Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

Using Latent Profile Analysis to Understand Caregiver Response to Their Rainbow Children in Aotearoa New Zealand

A thesis presented in partial fulfilment of the

requirements for the degree of

Master of Arts

in

Psychology

at Massey University, Distance,

Aotearoa New Zealand.

Andrina Anne Westerbaan

2025

Abstract

Parent and primary caregiver acceptance, rejection or a combination of acceptance and rejection of a child with a rainbow/LGBTQIA+ identity is influential in either reducing or contributing to poor health and well-being outcomes experienced by young rainbow people. Considering the persistent health and well-being disparities experienced by rainbow people and the influence of parent and caregiver response on their rainbow children, there is a need to better understand this nuanced group of parents and caregivers. This cross-sectional study replicated the work of Clark et al. (2022) who proposed that parents with rainbow children could be classified into three groups based on response to their rainbow child. It is unclear if the same classifications apply to Aotearoa New Zealand's unique cultural context. Online survey responses from parents and caregivers (N = 140) living in Aotearoa New Zealand, with at least one rainbow identifying child under 30 years of age, was collected to clarify whether the same three classes exist. Descriptive statistics were run using SPSS. Latent profile analysis was run using tidyLPA and mclust in R Studio to identify parent and caregiver response classes, of which two were found: positive (n = 120, 85.71%) and mixed (n = 20, 14.29%). An examination of the differences between response class, demographics, time since and age at initial rainbow identity disclosure, caregiver attachment style, parenting style, religiosity and ethnic group acceptance were conducted using SPSS. Significant differences were detected between response classes based on participant gender identity, ethnicity, relationship to their rainbow child, parenting style, and religiosity. Results indicate that there is a distinct group of parents and caregivers in Aotearoa New Zealand who may benefit from additional support in addressing conflicting responses towards their rainbow child so that they can become a safer and more encouraging support for their rainbow child.

Keywords: LGTBQIA+, parenting, rainbow child, latent class analysis

Acknowledgements

This thesis would not be in existence today without the unwavering support of my team and the participants who shared their experiences and thoughts with me. Thank you all!

Dr Ilana Seagar van Dyk, my supervisor and mentor, thank you. Your encouragement, knowledge, wisdom and sense of fun always impress me and have made this project enjoyable and manageable. I am forever appreciative of how you make the insurmountable feel attainable.

Members of the PRIDE lab at Massey University, your advice, support, recommendations, and shared experiences have inspired and helped me more than you may ever realise. You are all such kind and loving people, and I am so grateful to know you. Special thanks to Grey and Tyler for being part of the Raising Rainbows project; it's been a pleasure to work alongside you both and bask in your wisdom, knowledge, compassion, and curiosity.

My friends, particularly Adele, Ashley, Evelyn, Kylie, Leanne, and Wendy, thank you for keeping me sane while I embarked on this adventure. Your messages of support and encouragement, brief catchups, and constant belief in me has made such a difference. Leanne, my sincerest appreciation for the numerous times you have read this thesis to help me catch any errors (if any exist, they are completely my own).

Last but not least, my whānau. Mum, Dad, Lance, Hayden, and Ryan thank you for raising me to recognise the importance of, and value in, whānau. My greater whānau, especially Aunty Lyn, Aunty Elaine, Amanda, Amy, Kieren, and Melissa, thank you for making me smile and for just being there. Ezekiel, Ammon, and Zara, external pieces of my heart, without you I would not be a mum. Thank you for your sacrifice in allowing me to prioritise this research when at times it may have been inconvenient. Ramon, when words fail to express what is felt often simple and sincere is best, so … thank you, mi tesoro!

Table of Contents

Abstract ii

Acknowledgements iii

Table of Contents iv

List of Tables ix

List of Figures x

Abbreviation List xi

Note on Language xii

Chapter One: Introduction 1

Chapter Two: Literature Review 4

2.1 Health and Well-being Disparities Experienced by Rainbow Populations 4

2.2 Minority Stress Theory 7

2.2.1 What is Minority Stress? 7

2.2.2 Minority Stress and Rainbow Groups 9

2.3 Caregiver Responses to Their Rainbow-Identifying Child 13

2.3.1 Negative Caregiver Responses 13

2.3.2 Positive Caregiver Responses 14

2.3.3 Mixed Caregiver Responses 15

2.4 Chrisler's Conceptualisation of Caregiver Response to Their Rainbow Child 15

2.5 Clark et al. (2022) Study of Caregiver Responses to Their Rainbow Children 18

2.6 Present Study 19

2.6.1 Replication 19

2.6.2 Caregivers in Aotearoa New Zealand 21
2.6.3 The Influence of Time and Age on Caregiver Response 22
2.6.4 Characteristic Differences Across Caregiver Response Classes 24
2.6.5 Current Study Hypotheses 32
Chapter Three: Materials and Method 35
3.1 Research Design 35
3.2 Recruitment and Data Collection 35
3.3 Participants 37
3.3.1 Participant Demographics 38
3.3.2 Caregiving Demographics 38
3.4 Measures 39
3.4.1 General Demographics 40
3.4.2 Caregiving Demographics 41
3.4.3 Parent Response Indicators 42
3.4.4 Time and Age Since Rainbow Identity Disclosure 42
3.4.5 Child's Rainbow Identity 43
3.4.6 Caregiver Attachment Style 43
3.4.7 Parenting Practices Questionnaire 45
3.4.8 Caregiver Perceived Religious Acceptance of Rainbow People 46
3.4.9 Caregiver Perceived Ethnic Acceptance of Rainbow People 46
3.4.10 Other Measures 47

3.5 Procedure 47

3.6 Ethics 48

3.6.1 Whakapapa (Relationships) 49

3.6.2 Tika (Validity of the Research) 50

3.6.3 Manākitanga (Cultural and Social Responsibility and Respect for Persons) 50

3.6.4 Mana (Equity and Justice) 52

3.8 Data Analysis 53

Chapter Four: Results 56

4.1 Latent Profile Analysis of Caregiver Response to Their Rainbow Child (H1) 56

4.1.1 Differences in General Demographics Based on Caregiver Response Class Membership 57

4.1.2 Differences in Caregiving Demographics Based on Caregiver Response Class Membership 60

4.2 Differences in Time and Age Based on Caregiver Response Class Membership 62

4.2.1 Time Since Initial Disclosure of a Child's Rainbow Identity and Caregiver Response Class Membership (H2a) 62

4.2.2 Caregivers' Age at Initial Disclosure of Their Child's Rainbow Identity and Caregiver Response Class Membership (H2b) 63

4.2.3 Child's Age at Initial Disclosure of Their Rainbow Identity and Caregiver Response Class Membership (H2c) 64

4.3 Differences in Characteristics of Interest Based on Caregiver Response Class Membership 65

4.3.1 Child's Rainbow Group Identity and Caregiver Response Class Membership (H3a) 65

4.3.2 Caregiver Attachment Style and Caregiver Response Class Membership (H3b) ... 66

4.3.3 Caregiver Parenting Style and Caregiver Response Class Membership (H3c) 68

4.3.4 Caregiver Religiosity, Perceived Religious Acceptance, and Caregiver Response Class Membership (H3d) 69

4.3.5 Caregiver Perceived Ethnic Acceptance and Caregiver Response Class Membership (H3e) 70

Chapter Five: Discussion 71

5.1 Caregiver Response Classes (H1) 71

5.1.1 General Demographics and Caregiver Response Class 73

5.1.2 Caregiving Demographics and Caregiver Response Class 74

5.2 Time, Age, and Caregiver Response Class (H2) 76

5.3 Caregiver Characteristics of Interest and Caregiver Response Class 76

5.3.1 A Child's Rainbow Identity Group and Caregiver Response Class (H3a) 76

5.3.2 Caregiver Attachment Style and Caregiver Response Class (H3b) 78

5.3.3 Caregiver Parenting Style and Caregiver Response Class (H3c) 79

5.3.4 Caregiver Religiosity, Perceived Religious Acceptance and Caregiver Reponse Class (H3d) 80

5.3.5 Caregiver Perceived Ethnic Acceptance and Caregiver Response Class (H3e) 81

5.4 Implications 81

5.5 Future Directions 83

5.6 Strengths and Limitations 84

Chapter Six: Conclusion 87

References 89

Appendices 138

Appendix A: Te Reo Māori Ngā Whakamarama (Glossary) 138

Appendix B: Email Sent to Groups to Recruit Participants 140

Appendix C: Recruitment Flyers 142

Appendix D: Information Sheet 145

Appendix E: Survey 149

Appendix F: Three, Four, and Five-Class Models 160

List of Tables

Table 1. *General Demographics by Caregiver Response Class* 116

Table 2. *Caregiving Demographics by Caregiver Response Class* 120

Table 3. *Descriptive Statistics and Cronbach's Alpha for Variables of Interest* 124

Table 4. *Latent Profile Analysis Fit Criteria* 125

Table 5. *Mean Responses and Standard Deviations of the Parent Response Indicators by Caregiver Response Class* 126

Table 6. *Time and Age by Caregiver Response Class* 128

Table 7. *Comparison of Child's Age at Initial Disclosure and Rainbow Group Identity by Caregiver Response Class* 129

Table 8. *Characteristics of Interest by Caregiver Response Class* 130

Table 9. *Caregiver Attachment Style Means by Caregiver Response Class* 133

Table 10. *Caregiver Parenting Style Means by Caregiver Response Class* 134

List of Figures

Figure 1. *An Adapted Minority Stress Model Showing the Potential Impact of Caregiver Response on Their Rainbow Child's Health and Well-Being*.....135

Figure 2. *Two-Class Model of Latent Profiles of Caregiver Response to Their Rainbow Children* 137

Abbreviation List

AIC	Akaike information criteria
ANZ	Aotearoa New Zealand
ASQ	Attachment style questionnaire – short form
BIC	Bayesian information criteria
BLRT	Bootstrapped likelihood ratio test
EPCR	Experiences in parent-child relationship questionnaire
GLBQ	Gay, lesbian, bisexual, and queer or questioning
LGB	Lesbian, gay, and bisexual
LGBT	Lesbian, gay, bisexual, and transgender
LGBTQ	Lesbian, gay, bisexual, transgender, and queer
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other non-heterosexual or non-cisgender identities.
PRI	Parent response indicators
PRIDE	Program for Research on Identity, Development and Emotional well-being (psychology research lab based at Massey University)
PPQ	Parenting practices questionnaire
SABIC	Sample size adjusted Bayesian information criteria
US	the United States of America

Note on Language

Rainbow is an umbrella term referring to any sexual orientation or gender identity that differs from dominant norms of heterosexuality and cissexism, such as takatāpui, lesbian, gay, bisexual, asexual, transgender, queer, non-binary, gender fluid, intersex, and other non-heterosexual and non-cisgender identities (InsideOUT, 2020; New Zealand Government, 2024)[1]. The term heterosexual refers to an individual who is attracted to someone of a gender different to their own (e.g., a woman attracted to a man or a man attracted to a woman), and cisgender refers to an individual whose gender (e.g., woman) aligns with their sex assigned at birth (e.g., female; InsideOUT, 2020; New Zealand Government, 2024).

In some groups the constructs of sexuality, sex, and gender are often confused or conflated. In this thesis, the terms *sexuality* or *sexual orientation* refer to an individual's "emotional, romantic, and sexual attraction, identity, and behaviour" (McCoy et al., 2024, p. 1350), whereas *sex* would refer to an individual's anatomic, genetic, hormonal, and physiological traits (McCoy et al., 2024). The term *gender* will refer to both gender identity and gender expression. More specifically, gender identity refers to one's sense of self as being a woman or man or neither, or both (McCoy et al., 2024; Tasker & Wren, 2002). Gender identity develops much earlier than sexual identity development, which typically occurs during adolescence (Abreu et al., 2019; de Bres, 2022; Deardorff et al., 2019; Maccoby, 2000; Pachankis et al., 2020; Sunny & Deb, 2021). Based on cognitive child development theories, gender identity is generally understood by three years of age (Maccoby, 2000; Mallon & DeCrescenzo, 2006; Sunny & Deb, 2021). Gender is expressed

[1] In this thesis, the term *rainbow* will be used to describe all non-heterosexual and non-cisgender samples and research findings unless the research being reviewed focuses on a specific sub-group of rainbow communities. Where a specific sub-group is used, the language of the original study will be used instead (e.g., "LGB", "trans").

through the range of appearance preferences, interests, behaviours, and mannerisms in which an individual engages (McCoy et al., 2024).

Chapter One: Introduction

He tangi to te Tamariki, he whakamā to te pakeke.

The cry of the child is the shame of the adult.

Persistent and disproportionate disparities in health and well-being outcomes between rainbow/LGBTQIA+ and non-rainbow people continue to be a concern. Several theories have been utilised to understand and address these disparities. Bronfenbrenner's (1977) ecological systems theory highlights the importance of considering the context of rainbow people when examining these disparities. Minority stress theory is one theory which includes a consideration of an individual's context. Minority stress theory posits that people with rainbow identities experience additional stressors related to their minority identity which can be proximal and stem from internalised concerns (e.g., worry about other people knowing about one's rainbow identity) and/or distal which are often based on external events (e.g., a child being excluded because of their rainbow identity; Brooks, 1981; Meyer, 2003/2013).

Parents and other types of primary caregivers of rainbow children respond to their child and their child's rainbow identity in a variety of ways, which can either help or hinder the child. Some responses are positive and supportive, while others are negative and rejecting (Rosario & Schrimshaw, 2013; Ryan 2009; Seager van Dyk et al., 2022). Regardless of the type of behaviour, all responses have an impact on the child and can reduce or increase a child's risk of engaging in risky behaviours and/or experiencing poor health and well-being outcomes (Bosse, Clark et al., 2024; Bosse, Katz-Wise et al., 2024; Ryan, 2009; Willoughby et al., 2010). As the above whakataukī (proverb)[2] infers, it is vital that parents and caregivers

[2] Te reo Māori terms used throughout this thesis will in the first instance include an English translation in parentheses. A glossary of these terms can also be found in Appendix A.

support, nurture, respect and meet the needs of their children. Where minority stress theory considers the rainbow individuals context, Chrisler's (2017) conceptualisation of parent responses to their rainbow child considers the parent's context (e.g., attitudes, beliefs, and experiences) as a determining factor in how a parent or caregiver[3] responds to their child's rainbow identity.

A recent study conducted in the United States (US) identified three parent typologies based on parent responses to their rainbow child and examined correlations between parent typology and rainbow child mental health difficulties (e.g., anxiety and depression) and concerning behaviours (e.g., substance misuse and bullying; Clark et al., 2022). The study found that parent response class membership was associated with recent mental health and social difficulties experienced by the rainbow child. The ability to identify parents and caregivers who struggle to accept their child's rainbow identity is crucial, as it could help to identify parents who require greater support in accepting their child's rainbow identity. However, we don't know if these results apply outside the US context.

This study is therefore a direct replication of Clark et al.'s (2022) work using a sample of caregivers with rainbow children who live in Aotearoa New Zealand (ANZ). As caregivers are so influential, better understanding their response to their rainbow children may encourage greater acceptance and could be an effective way to provide indirect support through caregivers, alongside more direct initiatives and interventions. Caregivers in ANZ vary greatly as individuals, so it is pertinent to analyse differences and similarities between caregiver response and various caregiver characteristics. Potential insights may extend current knowledge and provide key points of difference in levels of support and acceptance of rainbow rangatahi (youth) in ANZ.

[3] Throughout the remainder of this thesis, the term *caregiver* will refer to any adult who is responsible for the daily care of any child/children regardless of biology. However, if a specific term (e.g., "parent", "mother") is used in a particular text being referred to, the original term will be used instead.

The rest of this thesis is set out as follows: In Chapter Two, an in-depth examination of scholarly literature concerning caregiver responses to rainbow children and potential differences between caregiver and their responses will be presented. Chapter Three elaborates on the research methodology and design employed to investigate caregiver response to their rainbow child and assess difference between caregiver response classes. In Chapter Four, the results of the data collected and analysed are presented. Chapter Five discusses the findings of this study, interpreting their implications and relevance, and suggesting future research directions. Lastly, Chapter Six provides a summary of the study, including the persistent concern being addressed, the current studies outcomes and its relevance.

Chapter Two: Literature Review

2.1 Health and Well-being Disparities Experienced by Rainbow Populations

Consistent findings over the last four decades and across numerous studies report higher rates of mental health problems and poorer well-being outcomes amongst rainbow individuals compared to their heterosexual and cisgender peers (e.g., Abreu et al., 2019; Atkinson et al., 1988; Bidell, 2014; Chakraborty et al., 2011; Cochran et al., 2003; D'Augelli, 1993; Demant et al., 2016; Fergusson et al., 1999, 2005; Gilman et al., 2001; Gonsiorek, 1988; Lucassen et al., 2011, 2014, 2017; Nurius, 1983; Plöderl & Tremblay, 2015; Rothblum, 1994; Ryan, 2009; Shilo & Savaya, 2012; Tan, Schmidt, et al., 2022; Tan, Wilson, et al., 2022). Most often, these studies have focused on depressive symptoms and mood disorders, anxiety-related disorders, suicidal behaviours and ideation, self-harm, and substance use. For example, depressive symptoms or moods disorders are up to three times more likely to be experienced by rainbow adolescents (Lucassen et al., 2017), lesbian and bisexual women (Gilman et al., 2001), and gay and bisexual men (Cochran et al., 2003), compared to their heterosexual peers. Another study reported significantly higher rates of anxiety disorders amongst both those who identify as predominantly gay (33% for women and 69.2% for men) and predominantly heterosexuals (26.9% for women and 32.7% for men) compared to exclusively heterosexual women (21.6%) and men (9.5%; Fergusson et al., 2005). Furthermore, self-harm and suicide are more often considered by young rainbow people over the age of 15 than their heterosexual and cisgender peers (22% vs 5%; Tan, Wilson, et al., 2022), and young sexual minority (e.g., lesbian, gay, bisexual) individuals (16-35 years) were found to exhibit significantly higher rates of illicit substance use compared to their heterosexual peers (Demant et al., 2016).

Mental health and well-being disparities between these populations can begin to be understood through Bronfenbrenner's (1977) ecological systems theory, as individuals do not

develop, nor exist, in complete isolation. Although the original model was proposed over fifty years ago, Bronfenbrenner's pivotal theory continues to be utilised as a foundation for examining the influence that factors, beyond the individual, have on development and various outcomes throughout a lifetime (e.g., Bidell, 2014; MacMullin, 2023; Noursi et al., 2021; Tudge et al., 2009; Veldhuis, 2022). The emphasis on how the interrelated systems potentially influence the development of, and outcomes for, an individual was a determining factor in its inclusion within this study.

According to the ecological systems theory, an individual's experience can be understood by examining the dynamic interactions between the interconnected environmental systems in which the individual exists (Bidell, 2014; Bronfenbrenner, 1977; MacMullin, 2023; Noursi et al., 2021; Veldhuis, 2022). There are five systems: microsystem, mesosystem, exosystem, macrosystem, and chronosystem.

Microsystems encompass an individual's immediate environment (Bronfenbrenner, 1977). Affirming and supporting interactions with whānau can significantly enhance well-being, while rejecting interactions typically increases the risk for adverse health and well-being outcomes. For example, a transmasculine adolescent may develop pride in his rainbow identity and greater confidence (enhanced well-being) if his caregiver (a microsystem) supports and affirms his choices in how he dresses and does his hair. Conversely, a lesbian girl who regularly hears her caregiver voice homophobic comments may withdraw from her caregiver and find her self-esteem declining as she internalises these homophobic beliefs (adverse well-being outcomes; Ryan et al., 2009; Shrader et al., 2024).

Mesosystems are the interactions that occur between various microsystems (Bronfenbrenner, 1977). For example, the interactions between a gender-fluid child's caregiver (a microsystem), friends and school (other microsystems). These interactions may be positive and enhance well-being (e.g., when a caregiver advocates for their child at school

for more inclusive school activities), or negative and increase the risk of adverse mental health and well-being outcomes (e.g., refusing to welcome their child's rainbow friends into the whānau home).

Exosystems do not directly involve, but indirectly influence, the individual (Bronfenbrenner, 1977). These may include a caregiver's workplace and local community services. For example, a young bisexual adult might experience increased support (an indirect effect) from their caregiver if that caregiver attends a local support group for parents with rainbow children (an exosystem).

Macrosystems refer to broader cultural, societal and legal contexts that shape the environment in which a rainbow child lives (Bronfenbrenner, 1977). For example, a lesbian adolescent may feel validated and more secure as she grows up seeing more positive representations of lesbians in the media (a macrosystem). While positive and protective legislation attempts to empower rainbow individuals, groups, and whānau of rainbow children to advocate for, attain equal rights, and foster greater societal acceptance, legislative change does not automatically result in societal change (Betts, 2020). For instance, in ANZ, the Homosexual Law Reform Act (1986), decriminalised consensual sexual relations between men over the age of 16, providing greater legisative protection (at the time) for gay men, yet many continued to experience discrimination for several decades (Betts, 2020).

The chronosystem refers to the dimension of time, including changes in societal attitude towards rainbow people, major global events such as COVID-19, and milestones such as completing university studies (Bronfenbrenner, 1977; MacMullin, 2023; Veldhuis, 2022). Individuals are at the centre of all these systems, each broader than the previous. Every system interacts reciprocally with the others, meaning an individual's behaviour and experiences both influence, and are influenced by, these interconnected systems (Bronfenbrenner, 1977; Noursi et al., 2021).

An ecological systems lens highlights the importance of context. Ecological systems theory is helpful for examining both the impact of a caregiver and their rainbow child, as interactions between systems encompassing each individual impacts the development and well-being of each other (Chrisler, 2017). Thus, a framework to examine particular system interactions helps to better understand the rainbow mental health and well-being disparities that continue to exist, specifically within the context of systems beyond the rainbow individual.

2.2 Minority Stress Theory

2.2.1 What is Minority Stress?

Minority stress theory is an effective framework for examining more closely the interactions between various systems, which too often result in the disparities in health and well-being evident between rainbow and heterosexual and cisgender populations. Minority stress theory posits that negative health and well-being outcomes are the product of the additional stress that rainbow people experience due to "stigmatized social status" (Frost & Meyer, 2023, p. 1), which heterosexual and cisgender individuals do not experience. Typically, the cause of minority stress is categorised as either distal or proximal stressors, with both arising from stigma and prejudice (Brooks, 1981; Frost et al., 2022; Frost & Meyer, 2023; Hendricks & Testa, 2012; Meyer, 2003/2013).

Distal stressors refer to objective causes of stress related to rainbow identification, which originates in systems beyond the individual (Frost & Meyer, 2023; Meyer, 2003/2013). Distal stressors may include exclusion from whānau gatherings, the withdrawal of parent or caregiver affection, or homelessness because of one's rainbow identity (Robinson, 2018; Ryan, 2009).

Proximal stressors are internalised subjective causes of stress related to one's rainbow identity and vary according to an individual's appraisal of, and response to, distal stressors

(Frost & Meyer, 2023; Meyer, 2003/2013). Proximal stressors include internalised stigma (e.g., rejecting one's self for being rainbow; Ryan et al., 2009; Shrader et al., 2024), expectations of rejection due to an awareness of social stigma, and identity concealment, which may be protective at times but also limits potential sources of support and affirmation (Frost & Meyer, 2023).

Together, stigmatised social status and distal and proximal stressors, alongside the general everyday life stress which everyone experiences, can result in an "excess stress burden" (Frost & Meyer, 2023, p. 2). A plethora of research has found that excessive and/or prolonged stress has a significantly negative impact on an individual's health and well-being (e.g., McEwen, 1998; O'Connor et al., 2021; Selye, 1950). The increased stress burden experienced by those with a rainbow identity can lead to, and helps explain (Frost & Meyer, 2023; Meyer, 2003/2013), the elevated risks of experiencing adverse health and well-being outcomes among rainbow people as evident in global and local studies (see Figure 1; e.g., Abreu et al., 2019; Bidell, 2014; D'Augelli, 1993; Lucassen et al., 2017; Plöderl & Tremblay, 2015; Tan et al., 2022).

However, the accumulation of stress and stigmatised social status does not always result in negative health and well-being outcomes. Minority stress proponents and numerous studies suggest that a rainbow individual's coping abilities and social support moderate health and well-being outcomes (Abreu et al., 2019, 2022, 2023; D'Amico et al., 2015; D'Augelli, 2002; de Bres & Morrison-Young, 2023; Frost et al., 2022; Meyer, 2003/2013; Morgan et al., 2024; Ryan et al., 2010; Seager van Dyk et al., 2022). For example, Ryan and colleagues (2010) found that higher levels of whānau acceptance were associated with greater self-esteem, social support and general health, and lower rates of depression, suicidal ideation and attempts, and risky sexual behaviours amongst lesbian, gay, bisexual, and transgender (LGBT) young adults.

2.2.2 Minority Stress and Rainbow Groups

The minority stress theory was originally developed to explain the experiences of lesbian women (Brooks, 1981). This theory has been adapted and often applied in studies which focus on sexual minorities (e.g., Demant et al., 2016; Meyer, 2003/2013; Shilo & Savaya, 2012). However, people with a rainbow identify are a heterogenous group with varying experiences and unique stressors (Henricks & Testa, 2012). Ignoring these differences by focusing on only one group (e.g., bisexuals) or employing measures which exclude some groups, yet referring to the whole rainbow community, may present inaccurate results (Suen et al., 2020).

Growing research suggests that the experiences of gender minorities often differ substantially from those of sexual minorities (e.g., Abreu et al., 2019; Hendricks & Testa, 2012; Smalley et al., 2016; Su et al., 2016). For example, a US study found that transgender women have higher rates of anxiety and stress, and experienced severe to extremely severe depression compared cisgender lesbians, cisgender gay males, cisgender bisexuals, and transgender men (Smalley et al., 2016). In another US study, transgender and other gender minority adults were found to have a greater likelihood of experiencing discrimination, depressive symptoms and attempting suicide than their sexual minority peers (Su et al., 2016).

The minority stress model has been adapted to more specifically explain the unique stressors gender minorities face and the resulting disparities experienced by these rainbow subgroups (Frost & Meyer, 2023; Hendricks & Testa, 2012). Like the minority stress model, the adapted gender minority stress model posits that a greater incidence of negative health and well-being outcomes is a direct result of the stress experienced because of one's gender minority identity (Hendricks & Testa, 2012; Hunter et al., 2021). According to research conducted in the US, gender minority adolescents who exhibited higher levels of internalised

transphobia (a proximal stressor) were more prone to meeting diagnostic criteria for major depressive disorder and generalised anxiety disorder (Chodzen et al., 2019). In the same study, those who had lower levels of congruence between their gender identity and appearance (prominence of one's minority identity) were even more likely to meet diagnostic criteria for major depressive disorder than those with higher levels of congruent gender identity appearance (Chodzen et al., 2019).

Gender minority stressors act as barriers which limit access to, and engagement with, healthcare services, thus leading to poorer health and well-being outcomes (Glick et al., 2018; Hendricks & Testa, 2012). For instance, a study exploring healthcare postponement found transfeminine individuals who anticipated and previously experienced discrimination (a distal stressor) in either healthcare or non-healthcare settings were 20 times more likely to delay seeking care compared to those who did not anticipate or had not experienced previous discrimination (Glick et al., 2018). A study in the United Kingdom found that the devaluation of gender identity, encounters with transphobia, and strained interpersonal relationships all contributed to increased risk of self-harm amongst transgender adolescents (Arcelus et al., 2016). Reluctance to engage with, or being prevented from accessing, appropriate and affirming healthcare is one of the unique stressors mentioned earlier (de Bres & Morrison-Young, 2023; Glick et al., 2018).

Another unique stressor faced by gender minorities is being in the political spotlight. Controversial reports (e.g., the UK's Cass Review; Cass, 2024; Horton, 2024), anti-trans legislation (e.g., bathroom bills which base access on sex assigned at birth; Schanzle et al., 2023), and anti-trans societal sentiments and disinformation (Carroll, 2024; Elischberger, 2024; Horton, 2024) are sadly increasing. These unique and specific gender minority stressors negatively impact transgender and other gender diverse people and has been linked

with the increased victimisation and suicidality of gender minority young people (Schanzle et al., 2023).

As gender identity occurs and expression is visible early in life, it is reasonable that many stressors experienced by gender minorities differ to those experienced by sexual minorities (Savin-Williams, 2001). Furthermore, some stressors may be experienced by both sexual and gender minority individuals, yet each group may experience these stressors differently based on their specific rainbow identities (Savin-Williams, 2001). During the early years of childhood, children typically experience growing independence, however, this remains limited for some time. For example, children rely on their caregivers to financially provide for them. A young girl (assigned female at birth) may be denied a shorter hairstyle, while a young boy (assigned male at birth) may be strongly encouraged to play rugby instead of taking ballet lessons to conform more closely to societal gender norms (Alanko et al., 2011). Targeted resources for parents of pre-school and primary school aged gender minority children are sparse, meaning caregivers who accept or want to accept their gender minority child may struggle to acquire accurate, reliable, and suitable information and support.

One shared source of stress experienced by individuals, but which varies between and within different sexual and gender groups, is puberty (Deardorff et al., 2019; Savin-Williams, 2001). Puberty marks the natural progression from childhood to adulthood manifested by physical growth, hormonal changes, maturation of secondary sexual characteristics, development of one's sense of self, and more intricate social interactions. During this period, all adolescents must renegotiate their relationship with their caregivers and need, and seek, love from them (Savin-Williams, 2001). However, the feelings of confusion and stress, that most adolescents experience, seem to be more intense and pronounced among sexual and gender minority adolescents. For instance, few heterosexual adolescents worry about their caregiver accepting their sexual orientation or ruminate about whether a discussion about it is

necessary (Savin-Williams, 2001). Research reports that sexual minority adolescents face more stigma and stress than their heterosexual peers, but gender minority adolescents experience the greatest levels of stress during puberty (Deardorff et al., 2019). The heightened and unique stressors experienced by gender minority adolescents may be based on internal conflicts regarding gender identity and additional pressure to conform to whānau wishes and cultural and societal norms (Deardorff et al., 2019).

A closer examination of both the minority stress model and the adapted gender minority stress model offers potential insight into how different systems impact a rainbow individual's health and well-being. Understanding the unique challenges facing gender minority people is vital because it highlights the unique and varied challenges both youth and their caregivers might face. Some of the gender minority stressors also create barriers and challenges for supportive and accepting caregivers (e.g., the pathologising of transgender people in medical settings, parental blame, and associative stigma in social settings; de Bres, 2022; de Bres & Morrison-Young, 2023, 2024). However, like sexual minority children, not all caregivers with a gender minority child are supportive. As mentioned previously, negative and rejecting caregiver behaviour can have a significantly negative impact on gender minority children (Abreu et al., 2019; Bosse, Clark, et al., 2024; Bosse, Katz-Wise, et al., 2024; Grossman et al., 2021; Pariseau et al., 2019). Interactions between a rainbow person (individual) and their whānau (microsystems) are one area worth rigorous examination. While it is well-known that caregiver responses exist on a continuum of negative and positive, research clearly indicates the significant impact of caregiver response on a rainbow-identifying child (Clark et al., 2022; Heatherington & Lavner, 2008; Kerekere, 2017; Meanly et al., 2021; Seager van Dyk et al., 2022).

