birth order, number of siblings, developmental stages), as well as how clinicians can best support families of transgender youth to promote acceptance and resiliency.

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