2.3 Caregiver Responses to Their Rainbow-Identifying Child

2.3.1 Negative Caregiver Responses

Research suggests that negative caregiver responses to a rainbow child are significantly associated with negative health and well-being outcomes for the child. Negative responses are here defined as any reactions which suggest to a rainbow individual that they and their rainbow identity are not accepted or affirmed by their caregiver (Seager van Dyk et al., 2022). Negative responses may include, but are not limited to, requesting that a rainbow child keep their rainbow identity secret (Ryan, 2009), refusing to acknowledge a child's rainbow identity disclosure (Rosario & Schrimshaw, 2013), failing to support a rainbow child when they struggle with identity-related challenges (Johnson et al., 2020; Ryan, 2009), preventing access to rainbow-based support resources (Ryan, 2009), intentionally failing to use a child's preferred pronouns (Johnson et al., 2020), pressuring a child to more closely align with their assigned sex at birth despite the child's protests (Ryan, 2009), excluding a rainbow child from whānau gatherings (Ryan, 2009), evicting a rainbow child from the whānau home (Bidell, 2014), and physical and verbal abuse (Bidell, 2014; Johnson et al., 2020; Rosario & Schrimshaw, 2013; Ryan, 2009). Of note, many caregivers fail to see how their responses, which may stem from a caregiver's desire to protect their child and help them fit in with heterosexual and cisgender social norms, could be construed as negative responses regardless of how subtle or well-intended (Ryan, 2009).

Despite intention, the effect of negative caregiver response has been researched in numerous studies. For example, negative caregiver response has been linked with more significant psychological distress and less emotional stability amongst LGBT homeless young adults (18-24 years; Bidell, 2014), an increased likelihood of internalising problems (e.g., depression, anxiety, feelings of inadequacy, and low self-esteem; Meanley et al., 2021; Ryan et al., 2009; Willoughby et al., 2010), increased risk of illegal drug use, risky sexual

behaviours, and attempted suicide (Ryan et al., 2009). Also, transgender and non-binary people tend to have higher odds of both suicide attempts and substance misuse when they experience negative caregiver responses (Grossman et al., 2021). Clearly, negative responses from caregivers have detrimental effects on rainbow children.

2.3.2 Positive Caregiver Responses

Although the majority of studies (e.g., Armesto & Weisman, 2001; Bozett & Sussman, 1990; Conley, 2011; Crosbie-Burnett et al., 1996; Glennon, 2012) focus on the caregivers that respond in primarily negative ways to their rainbow children, more recent research argues that many caregivers respond in positive ways to their rainbow children (de Bres, 2022; Gonzalez et al., 2013; Rosario & Schrimshaw, 2013; Ryan, 2009). Some researchers have suggested that parent responses to their rainbow child have been found to be "evenly divided between positive … and … negative" (Rosario & Schrimshaw, 2013, p. 92), with positive responses corresponding to positive impacts. Furthermore, it has been argued that "most parents … experience … positive transformation and growth" (Gonzalez et al., 2013, p. 325) as they accept and celebrate their rainbow child.

Positive caregiver response refers to any verbal or non-verbal reaction by a caregiver to their rainbow child, which is perceived by the child to suggest acceptance, support, affirmation, warmth, or tolerance of the child's rainbow identity (Mills-Koonce et al., 2018; Seager van Dyk et al., 2022). Positive responses include, but are not limited to, welcoming a child's rainbow friends into the home, advocating for the child when they are mistreated due to their rainbow identity, requiring that other whānau members respect a rainbow child, supporting a rainbow child's gender expression, efforts to self-educate, and engaging with other parents who have rainbow children (Bosse, Katz-Wise et al., 2024; Ryan, 2009).

Research indicates that positive caregiver responses are associated with improved health-seeking behaviours, reduced risk-taking behaviours (Bosse, Katz-Wise et al., 2024),

more self-esteem, greater life satisfaction and well-being, lower risk of mental and general health problems (Ryan, 2009; Ryan et al., 2010), more self-acceptance, and a reduced likelihood of suicidal ideation (D'Amico et al., 2015; Ryan, 2009).

2.3.3 Mixed Caregiver Responses

Positive and negative caregiver responses are not, and arguably have never been, mutually exclusive. Several studies indicate that caregiver response can be a combination of both negative and positive and often change over time (Clark et al., 2022; Johnson et al., 2020; Meanley et al., 2021; Savin-Williams, 2001; Seager van Dyk et al., 2022). The root of mixed caregiver responses appears to vary and be complex. Research suggests mixed caregiver response is associated with struggles to reconcile personal beliefs and love for their rainbow child, a lack of knowledge, understanding, and hope regarding life as a happy, healthy rainbow person, and potential stigma by association (Clark et al., 2022; Conley, 2011; Meanley et al., 2021; Savin-Williams, 2001).

2.4 Chrisler's Conceptualisation of Caregiver Response to Their Rainbow Child

Variability in caregiver response to their rainbow child has been explained through several theories (Abreu et al., 2019; Chrisler, 2017; Crosbie-Burnett et al., 1996; Heatherington & Lavner, 2008; Willoughby et al., 2008). Chrisler's (2017) theoretical framework explains caregiver response as a process often beginning with suspicions and includes Brofenbrenner's (1977) ecological systems theory to explain the influential role context has on caregiver response to sexual minority disclosure.

Chrisler's (2017) theory proposes that caregivers who suspect that their child identifies as a sexual minority engage in activities to alleviate their uncertainty. There are three types of uncertainty reduction behaviours: active, passive, and interactive. Active behaviours are intentional and include the accumulation of information from other sources (e.g., a child's siblings, one's co-caregiver, or snooping in the child's journal; Chrisler, 2017).

Passive behaviours tend to be indirect and include the gathering of information through daily observation or unintentional means (e.g., overhearing a child talking about their crush on a person of the same gender, or finding a child's gay porn; Chrisler, 2017). Interactive behaviours are the most direct means of dispelling uncertainty, involve the child themselves, and include a caregiver asking their child outright about their sexual orientation (Chrisler, 2017). Caregiver uncertainty reduction behaviours vary and continue until caregiver suspicions are either confirmed or disconfirmed.

When a caregiver's suspicions are confirmed, or an unsuspecting caregiver finds out about their child's rainbow identity, caregivers evaluate the significance of this new information through primary and secondary appraisals (Chrisler, 2017). Primary appraisal is when caregivers assess whether the new information aligns with or contradicts their beliefs and values (Chrisler, 2017). Secondary appraisal occurs concurrently with primary appraisal and assesses whether the caregiver believes they are able, and willing to, cope with this new information (Chrisler, 2017). For example, if a caregiver values future biological grandchildren, they may question whether having a rainbow child is congruent with this. However, as part of secondary appraisal, the same caregiver may think about the various options available to people in creating a children-filled whānau, such as adoption and in vitro fertilisation. The caregiver may respond negatively to their child if they believe there is a difference between adopted and biological grandchildren or positively if they consider there to be no difference.

After these simultaneous appraisals, Chrisler (2017) proposes that caregivers respond in one of four ways: either with a positive (e.g., pride), neutral (e.g. indifference), negative (e.g., sadness), or combined (e.g., pride and sadness) emotional response. The combined response as proposed by Chrisler (2017) aligns with what has previously been referred to as a mixed caregiver response (see 2.3.3 Mixed Caregiver Responses). The emotional response

appears to determine the caregiver's behavioural approach to coping with their child's newly discovered identity. Chrisler (2017) proposes that a positive or neutral emotional caregiver response most often results in a similar or improved parent-child relationship. These caregivers may remain the same or become actively engaged in behaviours that demonstrate their acceptance of, and unconditional love for, their rainbow child. For example, a caregiver may offer to accompany their rainbow child to a rainbow community event (Ryan, 2009).

A caregiver whose emotional response is negative or combined is, per Chrisler (2017), most likely to engage in avoidant or approach coping strategies. Avoidant strategies refer to any cognitive or behavioural strategy that involves a caregiver denying, ignoring, or dismissing their rainbow child's rainbow identity (Chrisler, 2017). For example, a caregiver may refuse to consider the implications of having a rainbow child (cognitive avoidance) or refuse to talk about their child's rainbow identity (behavioural avoidance; Chrisler, 2017; Ryan, 2019a).

Approach strategies refer to affirming and disconfirming cognitive or behavioural strategies that are actively engaged in to alleviate the caregiver's stress related to a child's rainbow identity (Chrisler, 2017). Cognitive approach strategies include any internal thought process a caregiver engages in to reduce the potential stress they experience upon learning their child has a rainbow identity (Chrisler, 2017). If a caregiver, for example, believes they caused their child's rainbow identity, they may cope by instead seeing their child's rainbow identity as innate or as their child's choice (Chrisler, 2017). Behavioural approach strategies are observable behaviours which reduce a caregiver's stress. For example, a caregiver may talk to a whānau member or friend who also has a rainbow child or become more educated about their child's specific rainbow identity through reading books and online blogs (Chrisler, 2017; Ryan, 2019b).

These approach strategies may be supportive or unsupportive of the rainbow child. For example, supportive approach strategies include when a caregiver listens respectfully to their rainbow child talk about their identity, even when the caregiver feels uncomfortable (Ryan, 2019b). Some caregivers engage in unsupportive approach strategies, such as refusing to allow their rainbow child to style their hair in a way that aligns better with their gender identity (Ryan, 2019a).

Engaging in coping strategies can alter a caregiver's initial appraisal of what it means to them to have a child with a rainbow identity and may prompt a reappraisal. When reappraisal occurs, caregivers may change their perspective, release previous expectations, address their own rainbow-related biases, develop new narratives and meanings within the parent-child relationship, and experience their own personal growth (Chrisler, 2017; Gonzalez et al., 2013; Morgan et al., 2024).

2.5 Clark et al. (2022) Study of Caregiver Responses to Their Rainbow Children

Utilising a cross-sectional correlational approach, Clark and colleagues (2022) investigated how parents respond to their rainbow children (up to 30 years old) and explored the link between distinct parental response typologies and the mental well-being of their rainbow child. Clark et al. (2022) found that the diverse range of parental responses could be categorised into three distinct classes, namely: negative, positive, and mixed. Negative and positive parental responses are somewhat self-explanatory and include those reactions or behaviours that are either rejecting (negative) or accepting and affirming (positive) by the parent towards their rainbow child. Mixed parental responses encompass a range of nuanced emotions and reactions, incorporating elements of acknowledgement, guilt, concern for their child, gratitude, denial, and acceptance, rather than being primarily supportive or rejective (Clark et al., 2022).

In the Clark et al. (2022) study, the negative parent response class had the highest proportion of male parents, had rainbow children identifying as either lesbian or gay, and parents in this response class were more likely to have children who experienced the most mental health and social difficulties (e.g., anxiety, substance use, and bullying). Most participants (68.8%) were in the positive parent response class and were most likely to have a college education and have rainbow children who were assigned female at birth compared to the other classes (Clark et al., 2022). Positive parental response correlated with lower odds of having rainbow children who experienced anxiety, depression, substance use, and bullying (Clark et al., 2022).

Interestingly, the positive parent response class were also more likely to have a rainbow child who identified as either transgender or gender diverse (e.g., non-binary; Clark et al., 2022). This is interesting but may be expected as gender identity development and expression occur much earlier than sexual identity, thus perhaps allowing more time for parents to adapt or become accustomed to their child's identity. The mixed parent response class had the highest proportion of bisexual children, and had the greatest proportion of religious parents whose religion was less accepting of rainbow identities (Clark et al., 2022). Children whose parents were in the mixed parent response class experienced high levels of bullying and depression (Clark et al., 2022).

2.6 Present Study

2.6.1 Replication

Replication has been described as the tool by which belief is transformed into knowledge (Shapin & Schaffer, 1985/2011). It illustrates reproducibility, validates or invalidates previous research findings, "establishes stability in our knowledge" (Schmidt, 2009, p. 92), demonstrates agreement amongst researchers, and verifies that initial findings were not due to chance or some specific conditions unique to the original study (Schmidt,

2009; Shapin & Schaffer, 1985/2011; Zwaan et al., 2018). Replication studies can be conducted to address sampling errors, manage researcher fraud, test generalisability across diverse populations, and verify hypotheses using methodologies different from those of an original study (Schmidt, 2009).

Replication studies can be conducted in a variety of ways (Zwaan et al., 2018). The two most common types are direct and conceptual replication. Direct replications focus on recreating an original study's key elements in anticipation of reproducing the original findings (Derksen & Morawski, 2022; Haig, 2022; Schmidt, 2009; Zwaan et al., 2018). Conceptual replications examine the underlying concepts of a phenomenon through making one or multiple meaningful changes to an original study's methods in anticipation of observing the same phenomenon as an original study (Derksen & Morawski, 2022; Haig, 2022; Nosek & Errington, 2020; Schmidt, 2009; Zwaan et al., 2018).

However, there is a great deal of controversy regarding which kind of replication is the gold standard. Some researchers argue that the importance of direct replication has been overemphasised and mischaracterised (Haig, 2022) while others call for more direct replications to be conducted (Derksen & Morawski, 2022). Derksen and Morawski (2022), posit that despite diverse views on replication studies, there is value in both conceptual and direct replication. Conceptual replications can emphasise the value of considering various perspectives over just one approach, and direct replications allow research to generate and confirm practical results which can lead to tangible impacts rather than theoretical validation alone (Derksen & Morawski, 2022).

There are three reasons for this study to directly replicate the work of Clark et al. (2022) and test the generalisability of their work amongst parents of rainbow children. First, there is value in robust replication and in extending an original study's findings (Luoma & Hietanen, 2024; Schmidt, 2009; Shapin & Schaffer, 1985/2011). Second,

there is limited research conducted on caregiver response to their rainbow children in ANZ. Third, research plays an important role in alleviating the mental health and well-being disparities experienced by rainbow individuals through informing future and refining present interventions, policies, and best practices (Reupert, 2023, 2024).

More specifically, this research will attempt to replicate the three parent response classes (negative, positive, and mixed) amongst primary caregivers of rainbow children (up to the age of 30 years to align with Clark et al., 2022). However, this study is only a partial replication as it did not seek to assess caregiver response class and the rainbow child's mental health and social difficulties. This study also attempts to briefly examine shared characteristics among caregiver response classes, some of which were not investigated in the original study conducted by Clark and colleagues (2022).

2.6.2 Caregivers in Aotearoa New Zealand

The decision to broaden the scope of participants to encompass any caregiver, rather than solely parents, was based on two key reasons. First, amongst Māori (the indigenous people of ANZ), children are considered to be the physical manifestation and embodiment of their tūpuna (ancestors) achievements, given to the whānau to care and protect (Herewini, 2018; Metge, 1995). Therefore, the raising and care of children are the responsibility of not just parents, but also the wider whānau and hapū (kinship group or subtribe) (Herewini, 2018). A crucial ethical component of research conducted in ANZ, and in order to align more closely with the core articles of Te Tiriti o Waitangi (Te Tiriti; the Treaty of Waitangi), the research includes Māori mātauranga (knowledge) and whanonga pono (values), as such, it is important to consider and include Māori tirohanga (views) or whakataurite (perspectives) wherever possible (Hudson et al., 2010; New Zealand Psychological Society et al., 2012).

Second, the number of children being raised by non-parent caregivers is increasing. Exact figures are unavailable; however, it has been reported that in 2022, approximately

13,000 caregivers in ANZ received financial support in caring for children who were not their biological, step, or adopted child, a marked increase from approximately 7,000 caregivers in 2010 (Keogh, 2023; Oranga Tamariki, 2023a). Of these 13,000 caregivers, approximately 96% of those receiving the orphan's benefit[4] and 89% of those receiving the unsupported child's benefit[4] were non-parent whānau members to the children they were caring for (Oranga Tamariki, 2023b). There are numerous reasons why parents can no longer act as caregivers for their children such as bereavement, family harm concerns, illness, parental drug use, and incarceration (Gordon, 2018; Oranga Tamariki, 2023b; Smith, 2010). Thus, for these reasons, extending the participant pool to include all adults who are responsible for the care of a rainbow child is an attempt to accurately reflect the current demographics of caregivers in ANZ, and to be ethically and culturally sensitive and inclusive in line with the professional standards expected of psychologists in ANZ (New Zealand Psychological Society et al., 2012).

2.6.3 The Influence of Time and Age on Caregiver Response

Alongside the direct partial replication of Clark and colleagues (2022) study, this research seeks to examine the extent to which time and age of both caregiver and child may influence caregiver response class membership. Several studies examining time since a child disclosed their rainbow identity to their whānau, report that caregivers and other whānau members tend to become more accepting, affirming, and supportive over time (Grossman et al., 2021; Huebner et al., 2019; Kuvalanka et al., 2014; Mattingly et al., 2016; Morgan et al., 2024; Samarova et al., 2014; Savin-Williams, 2001). In an Israeli study with lesbian, gay and bisexual (LGB) adolescents, 15% of participants reported receiving fully or almost fully rejecting initial responses from their parents (Samarova et al., 2014). Of this group, 45% of

[4] Both the orphan's benefit and unsupported child's benefit are financial assistance funds available to ANZ caregivers caring for a child whose parents are unable to do so (Ministry of Social Development, n.d.).

mothers and 39% of fathers had become more accepting over time, though no exact time periods were reported (Samarova et al., 2014). According to Huebner et al. (2019), parents experienced greater difficulty adjusting to their LGB children when less than two years had passed since their child's initial disclosure.

One study exploring the influence of parent age on parental response to rainbow children found younger parents to be more likely to accept their child's disclosure than older parents (Savin-Williams, 1990). It was posited that these results could be due to generational differences between younger and older parents with younger parents being influenced by the increasing visibility and acceptance of sexual minorities (Savin-Williams, 2001). Relatedly, the age of a rainbow child when disclosing their rainbow identity to their parent or parents has also been studied. Parents of older LGB children (when they first disclosed their rainbow identity) were found to have greater difficulty accepting and supporting their LGB children than parents of younger children (Huebner et al., 2019).

Changes in more supportive caregiver responses also occur among parents of gender minority children. An Australian qualitative study of transgender and gender diverse young people (14 -24 years) found that while parents had initially reacted negatively, these young people noticed, positive changes in parental response over time (Morgan et al., 2024). Participants attributed these positive changes to temporal factors, which afforded their parents the opportunity to recognise that their child's rainbow identity was not a transient phase. Additionally, time allowed parents to access high-quality rainbow-related information which was believed to deepen parental understanding and increase parental comfort (Morgan et al., 2024).

However, not all caregivers and whānau members adapt with time and not all change is positive (Mattingly et al., 2016; Samarova et al., 2014; Savin-Williams, 2001). In one US study, changes in parent response, resulted in greater rejection (Mattingly et al., 2016).

Mattingly and colleagues (2016) found religious parents who responded to their sexual minority children with conditional positivity became less affirming. Conditional positivity tended to involve "if …, then …" sentiments with support given when expectations were met. For example, support was given to a gay, lesbian, bisexual, and queer or questioning (GLBQ) child when no one else was around or when the child did not engage in a relationship with someone of the same gender. If expectations were not met, families tended to become less affirming, more hostile, more conscious-stricken, or more avoidant (Mattingly et al., 2016). However, Mattingly et al. (2016) proposed that this withdrawing of support would eventually lead to more affirming or accepting parental behaviours over time. The existing research was conducted outside ANZ so exploring time as a potential factor for promoting greater caregiver acceptance of their rainbow child is necessary within the ANZ context.

2.6.4 Characteristic Differences Across Caregiver Response Classes

Clark et al. (2022) found several characteristic differences between parental response classes in their study. Clark et al.'s (2022) study and several other studies suggest several novel factors, such as religion (Shilo & Savaya, 2012) and ethnicity (Abreu et al., 2022), that may be pertinent to caregiver acceptance of their rainbow child. Characteristics of interest include the specific rainbow group identity of the child, caregiver attachment and parenting style, caregiver religiosity or spirituality, and caregiver ethnicity. Examining differences between caregiver response classes in these variables may reveal potential opportunities for informing current and future interventions at individual, group, and societal levels which target specific caregiver classes according to their current level of acceptance.

2.6.4.1 Rainbow Group Identity of the Child. Growing research has suggested that individuals who identify as bisexual or as genders other than the cisgender binaries of woman and man are at even greater risk of mental health problems and poorer outcomes compared to their non-bisexual and cisgender peers (Abreu et al., 2019; Craig et al., 2020; de Bres &

Morrison-Young, 2024; Lucassen et al., 2011; Smalley et al., 2016; Tan, Schmidt, et al., 2022). For example, a study in ANZ found that among high school students, adolescents who were attracted to more than one gender were almost six times more likely to engage in self-harm and seven times more likely to attempt suicide compared to their heterosexual peers (Lucassen et al., 2011). Additionally, a recent study found that family rejection of a rainbow child's gender expression and identity, which did not conform to that assigned at birth, was associated with a greater prevalence of anxiety, depression, and minority stress among sexual and gender minority adolescents (13-17 years; Palmer & Francis, 2023).

Other studies have found negative parent responses to their child when the child engages in gender *atypical* behaviours (D'Augelli et al., 2008). In a study conducted by D'Augelli et al. (2008) most rainbow youth (15–19 years) reported that their parents' initial response was to try to alter or enforce behaviour changes when they engaged in gender atypical behaviours. Parents were perceived to be more negative toward their child, particularly when a boy engaged in typically feminine behaviours, with fathers being more negative than mothers (D'Augelli et al., 2008). Attempts to discourage gender atypical behaviours ranged in severity and included being told to stop or change, restricted or enforced activities, counselling, and punishment (D'Augelli et al., 2008).

Considering these findings, it is important to consider whether a specific rainbow group identity may predict certain caregiver responses. That is, whether a child's rainbow group identities may influence their caregiver's membership within a specific caregiver response class or movement from potentially negative or mixed caregiver response classes to the positive caregiver response class. Furthermore, it may be insightful to explore how the intersectionality of multiple rainbow identities (e.g., both gay and transgender, pansexual and gender fluid, or asexual and non-binary) may be associated with certain caregiver response

class membership. There appears to be a paucity of research examining rainbow identity intersectionality and caregiver response in ANZ.

2.6.4.2 Caregiver Attachment Style. Caregiver-child relationships are foundational in shaping a child's sense of self, security, and overall well-being (Ainsworth et al., 1978; Bowlby, 1969/1982, 1988/2005). For rainbow children, these relationships may have an even more significant impact on their adjustment due to the unique challenges they may face in relation to their rainbow identity. Attachment theory posits that the quality of early attachment experiences between infant and caregiver shapes an individual's attachment style, which can then influence their adult relationships, including those with their own children (Bowlby, 1988/2005; Jones et al., 2015). If, as research has found, attachment style influences relationship interactions, then it makes sense that a caregiver's attachment style could impact interactions within the caregiver-rainbow child relationship and could influence caregiver response to their rainbow child.

According to attachment researchers (e.g., Bowlby, 1969/1982, 1988/2005; Ainsworth, 1979, 1989; Iwanaga et al., 2018; Jiao & Segrin, 2021) there are three attachment styles: *anxious*, *avoidant*, and *secure*. An individual with an anxious attachment style often exhibits a preoccupation with relationships, requires constant reassurance, seeks closeness, and needs regular validation from others to have their emotional needs met (Iwanaga et al., 2018; Jones et al., 2015). An avoidant attachment style is characterised by a reluctance to form close bonds with others, a general lack of trust in interpersonal relationships, and can be further disaggregated into either dismissive or fearful subtypes (Iwanaga et al., 2018; Jones et al., 2015). Caregivers with either anxious and avoidant styles have been found to be less consistent, less caring, less accepting, and more authoritarian and/or permissive (Jones et al., 2015). Secure attachment typically manifests as confidence in establishing and maintaining

interpersonal relationships along with a comfort in relying on others for support and emotional connection (Iwanaga et al., 2018).

Studies exploring caregiver attachment and its impact on caregiver-child relationships have examined children at various ages: childhood, adolescence, and adulthood. A study investigating mother-adolescent relationships found that mothers with anxious or avoidant attachment tendencies were more likely to respond to their adolescent's negative emotions (e.g., distress, worry, sadness) with less supportive, more distressed, and harsher responses (Jones et al., 2014). In another study, parents with more anxious attachment tended to manage their own emotions by overparenting, while parents exhibiting avoidant attachment tendencies were inclined towards less responsive caregiving (Jiao & Segrin, 2021). Both groups prioritised their own emotional regulation over the developmental needs of their child and without consideration of their child's attachment patterns (Jiao & Segrin, 2021). A review of the literature did not identify any existing research linking caregiver attachment styles and caregiver response to their rainbow child. This gap in the available literature on the impact of caregiver attachment and child well-being suggests that exploring the potential links between caregiver attachment style and caregiver acceptance of a rainbow child could highlight key factors to consider in tailoring caregiver-based interventions.

2.6.4.3 Caregiver Parenting Style. Caregiver parenting styles have been studied since the 1930s, with many studies identifying a link between parenting style and child behaviour and well-being outcomes (Baumrind, 1967, 1975; Caldwell & Joyce, 2011; Enright et al., 1980; Freud, 1976; Koestner et al., 1984; Nimkoff, 1931; Power, 2013; Zucker, 1943). Parenting styles refers to the general parenting approach (e.g., parental attitudes and behaviours) caregivers engage in while rearing their child, and have been categorised as either *authoritative*, *authoritarian*, or *permissive* (Mohta et al., 2017; Power, 2013). Authoritative parenting is characterised by a combination of high warmth and high levels of

control, which is associated with children displaying assertive and self-reliant behaviour (Power, 2013). Authoritarian parenting, on the other hand, is marked by low warmth and high levels of control and is often linked to more discontented and withdrawn behaviour in a child. Permissive parenting tends to involve low levels of both warmth and control, correlating with lower levels of self-control and self-reliance amongst children (Power, 2013).

While there are an abundance of studies exploring caregiver parenting styles and child well-being (e.g., Chan & Koo, 2011; Francis et al., 2021; Sangawi et al., 2018; Tani et al., 2018), there is a dearth of research specifically examining the impact of parenting styles on rainbow children (e.g., Mohta et al., 2017). According to Mohta et al. (2017), more transgender individuals (18-40 years) viewed their parents as authoritarian (low warmth and high control) with the fewest number of transgender participants viewing their parents as permissive (low warmth and low control). Conversely, fewer non-transgender participants perceived their parents as authoritarian with most participants in the non-transgender comparative group perceiving their parents as authoritative (high warmth and high control) (Mohta et al., 2017). Causality could not be determined in this study; however, the results clearly suggest that transgender children are prone to experiencing feelings of rejection and lack of support from their parents, potentially stemming from disapproval conveyed through their parenting approach (Mohta et al., 2017).

Consideration of caregiver parenting style could be informative and may contribute to early interventions aimed at parents of rainbow children, such as parenting programmes which seek to educate caregivers and improve their parenting practices. This may be particularly pertinent in relation to caregivers who may struggle with a child's non-conforming gender identity as gender identity and expression develop at an earlier age than sexual orientation (Abreu et al., 2019; Maccoby, 2000; Sunny & Deb, 2021).

2.6.4.4 Caregiver Religiosity. All three of the major global religious traditions (i.e., Christianity, Judaism, and Islam) profess that love and support within the family are highly valued and should be prioritised (Chelladurai, 2020). While Judaism is not a prominent religion in ANZ, more than half of the people residing in ANZ identify as religious with 48.9% of religious individuals being Christian (Statistics New Zealand, 2014)[5]. Based on the universal importance of family, love, and support amongst the major religions, one may assume that religious caregivers and whānau members would be highly accepting of their rainbow child. However, historically, religious groups have tended to ostracise the rainbow community (Miller et al., 2020; Schope & Eliason, 2000). Currently, the levels of acceptance and support offered by the religious community to rainbow individuals and communities vary greatly between and across specific groups.

Etengoff and Daiute (2014) observed that whānau members used religion in one of two ways in responding to their rainbow relatives after learning of their rainbow identity; either theistic triangulation or theistic mediation. *Theistic triangulation* refers to the utilisation of religious resources (e.g., scripture, doctrine, and practices) by whānau members to depict God as being against rainbow individuals, for example, attributing one's perceived lack of spirituality as the origin of one's rainbow identity (Etengoff & Daiute, 2014). Theistic triangulation often results in increased conflict, verbal hostility, and emotional withdrawal between whānau members and a rainbow individual (Etengoff & Daiute, 2014; Mattingly et al., 2016).

Alternatively, *theistic mediation* is adaptive and employs religious resources to mitigate conflicts and provide support and empowerment to everyone involved (Etengoff & Daiute, 2014; Mattingly et al., 2016). For instance, a Christian caregiver employs theistic

[5] The 2013 New Zealand Census was used as the 2023 data was unavailable at the time of writing and the 2018 census had an 83% response rate and was carried out solely online and excluded many rural and older individuals.

mediation when they focus on the importance of loving and not judging their rainbow child to maintain a loving relationship with their child and to parent in a way that aligns with their Christian beliefs as taught in the Holy Bible (King James Version, 2003, Matthew 7:1, Matthew 22:37-40).

Other studies have also explored the associations between whānau response to rainbow children and religious affiliation (Maslowe & Yarhouse, 2015; Mattingly et al., 2016; Rosenkrantz et al., 2020; Shilo & Savaya, 2012). Many studies report less acceptance from highly religious whānau and more acceptance from less religious whānau. For example, an Israeli based study found that amongst LGB youth (16-23 years) who mainly identified as Jewish, those who were more religious tended to experience more rejection and internalised homophobia than their less religious LGB peers (Shilo & Savaya, 2012).

Interestingly, other studies report highly religious whānau to be more accepting (e.g., Miller et al., 2020). For instance, a study conducted in the US, found Jewish parents to be as accepting as non-religious parents and more accepting than parents affiliated with all other major religious and spiritual organisations (e.g., Buddhist, Hindu, Muslim, Christian; Miller et al., 2020).

Amongst 18 to 30-year-old GLBQ individuals affiliated with The Church of Jesus Christ of Latter-day Saints, whānau responses varied widely along a continuum which included hostility (verbal and physical), conscience-stricken (blame, guilt and distress), avoidance (physical and emotional distancing), conditional positivity (affirmation when certain conditions were met), and positive affirmation (supportive and open; Mattingly et al., 2016).

Previous research highlights the need to consider caregiver religiosity or spirituality in this study. While the current study does not seek to categorise based on religious affiliation or any religion's stance on rainbow-related issues, it may be helpful to consider caregiver

perceptions of their affiliated religion's stance on rainbow individuals and communities. One's perception of another person or group's attitudes, behaviours, and cognitions, or even one's own location, can influence an individual's own attitude, behaviour and cognition (Aarts & Dijksterhuis, 2003; Ferguson & Bargh, 2004; Garcia et al., 2002; Moskowitz & Skurnik, 1999; Stapel & Koomen, 2000). Because perception can influence behaviour and attitude, an exploration of caregiver perception regarding their affiliated religion's stance on rainbow individuals and communities is fitting in studying caregiver response to their rainbow child. Furthermore, better understanding how closely a caregiver agrees with their perceived view of their affiliated religion may be pertinent in caregiver response class membership.

2.6.4.5 Caregiver Ethnicity. Growing research has examined differences in caregiver and whānau response to rainbow children based on ethnicity. One US study found differences between all ethnic groups, with white lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals experiencing more LGBTQ-specific parental support then non-white peers and Asian, Black, and Latinx LGBTQ individuals experienced less LGBTQ-specific parental support; however, these differences tended to be moderate to small (Abreu et al., 2022). Similarly, another US study reported African-American and Latino parents had greater difficulty with having a rainbow child and knowing about their child's rainbow identity than white and non-Hispanic parents (Huebner et al., 2019). While differences have been found between ethnic group response to rainbow whānau members, the majority of studies have found that cultural nuances may exist. However, other factors, such as time since disclosure (Huebner et al., 2019; Ryan et al., 2010), specific rainbow identity (Alanko et al., 2011; D'Augelli et al., 2008), and religiosity (Ryan et al., 2010; Shilo & Savaya, 2012) appear to have greater influence in rejecting or accepting a rainbow child's identity.

Research on minority groups, particularly regarding ethnicity, can be contentious as it can lead to unintended misinterpretations, contribute to prejudices and biases, and further marginalise and oppress minority groups (Ball & Janyst, 2008; Mohr, 2009; Scheyvens et al., 2014; Smith, 2021; Tan et al., 2023). However, exploring how ethnicity may impact a caregiver's response to their rainbow child can contribute to the empowerment of marginalised groups who often remain invisible in research due to exclusion, tokenism, or researcher inaction (Tan et al., 2023).

One way researchers can potentially reduce contributing to further discrimination against rainbow people and other marginalised minority groups is to instead examine the perceptions of individuals within various groups (Ferguson & Bargh, 2004). Understanding how an individual perceives their groups' stance regarding rainbow individuals and communities, and the extent to which they personally agree or disagree with these perceived views, may highlight how ethnicity could impact a caregiver's response to their rainbow child.

2.6.5 Current Study Hypotheses

Research clearly indicates the importance of caregiver support and acceptance and the significant impact this has on a rainbow child's health and well-being. Based on the literature previously discussed, specifically Clark et al.'s (2022) findings of three distinct caregiver response classes, and relatively limited research conducted in ANZ, three main hypotheses are proposed for this research project.

Hypothesis one (H1): Based on caregiver response to their rainbow child, caregivers will be able to be categorised into three distinct classes: negative, positive, and mixed.

More specifically, caregiver response class will be based on participants reponses to the Parent Response Indicators (PRI; Clark et al., 2022). A negative caregiver response class will have higher mean scores on the negative PRI subscale and lower mean scores for the

positive PRI subscale. A positive caregiver response class will have lower mean scores on the negative PRI subscale and higher mean scores on the positive PRI subscale. A mixed caregiver response class will have moderate mean scores on both PRI subscales.

Hypothesis two (H2): Time since a child's initial rainbow identity disclosure and the age of both caregiver and child will be associated with caregiver response class membership. Specifically:

- **(H2a)** Negative caregiver response class membership will be associated with a shorter time period (less than two years), and positive caregiver response class membership with a longer time period (more than two years) since initial disclosure.
- **(H2b)** Older caregivers will be more likely to be in the negative caregiver response class with younger caregivers more likely in the positive caregiver response class.
- **(H2c)** A child's age at the time of initial rainbow identity disclosure will be associated with caregiver response class membership. More specifically, caregivers in the positive response class will be linked to either an older child disclosing a sexual minority rainbow identity (e.g., lesbian or gay) or a younger child disclosing a gender minority rainbow identity (e.g., transgender or non-binary).

Hypothesis three (H3): Five distinct characteristic differences will be evident among the caregiver response classes. Specifically:

- **(H3a)** Caregiver response class membership will vary depending on their child's rainbow identity group, with caregivers of gender minority children reporting a more negative response, and caregivers of sexual and gender minority children reporting a more mixed response.

- **(H3b)** More caregivers with a secure attachment style will be found in the positive caregiver response class, whereas caregivers with more avoidant or anxious attachment styles will be found in the negative or mixed caregiver response classes.
- **(H3c)** More caregivers with an authoritative parenting style will be found in the positive caregiver class, whereas caregivers with more authoritarian or permissive parenting styles will be found in the negative or mixed caregiver response classes.
- **(H3d)** Caregivers who agree with more accepting religious or spiritual groups will be found in the positive caregiver response class, while caregivers who disagree with their religions perceived stance (either more or less accepting) on rainbow individuals will be found in the mixed caregiver response class, and caregivers who agree with less accepting religions will be found in the negative caregiver response class.
- **(H3e)** Caregivers who agree with more accepting ethnic groups will be found in the positive caregiver response class, while caregivers who disagree with their ethnic groups perceived stance (either more or less accepting) on rainbow individuals will be found in the mixed caregiver response class, and caregivers who agree with less accepting ethnic groups will be found in the negative caregiver response class.

Chapter Three: Materials and Method

3.1 Research Design

The current study employed a quantitative cross-sectional survey design primarily due to it being a replication of Clark et al.'s (2022) work. Additionally, an ad hoc reflexive quantitative approach was employed by the researcher. Reflexive consideration of how the researcher's own beliefs, experiences, and context influenced the choice in research topic and design, data collection and analyses, and discussion and understanding of the research results (Luoma & Hietanen, 2024). A reflexive quantitative approach is important in research transparency and in recognising how these findings may be impacted by researcher- and context-specific factors (Luoma & Hietanen, 2024). For example, while the researcher does not hold a rainbow identity, several of the researcher's whānau members do and the researcher is a parent of two young adults and one adolescent, so the topic of rainbow mental health and the potential impact of parent or caregiver response is important to the researcher. A research journal was kept by the researcher for recording ideas, thoughts, and concerns throughout the research process.

3.2 Recruitment and Data Collection

Recruitment and anonymous survey data was collected online via Qualtrics from August 26th to November 29th, 2024 (a total of 95 days). The research team contacted a range of caregiving and rainbow support groups via email with details of the study (see Appendix B) and three recruitment flyers (see Appendix C). Groups were able to share the recruitment flyer (of their choice) with their members. Each flyer presented general eligibility requirements and invited prospective participants to share their experiences of being a caregiver with a rainbow child by completing the survey. All flyers included a QR code and URL link to the survey. When prospective participants scanned the QR code or followed the

link, they were taken to the information sheet (see Appendix D) and asked for consent if they wished to participate, then the participants were able to begin the survey.

Of the 51 groups contacted for recruitment help, 18 agreed to promote the flyers. The groups who helped to recruit prospective participants were all groups that promote inclusivity and provide affirmation and support to and for rainbow individuals, as well as caregivers and whānau with rainbow children. Two groups declined to help recruit, and most groups did not reply, so they may or may not have shared the flyers.

Additionally, the flyers were posted on the Program for Research on Identity, Development and Emotional well-being (PRIDE) lab website and Instagram account, and on the researcher's personal social media accounts (Facebook and Instagram). Paid Instagram advertising was also part of the recruitment strategy. Online posts sharing the study's flyers were shared by the researcher on Massey University and Psychology based Facebook groups to which the researcher belonged (e.g., Massey at Distance and Massey University Psychology Students). Recruitment was also conducted through word of mouth, in person and online by both the researcher and participants. No participants were incentivised or asked to recruit other participants, yet several participants contacted the researcher to say they did this of their own volition.

As this research is a replication of Clark et al. (2022), the target sample size was based on their sample size. The original study had 205 eligible participants. A similar sample size was sought for this study with the expectation that some responses would be excluded for various reasons (i.e., bots, nonsense responses, and participant ineligibility; Agans et al., 2024; Nur et al., 2024).

3.3 Participants

The target sample was ANZ caregivers who have at least one child with a rainbow identity. The inclusion criteria for this study were that participants must be over the age of 18 years old, currently reside in ANZ, fluent in English, and their rainbow child needed to be under the age of 30 years old. An age limit for participants' rainbow children was based on the premise that caregivers of rainbow children over the age of 30 years have most likely known about their child's identity for a longer period and may have greater difficulty recalling, or have repressed, their initial responses and become more accepting over time (Grossman et al., 2021; Huebner et al., 2019; Kuvalanka et al., 2014; Mattingly et al., 2016; Morgan et al., 2024; Samarova et al., 2014; Savin-Williams, 2001). Participants were excluded if they did not meet the inclusion criteria.

Of the 255 participants who consented to participate in this study, 115 participants were excluded. Eligibility criteria excluded 33 participants (25 participants were under 18 years old, 29 participants were not primary caregivers, and 22 participants were not living in ANZ or fluent in English). Further exclusions were due to suspected fraud[6] (58 participants), survey completion recorded as less than 10 minutes (15 participants), less than 50% survey completion (8 participants), and nonsense responses (1 participant). In total, the data of 140 participants were included and analysed in this study. While the final sample was below the 205-participant target, 255 participants were recruited to account for potential attrition. However, more fraud than anticipated was encountered, which could be due to the increased sophistication of fraud tools since Clark et al (2022) was conducted. This will be an important consideration for future research.

[6] Suspected fraud included, but were not limited to, duplication and location misrepresentation.

3.3.1 Participant Demographics

Participants in the final sample ranged between 25 and 66 years of age (M = 47.25 years, SD = 8.00). Most participants identified as heterosexual/straight (n = 87, 62.14%), cisgender (n = 125, 89.29%), binary (n = 120, 85.71%), and were not intersex (n = 122, 87.14%). Most participants reported their gender as female or woman (n = 113, 80.71%).

Most participants reported their ethnicity as ANZ European/Pākehā (n = 100, 71.43%), with the minority of participants identifying as ANZ Māori (n = 7, 5%), Chinese (n = 1, 0.71%), Indian (n = 1, 0.71%), Samoan (n= 1, 0.71%), another group (n = 10, 7.14%), or multi-ethnic or more than one ethnicity (n = 17, 12.14%). Multi-ethnic included combinations of ANZ Māori (n = 6, 4.29%), ANZ European/Pākehā (n = 8, 5.71%), Cook Island Māori (n = 4, 2.86%), Indian (n = 2, 1.43%), Niuean (n = 1, 0.71%), Samoan (n = 1, 0.71%), Tongan (n = 4, 2.86%), and another group (British, Irish, Jewish, and Romani; n = 3, 2.14%).

All participants reported living in ANZ. The plurality of participants had completed a postgraduate qualification (n = 55, 39.29%) and financially, were able to make ends meet with some difficulty (n = 46, 32.86%). Further details of participant demographics are presented in Table 1.

3.3.2 Caregiving Demographics

Participants were primarily parents (biological, step, adopted, or foster) to rainbow children (n = 129, 92.14%). Other relationships between participant and rainbow children included grandparents (biological, step, adopted, or foster; n = 3, 2.14%), aunts or uncles (biological, step, adopted, or foster; n = 4, 2.86%), and close whānau friends (n = 3, 2.14%).

Most participants parented with co-caregivers (n = 105, 75%). There was an average of 1.23 (SD = 0.69) co-caregivers. The relationship between co-caregiver and rainbow child varied between parent (n = 96, 68.57%), grandparent (n = 1, 0.71%), close whānau friend

(*n* = 1, 0.71%), and multiple relationships due to team co-caregiver dynamics made up of parent, grandparent, aunt or uncle and/or close whānau friend (*n* = 5, 3.57%).

Most participants lived full-time with their rainbow child (*n* = 96, 68.57%) and had an average of 2.25 (*SD* = 1.14) children in total. Participants had an average of 1.26 children with a rainbow identity, with a range of one to three rainbow children. The mean current age of participants' rainbow children was 16.60 years (*SD* = 4.65).

The majority of participants (*n* = 95, 67.86%) reported that their rainbow child had a rainbow or sexual minority sexual orientation (i.e., asexual, bisexual, gay, lesbian, pansexual, takatāpui, or some other non-heterosexual orientation). Two (1.43%) participants reported that their rainbow children identified as heterosexual, and 30 (21.43%) participants were unsure. Uncertainty was based on the current age of their rainbow child. Most participants reported that their rainbow child was not intersex (*n* = 107, 76.43%). The minority of participants reported their rainbow child as intersex (*n*= 8, 5.71%). More than half the participants reported that their rainbow child was assigned female at birth (*n* = 80, 57.14%). The minority of rainbow children were reported as being assigned male at birth (*n* = 48%) or indeterminate (*n* = 1, 0.71%).

Most participants reported that their rainbow child identified as transgender (*n* = 99, 70.71%), with the minority being cisgender (*n* = 13, 9.29%) and neither or unsure (*n* = 17, 12.14%). Most rainbow children were identified as being binary (*n* = 60, 42.86%) compared to non-binary (*n* = 49, 35%) and neither or unsure (*n* = 18, 12.86%). Further details of the caregiving demographics for the sample are presented in Table 2.

3.4 Measures

The survey contained 147 questions in total; however, only the relevant questions and measures for this thesis will be discussed (see Appendix E for exact wording of relevant items and response options). It was estimated to take participants 45 minutes to complete the

whole survey. Participants were able to leave the survey and return to complete it at a later time.

The first section of the survey was a four-item eligibility screener. To evaluate eligibility, participants were asked about their age, whether they resided in ANZ, if they were fluent in English, and whether they were the primary caregiver of a rainbow child younger than 30 years of age. Apart from age, all other questions were answered with either a yes or no response. Participants reported their age (in years) in an open text response box.

3.4.1 General Demographics

The general demographic questions related to participant gender, sexual orientation, ethnicity, education level, and economic security. Six items inquired about sexual orientation and gender which were informed by previous projects by Beischel et al. (2023) and Suen et al. (2020). The first item asked, "what is your gender?" with an open text response box for responding. The next item asked which "sexual orientation-related groups would [participants] like to be included in". Four response options were offered: "rainbow/sexual minority; heterosexual/straight; neither rainbow nor heterosexual; and unsure." Participants were asked two gender identity group questions about transgender and non-binary gender identities. Four response options were offered and item and included "transgender; cisgender; neither; and unsure." The second set of response options were similar but offered non-binary instead of transgender.

Participants were asked which ethnic group or groups they identified with and were given ten response options. Eight ethnic groups prominent in ANZ society were named along with an option for participants who were unsure about their ethnicity and an open text response box for those who were of an ethnicity not named. The eight named ethnic groups were New Zealand Māori, New Zealand European/Pākehā, Cook Island Māori, Chinese, Indian, Niuean, Samoan, and Tongan. Those who selected another group were asked to

specify which ethnic groups they identified with. Participants were encouraged to select all the ethnic groups that applied to them.

Participants were also asked about education and economic security. Participants were asked what level of education they had achieved or completed. Six response options were offered: “some high school; high school; some tertiary; bachelor’s degree; postgraduate qualification; and something else.” The economic security question asked how well a participant’s household was able to make ends meet. Participants reported their response on a 6-point Likert-type scale (0 = *with great difficulty* to 5 = *very easily*).

3.4.2 Caregiving Demographics

The caregiver profile was a novel self-report measure and contained seven items. The first item asked about the participant-child relationship. Fourteen response options were offered to describe the relationship (e.g., biological parent/whaea, matua; adopted grandparent/tīpuna whāngai; foster aunt or uncle/whaea kēkē whāngai, matua kēkē whāngai). Participants were asked if they parented or caregave with another adult to which they could respond either “yes or no.” If they responded yes, participants were asked how many co-caregivers they parented with. The following item asked about the co-caregiver-child relationship and offered the same response options as the participant-child relationship item.

Participants were asked how many total children they were the primary caregiver for and how many of their children had a rainbow identity. These items were responded to via an open text response box. Participants were also asked whether their rainbow child lived at the same address as themselves. Three response options were offered: “yes, full-time; yes, part-time; and no.”

3.4.3 Parent Response Indicators

The Parent Response Indicators (PRI) were used in the original study (Clark et al., 2022) and examined a range of negative and positive caregiver responses to their rainbow child. There were two subscales: negative and positive.

The negative subscale had five items and included items such as "My child and I get into disagreements related to their Rainbow/LGBTQIA+ status" and "My child coming out as Rainbow/LGBTQIA+ feels like the loss of the child I once had." The positive subscale also had five items and included items such as "I plan to ensure my child has social support to cope with some of the challenges of being Rainbow/LGBTQIA+" and "My relationship with my child has improved since my child came out as Rainbow/LGBTQIA+."

Unlike Clark et al. (2022), the scaling for these items were standardised following a recommendation from Clark (personal communication, 18 April 2024). Response options for both subscales were via a 6-point Likert scale (1 = *strongly disagree* to 6 = *strongly agree*). Mean responses were categorised into low (e.g., 1.00-2.49), moderate (e.g., 2.50 – 4.49) and high (e.g., 4.50 – 6.00). High mean responses to the negative PRI items and low mean responses to the positive PRI items indicate a negative caregiver response class. Low mean responses to the negative PRI items and high mean responses to the positive PRI items indicate a positive caregiver class. Moderate mean responses to both the negative and positive PRI items would indicate a mixed caregiver response class.

The negative subscale had a mean score of 9.04 (*SD* = 4.68) and acceptable reliability (α = .76). The positive subscale had a mean score of 26.01 (*SD* = 3.83) and questionable reliability (α = .67). The PRI subscales were presented in a randomised order.

3.4.4 Time and Age Since Rainbow Identity Disclosure

Three relevant items examined time and age. The first item asked how long participants had first become aware of their child's rainbow identity. Five response options

were offered: “less than six months; six months to one year; one to two years; three to five years; and more than five years.” The ages of both participant and child when the participant first became aware of their child’s rainbow identity were also examined with responses reported via an open text response box.

3.4.5 Child’s Rainbow Identity

The seven items in this section asked about the participants’ child’s rainbow identity. If participants had more than one rainbow child, they were asked to answer this and the following sections with only one (and the same) child in mind. The items and response options in this section were the same as those asked of the participant in the beginning regarding their own sexual orientation and gender. However, participants were also asked whether their child is intersex and for their child’s sex assigned at birth. Response options for whether a participant’s child was intersex included “yes; no; I don’t understand the question; and I don’t know.” Response options for sex assigned at birth were “female; male; and indeterminate.”

3.4.6 Caregiver Attachment Style

The Experiences in Parent-Child Relationships Questionnaire (EPCR; Jiao & Segrin, 2021) and the Attachment Style Questionnaire – Short Form (ASQ; Iwanaga et al., 2020) were both used in this study to assess caregiver attachment style and are self-report measures. The ASQ secure attachment subscale was included as the EPCR examined only the anxious and avoidant attachment styles. Additionally, as the EPCR was designed to assess attachment in parent-child relationships, it was the basis in examining caregiver attachment styles and in revising the ASQ secure attachment subscale to be more specifically applicable to the aims and participants in this study.

3.4.6.1 Parent-Child Relationships Questionnaire. The EPCR contained ten items evenly split across two subscales: anxious and avoidant. All items were worded as

statements. The anxious subscale included items such as “I worry that my child won’t care about me as much as I care about them” and “I find that my child does not want to get as close as I would like” (Jiao & Segrin, 2021). The avoidant subscale included items such as “I try to avoid getting too close to my child” and “I usually discuss my problems and concerns with my child” (reverse-coded; Jiao & Segrin, 2021).

Participants responded on a 7-point Likert-type scale (1 = *strongly disagree* to 7 = *strongly agree*) to indicate their agreement with each statement. The anxious subscale had a mean score of 11.67 (*SD* = 5.83) and good reliability (α = .80). The avoidant subscale had a mean score of 16.86 (*SD* = 4.43) and poor reliability (α = .46). In Jiao and Segrin (2021) the anxious subscale had good reliability (α = .80) and the avoidant subscale had questionable reliability (α = .67).

3.4.6.2 Attachment Style Questionnaire (Secure Attachment Subscale). In this study, revision of the ASQ meant rewording items of the secure attachment subscale to more clearly reflect the caregiver-child relationship (e.g., changing *other people* to *my child*) and presenting the response options on the same 7-point Likert-type scale (the original was a 6-point Likert-type scale) as the EPCR. The four items in the secure subscale included statements such as “I feel confident about relating to my child,” and “I am confident that my child likes and respects me” (Iwanaga et al., 2018, 2020). In this study, the secure attachment subscale had a mean score of 22.72 (*SD* = 4.28) and acceptable reliability (α = .77) which was slightly higher than in the validation study of the ASQ study (α = .74; Iwanaga et al., 2018).

For scoring the participant’s responses, after reverse-coding three items in the avoidant subscale, each subscale was averaged. Higher mean scores indicated a greater tendency toward an anxious, avoidant or secure attachment style (Jiao & Segrin, 2021). The

highest score of the three subscales was determined to be the participant's dominant attachment style.

3.4.7 Parenting Practices Questionnaire

The ANZ Parenting Practices Questionnaire (PPQ) was used to assess caregiver parenting style as it has been revised and used with an ANZ sample previously (Mulder, 2019) and is briefer than the original measure (Robinson et al., 1995). The PPQ is a 22-item self-report measure with participants' responses to each item being reported on a 5-point Likert-type scale (1 = *never* to 5 = *always*). The PPQ contained three subscales, one for each parenting style: authoritative, authoritarian, and permissive. The authoritative subscale had 12 items and included statements such as "I know the names of my child's friends" (Mulder, 2019). The authoritarian subscale had six items and included statements such as "I argue with my child" (Mulder, 2019). The permissive subscale had four items and included statements such as "I appear unsure of how to solve my child's misbehaviours" (Mulder, 2019). All three subscales were presented in a randomised format.

For scoring the participant's responses, after reverse coding one item in the permissive subscale, each subscale was averaged. Higher mean scores indicated greater authoritative, authoritarian, or permissive parenting tendencies (Mulder, 2019). The highest score of the three subscales was determined to be the participant's dominant parenting style. The authoritative subscale had a mean score of 38.04 (SD = 6.10) and good reliability (α = .86). The authoritarian subscale had a mean score of 6.24 (SD = 3.24) and acceptable reliability (α = .76). The permissive subscale had a mean score of 7.11 (SD = 1.93) and unacceptable reliability (α = .42). In Mulder (2019) the authoritative subscale had good reliability (α = .89), the authoritarian subscale had poor reliability (α = .51), and the permissive subscale had unacceptable reliability (α = .46).

3.4.8 Caregiver Perceived Religious Acceptance of Rainbow People

Caregiver religiosity was examined with a novel self-report measure which contained six items. The first item asked if participants identified as religious or spiritual. Response options were "yes or no." Those who answered no, completed no further questions in this section. Participants who answered yes, were asked if they affiliate with an organised religion or spiritual group. Again, response options were either "yes or no," and participants who answered no completed no further questions in this section. Participants who answered yes were offered an open text response box to specify which organised group they affiliated with. The next item asked about attendance at services or engagement with religious or spiritual practices. Five response options were offered: "daily; weekly; on special occasions; rarely; and never." The last three items asked how closely participants identified with their religion, how accepting their religion was of Rainbow people, and how much they agreed with their religion's views on Rainbow people. Responses for these three items were reported via a 6-point Likert-type scale (0 = *not at all* to 5 = *very much*). Higher scores indicate greater acceptance or agreement as perceived by the participant. How closely one identified with their affiliated religion had a mean score of 3.55 (*SD* = 1.30). Perceived acceptance of rainbow people by one's religion had a mean score of 2.52 (*SD* = 1.76). Agreement with one's perceived religion's level of acceptance of rainbow people had a mean score of 2.00 (*SD* = 1.83). These last three items had acceptable reliability (α = .71).

3.4.9 Caregiver Perceived Ethnic Acceptance of Rainbow People

This novel self-report measures contained three items. Two items explored participants' perception of their ethnic group's acceptance of rainbow people in both private (e.g., in one-on-one conversations) and public (e.g., promote support for Rainbow communities) settings. The final item asked participants to rate how much they agreed with their perceived view of their ethnic groups acceptance of Rainbow people. All three items

exploring participant perception and agreement were answered via a 6-point Likert-type scale (0 = *not at all* to 5 = *very much*; Tanujaya et al., 2022). Higher scores indicate greater acceptance or agreement as perceived by the participant. Perceived acceptance of rainbow people by one's ethnic group in private had a mean score of 3.44 (*SD* = 1.00). Perceived acceptance in public had a similar mean score (*M* = 3.18, *SD* = 1.02). Agreement with one's ethnic group's perceived acceptance had a mean score of 2.55 (*SD* = 1.59). These items examining perceived ethnic acceptance and participant agreement had acceptable reliability (α = .73).

3.4.10 Other Measures

Other measures, such as Hua Oranga (McClintock et al., 2013) and the Lesbian Gay Bisexual Affiliate Stigma Measure (Robinson, 2014), and questions regarding caregiver access to support resources were included in the survey. However, as these measures and items were unrelated to this study, they are not described here.

3.5 Procedure

Before recruitment of participants began, the survey was piloted amongst the researcher's postgraduate psychology colleagues within and outside of the PRIDE lab. Alterations were made to ensure the smooth and correct running of the survey. As described above (see 3.2 Recruitment and Data Collection), potential participants were recruited online through paid advertising and/or the posting of a survey flyer which had both a QR code and URL link to the study's information sheet and survey. After reading the information sheet, giving informed consent, and completing the eligibility screener, participants were able to access the survey (via Qualtrics).

Upon survey completion, participants were offered the opportunity to receive a summary of findings and/or enter the prize draw for one of 15 $40 electronic gift cards (e-gift cards) in recognition of participant time and as an expression of appreciation for their

participation. Participants who wished to, were redirected to a separate prize-draw survey. The prize-draw survey was the only place identifying data (an email address) was collected. The prize draw was conducted on December 10, 2024. Fifteen participants were selected using an online random number generator (www.random.org). The winners were contacted via email and asked to reply to confirm that the email address provided was correct. Upon email confirmation a $40 Prezzee gift card was emailed to the winning participants. After a month, three participants had failed to reply so a re-draw was conducted on January 22, 2025.

A koha of $43 was donated to seven groups who assisted with recruiting participants on January 17, 2025. While more than seven groups helped with recruitment, only seven groups had easily accessible ways to donate to their group.

3.6 Ethics

Ethics approval was given by the Massey University Human Ethics Committee Ohu Matatika 2 on the 30th of May 2024 (OM2 24/16). The ethical issues specific to this study were considered, discussed, and addressed over several months.

General and cultural ethical kōrero (discussions) were conducted with Dr Ilana Seager van Dyk (supervisor of this study), and other postgraduate researchers of the PRIDE lab, many of whom have rainbow identities. Culture specific kōrero were also conducted with a Kaitiaki at the local Hospital, a Māori translator, and a Māori mother and grandmother with an adult rainbow child and grandchild. The kōrero that occurred with these cultural consultants lead to the decision to include a broad definition of caregiver due to the diversity of whānau structures within some Māori communities, alongside other cultural and ethical considerations, which were addressed as outlined below.

Although this study does not primarily focus on Māori participants, their participation was sought to ensure the findings would be inclusive, representative, and relevant, as the research was conducted in ANZ (Tan et al., 2023). Furthermore, it was likely that Māori

would be represented among the participants as the 2020 Household Economic Survey suggests more Māori have rainbow identities (19.2%) compared to non-Māori (13.5%) (Statistics New Zealand, 2021). With these considerations in mind, it was critical to respect and adhere to the key principles and provisions embodied in Te Tiriti. Based on Māori tikanga (protocols and practices), Te Ara Tika Guidelines for Māori Research Ethics serves as a valuable resource for researchers wishing to align their research with Te Tiriti by providing a framework for addressing Māori informed ethical issues (Hudson et al., 2010). Te Ara Tika contains four principles, namely whakapapa (relationships), tika (validity of the research), manākitanga (cultural and social responsibility and respect for persons), and mana (equity and justice; Hudson et al., 2010).

3.6.1 Whakapapa (Relationships)

As the Kaitiaki of the local Hospital strongly impressed in their kōrero (personal communication, March 9th, 2024), people matter and so, relationships matter. While the study used an online anonymous survey to collect data, the importance of monitoring and developing the relationship between researcher and participant was considered and addressed. Clearly introducing the research team and stating why the research was necessary and valuable were included in the information sheet and helped to establish a strong and trusting relationship with participants (Hudson et al., 2010).

Whakapapa was also upheld through including a contact email address which meant any arising participant concerns could be monitored and addressed. Furthermore, the option of receiving a summary of the findings meant participants could be included throughout various stages of the research process and see how their responses contributed to the limited knowledge currently available regarding ANZ caregivers and their rainbow children (Hudson et al., 2010).

3.6.2 Tika (Validity of the Research)

Referring to doing what is right and good in any given situation, the principle of tika was upheld using robust and valid scientific research methods by an experienced research team (Hudson et al., 2010). The research team had prior experience using similar methods (online surveys) with similar populations (rainbow adults, youth, and their whānau). The researcher has lived experience as a parent of a rainbow rangatahi (youth), and the research supervisor has clinical psychology expertise including applying research to clinical practice with rainbow youth and their whānau. Additionally, both researcher and supervisor have Māori roots and are fiercely committed to upholding Te Tiriti in their mahi (work).

3.6.3 Manākitanga (Cultural and Social Responsibility and Respect for Persons)

The principle of manākitanga refers to cultural and social responsibility as well as respect for persons and focuses on ensuring the mana (prestige and power) of all involved is enhanced (Hudson et al., 2010). Participant confidentiality and obtaining informed consent is one form of showing respect to participants and ensures participant mana is enhanced which is necessary in upholding manākitanga (Hudson et al., 2010). Participants' confidentiality and privacy were of paramount importance as the study targeted individuals who may not currently be sharing their child's rainbow identity publicly, or for whom it may not be safe for the participant's child to be known as having a rainbow identity (New Zealand Psychological Society et al., 2012).

To respect and promote participant confidentiality and privacy, the survey was online so participants could participate in a private and safe environment of their choosing (Hudson et al., 2010; New Zealand Psychological Society et al., 2012). All survey responses were anonymous, and no identifiable data that could be linked to individual participant responses was collected. If participants chose to enter the prize draw, they were redirected to a separate

survey to provide a contact email address; thus, preserving participant privacy and survey anonymity.

All survey data were obtained and stored using Qualtrics, a secure software platform approved by Massey University as the most appropriate tool for collecting survey data by postgraduate students in the School of Psychology. Survey data is securely stored on the Massey University servers. After the prize draw was conducted and a summary of findings were sent to interested participants, all data from the separate prize draw survey was permanently deleted.

Manākitanga was also addressed by seeking informed consent (Hudson et al., 2010; New Zealand Psychological Society et al., 2012). As the survey was conducted online, no physical consent forms were obtained. Before starting the survey, participants were presented with an information sheet which detailed the study's purpose, what participation involved, their rights, and contact details for the research team. Participants were also warned that completing the survey implied consent and once submitted, their responses could not be withdrawn as the survey was anonymous and there was no way to identify their specific responses. At the end of the information sheet, participants were asked to confirm that they had read the information sheet and give consent for their responses to be collected (New Zealand Psychological Society et al., 2012).

The measures included in the survey were all validated using international samples. Thus, to further uphold manākitanga in this study, all questions were reviewed with cultural consultants, Māori rainbow identities (e.g., Takatāpui) were added, and te reo Māori was included where possible. For example, when participants were asked about their relationship to their rainbow child, both English and Māori terms were used to categorise different types of caregiver-child relationships (e.g., biological parent/whaea, matua and adopted aunt or uncle/whaea or matua kēkē whāngai). Researchers were also mindful of treating all collected

data with the respect and care it deserves to ensure that the mahi carried out was mana-enhancing for all parties (Hudson et al., 2010; New Zealand Psychological Society et al., 2012).

3.6.4 Mana (Equity and Justice)

This study aims to positively contribute to the mana of Māori and the wider ANZ community by advancing knowledge on caregiver response to their rainbow children and refining interventions that support whānau with rainbow individuals. By upholding Te Ara Tika principles of research, this study also promotes inclusivity and diversity (Hudson et al., 2010).

In Te Ara Tika, mana refers to "power and authority … gained … individually and collectively" (Hudson et al., 2010, p. 13) and requires consideration of the risks and benefits to participants and communities. While no risk of harm was anticipated, the potential for some of the survey questions (i.e., those relating to past caregiver response to their rainbow child) to cause psychological discomfort (e.g., embarrassment, guilt, or shame) for some participants was recognised (Hudson et al., 2010; New Zealand Psychological Society et al., 2012).

To uphold mana and address the risk of participant discomfort, all questions were reviewed and revised through peer-review kōrero and by the Massey Ethics Committee (Hudson et al., 2010; New Zealand Psychological Society et al., 2012). The information sheet clearly explained the topics covered in the survey. Thus, participants were able to identify any topics that might cause them potential discomfort and enabled them to make an informed decision about participation (Hudson et al., 2010; New Zealand Psychological Society et al., 2012). The information sheet stated that only the eligibility questions were mandatory and that participants could contact the supervisor or research team via email (email addresses were provided) if they had any concerns or questions. A list of relevant sources for support

(e.g., OUTLine), and a link to a list of resources specifically for caregivers of rainbow young people, were also included in the information sheet.

One of the aims of this study was to examine characteristic differences across caregiver response classes. Ethnicity was one of the characteristics of interest. The purpose of the ethnicity questions was to explore how participants perceived their ethnic group's acceptance or support of rainbow people in private and in public, and whether agreeing or disagreeing with perceived views contributed to caregiver response class membership. To further uphold the principle of mana, the decision to examine caregiver response class membership and ethnicity was determined by final sample size and was solely analysed on a group membership basis (Hudson et al., 2010; New Zealand Psychological Society et al., 2012).

3.8 Data Analysis

Once sufficient data was collected, it was cleaned for quality assurance. The responses from 140 surveys were used in this study (see 3.3 Participants). Data analyses were conducted in several stages, with most data analyses conducted using SPSS version 29 (IBM Corp, 2022). Latent profile analysis (LPA) was conducted using tidyLPA (Rosenberg et al., 2018) and mclust (Scrucca et al., 2023) packages in R Studio (R Core Team, 2024).

Descriptive statistics were run to clearly understand the demographics of the final sample and establish scores for the attachment and parenting styles measures and reliability (Cronbach's alpha) of the parenting response indicators, caregiver attachment and caregiver parenting style measures, as well as the relevant items examining perceived levels of acceptance by participants' religion and ethnic group (see Table 3).

Next, LPA was conducted to test H1 and determine if ANZ caregivers best fit into three response classes as in the original study by Clark et al. (2022). LPA is a statistical approach that helps to identify and describe latent classes, or subgroups, within a population

by examining their responses to a predetermined measure (Dziak et al., 2020; Lanza & Rhoades, 2013; Muthén & Muthén, 2000; Woo et al., 2018). The predetermined measure in this study was the PRI (Clark et al., 2022). Each participant in the sample was assigned to the latent class for which they exhibited the highest probability of membership based on their responses (Lanza & Rhoades, 2013; Woo et al., 2018). It is important to acknowledge that LPA does not identify or predict true class membership but rather identifies and describes the most likely class to which a participant is a member (Lanza & Rhoades, 2013). Some researchers use LPA to refer to both latent class analysis and LPA as they are so similar (Dziak et al., 2020). In this thesis, LPA will be the term used, as in Clark et al.'s (2022) study, to describe the analysis used to identify the latent classes to which caregivers most likely belong (Lanza & Rhoades, 2013; Muthén & Muthén, 2000; Woo et al., 2018).

LPA with maximum likelihood estimation was used to fit models with one to five classes. Aligning with prior research, the optimal class number was determined based on several criteria, including the Akaike information criterion (AIC), Bayesian information criterion (BIC), sample size adjusted Bayesian information criterion (SABIC), entropy, the bootstrapped likelihood ratio test (BLRT), class size, and common sense (Clark et al., 2022; Dziak et al., 2014, 2020; Lanza & Rhoades, 2013; Nylund et al., 2007; Nylund-Gibson & Choi, 2018; Woo et al., 2018). As per Nylund et al. (2002) and Nylund and Choi (2018), lower AIC, BIC, SABIC values, a significant BLRT value, and an entropy value closest to one indicated optimal fit. Common sense was based on whether the results are interpretable, clear and logical.

Once the optimal model was determined, the means were calculated for each item of the PRI to ascertain the most appropriate label for each latent class. After finding the optimal class model and identifying labels for each latent class, class data was uploaded to SPSS and used to analyse and compare differences between the identified latent classes. Descriptive

statistics were again conducted to determine the general and caregiving demographics of each latent class.

Comparison testing was conducted to observe variance across general and caregiving demographics and test hypotheses H2 (time and age) and H3 (caregiver characteristics of interest). Chi-square tests of independence and independent sample t-tests were conducted to investigate the differences between the latent classes (Franke et al., 2012; Weissgerber et al., 2018). Since the latent classes differed significantly in size, Levene's test for equality of variances was applied to the t-test results. If the significance was greater than .05, the t-test assuming equal variances was reported. If the significance was less than .05, the t-test assuming unequal variances was reported. While an analysis of variance (ANOVA) was conducted in the original study, it was not conducted here, as a two-class model was found to be the most fitting for the present data (Weissgerber et al., 2018). However, an ANOVA was run to test H2c, (child's age at initial disclosure, child's rainbow group identity, and caregiver response class membership). All comparison testing was conducted in SPSS (IBM Corp, 2022).

Chapter Four: Results

4.1 Latent Profile Analysis of Caregiver Response to Their Rainbow Child (H1)

The LPA results for this study found a 2-class model to be the optimal solution (see Table 4). The fit criteria used to determine the optimal class model was log likelihood, BIC, SABIC, AIC, entropy, BLRT, class sizes, and common sense. The log likelihood criterion result of -1970.45 suggested the four-class model as best. However, BIC, SABIC, and AIC suggested the three-class model to be optimal (BIC = 4040.98; SABIC = 4031.98; AIC = 4040.98). The entropy result (0.97) for both two or three-class models indicated an equal best fit. Both remaining fit criteria (BLRT and class sizes) suggested the two-class model as optimal (BLRT = 399.24; minimum class size = 20 or 14.29%; maximum class size = 120 or 85.71%). Plotting the mean parent response indicator scores of each item for each latent class of all class models and common sense posited that a two-class model was the optimal solution in this study (see Figure 2 for the two-class model and Appendix F for the three, four, and five-class models)[7]. Of note, the five-class model was not indicated as the best solution by any of the fit criteria and included one class with less than 1% of cases assigned to it; thus, it was never considered to be optimal.

The two-class model was determined to be the optimal solution. Class 1, positive caregiver response (n = 120; 85.71%), had low mean responses to all five of the negative parent response indicators and high mean responses to all five of the positive parent response indicators. The positive caregiver response class had mean responses to the positive PRI subscale ranging between 4.58 (SD = 1.35) and 5.88 (SD = 0.53). Conversely, mean

[7] There was a lot of overlap between the two and three class solutions however the three-class model was less interpretable than the two-class model. For example, items one and two on the negative PRI subscale had low to moderate mean responses for one class but the same class had a high mean response to item three on the negative PRI subscale. Based on the hypotheses, high responses to the negative items and low responses to the positive items would indicate a negative caregiver response class, low responses to the negative items and high responses to the positive items would indicate a positive caregiver response class, and moderate responses to all items would indicate a mixed caregiver response class.

responses to the negative PRI subscale ranged between 1.16 (*SD* = 0.45) and 2.11 (*SD* = 1.40). Class 2, mixed caregiver response (*n* = 20; 14.29%), had moderate mean responses to all ten of the PRI items. The mixed caregiver response class had mean responses to the negative PRI subscale ranging between 3.15 (*SD* = 1.84) and 3.55 (*SD* = 1.64). The mean responses to the positive PRI subscale ranged between 3.35 (*SD* = 1.57) and 4.25 (*SD* = 1.45; see Table 5 and Figure 2).

4.1.1 Differences in General Demographics Based on Caregiver Response Class Membership

Chi-square tests of independence (chi-square tests) and independent sample t-tests (t-tests) were run to assess the significance of the associations and effects of variables and caregiver response class membership. Only the details of the significant results[8] will be described here as full details of the caregiving demographics, overall and for each caregiver response class, are presented in Table 1.

A chi-square test showed a significant association between participant sexual orientation and caregiver response class membership, x^2 (2, N = 139) = 9.81, $p < .01$ (two-tailed)[9]. The majority of participants in both caregiver response classes reported being heterosexual/straight, although a greater proportion of participants in the mixed caregiver response class identified this way (*n* = 13, 65%)[10] than in the positive caregiver response class (*n* = 74, 61.67%). More caregivers in the positive caregiver response class held a sexual minority identity (*n* = 37, 30.83%) compared to participants in the mixed caregiver response class (*n* = 1, 5%). Conversely, a greater proportion of participants in the mixed caregiver response class were neither heterosexual/straight nor rainbow/sexual minority or were unsure (*n* = 5, 25%) compared to participants in the positive caregiver response class (*n* = 9, 7.50%).

[8] Significance of results based on either $p < .05$, $p < .01$, or $p < .001$.
[9] One cell (16.7%) had an expected count less than five with a minimum expected count of 1.91.
[10] Percentages do not total 100 as only 19 participants in the mixed caregiver response class responded.

Similarly, a chi-square test showed a highly significant association between participants being intersex and caregiver response class membership, x^2 (2, N = 138) = 15.28, p < .001 (two-tailed)[11]. More participants in the positive caregiver response class reported not being intersex (n = 110, 91.67%)[12] compared to participants in the mixed caregiver response class (n = 13, 65%). A greater proportion of participants in the mixed caregiver response class reported being intersex (n = 1, 5%) or were unsure (n = 6, 30%) compared to participants in the positive caregiver response class (intersex n = 3, 2.50%; unsure n = 6, 5%).

A chi-square test showed a highly significant association between participant transgender gender identity and caregiver response class membership, x^2 (2, N = 138) = 13.99, p < .001 (two-tailed)[13]. The majority of participants in both caregiver response classes identified as cisgender (positive n = 112, 93.33%; mixed n = 13, 65%)[12]. Yet, a greater proportion of participants in the mixed caregiver response class identified as transgender (n = 3, 15%) or were unsure (n = 3, 15%) compared to the positive caregiver response class (transgender n = 5, 4.17%; unsure n = 2, 1.67%).

A chi-square test showed a significant association between non-binary gender identity and caregiver response class membership, x^2 (2, N = 137) = 24.05, p < .001 (two-tailed)[14]. While the majority of both caregiver response classes identified as binary (positive n = 109, 90.83%; mixed n = 11, 55%)[15], a greater proportion of participants in the mixed caregiver response class identified as non-binary (n = 2, 10%) or unsure (n = 6, 30%) compared to the positive caregiver response class (non-binary n = 6, 5%; unsure n = 3, 2.50%).

[11] Three cells (50%) had an expected count less than five with a minimum expected count of 0.55.
[12] Percentages do not total 100 as only 119 participants in the positive caregiver response class and 19 participants in the mixed caregiver response class responded.
[13] Three cells (50%) had an expected count less than five with a minimum expected count of 0.69.
[14] Two cells (33.33%) had an expected count less than five with a minimum expected count of 1.11.
[15] Percentages do not total 100 as only 118 participants in the positive caregiver response class and 19 participants in the mixed caregiver response class responded.

A chi-square test showed a significant association between ethnicity and caregiver response class membership, x^2 (6, N = 139) = 17.24, p < .01 (two-tailed)[16]. A greater proportion of participants in the positive caregiver response class identified as ANZ Pākehā (n = 92, 76.67%) compared to the mixed caregiver response class (n = 9, 45%). However, a greater proportion of participants in the mixed caregiver response class identified with multiple ethnicities (n = 7, 35%) compared to participants in the positive caregiver response class (n = 10, 8.33%). Specifically, most of the participants in the positive caregiver response class reported their ethnicity as ANZ Pākehā (n = 92, 76.67%), with the minority of participants identifying as ANZ Māori (n = 6, 5%), Indian (n = 1, 0.83%), Samoan (n = 1, 0.83%), another group (n = 10, 8.33%), or were multi-ethnic (n = 10, 8.33%). In the mixed caregiver response class, the plurality of participants reported their ethnicity as ANZ Pākehā (n = 9, 45%), with the minority identifying as ANZ Māori (n = 1, 5%), Chinese (n = 1, 5%), another group (n = 1, 5%), multi-ethnic (n = 7, 35%) or were unsure (n = 1, 5%).

Age had no significant association with caregiver response class membership, t(140) = 1.36, p = .18 (two-tailed), Hedge's g = 0.33[17]. Additionally, chi-square tests showed no significant associations between caregiver response class and the following variables: self-reported gender, x^2 (2, N = 130) = 0.74, p = .69 (two-tailed)[18], participant education level, x^2 (5, N = 137) = 4.07, p = .54 (two-tailed)[19], and participant economic stability, x^2 (5, N = 138) = 5.90, p = .32 (two-tailed)[20].

[16] Nine cells (64.3%) had an expected count less than five with a minimum expected count of 0.14.
[17] For the analysis, equal variances were assumed indicating that Levene's test was non-significant ($p \geq .05$).
[18] Two cells (33.33%) had an expected count less than five with a minimum expected count of 0.54.
[19] Six cells (50%) had an expected count less than five with a minimum expected count of 0.42.
[20] Five cells (41.70%) had an expected count less than five with a minimum expected count of 0.43.

4.1.2 Differences in Caregiving Demographics Based on Caregiver Response Class Membership

Chi-square tests and t-tests were run to assess the significance of the associations and effects of variables and caregiver response class membership. Only the details of the significant results[8] will be described here as full details of the caregiving demographics, overall and for each caregiver response class, are presented in Table 2.

A chi-square test showed a highly significant association between participant-child relationship and caregiver response class membership, x^2 (3, N = 139) = 32.27, p < .001 (two-tailed)[21]. More participants in the positive caregiver response class were parents (n = 115, 95.83%)[22] compared to the mixed caregiver response class (n = 14, 70%). However, a greater proportion of participants in the mixed caregiver response class were aunts or uncles (n = 4, 20%) and grandparents (n = 2, 10%) than in the positive caregiver response class (aunt or uncle n = 0, 0%; grandparent n = 1, 0.83%). A greater proportion of participants in the positive caregiver response class were a close family friend (n = 3, 2.14%) compared to the mixed caregiver response class (n = 0, 0%).

Similarly, a chi-square test showed a highly significant association between co-caregiver (e.g., parent, grandparent, aunt) and rainbow child relationship and caregiver response class membership, x^2 (4, N = 104) = 24.74, p < .001 (two-tailed)[23]. A greater proportion of participants in the positive caregiver response class parented with another parent (n = 88, 73.33%)[24] compared to the mixed caregiver response class (n = 8, 40%). Also, a greater proportion of participants in the mixed caregiver response class parented with co-

[21] Six cells (75%) had an expected count less than five with a minimum expected count of 0.43.
[22] Percentages do not total 100 as only 119 participants in the positive caregiver response class responded.
[23] Eight cells (80%) had an expected count less than five with a minimum expected count of 0.12.
[24] Percentages do not total 100 as only 92 participants in the positive caregiver response class and 12 participants in the mixed caregiver response class responded.

caregivers in a team dynamic (n = 3, 15%) compared to the positive caregiver response class (n = 1, 0.83%).

A t-test showed that the total number of children participants had, had a highly significant association with caregiver response class membership, $t(128) = -2.84$, $p < .01$ (two-tailed), Hedge's $g = -0.93$[25]. Participants in the mixed caregiver response class had a higher mean number of children (M = 3.20, SD = 0.92) than participants in the positive caregiver response class (M = 2.17, SD = 1.12). Overall, participants had an average of 2.25 (SD = 1.14) children in total. Participants in the positive caregiver response class had between one and six children, while participants in the mixed caregiver response class had between two to five children.

Similarly, a t-test showed that the number of rainbow children participants had, had a highly significant association with caregiver response class membership, $t(118) = 5.65$, $p < .001$ (two-tailed), Hedge's $g = 0.53$[26]. Participants in the positive caregiver response class had a higher mean number of rainbow children (M = 1.28, SD = 0.54) than participants in the mixed caregiver response class (M = 1.00, SD = 0.00). Participants in the positive caregiver response class had between one and three rainbow children, while participants in the mixed caregiver response class had only one rainbow child.

Chi-square tests of independence showed no significant associations between caregiver response class and the following variables: whether participants parented with a co-caregiver, x^2 (1, N = 140) = 1.24, p = .27 (two-tailed)[27], whether participants lived with their rainbow child, x^2 (2, N = 129) = 2.03, p = .36 (two-tailed)[28], a rainbow child's sexual

[25] 130 participants completed this item. For the analysis, equal variances were assumed indicating that Levene's test was non-significant ($p \geq .05$).
[26] 129 participants completed this item. For the analysis, equal variances were not assumed indicating that Levene's test was significant ($p < .05$).
[27] No cells (0%) had an expected count of less than five.
[28] Two cells (33.33%) had an expected count less than five with a minimum expected count of 1.09.

orientation, x^2 (2, N = 127) = 5.79, p = .06 (two-tailed)[29], whether a rainbow child was intersex, x^2 (2, N = 129) = 3.55, p = .17 (two-tailed)[30], a rainbow child's sex assigned at birth, x^2 (2, N = 129) = 1.51, p = .47 (two-tailed)[31], a rainbow child's transgender gender identity, x^2 (2, N = 129) = 4.40, p = .11 (two-tailed)[32], and a rainbow child's non-binary gender identity, x^2 (2, N = 127) = 0.71, p = .70 (two-tailed)[33].

T-tests showed the following variables had no significant association with caregiver response class membership: the number of co-caregivers, t(89) = 0.83, p = .41 (two-tailed), Hedge's g = 0.35[34], and a rainbow child's current age, t(127) = -0.57, p = .57 (two-tailed), Hedge's g = -0.19[35].

4.2 Differences in Time and Age Based on Caregiver Response Class Membership

4.2.1 Time Since Initial Disclosure of a Child's Rainbow Identity and Caregiver Response Class Membership (H2a)

A chi-square test showed no significant association between time since the initial disclosure of a child's rainbow identity and caregiver response class, x^2 (4, N = 123) = 5.10, p = .28 (two-tailed)[36]. Overall, the greater proportion of participants in both caregiver response classes had known about their child's rainbow identity for three or more years (positive n = 80, 66.67%; mixed n = 8, 40%)[37]. A small proportion of participants in the positive caregiver response class had known about their child's rainbow identity for less than

[29] Three cells (50%) had an expected count less than five with a minimum expected count of 0.16.
[30] Two cells (33.33%) had an expected count less than five with a minimum expected count of 0.62.
[31] Three cells (50%) had an expected count less than five with a minimum expected count of 0.08.
[32] Two cells (50%) had an expected count less than five with a minimum expected count of 1.01.
[33] Three cells (50%) had an expected count less than five with a minimum expected count of 1.42.
[34] 91 participants completed this item. For the analysis, equal variances were assumed indicating that Levene's test was non-significant ($p \geq .05$).
[35] 129 participants completed this item. For the analysis, equal variances were assumed indicating that Levene's test was non-significant ($p \geq .05$).
[36] Seven cells (70%) had an expected count of less than five with a minimum expected count of 0.24.
[37] Percentages do not total 100 as only 123 participants responded, 113 in the positive caregiver response class and 10 in the mixed caregiver response class.

one year (n = 8, 6.67%). No participants in mixed caregiver response class reported knowing about their child's rainbow identity for less than one year (see Table 6 for further details).

Similarly, a chi-square test showed no significant association between when a child had begun to publicly share their rainbow identity compared to the participants knowing and caregiver response class membership, x^2 (3, N = 129) = 4.43, p = .22 (two-tailed)[38]. The plurality of participants in both caregiver response classes learned of their child's rainbow identity at a similar time as others (positive n = 50, 41.67%; mixed n = 5, 25%)[39]. A greater proportion of participants in the positive caregiver response class knew of their child's rainbow identity before it was shared publicly (n = 47, 39.17%) compared to the mixed caregiver response class (n = 1, 5%). Similar proportions of participants in both caregiver response classes learned of their child's rainbow identity after others (positive n = 17, 14.17%; mixed n = 3, 15%). The smallest proportion of participants in both caregiver response classes had a child who were not yet sharing their rainbow identity publicly (positive n = 5, 4.17%; mixed n = 1, 5%). Details of these results are presented in Table 6.

4.2.2 Caregivers' Age at Initial Disclosure of Their Child's Rainbow Identity and Caregiver Response Class Membership (H2b)

A t-test showed that a participant's age at the initial disclosure of their child's rainbow identity had no significant association with caregiver response class membership, t(121) = -1.34, p = .18 (two-tailed), Hedge's g = -0.44[40]. The mean age of participants, at the time of initial rainbow identity disclosure, in the positive caregiver response class was younger (M = 40.46, SD = 11.12) than in the mixed caregiver response class (M = 42.50, SD = 12.68). Details of these results are presented in Table 6.

---

[38] Four cells (50%) had an expected count less than five with a minimum expected count of 0.47.
[39] Percentages do not total 100 as only 119 participants in the positive caregiver response class and 10 participants in the mixed caregiver response class responded.
[40] Only 123 participants completed this item. For the analysis, equal variances were assumed indicating that Levene's test was non-significant ($p \geq .05$).

4.2.3 Child's Age at Initial Disclosure of Their Rainbow Identity and Caregiver Response Class Membership (H2c)

A t-test showed that a child's age at the initial disclosure of a rainbow identity had no significant association with caregiver response class membership, $t(121) = -1.28$, $p = .20$ (two-tailed), Hedge's $g = -0.42$[40]. The mean age of a rainbow child at the time of initial disclosure to their caregiver, in the positive caregiver response class was younger ($M = 11.65$, $SD = 4.37$) than in the mixed caregiver response class ($M = 13.50$, $SD = 4.22$). Details of these results are presented in Table 6.

Additionally, a chi-square test showed no significant association between whether a rainbow child was younger (0-12 years), a child's rainbow group identity (sexual minority, gender minority or sexual and gender minority), and caregiver response class membership, x^2 (3, $N = 63$) = 0.76, $p = .86$ (two-tailed)[41]. A greater proportion of participants had rainbow children who were younger when they (the participant) learned of their child's rainbow identity ($n = 61$, 50.83%)[42] compared to the mixed caregiver response class ($n = 2$, 10%). The plurality of participants in the positive caregiver response class had younger children who had both a sexual (e.g., lesbian) and gender (e.g., transgender) minority identity ($n = 44$, 36.67%). Less participants in the positive caregiver response class had younger children with only a gender minority identity ($n = 14$, 11.67%). The fewest participants in the positive caregiver response class had younger children with only a sexual minority identity ($n = 3$, 2.50%). Only two (10%) participants in the mixed caregiver response class had younger rainbow children and both rainbow child had sexual and gender minority identities (see Table 7 for further details).

[41] Six cells (75%) had an expected count less than five with a minimum expected count of 0.03.
[42] Percentages do not total 100 as only 121 participants responded to all three variables.

Similarly, a chi-square test showed no significant association between whether a rainbow child was older (13-24 years), a child's rainbow group identity, and caregiver response class membership, x^2 (2, N = 58) = 1.60, p = .45 (two-tailed)[43]. More participants in both caregiver response classes had older children who had both sexual (e.g., gay) and gender (e.g., non-binary) minority identities (positive n = 40, 33.33%; mixed n = 5, 25%)[42]. Equal numbers of participants in the positive caregiver response class had older children who held only a sexual minority identity and only a gender minority identity (n = 5, 4.17%). Fewer participants in the mixed caregiver response class had older children who held only a gender minority identity (n = 1, 5%) compared to those, in the same caregiver response class, whose older children held only a sexual minority identity (n = 2, 10%). Details of these results are presented in Table 7.

4.3 Differences in Characteristics of Interest Based on Caregiver Response Class Membership

Table 3 presents the descriptive statistics and reliability (Cronbach's alpha), for the PRI, Caregiver Attachment Style, PPQ (caregiver parenting style), caregiver perceptions of how accepting their affiliated religion is of rainbow people and how much they agree with that religion's perceived view, and caregiver perceptions of how accepting their ethnic group or groups are of rainbow people in private and public settings, as well as how much they agree with the group's perceived view.

4.3.1 Child's Rainbow Group Identity and Caregiver Response Class Membership (H3a)

A chi-square test showed no significant association between a child's rainbow group identity and caregiver response class membership, x^2 (2, N = 129) = 2.41, p = .30 (two-tailed)[44]. Overall, most participants identified their children as having both a sexual (e.g.,

[43] Two cells (33.33%) had an expected count less than five with a minimum expected count of 0.83.
[44] Two cells (33.33%) had an expected count less than five with a minimum expected count of 0.78.

bisexual) and gender (e.g., gender fluid) minority identity (n = 98, 70%)[45]. Less participants reported having children with only a gender minority identity (n = 21, 15%). Even fewer participants identified their child as having a sexual minority identity (n = 10, 7.14%).

In the positive caregiver response class, most participants reported that their child had both a sexual and gender minority identity (n = 91, 75.83%). Less participants identified their children as having a gender minority identity (n = 20, 16.67%). Even fewer participants identified their children as having a sexual minority identity (n = 8, 6.67%). The one participant who was unsure about how their child identified was part of this latent class.

In the mixed caregiver response class, the plurality of participants reported their child's identity as both a sexual and gender minority (n = 7, 35%). Few participants in this caregiver response class reported their child having only a sexual minority identity (n = 2, 10%) with the fewest participants reporting only a gender minority identity (n = 1, 5%). Details of these results are presented in Table 8.

4.3.2 Caregiver Attachment Style and Caregiver Response Class Membership (H3b)

A chi-square test showed a highly significant association between caregiver attachment style and caregiver response class membership, x^2 (4, N = 131) = 30.49, p < .001 (two-tailed)[46]. A greater proportion of the participants in the positive caregiver response class had a secure attachment style (n = 105, 87.5%)[47] compared to participants in the mixed caregiver response class (n = 10, 50%). A greater proportion of participants with an anxious attachment style were in the mixed caregiver response class (n = 4, 20%) compared to participants in the positive caregiver response style (n = 2, 1.67%). Similarly, a greater proportion of participants with an avoidant attachment style were in the mixed caregiver

[45] Percentages do not total 100 as only 119 participants in the positive caregiver response class and 10 participants in the mixed caregiver response class responded.
[46] Six cells (60%) had an expected count less than five with a minimum expected count of 0.15.
[47] Percentages do not total 100 as only 112 participants in the positive response class and 19 participants in the mixed caregiver response class responded.

response class (n = 4, 20%) compared to participants in the positive caregiver response class (n = 4, 3.33%). One participant in the positive caregiver response class had an anxious and secure attachment style (0.83%). One participant in the mixed caregiver response class had an avoidant and secure attachment style (5%). No participant had an anxious and avoidant attachment style. Details of these results are presented in Table 8.

T-tests were also conducted based on the mean scores for each attachment style. A t-test showed that a secure caregiver attachment style had a large and highly significant association with caregiver response class membership, $t(21) = 5.39$, $p < .001$ (two-tailed), Hedge's $g = 1.78$[48]. Participants with a secure attachment style were significantly more likely to be in the positive caregiver response class than in the mixed caregiver response class. Participants in the positive caregiver response class had mean score of 5.92 (SD = 0.83) on the secure subscale while participants in the mixed caregiver response class had a mean score of 4.29 (SD = 1.27). A t-test also showed that an anxious attachment style had a large and significant association with caregiver response class membership, $t(128) = -3.24$, $p < .01$ (two-tailed), Hedge's $g = -0.80$[49]. Participants with an anxious attachment style were more likely to be in the mixed caregiver response class than in the positive caregiver response class. Participants in the mixed caregiver response class had a mean score of 3.11 (SD = 1.25) on the anxious subscale while participants in the positive caregiver response class had a mean score of 2.20 (SD = 1.10). A t-test showed that an avoidant attachment style had no significant association with caregiver response class membership, $t(129) = -1.04$, $p = .30$ (two-tailed), Hedge's $g = -0.26$[50]. Further details are presented in Table 9.

[48] Only 131 participants completed the secure caregiver attachment style subscale. For the analysis, equal variances were not assumed indicating that Levene's test was significant ($p < .05$).
[49] Only 130 participants completed the anxious caregiver attachment style subscale. For the analysis, equal variances were assumed indicating that Levene's test was non-significant ($p \geq .05$).
[50] Only 131 participants completed the avoidant caregiver attachment style subscale. For the analysis, equal variances were assumed indicating that Levene's test was non-significant ($p \geq .05$).

4.3.3 Caregiver Parenting Style and Caregiver Response Class Membership (H3c)

A chi-square test showed a significant association between caregiver parenting style and caregiver response class membership, x^2 (2, N = 105) = 7.70, $p < .05$ (two-tailed)[51]. The most common style of parenting overall was an authoritative (high warmth and high control) parenting style, with a greater proportion of participants in positive caregiver response class (n = 61, 50.83%)[52] compared to the mixed caregiver response class (n = 5, 25%). The permissive (high warmth and low control) parenting style was the next most common parenting style, with a greater proportion of participants in the mixed caregiver response class (n = 7, 35%) compared to the positive caregiver response class (n = 24, 20%). The least common parenting style was authoritarian (low warmth and high control), with a greater proportion of participants in the mixed caregiver response style (n = 3, 15%) compared to the positive caregiver response class (n = 5, 4.17%). These results suggest that an authoritative parenting style is more likely to be associated with the positive caregiver response class while a permissive or authoritative parenting style is associated with the mixed caregiver response class (see Table 8 for further details).

A t-test showed that a permissive parenting style had a moderate association with caregiver response class membership, $t(85) = -1.99$, $p < .05$ (two-tailed), Hedge's $g = -0.64$[53]. Participants with a permissive style of parenting were more likely to be in the mixed caregiver response class than in the positive caregiver response class. Participants in the mixed caregiver response class had a mean score of 2.05 (SD = 0.60) on the permissive subscale while participants in the positive caregiver response class had a mean score of 1.74 (SD = 0.46). A t-test showed that an authoritative parenting style had no significant

[51] Two cells (33.3%) had an expected count less than 5 with a minimum expected count of 1.14.
[52] Percentages do not total 100 as only 90 participants in the positive caregiver response class and 15 participants in the mixed caregiver response class responded.
[53] Only 87 participants completed the items on the permissive PPQ subscale. For the analysis, equal variances were assumed indicating that Levene's test was non-significant ($p \geq .05$).

association with caregiver response class membership, $t(5) = 2.34$, $p = .06$ (two-tailed), Hedge's $g = 1.94$[54]. Similarly, a t-test showed that an authoritarian parenting style also had no significant association with caregiver response class membership, $t(9) = -1.87$, $p = .09$ (two-tailed), Hedge's $g = -1.28$[55]. Details are presented in Table 10.

4.3.4 Caregiver Religiosity, Perceived Religious Acceptance, and Caregiver Response Class Membership (H3d)

Chi-square tests and t-tests were run to assess the significance of the associations and effects of religiosity-related variables and caregiver response class membership. Only the details of the significant results[8] will be described here as full details regarding participant religiosity, overall and for each caregiver response class, are presented in Table 8.

A chi-square test showed an association between participant religiosity and caregiver response class membership, x^2 (1, $N = 128$) = 6.71, $p < .05$ (two-tailed)[56]. While less than half of the overall sample identified as religious or spiritual, a greater proportion of participants in the mixed caregiver response class did identify as religious or spiritual ($n = 12$, 60%)[57] compared to participants in the positive caregiver response class ($n = 35$, 29.17%).

A chi-square test showed a significant association between affiliation with a religion or spiritual group and caregiver response class membership, x^2 (1, $N = 48$) = 7.31, $p < .01$ (two-tailed)[56]. Of those participants who considered themselves to be religious or spiritual, the majority of participants in the mixed caregiver response class affiliated with an organised religion or spiritual group ($n = 11$, 91.67%)[58] while participants in the positive caregiver response class were less likely to have a religious or spiritual affiliation ($n = 17$, 48.57%).

---

[54] Only 67 participants completed the items on the authoritative PPQ subscale. For the analysis, equal variances were not assumed indicating that Levene's test was significant ($p < .05$).
[55] Only 91 participants completed the items on the authoritarian PPQ subscale. For the analysis, equal variances were not assumed indicating that Levene's test was significant ($p < .05$).
[56] No cells (0%) had an expected count less than five.
[57] Percentages do not total 100 as only 109 participants in the positive caregiver response class and 19 participants in the mixed caregiver response class responded.
[58] Numbers ($N = 48$) and percentages are based on participants who self-identified as religious or spiritual.

A chi-square test showed no significant association between attendance at religious services or engagement in religious or spiritual practices and caregiver response class membership, x^2 (4, N = 28) = 7.56, p = .11 (two-tailed)[59].

T-tests showed the following variables had no significant association with caregiver response class membership: how close a participant identified with their affiliated religion or spiritual group, $t(10) = 2.06$, p = .07 (two-tailed), Hedge's $g = 0.97$[60], the level of acceptance toward rainbow people by their affiliated religion or spiritual group as perceived by the participant, $t(26) = 0.06$, p = .95 (two-tailed), Hedge's $g = 0.02$[61], and participant agreement with their perceived level of acceptance of rainbow people by their affiliated religion or spiritual group, $t(22) = 0.00$, p = 1.00 (two-tailed), Hedge's $g = 0.00$[62].

4.3.5 Caregiver Perceived Ethnic Acceptance and Caregiver Response Class Membership (H3e)

T-tests showed the following variables had no significant association with caregiver response class membership: the level of acceptance toward rainbow people by participants' ethnic group or groups in private settings (e.g., at home) as perceived by participants, $t(138) = 1.65$, p = .10 (two-tailed), Hedge's $g = 0.40$[63], the level of acceptance toward rainbow people by participants' ethnic group or groups in public settings (e.g., at public social gatherings) as perceived by the participant, $t(138) = 0.14$, p = .89 (two-tailed), Hedge's $g = 0.03$[63], and participant agreement with their perceived level of acceptance of rainbow people by their ethnic group or groups, $t(138) = 0.15$, p = .88 (two-tailed), Hedge's $g = 0.04$[63]. Details of these results are presented in Table 8.

---

[59] Nine cells (90%) had an expected count less than five with a minimum expected count of 0.39.
[60] Only 28 participants completed this item. For the analysis, equal variances were not assumed indicating that Levene's test was significant ($p < .05$).
[61] Only 28 participants completed this item. For the analysis, equal variances were assumed indicating that Levene's test was non-significant ($p \geq .05$).
[62] Only 25 participants completed this item. For the analysis, equal variances were not assumed indicating that Levene's test was significant ($p < .05$).
[63] For the analysis, equal variances were assumed indicating that Levene's test was non-significant ($p \geq .05$).

Chapter Five: Discussion

A copious amount of research reveals that greater numbers of people with rainbow identities are confronted with, and must navigate, the complexities of poorer health and well-being outcomes than their non-rainbow peers (e.g., D'Augelli, 2002; Lucassen et al., 2017; Tan et al., 2022). One study in the US investigated parental responses to their rainbow children and examined the correlations between parental response and rainbow child mental health (Clark et al., 2022). The increased risk of health and well-being concerns among rainbow young people, the influence of more accepting caregivers, and limited research conducted in ANZ, highlighted a need for further examination in this area. Thus, this is the first known study conducted in ANZ which examines caregiver response to their rainbow children, identifies latent classes based on caregiver response, and examines differences in caregiver characteristics between latent classes. However, there are two important caveats to keep in mind while interpreting these findings. One, the sample size is small and two, response rate varied, so caution must be taken when interpreting or generalising results beyond this sample.

5.1 Caregiver Response Classes (H1)

Two latent classes were identified in this study, a positive caregiver response class and a mixed caregiver response class. This finding aligns with previous research which found caregiver response could be a combination of both accepting and rejecting behaviours (Clark et al., 2022; Conley, 2011; Johnson et al., 2020; Meanley et al., 2021; Savin-Williams, 2001; Seager van Dyk et al., 2022). While three latent classes were not identified, as hypothesised in H1 and seen in the Clark et al. (2022) study, there were similarities in the number of participants in each of these classes across the two studies. The positive caregiver response class in the current study had 120 participants while Clark et al.'s (2022) positive class had

152. The mixed caregiver response class in this study had 20 participants and in Clark et al.'s study (2022) the same group had 22 participants.

The caregiver response classes in this study also aligned with their matching class in Clark et al.'s (2022) study in how participants responded to the PRI. The positive caregiver response classes had the lowest responses to the five negative PRI subscale items and the highest responses to the five positive PRI subscale items. The mixed caregiver response class had moderate responses to all ten PRI items. This finding makes sense as caregiver levels of acceptance would be expected to reflect in responses to the PRI. Furthermore, it suggests that caregivers in the US and ANZ are responding similarly to the PRI items.

The results partially support H1 which proposed that three latent classes would be identified as observed in Clark et al. (2022) study. There may be several reasons why only two latent classes were observed in this study. First, the current overall sample may be too small to observe enough variance to make a third class more evident (Lohr, 2019; Rusticus & Lovato, 2014). A future replication could recruit a larger sample to address this concern. Second, more rejecting caregivers, who would be likely to make up a negative caregiver response class, may be less willing to participate in research which focuses on raising rainbow children. Third, (although there is limited evidence for this) there may be fewer rejecting caregivers in ANZ which may be attributed to cultural differences in parenting ethos or acceptance of rainbow people. For example, same-sex marriage became legal two years earlier in ANZ than in the US (Marriage Amendment Act, 2013; Obergefell v. Hodges, 2015). Replications of this study could be conducted in several other countries, such as Brazil, Egypt, Japan, Israel, and the Netherlands (the first country to legally recognise same-sex marriage; Trandafir, 2014), to examine how influential culture may be on parenting practices and how this may relate to caregiver acceptance of a rainbow child. Such studies could lay

the groundwork for future interventions aimed at promoting more accepting and affirming parenting interventions.

5.1.1 General Demographics and Caregiver Response Class

Statistical significance was found between caregiver response class membership and participants' sexual orientation, whether participants themselves were intersex, and participants' gender group identities. While the majority of participants in both caregiver response classes identified as heterosexual/straight, not intersex, transgender or non-binary, more participants in the mixed caregiver response class were neither or unsure than the positive caregiver response class. For example, 30% of caregivers in the mixed class were neither or unsure about whether they were non-binary or binary. It is possible that more participants in the mixed caregiver response class were more unsure about different gender terminology and what they mean; thus, these results could reflect a difference in understanding, rather than a difference in identity between the two groups. Alternatively, more participants in the mixed caregiver response class could be figuring out their own identity than in the positive caregiver response class, which could mean they are unsure how to respond to their rainbow child while discovering, or rediscovering, their own self-identity. Future research could consider the level of understanding or education around gender terminology of caregivers of rainbow children and caregiver response class membership. Investigating self-identity changes in caregivers and parenting practices could also lead to the further understanding of caregivers of rainbow children and potential changes they experience while adjusting to their child's rainbow identity.

A significant difference between the two caregiver response classes based on ethnicity was observed. It is unsurprising that most participants in both caregiver response classes identified as ANZ Pākehā as this ethnicity makes up much of the ANZ population. However, it is interesting to note how a greater proportion of participants in the mixed caregiver

response class identified with more than one ethnicity compared to the positive caregiver response class. The observed differences may be attributed to generational differences in reporting ethnicity, as the mixed caregiver response class had a slightly younger mean age, or to the increasingly diverse range of ethnicities that live in ANZ. Future research could investigate these factors further.

5.1.2 Caregiving Demographics and Caregiver Response Class

A highly significant association between caregiver response class membership and participant-child relationship was observed. While most participants were parents to their rainbow child, 30% of participants in the mixed caregiver response class (compared to 3.33% in the positive caregiver response class) were either a grandparent, aunt or uncle. It could be pertinent to re-examine this result more closely. Obtaining a larger sample would enable a comparison of the types of parents (e.g., biological, step, adopted, foster) and caregiver response class membership. This could be helpful for prevention and intervention purposes to understand whether, for example, foster parents are more likely to be in the mixed caregiver response class than the positive caregiver response class.

While the number of co-caregivers was not significant, a highly significant association was observed between co-caregiver and rainbow child relationship and caregiver response class membership. Interestingly, more participants in the mixed caregiver response class reported parenting with a team of co-caregivers than participants in the positive caregiver response class. Caregiver teams were made up of a combination of parent, grandparent, aunt or uncle, and close whānau friend. Several reasons could explain this difference. First, cross-generational co-caregiver teams (e.g., parent and grandparent) might increase the likelihood of differing levels of acceptance towards, and beliefs about, rainbow people within the parenting team (due to different levels of acceptance of rainbow people across time). These differences in beliefs might influence a caregiver's behaviour, including

their reaction to their rainbow child (as captured by the PRI). Second, parenting with a less accepting co-caregiver may promote a mixed response in a caregiver as they try to navigate their own and their co-caregivers' beliefs and feelings alongside supporting their rainbow child. Third, having more co-caregivers likely increases variance within the caregiving team dynamic and thus also increases the variety of responses to the rainbow child. It could also be insightful to evaluate different whānau generations' levels of acceptance and support of rainbow people. For example, is a grandparent more or less likely to be in positive, mixed or negative response class compared to a parent or sibling of a rainbow individual? And how do rainbow children cope if their whānau is comprised of people with varying degrees of acceptance and support?

Future research could explore differences in acceptance levels between co-caregivers (e.g., using dyadic study designs) and how this influences caregiver response class membership. Additionally, studies could investigate different co-caregiver (e.g., close whānau friend vs grandparent) and rainbow child relationships and how these may differ in acceptance levels to primary caregivers.

The number of children (total and rainbow specifically) participants had, had a significant association with caregiver response class membership. Participants in the mixed caregiver response class were more likely to have more total children than participants in the positive caregiver response class. Conversely, participants in the positive caregiver response class were more likely to have more rainbow children than participants in the mixed caregiver response class. These results could suggest that caregivers with fewer total children have more time and energy to dedicate to self-education or engaging in support groups to address their concerns and gain more information and support in accepting and supporting their rainbow child. Furthermore, participants with more than one rainbow child may be more accepting with each additional rainbow child they have, as the potential shock of finding out

about a child's rainbow identity and the length of time potentially needed to adjust and accept the child's rainbow identity may lessen. A future cross-sectional study focusing on caregivers with more than one rainbow child could examine potential differences in caregiver acceptance to the first and subsequent rainbow children. Potential findings could elucidate the process in accepting a rainbow child and provide insights that strengthen interventions aimed at caregivers who require additional support in accepting their child, such as those in the mixed caregiver response class.

5.2 Time, Age, and Caregiver Response Class (H2)

Results relating to time since the initial disclosure of a child's rainbow identity (H2a), the rainbow child's age (H2b) and caregiver's age (H2c) at the time of disclosure were not found to be significant in this study, so H2a, H2b, and H2c were not supported. While no statistical difference was observed, it is interesting to note that no participants in the mixed caregiver response class had known about their child's rainbow identity for less than one to two years. Only eight participants reported knowing about their child's rainbow identity for less than one year and all eight caregivers were in the positive response class. This could be because more accepting caregivers may also be more willing to participate in research about raising rainbow children sooner than those who may be in a mixed caregiver response class.

5.3 Caregiver Characteristics of Interest and Caregiver Response Class

5.3.1 A Child's Rainbow Identity Group and Caregiver Response Class (H3a)

Results suggest that the differences in a child's rainbow group identity (e.g., a sexual minority identity such as bisexual or a gender minority group such as gender fluid) were not significant. H3a, which presupposed that the negative caregiver response class would more likely have children with a gender minority identity and the mixed caregiver response class would likely have a rainbow child with a sexual and gender minority identity, was not supported. There was no negative caregiver response class identified and only half of the

participants in the mixed caregiver response class responded to the relevant items making it difficult to have any certainty regarding this group.

This lack of support for H3a may be because the current sample had more rainbow children with sexual and gender minority identities and fewer children with only a sexual or gender minority identity than previous studies. Previous research showed more negative caregiver responses to children with a gender minority identity, yet the findings in this study have not closely aligned with previous studies (Alanko et al., 2011; D'Augelli et al., 2008). Future insights could be gained by investigating whether more rainbow children have combined sexual and gender minority identities in the present compared to the past, or if greater visibility and general acceptance are making it more likely for a combined rainbow identity to be shared. However, this may just be a unique feature of the current sample. Alternatively, it's possible that caregivers of sexual minority youth are generally more accepting, as having a gay or lesbian child is becoming more normalised. As a result, parents seeking information about rainbow children might be more likely to be parents of gender minorities, around whom there is ongoing concern and debate. These may be the caregivers found through the recruitment process. Examining initial caregiver response to the disclosure of their child's rainbow identity and comparing this to current responses may be insightful.

Future studies could also investigate whether rainbow children with more than one rainbow identity disclose these together at once, or one rainbow identity at a time. For example, does a caregiver find out about their rainbow child being both pansexual and non-binary at once or at different times and how this may impact the caregiver's response and acceptance level. Potential findings could be important as gender and sexual identity develops at different ages (Savin-Williams, 2001). Given the stigma associated with gender minority identities, it is possible that disclosure of a gender minority identity is delayed. Research shows that the age of disclosure among sexual minorities has decreased over time

as sexual minorities have become more accepted (e.g., Dunlap, 2016). It will be interesting to see if the same thing happens amongst gender minorities too.

5.3.2 Caregiver Attachment Style and Caregiver Response Class (H3b)

While over 80% of participants in the overall sample had a secure attachment style, participants with a secure attachment style were more likely to be in the positive caregiver attachment style whereas participants with an anxious or avoidant attachment style were more likely to be in the mixed caregiver response class. Caregiver attachment mean scores by caregiver response class were also analysed and t-tests found that both an anxious and a secure attachment style had significant effects on caregiver response class membership. Participants in the mixed caregiver response class were associated with higher levels of anxious attachment whereas, participants in the positive caregiver response class were associated with higher levels of secure attachment. These findings provide evidence in support of H3b, which hypothesised that more secure attachment styles would be found among the positive caregiver response class and more anxious or avoidant attachment styles would be found among the mixed caregiver response class.

Previous research has shown that caregivers with an anxious or avoidant attachment style tend to be less consistent and less accepting (Jones et al., 2015); thus, caregivers with these attachments style may be more likely to engage in inconsistent or mixed responses towards their rainbow child. It has been suggested by Bowlby (1969/1982) and other researchers (e.g., Cozzarelli et al., 2003; Jones et al., 2015) that attachment styles are relatively flexible with people being able to become more or less secure over time. Future studies could examine how a caregiver with an anxious or avoidant attachment style can become more secure and whether a change in caregiver attachment style correlates with a change in acceptance of a rainbow child. Alternatively, a future study could examine if caregiver attachment style influences rainbow children's mental health or well-being

outcomes as a previous study has linked attachment style to one's own mental health outcomes (Cozzarelli et al., 2003). Considering the influence of caregivers and the poorer health and well-being outcomes experienced by rainbow young people, researching a variety of ways to improve current statistics is crucial and potential findings could contribute to doing this.

5.3.3 Caregiver Parenting Style and Caregiver Response Class (H3c)

Participant parenting style was found to be significantly associated with caregiver response class membership, such that participants in the positive caregiver response class were more likely to employ authoritative parenting techniques (e.g., supporting and encouraging their rainbow child to choose a sport, regardless of the child's sex assigned at birth or social norms). Comparatively, the participants in the mixed caregiver response class were more likely to use a permissive parenting style (e.g., leaving their rainbow child to deal with rainbow-related issues independently). An authoritarian style of parenting was uncommon in both caregiver response classes. Like the caregiver attachment style, caregiver parenting style mean scores by caregiver response class were also analysed and t-tests found that a permissive parenting approach had a moderate association with caregiver response class. Higher levels of permissiveness were seen amongst participants in the mixed caregiver response class. These findings align with other studies suggesting that parenting in ANZ tends to be more authoritative or permissive and less authoritarian (Howe et al., 2017; Mulder, 2019). The findings support H3c which presupposed that participants in the positive caregiver response class would primarily employ an authoritative style of parenting and the participants in the mixed caregiver response class would more likely employ a permissive style of parenting.

While previous research has found gender minority children to view their parents parenting style to be more authoritarian, this study found caregivers tend to report more

authoritative and permissive parenting techniques (Mohta et al., 2017). A comparative study investigating caregiver reporting of parenting style and rainbow child reporting of their caregiver's parenting style could elucidate the difference in findings. Alternatively, a comparative study could examine whether there are differences in perceived parenting styles between different rainbow group identities (e.g., is there a difference between how gender minority children and sexual minority children perceive their caregivers parenting style?). Potential insights from such studies could provide crucial guidance in updating current, or creating new, parenting courses for caregivers with rainbow children.

5.3.4 Caregiver Religiosity, Perceived Religious Acceptance and Caregiver Response Class (H3d)

Overall, the majority of the sample did not identify as religious or spiritual. Differences between caregiver response classes and whether participants identified as religious or spiritual, and religious or spiritual affiliation were significant. Participants in the positive caregiver response class were less likely to identify as religious or spiritual and were less likely to affiliate with an organised religion or spiritual group compared to those in the mixed caregiver response class. Interestingly, no significant association was found between caregiver response classes, despite all participants in the mixed caregiver response class attending services or engaging in practices either daily or weekly, compared to half of the participants doing so in the positive caregiver response class. Perceived religious acceptance of rainbow people and agreement with perceived acceptance had no significant association with caregiver response class membership. These findings do not support H3e, which presupposed caregivers who agreed with more accepting religious or spiritual groups to be identified within the positive caregiver response class and caregivers in the mixed response class would primarily be those who disagreed with their religious or spiritual group's perceived levels of acceptance of rainbow people.

Recruitment focusing on more religious or spiritual groups could provide a larger religious sample to re-examine caregiver response class membership and caregiver religiosity to confirm these findings. It might also be interesting to study rainbow people who consider themselves religious or spiritual and see how their perception of acceptance differs or is similar to religious caregivers of rainbow children.

5.3.5 Caregiver Perceived Ethnic Acceptance and Caregiver Response Class (H3e)

Overall, ethnic groups were perceived to be moderately accepting in private and public settings. Participants somewhat agreed with their perceived view on their ethnic groups' acceptance level towards rainbow people. However, H3e was not supported as participants in both caregiver response classes considered their ethnic groups to be similarly accepting regardless of setting and similarly agreed with their perceived acceptance levels.

More ANZ Pākehā caregivers were in the positive response class whereas the same ethnicity made up less than half of the mixed response class. This suggests a larger and more diverse sample is required to confirm these findings or better elucidate the potential impact ethnicity may have on caregiver response class membership. Targeted recruitment in more diverse places may help in obtaining a sample with greater non-Pākehā caregiver representation.

5.4 Implications

This study has implications for clinicians, communities, and other researchers. From these findings, it is evident that clinicians, working with caregivers of rainbow children, need to include a holistic examination of a client's wider context. Clinicians might consider their client's demographics, attachment style, parenting approach, and religiosity when assessing how the client has responded to their rainbow child. For example, if a client identifies with more than one ethnic group, is a non-parent caregiver, caregives with a combination of co-caregivers (e.g., grandparent and whānau friend), has an anxious or avoidant attachment

style, uses more permissive parenting techniques, and affiliates with a religion, they might be more likely to fall in the mixed category, whereas if they hold a rainbow identity, are a parent to their rainbow child, caregive with another parent, exhibit a secure attachment style, primarily employ authoritative parenting practices, and do not affiliate with a religion they may fall in the positive category. This can help clinicians understand what they are dealing with so that they can tailor their future interventions to be responsive to the client's needs.

This study's findings also imply that attachment and parent-based therapies may be a vital component for clinicians working with clients who exhibit more mixed responses to their rainbow children. These types of interventions have been found to increase the acceptance levels of less or non-accepting caregivers (e.g., Diamond et al., 2022; Malpas et al., 2022; Zavala & Waters, 2024). While further research is needed to identify exactly how treatment needs might be different across caregiver classes, this study provides that first step for clinicians seeking to understand what type of parent they have in front of them.

These findings may also be of interest to community groups who support rainbow young people and their whānau. Most ANZ-based rainbow organisations include resources for caregivers and whānau of rainbow people so these findings may encourage these groups to consider regular online or in person support group meetings for caregivers or whānau of rainbow people. Furthermore, a better understanding of caregiver response to their rainbow child could be included in parenting programmes which are disseminated online and within local community groups. While not every caregiver will have a rainbow child, increasing awareness and knowledge may prompt caregivers of rainbow children to better understand themselves and engage in available supports as they work towards increasing their level of acceptance.

As disparities in health and well-being outcomes between rainbow and non-rainbow people continue, there remains a need for researchers to continue exploring a wide range of

factors relating to caregivers and whānau of rainbow people in ANZ. This replication study could act as a starting point for other researchers.

5.5 Future Directions

While the original Clark et al. (2022) study limited participants to only parents who did not themselves hold a rainbow identity, such restrictions were not included for this study as the sample size was smaller than the original study. However, a future replication could recruit a larger sample and compare latent class membership by participant rainbow or non-rainbow identity.

Future examination of rainbow children and their perspectives on the same caregiver characteristics and caregiver response class membership could extend current knowledge in this area. Obtaining both child and caregiver perspectives is important, despite potential informant discrepancies, as studies have found multi-informant reports can identify concerns within a specific context and may uncover differences between a child's experience and that of their caregiver (De Los Reyes et al., 2015; De Los Reyes & Epkins, 2023). For example, if a caregiver's responses indicated a secure attachment or a permissive parenting style, does the rainbow child's response match? Could a mismatch between the rainbow child's responses and the caregivers' responses increase youth distal stress as understood in minority stress theory? Are mismatches between child and caregiver more likely within a particular caregiver response class?

A longitudinal study examining caregiver attitudes and behaviours over time could provide insights into caregiver response class membership dynamics. Research examining movement between caregiver response classes may be crucial in the development and strengthening of interventions aimed at supporting caregivers in becoming more accepting of their child's rainbow identity. Previous research in other countries show movement from rejection to acceptance, as well as from conditional acceptance to rejection and, in some

cases, on to acceptance (Chrisler, 2017; Mattingly et al., 2016; Morgan et al., 2014; Samarova et al., 2014; Savin-Williams, 2001). However, it remains unclear how mixed caregiver responses fit into observed movements between caregiver response classes. Examining if, when, and how movement between caregiver response classes occurs, whether movement occurs from mixed to positive caregiver response classes, and whether particular types of interventions or resources promote or hinder greater acceptance could be incredibly beneficial.

5.6 Strengths and Limitations

This study has several strengths. First, this study is a replication conducted with an ANZ sample. Limited research focusing on ANZ caregivers of rainbow children means this study is of importance in establishing ANZ-specific knowledge relating to this nuanced group of people. Second, the participants were caregivers of rainbow children, and it is crucial to obtain caregiver perspectives regarding their experiences and responses to finding out about their child's rainbow identity rather than solely relying on the child's perspective. Third, this study included rainbow caregivers as well as non-rainbow caregivers. While it was not an intentional inclusion, it importantly reflects the demographic range of caregivers in ANZ. Current numbers of caregivers with rainbow identities are unavailable. However, a 2007 survey of rainbow people in ANZ reported approximately 25% of their sample (more than 2250 participants) were parents (Henrickson et al., 2007). This suggest that rainbow caregivers should not be excluded from research focusing on parenting in ANZ. Finally, although small in size, the sample reflected the diverse range of ethnic groups which make up the current population of ANZ. Participants were predominantly Pākehā, with the second largest single ethnic group being Māori. The sample also included a multi-ethnic group with much of this group including Māori.

Alongside these strengths, this study has several limitations which need to be acknowledged. A cross-sectional design means causation cannot be inferred from these data. Considering the nature of the variables of interest, experimental research may be unethical (e.g., adding another child with a rainbow identity to a whānau to observe whether the caregivers continue to show mixed responses when they have a second rainbow child) and difficult to conduct, but phenomenological or ethnographic research could provide a more in-depth understanding of caregiver experiences and responses to their rainbow children. Alternatively, a mixed methods approach could have been used to identify latent caregiver response classes and perhaps clarify participants responses to items that could be understood in a variety of ways. For example, when participants responded to the item "my relationship with my child has improved since my child came out as rainbow/LGBTQIA+", participants whose relationships with their child were strong and supportive before finding out about their child's rainbow identity may have remained similar to before. This could result in no reported improvement but not due to the caregiver rejection. Alternatively, the reasons behind the improved relationship may not be directly related to the caregiver's acceptance level. Rather, worry or concern for their child, paired with a child who is depressed due to fear of disclosing their identity or facing proximal and distal minority stressors alone, could negatively affect the caregiver-child relationship (Frost & Meyer, 2023; Seager van Dyk et al., 2022).

Several items (e.g., caregiver religiosity items) had a significant attrition rate. The complete survey had 147 items as it involved several projects and the items with more varied response rates were presented later in the survey. Future research may consider utilising shorter surveys to reduce potential participant abandonment or placing key items earlier in the survey to ensure better response rates.

A sample size smaller than the original study may have impacted the current findings. This may have reduced the potential for observable variance and could explain why no

negative response class was identified. Furthermore, the small size of the mixed caregiver response class and reduced response rate from this class means additional research is needed to increase generalisability and ensure the findings are representative of this unique group of ANZ caregivers.

Additionally, several of the hypotheses included somewhat ambiguous language. For example, H2c did not clearly state what age constituted an older or younger child. More precise hypotheses would provide clear benchmarks to better determine support from the findings.

Chapter Six: Conclusion

Differences in health and well-being outcomes for rainbow people is a well-researched yet persistent concern. How caregivers' respond to their child when and after learning of their child's rainbow identity has been found to have a significant impact on the child. Acceptance and support by caregivers act as buffers against stress and reduces risk of poorer health and well-being outcomes, while caregiver rejection contributes to an increased risk of engagement in risky behaviours and poorer health and well-being outcomes (Bosse, Katz-Wise, et al., 2024; D'Amico et al., 2015; Frost & Meyer, 2023; Ryan, 2019a, 2019b; Ryan et al., 2009).

Two latent caregiver response classes (positive and mixed) were found based on participants responses to the PRI and used to examine caregiver context and characteristics. Overall, significant variances were observed in a third of the variables analysed. Most participants in this sample were found to be accepting and supportive based on their PRI responses. Participants in the positive caregiver response class were more likely to be heterosexual, not intersex, cisgender, binary, ANZ Pākehā, a parent caregiving with another parent, with more rainbow children but fewer total children. Positive caregiver response class membership was also linked with a secure attachment style, an authoritative parenting style, and not identifying as religious or spiritual nor affiliating with an organised religion or spiritual group.

A second smaller latent caregiver response class was also identified which consisted of participants who engaged in both accepting and rejecting behaviours. While participants in this mixed caregiver response class were also more likely to identify as heterosexual, not intersex, cisgender, and binary, a greater proportion of them were also more likely to be unsure about their sexual orientation and gender identity groups then those in the positive caregiver response class. Participants in the mixed caregiver response class were parents to

their rainbow child, parented with either another parent or with a team of co-caregivers (e.g., aunt and whānau friend), and have more total children but fewer rainbow children. While a secure attachment was also the most common attachment style in this caregiver response class, a greater proportion of participants had anxious or avoidant attachment styles in the mixed caregiver response class. Mixed caregiver response class participants were more likely to use a permissive parenting style, identify as religious or spiritual and affiliate with an organised religion or spiritual group.

Results suggest that caregivers in ANZ tend to be accepting however, there is a visible need for additional research, resources, and interventions to better understand and assist caregivers who may struggle with acceptance or who engage in conflicting responses to their rainbow children. Encouraging and supporting caregivers to increase their levels of acceptance and support can only help improve outcomes for young rainbow people in ANZ.

References

Aarts, H., & Dijksterhuis, A. (2003). The silence of the library: Environment, situational norm, and social behavior. *Journal of Personality and Social Psychology*, *84*(1), 18–28. https://doi.org/10.1037/0022-3514.84.1.18

Abreu, R. L., Gonzalez, K. A., Rosario, C. C., Pulice-Farrow, L., & Rodríguez, M. M. D. (2020). "Latinos have a stronger attachment to the family": Latinx fathers' acceptance of their sexual minority children. *Journal of GLBT Family Studies*, *16*(2), 192–210. https://doi.org/10.1080/1550428X.2019.1672232

Abreu, R. L., Lefevor, G. T., Gonzalez, K. A., Barrita, A. M., & Watson, R. J. (2023). Bullying, depression, and parental acceptance in a sample of Latinx sexual and gender minority youth. *Journal of LGBT Youth*, *20*(3), 585–602. https://doi.org/10.1080/19361653.2022.2071791

Abreu, R. L., Lefevor, G. T., Gonzalez, K. A., Teran, M., & Watson, R. J. (2022). Parental support, depressive symptoms, and LGBTQ adolescents: Main and moderation effects in a diverse sample. *Journal of Clinical Child & Adolescent Psychology*, 1–16. https://doi.org/10.1080/15374416.2022.2096047

Abreu, R. L., Rosenkrantz, D. E., Ryser-Oatman, J. T., Rostosky, S. S., & Riggle, E. D. B. (2019). Parental reactions to transgender and gender diverse children: A literature review. *Journal of GLBT Family Studies*, *15*(5), 461–485. https://doi.org/10.1080/1550428X.2019.1656132

Agans, J. P., Schade, S. A., Hanna, S. R., Chiang, S.-C., Shirzad, K., & Bai, S. (2024). The inaccuracy of data from online surveys: A cautionary analysis. *Quality & Quantity*, *58*(3), 2065–2086. https://doi.org/10.1007/s11135-023-01733-5

Ainsworth, M. D. S. (1978). The Bowlby-Ainsworth attachment theory. *Behavioral and Brain Sciences*, *1*(3), 436–438. http://doi.org/10.1017/S0140525X00075828

Ainsworth, M. S. (1979). Infant–mother attachment. *American Psychologist*, *34*(10), 932–937. https://doi.org/10.1037/0003-066X.34.10.932

Ainsworth, M. S. (1989). Attachments beyond infancy. *American Psychologist*, *44*(4), 709–716. https://doi.org/10.1037/0003-066X.44.4.709

Alanko, K., Santtila, P., Salo, B., Jern, P., Johansson, A., & Sandnabba, N. K. (2011). Testing causal models of the relationship between childhood gender atypical behaviour and parent–child relationship. *British Journal of Developmental Psychology*, *29*(2), 214–233. https://doi.org/10.1348/2044-835X.002004

Arcelus, J., Claes, L., Witcomb, G. L., Marshall, E., & Bouman, W. P. (2016). Risk factors for non-suicidal self-injury among trans youth. *The Journal of Sexual Medicine*, *13*(3), 402–412. https://doi.org/10.1016/j.jsxm.2016.01.003

Armesto, J. C., & Weisman, A. G. (2001). Attributions and emotional reactions to the identity disclosure ("coming out") of a homosexual child. *Family Process*, *40*(2), 145–161. https://doi.org/10.1111/j.1545-5300.2001.4020100145.x

Atkinson, J. H., Grant, I., Kennedy, C. J., Richman, D. D., Spector, S. A., & McCutchen, J. A. (1988). Prevalence of psychiatric disorders among men infected with human immunodeficiency virus: A controlled study. *Archives of General Psychiatry*, *45*(9), 859. https://doi.org/10.1001/archpsyc.1988.01800330091011

Ball, J., & Janyst, P. (2008). Enacting research ethics in partnerships with indigenous communities in Canada: "Do it in a good way." *Journal of Empirical Research on Human Research Ethics*, *3*(2), 33–51. https://doi.org/10.1525/jer.2008.3.2.33

Baumrind, D. (1967). Child care practices anteceding three patterns of preschool behavior. *Genetic Psychology Monographs*, *75*(1), 43–88. [PubMed: 6032134]

Baumrind, D. (1975). The contributions of the family to the development of competence in children. *Schizophrenia Bulletin*, *1*(14), 12–37. https://doi.org/10.1093/schbul/1.14.12

Betts, D. (2020). “Civil rights? Yeah right!”: Reflections on legislative changes from older sexual and gender minorities in Aotearoa New Zealand. *Aotearoa New Zealand Social Work*, *32*(1), 5–16. http://search.informit.org/doi/abs/10.3316/informit.080065896122937

Bidell, M. P. (2014). Ecological factors and psychological distress: Understanding LGBTQ homeless youth within systemic context. In H. Pereira & P. Costa (Eds.), *Coming-out for LGBT* (pp. 82–88). University of Beira Interior. https://ecommons.luc.edu/cgi/viewcontent.cgi?article=1050&context=social_justice&httpsredir=1&referer=#page=84

Bosse, J. D., Clark, K. D., Dion, K. A., & Chiodo, L. M. (2024). Transgender and nonbinary young adults’ depression and suicidality is associated with sibling and parental acceptance-rejection. *Journal of Nursing Scholarship*, *56*(1), 87–102. https://doi.org/10.1111/jnu.12917

Bosse, J. D., Katz-Wise, S. L., & Chiodo, L. M. (2024). Sexual and gender diverse young adults’ perception of behaviors that are supportive and unsupportive of sexual orientation and gender identities. *Journal of Adolescent Research*, *39*(1), 165–195. https://doi.org/10.1177/07435584221124957

Bowlby, J. (1982). *Attachment and loss* (2nd ed.). Hogarth Press. (Original work published in 1969)

Bowlby, J. (2005). *A secure base: Clinical applications of attachment theory*. Routledge. (Original work published in 1988)

Bozett, F. W., & Sussman, M. B. (1990). Homosexuality and family relations: Views and research issues. In *Homosexuality and family relations* (pp. 1–8). Haworth Press. https://doi-org. /10.4324/9780203056530

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, *32*(7), 513–531. https://doi.org/10.1037/0003-066X.32.7.513

Brooks, V. R. (1981). *Minority stress and lesbian women*. Lexington Books.

Caldwell, L., & Joyce, A. (2011). *Reading Winnicott*. Routledge. https://doi.org/10.4324/9780203813591

Carroll, R. (2024). NZ is consulting the public on regulations for puberty blockers—This should be a medical decision not a political one. *The Conversation*. https://theconversation.com/nz-is-consulting-the-public-on-regulations-for-puberty-blockers-this-should-be-a-medical-decision-not-a-political-one-245020

Cass, H. (2024). *Independent review of gender identity services for children and young people: Final report* (pp. 1–388). https://cass.independent-review.uk/home/publications/final-report/

Chakraborty, A., McManus, S., Brugha, T. S., Bebbington, P., & King, M. (2011). Mental health of the non-heterosexual population of England. *British Journal of Psychiatry*, *198*(2), 143–148. https://doi.org/10.1192/bjp.bp.110.082271

Chan, T. W., & Koo, A. (2011). Parenting style and youth outcomes in the UK. *European Sociological Review*, *27*(3), 385–399. https://doi.org/10.1093/esr/jcq013

Chelladurai, J. M. (2020). *Love at home: Exploring love in family relationships* [Doctoral dissertation, Brigham Young University]. https://scholarsarchive.byu.edu/etd/8420

Cheng, F. K. (2018). Overcoming internalised phobia among Buddhist sexual minorities through mindfulness. *Contemporary Buddhism*, *19*(2), 223–236. https://doi.org/10.1080/14639947.2018.1572326

Chodzen, G., Hidalgo, M. A., Chen, D., & Garofalo, R. (2019). Minority stress factors associated with depression and anxiety among transgender and gender-nonconforming

youth. *Journal of Adolescent Health*, *64*(4), 467–471. https://doi.org/10.1016/j.jadohealth.2018.07.006

Chrisler, A. J. (2017). Understanding parent reactions to coming out as lesbian, gay, or bisexual: A theoretical framework. *Journal of Family Theory & Review*, *9*(2), 165–181. https://doi.org/10.1111/jftr.12194

Clark, K. A., Dougherty, L. R., & Pachankis, J. E. (2022). A study of parents of sexual and gender minority children: Linking parental reactions with child mental health. *Psychology of Sexual Orientation and Gender Diversity*, *9*(3), 300–308. https://doi.org/10.1037/sgd0000456

Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among Lesbian, Gay, and Bisexual adults in the United States. *Journal of Consulting and Clinical Psychology*, *71*(1), 53–61. https://doi.org/10.1037/0022-006X.71.1.53

Conley, C. L. (2011). Learning about a child's gay or lesbian sexual orientation: Parental concerns about societal rejection, loss of loved ones, and child well being. *Journal of Homosexuality*, *58*(8), 1022–1040. https://doi.org/10.1080/00918369.2011.598409

Cozzarelli, C., Karafa, J. A., Collins, N. L., & Tagler, M. J. (2003). Stability and change in adult attachment styles: Associations with personal vulnerabilities, life events, and global construals of self and others. *Journal of Social and Clinical Psychology*, *22*(3), 315–346. https://doi.org/10.1521/jscp.22.3.315.22888

Craig, S. L., Austin, A., Levenson, J., Leung, V. W. Y., Eaton, A. D., & D'Souza, S. A. (2020). Frequencies and patterns of adverse childhood events in LGBTQ+ youth. *Child Abuse & Neglect*, *107*, 104623. https://doi.org/10.1016/j.chiabu.2020.104623

Crosbie-Burnett, M., Foster, T. L., Murray, C. I., & Bowen, G. L. (1996). Gay's and lesbians' families-of-origin: A social-cognitive-behavioral model of adjustment. *Family Relations*, *45*(4), 397. https://doi.org/10.2307/585169

D'Amico, E., Julien, D., Tremblay, N., & Chartrand, E. (2015). Gay, lesbian, and bisexual youths coming out to their parents: Parental reactions and youths' outcomes. *Journal of GLBT Family Studies*, *11*(5), 411–437. https://doi.org/10.1080/1550428X.2014.981627

D'Augelli, A. R. (1993). Preventing mental health problems among lesbian and gay college students. *The Journal of Primary Prevention*, *13*(4), 245–261. https://doi.org/10.1007/BF01324561

D'Augelli, A. R. (2002). Mental Health Problems among Lesbian, Gay, and Bisexual Youths Ages 14 to 21. *Clinical Child Psychology and Psychiatry*, *7*(3), 433–456. https://doi.org/10.1177/1359104502007003010

D'Augelli, A. R., Grossman, A. H., & Starks, M. T. (2008). Gender atypicality and sexual orientation development among lesbian, gay, and bisexual youth: Prevalence, sex differences, and parental responses. *Journal of Gay & Lesbian Mental Health*, *12*(1–2), 121–143. https://doi.org/10.1300/J529v12n01_08

de Bres, J. (2022). Research on parents of gender-diverse children: From pathologization to affirmation. *LGBTQ+ Family: An Interdisciplinary Journal*, *18*(2), 135–150. https://doi.org/10.1080/27703371.2022.2058669

de Bres, J., & Morrison-Young, I. (2023). Storm clouds and rainbows: Visual metaphors of parents of transgender children in Aotearoa (New Zealand). *LGBTQ+ Family: An Interdisciplinary Journal*, *19*(5), 382–404. https://doi.org/10.1080/27703371.2023.2231371

de Bres, J., & Morrison-Young, I. (2024). Intersectional perspectives of parents of transgender children in Aotearoa (New Zealand). *International Journal of Transgender Health*, 1–18. https://doi.org/10.1080/26895269.2024.2316689

Deardorff, J., Hoyt, L. T., Carter, R., & Shirtcliff, E. A. (2019). Next steps in puberty research: Broadening the lens toward understudied populations. *Journal of Research on Adolescence*, *29*(1), 133–154. https://doi.org/10.1111/jora.12402

De Los Reyes, A., Augenstein, T. M., Wang, M., Thomas, S. A., Drabick, D. A. G., Burgers, D. E., & Rabinowitz, J. (2015). The validity of the multi-informant approach to assessing child and adolescent mental health. *Psychological Bulletin*, *141*(4), 858–900. https://doi.org/10.1037/a0038498

De Los Reyes, A., & Epkins, C. C. (2023). Introduction to the special issue. a dozen years of demonstrating that informant discrepancies are more than measurement error: Toward guidelines for integrating data from multi-informant assessments of youth mental health. *Journal of Clinical Child & Adolescent Psychology*, *52*(1), 1–18. https://doi.org/10.1080/15374416.2022.2158843

Demant, D., Hides, L., Kavanagh, D. J., White, K. M., Winstock, A. R., & Ferris, J. (2016). Differences in substance use between sexual orientations in a multi-country sample: Findings from the Global Drug Survey 2015. *Journal of Public Health*, *39*(3), 532–541. https://doi.org/10.1093/pubmed/fdw069

Derksen, M., & Morawski, J. (2022). Kinds of replication: Examining the meanings of "conceptual replication" and "direct replication." *Perspectives on Psychological Science*, *17*(5), 1490–1505. https://doi.org/10.1177/17456916211041116

Diamond, G. M., Boruchovitz-Zamir, R., Nir-Gotlieb, O., Gat, I., Bar-Kalifa, E., Fitoussi, P., & Katz, S. (2022). Attachment-based family therapy for sexual and gender minority

young adults and their nonaccepting parents. *Family Process*, *61*(2), 530–548. https://doi.org/10.1111/famp.12770

Dunlap, A. (2016). Changes in coming out milestones across five age cohorts. *Journal of Gay & Lesbian Social Services*, *28*(1), 20–38. https://doi.org/10.1080/10538720.2016.1124351

Dziak, J. J., Coffman, D. L., Lanza, S. T., Li, R., & Jermiin, L. S. (2020). Sensitivity and specificity of information criteria. *Briefings in Bioinformatics*, *21*(2), 553–565. https://doi.org/10.1093/bib/bbz016

Dziak, J. J., Lanza, S. T., & Tan, X. (2014). Effect size, statistical power, and sample size requirements for the bootstrap likelihood ratio test in latent class analysis. *Structural Equation Modeling: A Multidisciplinary Journal*, *21*(4), 534–552. https://doi.org/10.1080/10705511.2014.919819

Elischberger, H. B. (2024). Science v. fiction: Gen Z's skepticism of disinformation used to justify anti-trans legislation in the USA. *Sexuality Research and Social Policy*. https://doi.org/10.1007/s13178-024-01035-x

Enright, R. D., Lapsley, D. K., Drivas, A. E., & Fehr, L. A. (1980). Parental influences on the development of adolescent autonomy and identity. *Journal of Youth and Adolescence*, *9*(6), 529–545. https://doi.org/10.1007/BF02089889

Etengoff, C., & Daiute, C. (2014). Family members' uses of religion in post–coming-out conflicts with their gay relative. *Psychology of Religion and Spirituality*, *6*(1), 33–43. https://doi.org/10.1037/a0035198

Ferguson, M. J., & Bargh, J. A. (2004). How social perception can automatically influence behavior. *Trends in Cognitive Sciences*, *8*(1), 33–39. https://doi.org/10.1016/j.tics.2003.11.004

Fergusson, D. M., Horwood, L. J., & Beautrais, A. L. (1999). Is sexual orientation related to mental health problems and suicidality in young people? *Archives of General Psychiatry*, *56*(10), 876. https://doi.org/10.1001/archpsyc.56.10.876

Fergusson, D. M., Horwood, L. J., Ridder, E. M., & Beautrais, A. L. (2005). Sexual orientation and mental health in a birth cohort of young adults. *Psychological Medicine*, *35*(7), 971–981. https://doi.org/10.1017/S0033291704004222

Francis, A., Pai, M. S., & Badagabettu, S. (2021). Psychological well-being and perceived parenting style among adolescents. *Comprehensive Child and Adolescent Nursing*, *44*(2), 134–143. https://doi.org/10.1080/24694193.2020.1743796

Franke, T. M., Ho, T., & Christie, C. A. (2012). The chi-square test: Often used and more often misinterpreted. *American Journal of Evaluation*, *33*(3), 448–458. https://doi.org/10.1177/1098214011426594

Freud, A. (1976). Psychopathology seen against the background of normal development: The forty-ninth maudsley lecture, delivered before the royal college of psychiatrists, 21 November 1975. *British Journal of Psychiatry*, *129*(5), 401–406. https://doi.org/10.1192/bjp.129.5.401

Frost, D. M., & Meyer, I. H. (2023). Minority stress theory: Application, critique, and continued relevance. *Current Opinion in Psychology*, *51*, 101579. https://doi.org/10.1016/j.copsyc.2023.101579

Frost, D. M., Meyer, I. H., Lin, A., Wilson, B. D. M., Lightfoot, M., Russell, S. T., & Hammack, P. L. (2022). Social change and the health of sexual minority individuals: Do the effects of minority stress and community connectedness vary by age cohort? *Archives of Sexual Behavior*, *51*(4), 2299–2316. https://doi.org/10.1007/s10508-022-02288-6

Garcia, S. M., Weaver, K., Moskowitz, G. B., & Darley, J. M. (2002). Crowded minds: The implicit bystander effect. *Journal of Personality and Social Psychology*, *83*(4), 843–853. https://doi.org/10.1037/0022-3514.83.4.843

Gilman, S. E., Cochran, S. D., Mays, V. M., Hughes, M., Ostrow, D., & Kessler, R. C. (2001). Risk of psychiatric disorders among individuals reporting same-sex sexual partners in the national comorbidity survey. *American Journal of Public Health*, *91*(6), 933–939. https://doi.org/10.2105/AJPH.91.6.933

Glennon, B. (2012). Heterosexual parents of gay and lesbian individuals: Social interaction issues. *Journal of Family Theory & Review*, *4*(4), 332–353. https://doi.org/10.1111/j.1756-2589.2012.00138.x

Glick, J. L., Theall, K. P., Andrinopoulos, K. M., & Kendall, C. (2018). The role of discrimination in care postponement among trans-feminine individuals in the U.S. national transgender discrimination survey. *LGBT Health*, *5*(3), 171–179. https://doi.org/10.1089/lgbt.2017.0093

Gonsiorek, J. C. (1988). Mental health issues of gay and lesbian adolescents. *Journal of Adolescent Health Care*, *9*(2), 114–122. https://doi.org/10.1016/0197-0070(88)90057-5

Gonzalez, K. A., Rostosky, S. S., Odom, R. D., & Riggle, E. D. B. (2013). The positive aspects of being the parent of an LGBTQ child. *Family Process*, *52*(2), 325–337. https://doi.org/10.1111/famp.12009

Gordon, L. (2018). “My daughter is a drug addict”: Grandparents caring for the children of addicted parents. *Kōtuitui: New Zealand Journal of Social Sciences Online*, *13*(1), 39–54. https://doi.org/10.1080/1177083X.2017.1413664

Grossman, A. H., Park, J. Y., Frank, J. A., & Russell, S. T. (2021). Parental responses to transgender and gender nonconforming youth: Associations with parent support,

parental abuse, and youths' psychological adjustment. *Journal of Homosexuality*, *68*(8), 1260–1277. https://doi.org/10.1080/00918369.2019.1696103

Haig, B. D. (2022). Understanding replication in a way that is true to science. *Review of General Psychology*, *26*(2), 224–240. https://doi.org/10.1177/10892680211046514

Heatherington, L., & Lavner, J. A. (2008). Coming to terms with coming out: Review and recommendations for family systems-focused research. *Journal of Family Psychology*, *22*(3), 329–343. https://doi.org/10.1037/0893-3200.22.3.329

Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the minority stress model. *Professional Psychology: Research and Practice*, *43*(5), 460–467. https://doi.org/10.1037/a0029597

Henrickson, M., Neville, S., Jordan, C., & Donaghey, S. (2007). Lavender islands: The New Zealand study. *Journal of Homosexuality*, *53*(4), 223–248. https://doi.org/10.1080/00918360802103514

Herewini, N. (2018). *Māori communities raising children: The roles of extended whānau in child rearing in Māori society*. Ngā Pae o te Māramatanga and Michael and Suzanne Borrin Foundation. https://www.borrinfoundation.nz/wp-content/uploads/2020/08/Herewini-2018-Ma%CC%84ori-Communities-Raising-Children.pdf

Homosexual Law Reform Act, 33 (1986). https://www.legislation.govt.nz/act/public/1986/0033/latest/whole.html

Horton, C. (2024). The Cass Review: Cis-supremacy in the UK's approach to healthcare for trans children. *International Journal of Transgender Health*, 1–25. https://doi.org/10.1080/26895269.2024.2328249

Howe, A. S., Heath, A.-L. M., Lawrence, J., Galland, B. C., Gray, A. R., Taylor, B. J., Sayers, R., & Taylor, R. W. (2017). Parenting style and family type, but not child temperament, are associated with television viewing time in children at two years of age. *PLOS ONE*, *12*(12), e0188558. https://doi.org/10.1371/journal.pone.0188558

Hudson, M., Milne, M., Reynolds, P., Russell, K., & Smith, B. (2010). *Te ara tika: Guidelines for Māori research ethics: A framework for researchers and ethics committee members*. Health Research Council of New Zealand on behalf of the Pūtaiora Writing Group.

Huebner, D. M., Roche, K. M., & Rith, K. A. (2019). Effects of family demographics and the passage of time on parents' difficulty with their lesbian, gay, or bisexual youth's sexual orientation. *Archives of Sexual Behavior*, *48*(5), 1581–1588. https://doi.org/10.1007/s10508-019-1430-9

Hunter, J., Butler, C., & Cooper, K. (2021). Gender minority stress in trans and gender diverse adolescents and young people. *Clinical Child Psychology and Psychiatry*, *26*(4), 1182–1195. https://doi.org/10.1177/13591045211033187

IBM Corp. (2022). *IBM SPSS Statistics for Windows* (Version 29.0) [Computer software]. IBM Corp.

InsideOUT. (2020). *Rainbow terminology: Sex, gender, sexuality, and other key terms*. InsideOUT. https://insideout.org.nz/wp-content/uploads/2021/06/InsideOUT-rainbow-terminology-.pdf

Iwanaga, K., Blake, J., Yaghmaian, R., Umucu, E., Chan, F., Brooks, J. M., Rahimi, M., & Tansey, T. N. (2018). Preliminary validation of a short-form version of the Attachment Style Questionnaire for use in clinical rehabilitation counseling research and practice. *Rehabilitation Counseling Bulletin*, *61*(4), 205–216. https://doi.org/10.1177/0034355217709477

Iwanaga, K., Blake, J., Yaghmaian, R., Umucu, E., Chan, F., Brooks, J. M., Rahimi, M., & Tansey, T. N. (2020). *Attachment style questionnaire—Short-form* [Dataset]. https://doi.org/10.1037/t75708-000

Jiao, J., & Segrin, C. (2021). Parent–emerging-adult-child attachment and overparenting. *Family Relations*, *70*(3), 859–865. https://doi.org/10.1111/fare.12473

Johnson, K. C., LeBlanc, A. J., Sterzing, P. R., Deardorff, J., Antin, T., & Bockting, W. O. (2020). Trans adolescents' perceptions and experiences of their parents' supportive and rejecting behaviors. *Journal of Counseling Psychology*, *67*(2), 156–170. https://doi.org/10.1037/cou0000419

Jones, J. D., Brett, B. E., Ehrlich, K. B., Lejuez, C. W., & Cassidy, J. (2014). Maternal attachment style and responses to adolescents' negative emotions: The mediating role of maternal emotion regulation. *Parenting*, *14*(3–4), 235–257. https://doi.org/10.1080/15295192.2014.972760

Jones, J. D., Cassidy, J., & Shaver, P. R. (2015). Adult attachment style and parenting. In J. A. Simpson & W. S. Rholes (Eds.), *Attachment theory and research: New directions and emerging themes* (pp. 234–260). The Guilford Press.

Keogh, B. (2023, April 4). The "hidden" care kids: Need for benefits to raise someone else's child up 50%. *Stuff*. https://www.stuff.co.nz/national/131620571/the-hidden-care-kids-need-for-benefits-to-raise-someone-elses-child-up-50#:~:text=In%202010%2C%208706%20people%20were,2022%2C%20that%20figure%20was%2013%2C209.

Kerekere, E. (2017). *Growing up takatāpui: Whānau journeys*. Tīwhanawhana Trust and RainbowYOUTH. https://takatapui.nz/growing-up-takatapui

Koestner, R., Ryan, R. M., Bernieri, F., & Holt, K. (1984). Setting limits on children's behavior: The differential effects of controlling vs. informational styles on intrinsic

motivation and creativity. *Journal of Personality*, *52*(3), 233–248. https://doi.org/10.1111/j.1467-6494.1984.tb00879.x

Kuvalanka, K. A., Weiner, J. L., & Mahan, D. (2014). Child, family, and community transformations: Findings from interviews with mothers of transgender girls. *Journal of GLBT Family Studies*, *10*(4), 354–379. https://doi.org/10.1080/1550428X.2013.834529

Lanza, S. T., & Rhoades, B. L. (2013). Latent class analysis: An alternative perspective on subgroup analysis in prevention and treatment. *Prevention Science*, *14*(2), 157–168. https://doi.org/10.1007/s11121-011-0201-1

Lohr, S. L. (2019). *Sampling: Design and analysis* (2nd ed.). Chapman and Hall/CRC. https://doi.org/10.1201/9780429296284

Lucassen, M. F. G., Clark, T. C., Moselen, E., Robinson, E. M., & The Adolescent Health Research Group. (2014). *Youth'12 The health and wellbeing of secondary school students in New Zealand: Results for young people attracted to the same sex or both sexes.* (p. 44). The University of Auckland. https://oro.open.ac.uk/43995/1/Same%20Sex%20Report_14NM.pdf

Lucassen, M. F. G., Merry, S. N., Robinson, E. M., Denny, S., Clark, T., Ameratunga, S., Crengle, S., & Rossen, F. V. (2011). Sexual attraction, depression, self-harm, suicidality and help-seeking behaviour in New Zealand secondary school students. *Australian & New Zealand Journal of Psychiatry*, *45*(5), 376–383. https://doi.org/10.3109/00048674.2011.559635

Lucassen, M. F. G., Stasiak, K., Samra, R., Frampton, C. M., & Merry, S. N. (2017). Sexual minority youth and depressive symptoms or depressive disorder: A systematic review and meta-analysis of population-based studies. *Australian & New Zealand Journal of Psychiatry*, *51*(8), 774–787. https://doi.org/10.1177/0004867417713664

Luoma, J., & Hietanen, J. (2024). Reflexive quantitative research. *Academy of Management Review*, amr.2021.0234. https://doi.org/10.5465/amr.2021.0234

Maccoby, E. E. (2000). Perspectives on gender development. *International Journal of Behavioral Development*, *24*(4), 398–406. https://doi.org/10.1080/016502500750037946

MacMullin, L. (2023). *An ecological systems approach to understanding risk and promoting resilience among trans and gender-diverse youth* [Doctoral dissertation, University of Toronto]. https://tspace.library.utoronto.ca/bitstream/1807/128184/3/MacMullin_Laura_Nicole_202311_PhD_thesis.pdf

Mallon, G. P., & DeCrescenzo, T. (2006). Transgender children and youth: A child welfare practice perspective. *Child Welfare*, *85*(2), 215–241. https://doi/10.2307/45398762

Malpas, J., Pellicane, M. J., & Glaeser, E. (2022). Family-based interventions with transgender and gender expansive youth: Systematic review and best practice recommendations. *Transgender Health*, *7*(1), 7–29. https://doi.org/10.1089/trgh.2020.0165

Marriage (Definition of Marriage) Amendment Act, No. 20. (2013). https://www.legislation.govt.nz/act/public/2013/0020/latest/whole.html

Maslowe, K. E., & Yarhouse, M. A. (2015). Christian parental reactions when a LGB child comes out. *The American Journal of Family Therapy*, *43*(4), 352–363. https://doi.org/10.1080/01926187.2015.1051901

Mattingly, M. S., Galliher, R. V., Dehlin, J. P., Crowell, K. A., & Bradshaw, W. S. (2016). A mixed methods analysis of the family support experiences of GLBQ Latter Day Saints. *Journal of GLBT Family Studies*, *12*(4), 386–409. https://doi.org/10.1080/1550428X.2015.1085345

McClintock, K., Sokratov, A., Mellsop, G., & Kingi, T. K. (2013). Hua oranga: Service utility pilot of a mental health outcome measurement for an Indigenous population. *International Indigenous Policy Journal*, *4*(3). https://doi.org/10.18584/iipj.2013.4.3.7

McCoy, M., Menashe, S., Wright, J. N., & Zavaletta, V. (2024). Understanding sex and gender: Concepts and terminology for gender affirming care. *Pediatric Radiology*, *54*(8), 1345–1351. https://doi.org/10.1007/s00247-024-05959-9

McEwen, B. S. (1998). Protective and damaging effects of stress mediators. *New England Journal of Medicine*, *338*(3), 171–179. https://doi.org/10.1056/NEJM199801153380307

Meanley, S., Flores, D. D., Listerud, L., Chang, C. J., Feinstein, B. A., & Watson, R. J. (2021). The interplay of familial warmth and LGBTQ+ specific family rejection on LGBTQ+ adolescents' self-esteem. *Journal of Adolescence*, *93*(1), 40–52. https://doi.org/10.1016/j.adolescence.2021.10.002

Metge, J. (1995). *New growth from old: The whānau in the modern world*. Victoria University Press.

Meyer, I. H. (2013). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychology of Sexual Orientation and Gender Diversity*, *1*(S), 3–26. https://doi.org/10.1037/2329-0382.1.S.3 (original work published in 2003)

Miller, K. K., Watson, R. J., & Eisenberg, M. E. (2020). The intersection of family acceptance and religion on the mental health of LGBTQ youth. *Annals of LGBTQ Public and Population Health*, *1*(1), 27–42. https://doi.org/10.1891/LGBTQ.2019-0005

Mills-Koonce, W. R., Rehder, P. D., & McCurdy, A. L. (2018). The significance of parenting and parent–child relationships for sexual and gender minority adolescents. *Journal of Research on Adolescence*, *28*(3), 637–649. https://doi.org/10.1111/jora.12404

Mohr, J. M. (2009). Oppression by scientific method: The use of science to "other" sexual minorities. *Journal of Hate Studies*, *7*(1), 21–45. https://doi.org/10.33972/jhs.57

Mohta, A., Roy, P. K., & Saha, P. K. (2017). A study on perceived parenting style among transgender. *Open Journal of Psychiatry & Allied Sciences*, *8*(2), 157. https://doi.org/10.5958/2394-2061.2017.00014.3

Morgan, H., Lin, A., Perry, Y., Cook, A., Winter, S., Watson, V., Wright Toussaint, D., & Strauss, P. (2024). The positive aspects of being the parent of a trans child: Findings from trans pathways. *LGBTQ+ Family: An Interdisciplinary Journal*, *20*(2), 93–104. https://doi.org/10.1080/27703371.2023.2292537

Moskowitz, G. B., & Skurnik, I. W. (1999). Contrast effects as determined by the type of prime: Trait versus exemplar primes initiate processing strategies that differ in how accessible constructs are used. *Journal of Personality and Social Psychology*, *76*(6), 911–927. https://doi.org/10.1037/0022-3514.76.6.911

Mulder, G. (2019). *The influence of culture on parenting practices and children's social competence: A multiple case study* [Master's thesis, University of Canterbury]. https://ir.canterbury.ac.nz/server/api/core/bitstreams/6739a3e1-69b7-4bc4-808b-13f9c210d07f/content

Muthén, B., & Muthén, L. K. (2000). Integrating person-centered and variable-centered analyses: Growth mixture modeling with latent trajectory classes. *Alcoholism: Clinical and Experimental Research*, *24*(6), 882–891. https://doi.org/10.1111/j.1530-0277.2000.tb02070.x

New Zealand Government. (2024). *Kuputaka—Te kanorau me te whakaurunga, me ngā tapanga āniwaniwa he auau te whakamahinga Glossary—Diversity and inclusion, common rainbow terms*. https://www.publicservice.govt.nz/guidance/glossary/diversity-and-inclusion

New Zealand Psychological Society, New Zealand Psychologists Board, & New Zealand College of Clinical Psychologists. (2012). *Code of ethics for psychologists working in Aotearoa/New Zealand.* https://www.psychology.org.nz/members/professional-resources/code-ethics

Nimkoff, M. F. (1931). The relation of parental dominance to parent-child conflict. *Social Forces*, *9*(4), 559. https://doi.org/10.2307/3006153

Nosek, B. A., & Errington, T. M. (2020). What is replication? *PLOS Biology*, *18*(3), e3000691. https://doi.org/10.1371/journal.pbio.3000691

Noursi, S., Saluja, B., & Richey, L. (2021). Using the ecological systems theory to understand black/white disparities in maternal morbidity and mortality in the United States. *Journal of Racial and Ethnic Health Disparities*, *8*(3), 661–669. https://doi.org/10.1007/s40615-020-00825-4

Nur, A. A., Leibbrand, C., Curran, S. R., Votruba-Drzal, E., & Gibson-Davis, C. (2024). Managing and minimizing online survey questionnaire fraud: Lessons from the Triple C project. *International Journal of Social Research Methodology*, *27*(5), 613–619. https://doi.org/10.1080/13645579.2023.2229651

Nurius, P. S. (1983). Mental health implications of sexual orientation. *The Journal of Sex Research*, *19*(2), 119–136. https://www.jstor.org/stable/3812493

Nylund, K. L., Asparouhov, T., & Muthén, B. O. (2007). Deciding on the number of classes in latent class analysis and growth mixture modeling: A Monte Carlo simulation

study. *Structural Equation Modeling: A Multidisciplinary Journal*, *14*(4), 535–569. https://doi.org/10.1080/10705510701575396

Nylund-Gibson, K., & Choi, A. Y. (2018). Ten frequently asked questions about latent class analysis. *Translational Issues in Psychological Science*, *4*(4), 440–461. https://doi.org/10.1037/tps0000176

Obergefell v. Hodges, 576 U.S. 644 (2015). https://supreme.justia.com/cases/federal/us/576/644/

O'Connor, D. B., Thayer, J. F., & Vedhara, K. (2021). Stress and health: A review of psychobiological processes. *Annual Review of Psychology*, *72*(1), 663–688. https://doi.org/10.1146/annurev-psych-062520-122331

Oranga Tamariki. (2023a). *Orphan's benefit and unsupported child's benefit: Caregiver engagement report*. https://ot.govt.nz/about-us/research/our-research/orphans-benefit-and-unsupported-childs-benefit-caregiver-engagement-report/

Oranga Tamariki. (2023b). *Safety of children in care: Annual report July 2021 to June 2022*. https://www.orangatamariki.govt.nz/assets/Uploads/About-us/Performance-and-monitoring/safety-of-children-in-care/2021-22/OT-Safety-In-Care-2022.pdf

Pachankis, J. E. (2007). The psychological implications of concealing a stigma: A cognitive-affective-behavioral model. *Psychological Bulletin*, *133*(2), 328–345. https://doi.org/10.1037/0033-2909.133.2.328

Pachankis, J. E., Mahon, C. P., Jackson, S. D., Fetzner, B. K., & Bränström, R. (2020). Sexual orientation concealment and mental health: A conceptual and meta-analytic review. *Psychological Bulletin*, *146*(10), 831–871. https://doi.org/10.1037/bul0000271

Palmer, C. W., & Francis, S. E. (2023). The role of family rejection of gender expression on minority stress and mental health of sexual and gender minority adolescents. *Sexuality Research and Social Policy*. https://doi.org/10.1007/s13178-023-00881-5

Pariseau, E. M., Chevalier, L., Long, K. A., Clapham, R., Edwards-Leeper, L., & Tishelman, A. C. (2019). The relationship between family acceptance-rejection and transgender youth psychosocial functioning. *Clinical Practice in Pediatric Psychology*, *7*(3), 267–277. https://doi.org/10.1037/cpp0000291

Plöderl, M., & Tremblay, P. (2015). Mental health of sexual minorities: A systematic review. *International Review of Psychiatry*, *27*(5), 367–385. https://doi.org/10.3109/09540261.2015.1083949

Power, T. G. (2013). Parenting dimensions and styles: A brief history and recommendations for future research. *Childhood Obesity*, *9*(s1), S-14-S-21. https://doi.org/10.1089/chi.2013.0034

R Core Team. (2024). *R: A language and environment for statistical computing* [Computer software]. R Foundation for Statistical Computing. https://www.R-project.org

Reupert, A. (2023). Research-based, clinically informed, client- and family-centred 'best practice.' *Advances in Mental Health*, *21*(1), 1–3. https://doi.org/10.1080/18387357.2023.2180847

Reupert, A. (2024). Evidence that matters: Evidence to inform the mental health field. *Advances in Mental Health*, *22*(2), 119–121. https://doi.org/10.1080/18387357.2024.2348194

Robinson, B. A. (2018). Conditional families and lesbian, gay, bisexual, transgender, and queer youth homelessness: Gender, sexuality, family instability, and rejection. *Journal of Marriage and Family*, *80*(2), 383–396. https://doi.org/10.1111/jomf.12466

Robinson, C. C., Mandleco, B., Olsen, S. F., & Hart, C. H. (1995). Authoritative, authoritarian, and permissive parenting practices: Development of a new measure. *Psychological Reports*, *77*(3), 819–830. https://doi.org/10.2466/pr0.1995.77.3.819

Robinson, M. (2014). *The development of the lesbian, gay, bisexual affiliate stigma measure*. https://doi.org/10.7916/D8445JNP

Rood, B. A., Reisner, S. L., Surace, F. I., Puckett, J. A., Maroney, M. R., & Pantalone, D. W. (2016). Expecting rejection: Understanding the minority stress experiences of transgender and gender-nonconforming individuals. *Transgender Health*, *1*(1), 151–164. https://doi.org/10.1089/trgh.2016.0012

Rosario, M., & Schrimshaw, E. W. (2013). The sexual identity development and health of lesbian, gay, and bisexual adolescents: An ecological perspective. In C. Patterson & A. R. D'Augelli (Eds.), *Handbook of psychology and sexual orientation* (1st ed). Oxford University Press.

Rosenberg, J., Beymer, P., Anderson, D., Van Lissa, C. J., & Schmidt, J. (2018). TidyLPA: An R package to easily carry out latent profile analysis (lpa) using open-source or commercial software. *Journal of Open Source Software*, *3*(30), 978. https://doi.org/10.21105/joss.00978

Rosenkrantz, D. E., Rostosky, S. S., Toland, M. D., & Dueber, D. M. (2020). Cognitive-affective and religious values associated with parental acceptance of an LGBT child. *Psychology of Sexual Orientation and Gender Diversity*, *7*(1), 55–65. https://doi.org/10.1037/sgd0000355

Rothblum, E. D. (1994). "I only read about myself on bathroom walls": The need for research on the mental health of lesbians and gay men. *Journal of Consulting and Clinical Psychology*, *62*(2), 213–220. https://research.ebsco.com/c/4egzpd/viewer/pdf/bo5vjztndv

Rusticus, S. A., & Lovato, C. Y. (2014). Impact of sample size and variability on the power and type I error rates of equivalence tests: A simulation study. *Practical Assessment, Research & Evaluation*, *19*(11). https://eric.ed.gov/?id=EJ1038106

Ryan, C. (2009). *Supportive families, healthy children: Helping families with Lesbian, Gay, Bisexual, and Transgender children.* Family Acceptance Project. https://familyproject.sfsu.edu/publications

Ryan, C. (2019a). *Family behaviors that increase your LGBTQ child's health and well-being: Behaviors that help* [Poster]. https://familyproject.sfsu.edu/posters

Ryan, C. (2019b). *Family behaviors that increase your LGBTQ child's risk for serious health and mental health problems: Behaviors that hurt* [Poster]. https://familyproject.sfsu.edu/posters

Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, *123*(1), 346–352. https://doi.org/10.1542/peds.2007-3524

Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing*, *23*(4), 205–213. https://doi.org/10.1111/j.1744-6171.2010.00246.x

Samarova, V., Shilo, G., & Diamond, G. M. (2014). Changes in youths' perceived parental acceptance of their sexual minority status over time. *Journal of Research on Adolescence*, *24*(4), 681–688. https://doi.org/10.1111/jora.12071

Sangawi, H., Adams, J., & Reissland, N. (2018). The impact of parenting styles on children developmental outcome: The role of academic self-concept as a mediator. *International Journal of Psychology*, *53*(5), 379–387. https://doi.org/10.1002/ijop.12380

Savin-Williams, R. C. (1990). *Gay and lesbian youth: Expressions of identity*. Hemisphere Publishing.

Savin-Williams, R. C. (2001). *Mom, Dad, I'm gay: How families negotiate coming out*. American Psychological Association.

Schanzle, J., Kennedy, J., Rahman, F., & Hill, S. (2023). Anti-trans legislation in the US: Potential implications on self-reported victimization and suicidality among trans youth. *Journal of Adolescent Health*, *72*(3), S17–S18. https://doi.org/10.1016/j.jadohealth.2022.11.018

Scheyvens, R., Scheyvens, H., & Murray, W. E. (2014). Working with marginalised, vulnerable or privileged groups. In R. Scheyvens (Ed.), *Development fieldwork: A practical guide* (2nd ed., pp. 188–214). SAGE.

Schmidt, S. (2009). Shall we really do it again? The powerful concept of replication is neglected in the social sciences. *Review of General Psychology*, *13*(2), 90–100. https://doi.org/10.1037/a0015108

Schope, R. D., & Eliason, M. J. (2000). Thinking versus acting: Assessing the relationship between heterosexual attitudes and behaviors toward homosexuals. *Journal of Gay & Lesbian Social Services*, *11*(4), 69–92. https://doi.org/10.1300/J041v11n04_04

Scrucca, L., Fraley, C., Murphy, T. B., & Adrian E., R. (2023). *Model-based clustering, classification, and density estimation using mclust in R* (1st ed.). Chapman and Hall/CRC. https://doi.org/10.1201/9781003277965

Seager van Dyk, I., Clark, K. A., Dougherty, L. R., & Pachankis, J. E. (2022). Parent responses to their sexual and gender minority children: Implications for parent-focused supportive interventions. *Psychology of Sexual Orientation and Gender Diversity*. https://doi.org/10.1037/sgd0000589

Selye, H. (1950). Stress and the general adaptation syndrome. *British Medical Journal*, *1*(4667), 1383–1392. https://doi.org/10.1136/bmj.1.4667.1383

Shapin, S., & Schaffer, S. (2011). *Leviathan and the air-pump: Hobbes, Boyle, and the experimental life*. Princeton University Press. (Original work published in 1985)

Shrader, C.-H., Salerno, J. P., Lee, J.-Y., Johnson, A. L., & Algarin, A. B. (2024). Mental health impact of multiple sexually minoritized and gender expansive stressors among LGBTQ+ young adults: A latent class analysis. *Epidemiology and Psychiatric Sciences*, *33*, e22. https://doi.org/10.1017/S2045796024000118

Shilo, G., & Savaya, R. (2012). Mental health of lesbian, gay, and bisexual youth and young adults: Differential effects of age, gender, religiosity, and sexual orientation. *Journal of Research on Adolescence*, *22*(2), 310–325. https://doi.org/10.1111/j.1532-7795.2011.00772.x

Smalley, K. B., Warren, J. C., & Barefoot, K. N. (2016). Variations in psychological distress between gender and sexual minority groups. *Journal of Gay & Lesbian Mental Health*, *20*(2), 99–115. https://doi.org/10.1080/19359705.2015.1135843

Smith, C. (2010). Māori grandparents: Raising mokopuna fulltime. In J. S. Te Rito & S. M. Healy (Eds.), *Te Tatau Pounamu = The Greenstone Door: Traditional knowledge and gateways to balanced relationships, 2008. June 8-11, 2008 Auckland, New Zealand* (pp. 261–265). Ngā Pae o te Maramatanga. https://www.maramatanga.ac.nz/publication/te-tatau-pounamu-greenstone-door-traditional-knowledge-and-gateways-balanced

Smith, L. T. (2021). *Decolonizing methodologies: Research and indigenous peoples*. Zed Books. https://doi.org/10.5040/9781350225282

Stapel, D. A., & Koomen, W. (2000). How far do we go beyond the information given? The impact of knowledge activation on interpretation and inference. *Journal of*

Personality and Social Psychology, *78*(1), 19–37. https://doi.org/10.1037/0022-3514.78.1.19

Statistics New Zealand. (2014). *2013 quickstats. About culture and identity*. Statistics New Zealand. www.stats.govt.nz

Statistics New Zealand. (2021). *LGBT+ population of Aotearoa: Year ended June 2020*. https://www.stats.govt.nz/reports/lgbt-plus-population-of-aotearoa-year-ended-june-2020

Su, D., Irwin, J. A., Fisher, C., Ramos, A., Kelley, M., Mendoza, D. A. R., & Coleman, J. D. (2016). Mental health disparities within the LGBT population: A comparison between transgender and nontransgender individuals. *Transgender Health*, *1*(1), 12–20. https://doi.org/10.1089/trgh.2015.0001

Suen, L. W., Lunn, M. R., Katuzny, K., Finn, S., Duncan, L., Sevelius, J., Flentje, A., Capriotti, M. R., Lubensky, M. E., Hunt, C., Weber, S., Bibbins-Domingo, K., & Obedin-Maliver, J. (2020). What sexual and gender minority people want researchers to know about sexual orientation and gender identity questions: A qualitative study. *Archives of Sexual Behavior*, *49*(7), 2301–2318. https://doi.org/10.1007/s10508-020-01810-y

Sunny, A. M., & Deb, S. (2021). Parent–teacher non-acceptance to early gender-diverse behaviours of transgender children. *International Journal on Child Maltreatment: Research, Policy and Practice*, *4*(4), 493–515. https://doi.org/10.1007/s42448-021-00093-7

Tan, K. K. H., Schmidt, J. M., Ellis, S. J., Veale, J. F., & Byrne, J. L. (2022). 'It's how the world around you treats you for being trans': Mental health and wellbeing of transgender people in Aotearoa New Zealand. *Psychology & Sexuality*, *13*(5), 1109–1121. https://doi.org/10.1080/19419899.2021.1897033

Tan, K. K. H., Wilson, A. B., Flett, J. A. M., Stevenson, B. S., & Veale, J. F. (2022). Mental health of people of diverse genders and sexualities in Aotearoa/New Zealand: Findings from the New Zealand Mental Health Monitor. *Health Promotion Journal of Australia*, *33*(3), 580–589. https://doi.org/10.1002/hpja.543

Tan, K., Stolte, O., Waitoki, W., & Scarf, D. (2023). How well does psychological research in Aotearoa New Zealand reflect diversity? *Journal of the New Zealand College of Clinical Psychologists*, *33*(1), 79–91. https://doi.org/10.5281/ZENODO.8187842

Tani, F., Pascuzzi, D., & Raffagnino, R. (2018). The relationship between perceived parenting style and emotion regulation abilities in adulthood. *Journal of Adult Development*, *25*(1), 1–12. https://doi.org/10.1007/s10804-017-9269-6

Tanujaya, B., Prahmana, R. C. I., & Mumu, J. (2022). Likert Scale in Social Sciences Research: Problems and Difficulties. *FWU Journal of Social Sciences*, 89–101. https://doi.org/10.51709/19951272/Winter2022/7

Tasker, F., & Wren, B. (2002). Editorial: Sexual identity and gender identity: Understanding difference. *Clinical Child Psychology and Psychiatry*, *7*(3), 315–319. https://doi.org/10.1177/1359104502007003001

Trandafir, M. (2014). The effect of same-sex marriage laws on different-sex marriage: Evidence from the Netherlands. *Demography*, *51*(1), 317–340. https://doi.org/10.1007/s13524-013-0248-7

Tudge, J. R. H., Mokrova, I., Hatfield, B. E., & Karnik, R. B. (2009). Uses and misuses of Bronfenbrenner's bioecological theory of human development. *Journal of Family Theory & Review*, *1*(4), 198–210. https://doi.org/10.1111/j.1756-2589.2009.00026.x

Veldhuis, C. (2022). *The LGBTQIA+ Social-Ecological Model*. https://doi.org/10.31234/osf.io/zgkn8

Weissgerber, T. L., Garcia-Valencia, O., Garovic, V. D., Milic, N. M., & Winham, S. J. (2018). Why we need to report more than "Data were Analyzed by t-tests or ANOVA." *eLife*, *7*, e36163. https://doi.org/10.7554/eLife.36163

Willoughby, B. L. B., Doty, N. D., & Malik, N. M. (2008). Parental reactions to their child's sexual orientation disclosure: A family stress perspective. *Parenting*, *8*(1), 70–91. https://doi.org/10.1080/15295190701830680

Willoughby, B. L. B., Doty, N. D., & Malik, N. M. (2010). Victimization, family rejection, and outcomes of gay, lesbian, and bisexual young people: The role of negative GLB identity. *Journal of GLBT Family Studies*, *6*(4), 403–424. https://doi.org/10.1080/1550428X.2010.511085

Woo, S. E., Jebb, A. T., Tay, L., & Parrigon, S. (2018). Putting the "person" in the center: Review and synthesis of person-centered approaches and methods in organizational science. *Organizational Research Methods*, *21*(4), 814–845. https://doi.org/10.1177/1094428117752467

Zavala, C., & Waters, L. (2024). "It's a family matter": A strengths-based intervention for parents of sexual minority individuals. *Journal of Gay & Lesbian Mental Health*, *28*(1), 46–67. https://doi.org/10.1080/19359705.2022.2113948

Zucker, H. (1943). The emotional attachment of children to their parents as related to standards of behavior and delinquency. *The Journal of Psychology*, *15*(1), 31–40. https://doi.org/10.1080/00223980.1943.9917134

Zwaan, R. A., Etz, A., Lucas, R. E., & Donnellan, M. B. (2018). Making replication mainstream. *Behavioral and Brain Sciences*, *41*, e120. https://doi.org/10.1017/S0140525X17001972

Table 1

General Demographics by Caregiver Response Class

Variable	Overall sample (*N* = 140)		Positive caregiver response class (*n* = 120)		Mixed caregiver response class (*n* = 20)			
	n	%	*n*	%	*n*	%	*t* or x^2	Hedge's *g*
Age in years *M* (*SD*)	47.25 (8.00)		47.63 (8.08)		45.00 (7.23)		1.1[=]	0.33
Self-reported gender (*n* = 130)[#]							0.74[a]	---
Female/woman	114	81.43	105	87.50	9	45.00		
Male/man	9	6.43	8	6.67	1	5.00		
Something else[1]	7	5.00	7	5.83	0	0.00		
Sexual orientation (*n* = 139)[#]							9.81[b]**	---
Rainbow/sexual minority [2]	38	27.14	37	30.83	1	5.00		
Heterosexual/straight	87	62.14	74	61.67	13	65.00		
Neither or unsure [3]	14	10.00	9	7.50	5	25.00		
Intersex (*n* = 138)[#]							15.28[c]***	---
Yes	4	2.86	3	2.50	1	5.00		
No	122	87.14	110	91.67	12	60.00		
Unsure	12	8.57	6	5.00	6	30.00		
Transgender gender identity group (*n* = 138)[#]							13.99[d]***	---
Transgender	8	5.71	5	4.17	3	15.00		
Cisgender	125	89.29	112	93.33	13	65.00		
Neither or unsure [4]	5	3.57	2	1.67	3	15.00		
Non-binary gender identity group (*n* = 137)[#]							24.05[e]***	---
Non-binary	8	5.71	6	5.00	2	10.00		
Binary	120	85.71	109	90.83	11	55.00		
Neither or unsure[5]	9	6.43	3	2.50	6	30.00		

(continued)

Table 1 continued

General Demographics by Caregiver Response Class

Variable	Overall sample (*N* = 140) *n*	%	Positive caregiver response class (*n* = 120) *n*	%	Mixed caregiver response class (*n* = 20) *n*	%	*t* or x^2	Hedge's *g*
Ethnicity							17.24[f]**	---
Aotearoa New Zealand Māori	7	5.00	6	5.00	1	5.00		
Aotearoa New Zealand European/Pākehā	101	72.14	92	76.67	9	45.00		
Chinese	1	0.71	0	0.00	1	5.00		
Indian	1	0.71	1	0.83	0	0.00		
Samoan	1	0.71	1	0.83	0	0.00		
Another group[6]	11	7.86	10	8.33	1	5.00		
Multi-ethnic[7]	17	12.14	10	8.33	7	35.00		
Unsure	1	0.71	0	0.00	1	5.00		
Education level (*n* = 137)[#]							4.07[g]	---
Some high school	8	5.71	7	5.83	1	5.00		
High school	9	6.43	7	5.83	2	10.00		
Some tertiary	31	22.14	27	22.50	4	20.00		
Bachelor's degree	31	22.14	24	20.00	7	35.00		
Postgraduate qualification	55	39.29	50	41.67	5	25.00		
Something else [7]	3	2.14	3	2.50	0	0.00		

(continued)

Table 1 continued

General Demographics by Caregiver Response Class

Variable	Overall sample (*N* = 140)		Positive caregiver response class (*n* = 120)		Mixed caregiver response class (*n* = 20)			
	n	%	*n*	%	*n*	%	*t* or x^2	Hedge's *g*
Able to financially make ends meet (*n* = 138)[#]							5.90[h]	---
With great difficulty	3	2.14	3	2.50	0	0.00		
With difficulty	4	2.86	4	3.33	0	0.00		
With some difficulty	46	32.86	43	35.83	3	15.00		
Fairly easily	39	27.86	32	26.67	7	35.00		
Easily	36	25.71	28	23.33	8	40.00		
Very easily	10	7.14	8	6.67	2	10.00		

Note. Percentages in ethnicity do not total 100 as participants were able to select more than one ethnicity.
[1] Agender, gender queer, femme-aligned, ftm, non-binary, and trans male; [2] Asexual, bisexual, gay, lesbian, pansexual, takatāpui, or some other non-heterosexual orientation; [3] "Rainbow in a heteronormative relationship, no need to be categorised, just a person attracted to people, husband is rainbow so I'm not quite heterosexual or queer, and still figuring this out;" [4] "Align between cis and enby and do not identify with gender norms at all;" [5] "Align between cis and enby, object to gender stereotyping, and I reject gender norms"; [6] American, American Caucasian, Australian European, British, Caribbean, Celtic, English, European, Irish, Jewish, Romani, and Russian; [7] Multi-ethnic included any combination of Aotearoa New Zealand Māori, Aotearoa New Zealand Pākehā, Cook Island Māori, Indian, Niuean, Samoan, Tongan, or another group (British, Irish, Jewish, and Romani); [8] Certificate and diploma.
[#]Variation in *n*'s in the variable column reflect the participant response rate for that item. Where there is no (*n*) the full sample responded.
[=] For analysis, equal variances were assumed indicating indicating that Levene's test was non-significant ($p \geq .05$).
[a] 2 cells (33.3%) have an expected count less than 5 with a minimum expected count of 0.54; [b] 1 cell (16.7%) have an expected count less than 5 with a minimum expected count of 1.91; [c] 3 cells (50%) have an expected count less than 5 with a minimum expected count of 0.55; [d] 3 cells (50%) have an expected count less than 5 with a minimum expected count of 0.69; [e] 2 cells (33.3%) have an expected count less than 5 with a minimum expected count of 1.11; [f] 9 cells (64.3%) have an expected count less than 5 with a minimum expected count of 0.14; [g] 6 cells (50%)

have expected count less than 5 with a minimum expected count of 0.42; [h] 5 cells (41.7%) have an expected count less than 5 with a minimum expected count of 0.43.
* $p < .05$, ** $p < .01$, *** $p < .001$

Table 2

Caregiving Demographics by Caregiver Response Class

Variable	Overall sample (*N* = 140)		Positive caregiver response class (*n* = 120)		Mixed caregiver response class (*n* = 20)		*t* or x^2	Hedge's *g*
	n	%	*n*	%	*n*	%		
Relationship to one's rainbow child (*n* = 139)[#]							32.27[a]***	---
Parent [1]	129	92.14	115	95.83	14	70.00		
Grandparent[1]	3	2.14	1	0.83	2	10.00		
Aunt or uncle[1]	4	2.86	0	0.00	4	20.00		
Close family friend	3	2.14	3	2.50	0	0.00		
Co-caregivers							1.24[b]	---
Parent with co-caregivers	105	75.00	92	76.67	13	65.00		
Parent with no other co-caregivers	35	25.00	28	23.33	7	35.00		
Number of co-caregivers (*n* = 91)[#]							-1.74[=]	0.35
M (*SD*)	1.20 (0.59)		1.12 (0.36)		1.82 (1.33)			
Relationship between rainbow child and co-caregiver (*n* = 104)[#]							24.74[c]***	---
Parent [1]	97	69.29	89	74.17	8	40.00		
Grandparent[1]	1	0.71	1	0.83	0	0.00		
Aunt or uncle[1]	1	0.71	0	0.00	1	5.00		
Close family friend	1	0.71	1	0.83	0	0.00		
Combination of relationships[2]	4	2.86	1	0.83	3	15.00		
Rainbow child's current living arrangements (*n* = 129)[#]							2.03[d]	---
Same address as caregiver, full-time	96	68.57	90	75.00	6	30.00		
Same address as caregiver, part-time	14	10.00	13	10.83	1	5.00		
Different address as caregiver	19	13.57	16	13.33	3	15.00		

(continued)

Table 2 continued

Caregiving Demographics by Caregiver Response Class

Variable	Overall sample (*N* = 140) *n*	%	Positive caregiver response class (*n* = 120) *n*	%	Mixed caregiver response class (*n* = 20) *n*	%	*t* or x^2	Hedge's *g*
Number of children (*n* = 130)[#]							-2.84**[=]	-0.93
M (*SD*)	2.25 (1.14)		2.17 (1.12)		3.20 (0.92)			
Number of rainbow children (*n* = 129)[#]							5.65***[≠]	0.53
M (*SD*)	1.26 (0.52)		1.28 (0.54)		1.00 (0.00)			
Rainbow child's current age in years (*n* = 129)[#]							-0.57[=]	-0.19
M (*SD*)	16.60 (4.65)		16.53 (4.78)		17.40 (2.99)			
Rainbow child's sexual orientation (*n* = 127)[#]							5.79	---
Rainbow/sexual minority [3]	95	67.86	87	72.50	8	40.00		
Heterosexual/straight	2	1.43	1	0.83	1	5.00		
Neither or unsure [4]	30	21.43	29	24.17	1	5.00		
Rainbow child intersex (*n* = 129)[#]							3.55[e]	---
Yes	8	5.71	6	5.00	2	10.00		
No	107	76.43	100	83.33	7	35.00		
Unsure	14	10.00	13	10.83	1	5.00		
Rainbow child's sex assigned at birth (*n* = 129)[#]							1.51[f]	---
Female	80	57.14	72	60.00	8	40.00		
Male	48	34.29	46	38.33	2	10.00		
Indeterminate	1	0.71	1	0.83	0	0.00		

(continued)

Table 2 continued

Caregiving Demographic by Caregiver Response Class

Variable	Overall sample (*N* = 140) *n*	%	Positive caregiver response class (*n* = 120) *n*	%	Mixed caregiver response class (*n* = 20) *n*	%	*t* or x^2	Hedge's *g*
Rainbow child's gender identity groups								
Transgender (*n* = 129)#							4.40[g]	---
Transgender	99	70.71	94	78.33	5	25.00		
Cisgender	13	9.29	11	9.17	2	10.00		
Neither or unsure[5]	17	12.14	14	11.67	3	15.00		
Non-binary (*n* = 127)#							0.71[h]	---
Non-binary	49	35.00	46	38.33	3	15.00		
Binary	60	42.86	54	45.00	6	30.00		
Neither or unsure [6]	18	12.86	17	14.17	1	5.00		

Note. Participants were able to select multiple types of relationships between their rainbow child and co-caregivers as relevant to their situation. [1] Biological, step, adopted, or foster; [2] Co-caregiver teams made up of a combination of either parent, grandparent, aunt or uncle and/or close whānau friend.; [3] Asexual, bisexual, gay, lesbian, pansexual, takatāpui, or some other non-heterosexual orientation; [4] "Not yet discussed due to child's age;" [5] Agender, changeable, gender diverse, gender fluid, re-transitioning but still not cisgender, still figuring this out;" [6] "Gender diverse, male but sometimes presents with feminine traits, still figuring this out."

Variation in *n*'s in the variable column reflect the participant response rates for that item. Where there is no (*n*) the full sample responded.

[=] Equal variances were assumed indicating that Levene's test was non-significant ($p \geq .05$); [≠] equal variances were not assumed indicating that Levene's test was significant ($p < .05$).

[a] 6 cells (75%) have an expected count less than 5 with a minimum expected count of 0.43; [b] 0 cells (0%) have an expected count less than 5 with a minimum expected count of 5.00; [c] 8 cells (80%) have an expected count less than 5 with a minimum expected count of 0.12; [d] 2 cells (33.3%) have an expected count less than 5 with a minimum expected count of 1.09; [e] 2 cells (33.3%) have an expected count less than 5 with a minimum expected count of 0.62; [f] 3 cells (50%) have an expected count less than 5 with a minimum expected count of 0.08; [g] 2 cells (33.3%) have an

expected count less than 5 with a minimum expected count of 1.01; [h] 3 cells (50%) have an expected count less than 5 with a minimum expected count of 1.42.
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 3

Descriptive Statistics and Cronbach's Alpha for Variables of Interest

Variable	*M*	*SD*	α
Parent response indicators[1]			
Negative	9.04	4.68	0.76
Positive	26.01	3.83	0.67
Caregiver attachment style[2]			
Anxious	11.67	5.83	0.80
Avoidant	16.86	4.43	0.46
Secure	22.72	4.28	0.77
Parenting practices questionnaire[3]			
Authoritative	38.04	6.10	0.86
Authoritarian	6.24	3.24	0.76
Permissive	7.11	1.93	0.42
Caregiver religiosity[4]			0.71
How closely one identifies with their religion or spiritual group	3.55	1.30	
Perceived group acceptance of rainbow people	2.73	1.75	
Agreement with perceived acceptance of rainbow people	2.09	1.93	
Caregiver perceived acceptance by ethnic groups[4]			0.42
Perceived group acceptance of rainbow people in private	3.44	0.99	
Perceived group acceptance of rainbow people in public	3.18	1.02	
Agreement with perceived acceptance of rainbow people	2.55	1.59	

Note. [1] The parent response indicator scores ranged between 1-6, with higher scores indicating a greater tendency to engage in more negative or more positive behaviours in relation to their Rainbow child (Clark et al., 2022); [2] The caregiver attachment style scores ranged between 1-7, with higher scores indicating a tendency for a particular style of attachment with their Rainbow child (Jiao & Segrin, 2021; Iwanaga et al., 2020); [3] The parenting practices questionnaire scores ranged between 1-5, with higher scores indicating a greater tendency to utilise a particular style of strategy in parenting practices (Mulder, 2019); [4] Caregiver religiosity and caregiver ethnicity responses ranged between 0-5, with higher scores indicating greater perceived acceptance or agreement.

Table 4

Latent Profile Analysis Fit Criteria

Latent profile analysis fit index	One-class model	Two-class model	Three-class model	Four-class model	Five-class model
Log likelihood	-2232.15	-2032.53	-1978.49	-1970.45	-1971.62
Bayesian information criteria (BIC)	4504.30	4127.07	4040.98	4046.89	4071.24
Sample size adjusted BIC	4499.86	4120.18	4031.98	4035.12	4057.02
Akaike information criteria	4504.30	4127.07	4040.98	4046.89	4071.25
Entropy	1.00	0.97	0.97	0.95	0.74
Bootstrapped likelihood ratio test	---	399.24**	108.08**	16.09	-2.35
Minimum class, *n* (%)	---	20 (14.29)	16 (11.43)	9 (6.43)	0 (0.00)
Maximum class, *n* (%)	140 (100)	120 (85.71)	87 (62.14)	78 (55.71)	89 (63.57)

Note. One class in the five-class model was not assigned any cases with more than 1% probability.
* $p < .05$, ** $p < .01$, *** $p < .001$

Table 5

Mean Responses and Standard Deviations of the Parent Response Indicators by Caregiver Response Class

Parent response indicators	Overall sample (N = 140)		Positive caregiver response class (n = 120)		Mixed caregiver response class (n = 20)			
	M	*SD*	*M*	*SD*	*M*	*SD*	*t*	*Hedge's g*
Negative								
My child and I get into disagreements related to their Rainbow/LGBTQIA+ status.	1.61	1.22	1.36	0.86	3.15	1.84	-4.27***$^{\neq}$	-1.70
I feel sad that my child came out as Rainbow/LGBTQIA+.	2.15	1.53	1.93	1.32	3.45	2.01	-3.26**$^{\neq}$	-1.05
My child coming out as Rainbow/LGBTQIA+ feels like the loss of the child I once had.	2.31	1.52	2.11	1.40	3.55	1.64	-4.16***$^{=}$	-1.00
My relationship with my child has gotten worse since my child came out as Rainbow/LGBTQIA+.	1.46	1.05	1.16	0.45	3.25	1.68	-5.53***$^{\neq}$	-2.77
I feel shame for my child being Rainbow/LGBTQIA+.	1.51	1.14	1.21	0.59	3.30	1.84	-5.05***$^{\neq}$	-2.37
Positive								
I feel accepting towards my Rainbow/LGBTQIA+ child.	5.59	1.11	5.87	0.53	3.85	1.90	4.74***$^{\neq}$	2.35
I plan to ensure my child has social support to cope with some of the challenges of being Rainbow/LGBTQIA+.	5.54	0.9	5.78	0.49	4.05	1.32	5.82***$^{\neq}$	2.59
I plan to support my child by educating myself to understand my child and the Rainbow/LGBTQIA+ community better.	5.53	0.91	5.74	0.56	4.25	1.45	4.56***$^{\neq}$	1.99
I plan to support my child by showing my support for the Rainbow/LGBTQIA+ community (e.g., by getting involved in activism and Rainbow/LGBTQIA+ rights campaigns, and joining Rainbow/LGBTQIA+ groups).	4.96	1.35	5.22	1.08	3.40	1.76	4.48***$^{\neq}$	1.51
My relationship with my child has improved since my child came out as Rainbow/LGBTQIA+.	4.41	1.44	4.58	1.35	3.35	1.57	3.71***$^{=}$	0.89

Note. Clark et al. (2022).

$^{=}$ Equal variances were assumed indicating that Levene's test was non-significant ($p \geq .05$); $^{\neq}$ equal variances were not assumed indicating that Levene's test was significant ($p < .05$).
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 6

Time and Age by Caregiver Response Class

Variable	Overall sample (*N* = 140) *n*	%	Positive caregiver response class (*n* = 120) *n*	%	Mixed caregiver response class (*n* = 20) *n*	%	*t* or x^2	Hedge's *g*
Time since caregiver knew about their child's rainbow identity (*n* = 123)[#]							5.10[a]	---
Less than six months	3	2.14	3	2.50	0	0.00		
Six months to one year	5	3.57	5	4.17	0	0.00		
One to two years	27	19.29	25	20.83	2	10.00		
Three to five years	48	34.29	41	34.17	7	35.00		
More than five years	40	28.57	39	32.50	1	5.00		
When child publicly shared their rainbow identity (*n* = 129)[#]							4.43[b]	---
Before caregiver became aware	20	14.29	17	14.17	3	15.00		
Similar time as caregiver became aware	55	39.29	50	41.67	5	25.00		
After caregiver became aware	48	34.29	47	39.17	1	5.00		
Not yet sharing	6	4.29	5	4.17	1	5.00		
Age (in years) at initial disclosure of child's rainbow identity (*n* = 123)[#]							-1.34[=]	-0.44
M (*SD*)	42.57 (8.00)		42.28 (8.10)		45.80 (6.22)			
Child's age (in years) at initial disclosure of their rainbow identity (*n* = 123)[#]							-1.25[=]	-0.42
M (*SD*)	11.80 (4.37)		11.65 (4.37)		13.50 (4.22)			

Note. [#] Variation in *n*'s in the variable column reflect the participant response rates for that item. Where there is no (*n*) the full sample responded.
[=] Equal variances were assumed indicating that Levene's test was non-significant ($p \geq .05$).
[a] 7 cells (70%) have an expected count less than 5 with a minimum expected of 0.24; [b] 4 cells (50%) have an expected count less than 5 with a minimum expected count of 0.47.
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 7

Comparison of Child's Age at Initial Disclosure and Rainbow Group Identity by Caregiver Response Class

Child's age at initial disclosure to caregiver	Caregiver response class	Rainbow group identity: SM *n*	SM %	GM *n*	GM %	SGM *n*	SGM %	x^2
0-12 years	Positive (*n* = 61)	3	2.50	14	11.67	44	36.67	0.76[a]
	Mixed (*n* = 2)	0	0.00	0	0.00	2	10.00	
13-24 years	Positive (*n* = 50)	5	4.17	5	4.17	40	33.33	1.60[b]
	Mixed (*n* = 8)	2	10.00	1	5.00	5	25.00	

Note. SM = sexual minority, GM = gender minority, SGM = sexual and gender minority.
[a] 6 cells (75%) have an expected count less than 5 with a minimum expected count of 0.03; [b] 2 cells (33.3%) have an expected count less than 5 with a minimum expected count of 0.83.

Table 8

Characteristics of Interest by Caregiver Response Class

Variable	Overall sample (N = 140)		Positive caregiver response class (n = 120)		Mixed caregiver response class (n = 20)			
	n	%	*n*	%	*n*	%	*t* or x^2	Hedge's *g*
Child's rainbow identity group (n = 129)[#]							2.41[a]	---
Sexual minority	10	7.14	8	6.67	2	10.00		
Gender minority	21	15.00	20	16.67	1	5.00		
Sexual and gender minority	98	70.00	91	75.83	7	35.00		
Attachment style[1] (n = 131)[#]							30.49[b]***	---
Anxious	6	4.29	2	1.67	4	20.00		
Avoidant	8	5.71	4	3.33	4	20.00		
Secure	115	82.14	105	87.50	10	50.00		
Anxious/secure	1	0.71	1	0.83	0	0.00		
Avoidant/secure	1	0.71	0	0.00	1	5.00		
Parenting style[2] (n = 105)[#]							7.70[c]*	---
Authoritative	66	47.14	61	50.83	5	25.00		
Authoritarian	8	5.71	5	4.17	3	15.00		
Permissive	31	22.14	24	20.00	7	35.00		

(continued)

Table 8 continued

Characteristics of Interest by Caregiver Response Class

Variable	Overall sample (N = 140)		Positive caregiver response class (n = 120)		Mixed caregiver response class (n = 20)			
	n	%	*n*	%	*n*	%	*t* or x^2	Hedge's *g*
Caregiver religiosity								
Self-identified as religious or spiritual (n = 128)[#]							6.71[d]*	---
Yes	47	33.57	35	29.17	12	60.00		
No	81	57.86	74	61.67	7	35.00		
Affiliation with an organised religion or spiritual group[3] (n = 48)[#]							7.31[d]**	---
Yes	28	59.57	17	48.57	11	91.67		
No	19	40.43	19	54.29	1	8.33		
Attend services or engage in practices[4] (n = 28)[#]							7.56[e]	---
Daily	8	28.57	3	17.65	5	45.45		
Weekly	12	42.86	6	35.29	6	54.55		
On special occasions	4	14.29	4	23.53	0	0.00		
Rarely	3	10.71	3	17.65	0	0.00		
Never	1	3.57	1	5.88	0	0.00		
	M	*SD*	*M*	*SD*	*M*	*SD*	*t*	Hedge's *g*
Closeness of identity with group[4] (n = 25)[#]	3.24	1.56	3.71	1.05	2.25	2.05	1.89[≠]	0.97
Perceived group acceptance of rainbow people[4] (n = 28)[#]	2.57	1.69	2.59	1.81	2.55	1.57	0.06[=]	0.02
Agreement with perceived acceptance of rainbow people[4] (n = 25)[#]	2.00	1.83	2.00	2.09	2.00	1.20	0.00[≠]	0.00
Caregiver perceived acceptance by ethnic groups								
Perceived group acceptance of rainbow people in private	3.44	0.99	3.49	0.93	3.10	1.29	1.65[=]	0.40
Perceived group acceptance of rainbow people in public	3.18	1.02	3.18	0.96	3.15	1.35	0.14[=]	0.03
Agreement with perceived acceptance of rainbow people	2.55	1.59	2.56	1.59	2.50	1.64	0.15[=]	0.04

Note. [1] Caregiver attachment style was measured using the Attachment Style Questionnaire (Iwanaga et al., 2020) and the Experiences in Parent-Child Relationships Questionnaire (Jiao & Segrin, 2021); [2] caregiver parenting style was measured using the Aotearoa New Zealand Parenting Practices Questionnaire, Mulder (2019); [3] percentages for these items were based on the number of participants who self-identified as religious or spiritual; [4] percentages are based on the number of participants who affiliate with an organised religion or spiritual group.
[#] Variation in *n*'s in the variable column reflect the participant response rates for that item. Where there is no (*n*) the full sample responded.
[=] Equal variances were assumed indicating that Levene's test was non-significant ($p \geq .05$); [≠] equal variances were not assumed indicating that Levene's test was significant ($p < .05$).
[a] 2 cells (33.33%) have an expected count less than 5 with a minimum expected count of 0.78; [b] 6 cells (60%) have an expected count less than 5 with a minimum expected count of 0.15; [c] 2 cells(33.3%) have an expected count less than 5 with a minimum expected count of 1.14; [d] 0 cells (0%) have an expected count less than 5 with the minimum expected count of 5.00; [e] 9 cells (90%) have expected count of less than 5 with a minimum expected count of 0.39.
* $p < .05$, ** $p < .01$, *** $p < .001$

Table 9

Caregiver Attachment Style Means by Caregiver Response Class

Variable	Overall sample (N = 140)		Positive caregiver response class (n = 120)		Mixed caregiver response class (n = 20)			
	M	*SD*	*M*	*SD*	*M*	*SD*	*t*	Hedge's *g*
Caregiver attachment style (n = 131)[#]								
Anxious	2.33	1.17	2.2	1.10	3.11	1.25	-3.23**[=]	-0.80
Avoidant	3.37	0.89	3.34	0.83	3.57	1.16	-1.04[=]	-0.26
Secure	5.68	1.07	5.92	0.83	4.29	1.27	5.39***[≠]	1.78

Note. Caregiver attachment style was measured using the Attachment Style Questionnaire (Iwanaga et al., 2020) and the Experiences in Parent-Child Relationships Questionnaire (Jiao & Segrin, 2021).

[#] Variation in *n*'s in the variable column reflect the participant response rate for that item.

[=] Equal variances were assumed indicating that Levene's test was non-significant ($p \geq .05$); [≠] equal variances were not assumed indicating that Levene's test was significant ($p < .05$).

* $p < .05$, ** $p < .01$, *** $p < .001$

Table 10

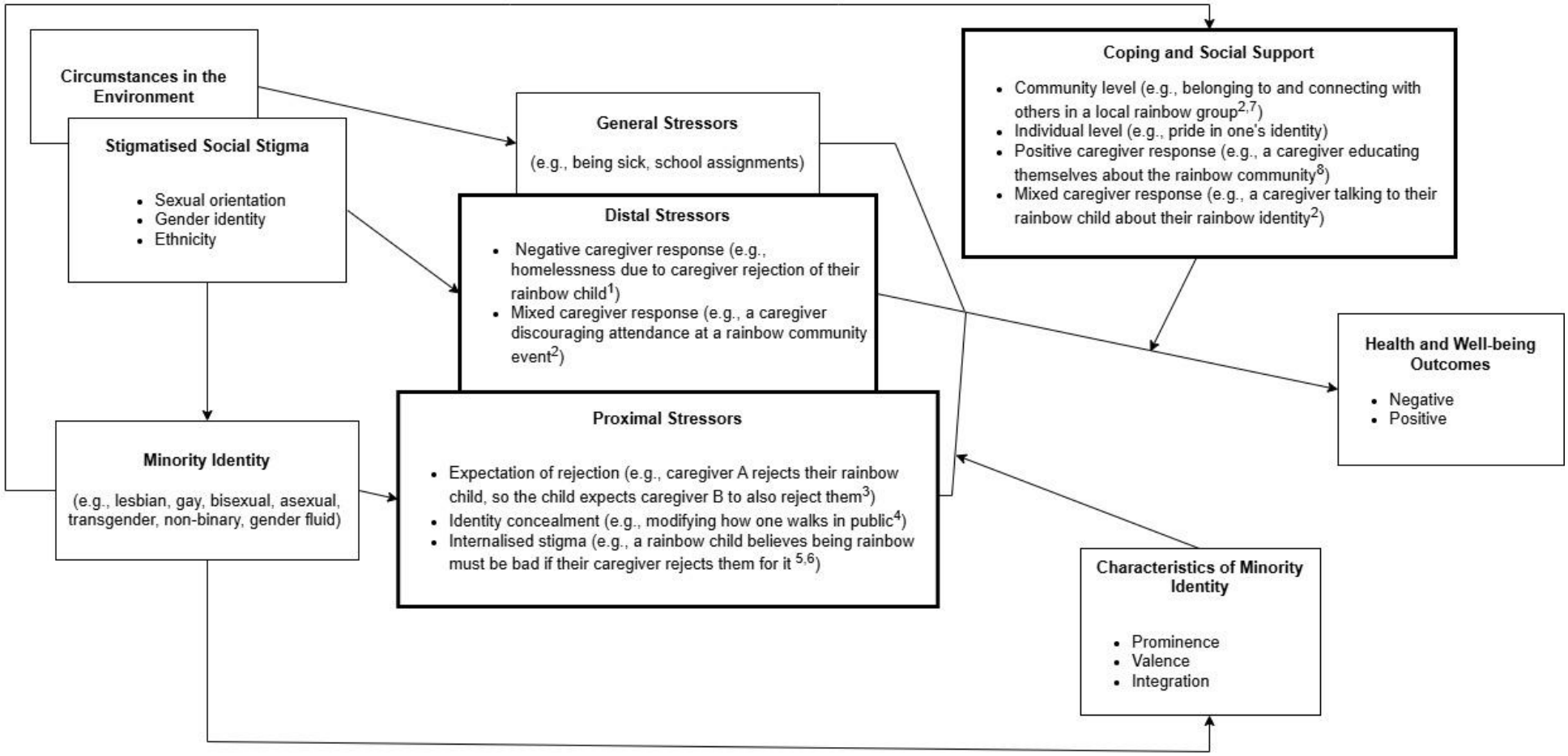
Caregiver Parenting Style Means by Caregiver Response Class

Variable	Overall sample (N = 140)		Positive caregiver response class (n = 120)		Mixed caregiver response class (n = 20)			
	M	*SD*	*M*	*SD*	*M*	*SD*	*t*	Hedge's *g*
Caregiver parenting style (n = 105)[#]								
Authoritative	3.17	0.51	3.25	0.38	2.38	0.91	2.34[≠]	1.94
Authoritarian	1.04	0.54	0.97	0.38	1.62	1.09	-1.87[≠]	-1.28
Permissive	1.78	0.48	1.74	0.46	2.05	0.60	-1.99*[=]	-0.64

Note. Caregiver parenting style was measured using the Aotearoa New Zealand Parenting Practices Questionnaire (Mulder, 2019).
[#] Variation in *n*'s in the variable column reflect the participant response rate for that item.
[=] Equal variances were assumed indicating that Levene's test was non-significant ($p \geq .05$); [≠] equal variances were not assumed indicating that Levene's test was significant ($p < .05$).
* $p < .05$, ** $p < .01$, *** $p < .001$

Figure 1

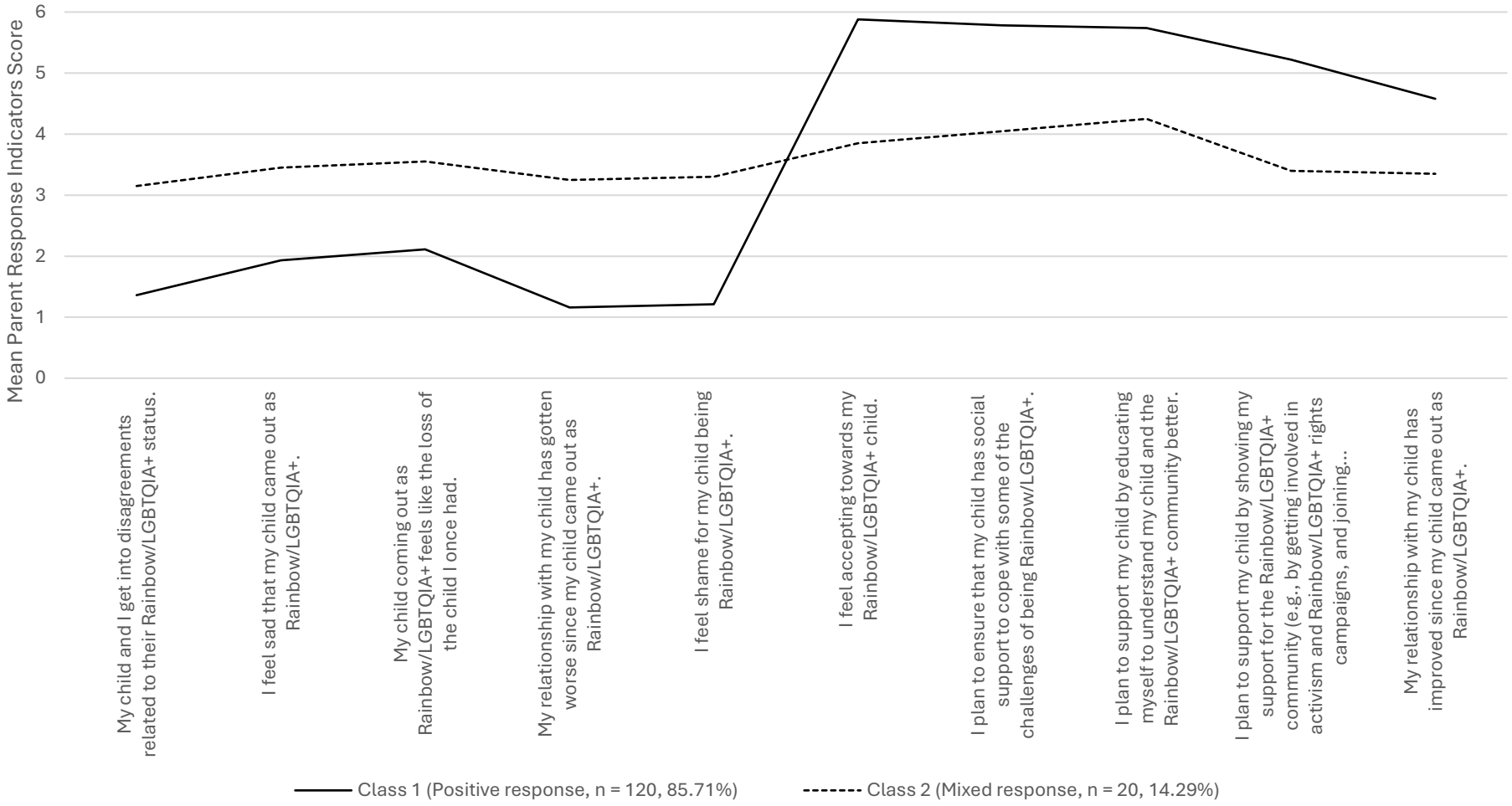
An Adapted Minority Stress Model Showing the Potential Impact of Caregiver Response on Their Rainbow Child's Health and Well-Being



Note. This figure is adapted from Meyer's (2013) minority stress model. Caregiver response may be either a distal and/or proximal stressor or a coping and social support factor. Of note is the mixed caregiver response, as these responses may be conflicting and act as both a stressor and a source of social support. Boxes in bold highlight caregiver response.
[1] Robinson (2018); [2] Ryan (2009); [3] Rood et al. (2016); [4] Pachankis (2007); [5] Ryan et al. (2009); [6] Shrader et al. (2024); [7] Frost et al. (2022); [8] Clark et al. (2022).

Figure 2

Two-Class Model of Latent Profiles of Caregiver Response to Their Rainbow Children



Appendices

Appendix A: Te Reo Māori Ngā Whakamarama (Glossary)

Aotearoa	the Māori name for New Zealand, often used alone or with the name New Zealand in recognition of the importance of the Māori language.
Hapū	kinship group, clan, tribe, or subtribe.
Kaitiaki	trustee, minder, guard, caregiver, or keeper.
Kōrero	to tell, say, speak, read, talk, or address.
Mahi	to work, do, perform, make, or accomplish.
Mana	prestige, authority, power, influence, status, spiritual power, equity, justice[64].
Manākitanga	cultural and social responsibility, respect for persons[64].
Māori	indigenous New Zealander.
Mātauranga	knowledge, wisdom, understanding, or skill.
Matua	father.
Matua kēkē	uncle.
Rangatahi	youth, young person, younger generation.
Te Tiriti o Waitangi	the foundational document of Aotearoa New Zealand signed by Māori and the British Crown, or the Treaty of Waitangi[65].
Tirohanga	views.
Tipuna/Tūpuna	ancestor, grandparent (singular/plural).
Tikanga	protocols and practices.
Tika	validity of research[64].
Takatāpui	close or intimate friend of same gender, lesbian, gay, homosexual.

[64] Te Ara Tika Guidelines to Māori Research Ethics (Hudson et al., 2010)
[65] Te Ara: Encyclopedia of New Zealand (https://teara.govt.nz/en/te-tiriti-o-waitangi-the-treaty-of-waitangi/).

Whakataurite	perspectives.
Whanonga pono	principles, values.
Whaea	mother.
Whāngai	a customary practice among Māori of openly adopting or raising a child by a blood relative.
Whakaangi	step relationship.
Whaea kēkē	aunt.
Whakapapa	relationships[64].
Whakataukī	proverb or significant saying.
Whānau	family or kinship group.

The te reo Māori terms used in this thesis are used in accordance with those found on the Te Aka: Māori Dictionary website (https://maoridictionary.co.nz/) unless otherwise indicated.

Appendix B: Email Sent to Groups to Recruit Participants

Raising Rainbows Project

Kia ora [organisation name or contact person],

Our names are Dr Ilana Seager van Dyk (Senior Clinical Psychology Lecturer and PRIDE Lab Director), Tyler Chapman (Master of Psychology postgraduate student), Andrina Westerbaan (Master of Psychology postgraduate student), and Grey Woods (Clinical Psychology Doctoral student) at Massey University. We are interested in better understanding caregiver responses to their Rainbow/Takatāpui/LGBTQIA+ children in order to highlight how caregivers might move from rejecting or conflicting attitudes and behaviours to more accepting and supportive ones. As Rainbow young people experience higher rates of mental distress and caregiver acceptance has been found to be either protective against or increase the risk of poor mental health and well-being, it is crucial that research contributes to the improvement of well-being for Rainbow young people via the support and acceptance of their caregivers and whānau/family.

The aim of our project is to answer the following research questions:

- How do caregivers respond to their Rainbow children when they become aware of their child's Rainbow identity?
- What is the relationship like between caregivers and their Rainbow children?
- What helps caregivers move towards more accepting behaviours and support for their Rainbow child?

We are reaching out to your organisation as we believe your role in supporting Rainbow folks and their whānau/family could help us reach those we want to hear from. We are seeking adults (over the age of 18 years) who are the primary caregivers (responsible for the daily care) of Rainbow young people (under the age of 30 years) living in Aotearoa New Zealand to answer an anonymous online survey. We are interested in recruiting participants through your organisation via your social media posts, website, and/or printed flyers.

We appreciate your time and your consideration of our project. We would be happy to provide a research summary of our findings once the project is complete if that would be of interest to your organisation. Please do not hesitate to contact us if you have any questions and we look forward to hearing from you soon.

Ngā mihi nui,

Dr. Ilana Seager van Dyk, Tyler Chapman, Andrina Westerbaan, and Grey Woods.

i.seagervandyk@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 2, Application OM2 24/16. If you have any concerns about the conduct of this

research, please contact Associate Professor Fiona Te Momo, Chair, Massey University Human Ethics Ohu Matatika 2, email humanethics2@massey.ac.nz.

Appendix C: Recruitment Flyers

RAISING RAINBOWS
Are you a primary caregiver of a young person, 30 years or below who identifies as Takatāpui/Rainbow/LGBTQIA+/MVPFAFF+?
We want to hear about your experiences as a caregiver of a young rainbow person in Aotearoa
Take the survey and go in the draw to win a $40 voucher!
SCAN ME
TINYURL.COM/RAISINGRAINBOWS
CONTACT US - PRIDELABNZ@GMAIL.COM

RAISING RAINBOWS
Are you a primary caregiver of a young person under 30 who identifies as Takatāpui/Rainbow/LGBTQIA+/MVPFAFF+?
We want to hear about your experiences!
Take the survey and go in the draw to win a $40 voucher!
SCAN ME
TINYURL.COM/RAISINGRAINBOWS
CONTACT US - PRIDELABNZ@GMAIL.COM

Appendix D: Information Sheet

Raising Rainbows: Understanding primary caregiver responses to their Rainbow/LGBTQIA+ children in Aotearoa New Zealand

Information sheet for participants

We appreciate your interest in this project. Please read through this information before deciding whether you would like to participate or not. If you choose to be a part of this project, thank you! If you decide not to take part, thank you for considering our request.

Who we are

Our names are Dr. Ilana Seager van Dyk, Andrina Westerbaan, Grey Woods, and Tyler Chapman. We are all members of the PRIDE research lab based at Massey University. Our research team and extended network of contributors include people with a range of Rainbow identities, including queer, bisexual, trans, takatāpui, and gay folks, as well as parents/caregivers of Rainbow young people.

- Ilana is a senior lecturer at Massey University who specialises in Rainbow/LGBTQIA+ mental health. She is the lead researcher on this project as well as being Andrina, Grey, and Tyler's research supervisor.
- Andrina is a Master of Arts student specialising in psychology at Massey University and a parent.
- Grey is a postgraduate student specialising in psychology at Massey University. His work on this project will contribute towards his Doctorate of Clinical Psychology at Massey University, beginning in 2025.
- Tyler is a postgraduate student specialising in psychology at Massey University. His work on this project will contribute towards his Master of Arts at Massey University, beginning in 2025.

For more information about us, check out the PRIDE website at pridelabnz.com.

Why we are doing this research

Rainbow/LGBTQIA+ young people experience disproportionately high rates of mental distress compared to non-Rainbow youth. Numerous studies report significant benefits to Rainbow/LGBTQIA+ children when they have or perceive caregiver acceptance and support. However, the literature is less clear on how clinicians and others can support caregivers in developing acceptance towards their Rainbow young people. Research on Aotearoa-based

caregivers of Rainbow kids is also limited, and therefore misses the perspectives of Māori whānau. As a result, we are doing this study so that we can fill in some of these research gaps, and improve the resources and supports we have for whānau of Rainbow/LGBTQIA+ young people in Aotearoa.

The aim of the project

We are interested in answering the following research questions:

- How do caregivers respond to their Rainbow/LGBTQIA+ children when they learn about their Rainbow identities? Are there patterns?
- What are the relationships like between caregivers and their Rainbow/LGBTQIA+ children?
- What resources and/or strategies help caregivers of Rainbow/LGBTQIA+ children?

How you can help

If you are a primary caregiver of one or more children who identify as Rainbow/LGBTQIA+ (or you were the primary caregiver of a Rainbow/LGBTQIA+ adult who is currently under 30 years old), live in Aotearoa New Zealand, are aged 18 or older, and are fluent in English, you are eligible to complete this survey.

What the survey involves

Here's what you need to know about the online survey:

- It will take approximately 45 minutes to complete.
- First, we will ask a few questions to see if you are eligible for the survey. If you are not eligible, the survey will end, and your responses will be discarded.
- Next, we will ask some demographic questions about yourself, including details about your ethnicity, gender, sexuality, and other personal characteristics.
- We will then ask you about your caregiving profile (e.g., the number of children you care for), your child or children's Rainbow/LGBTQIA+ identity, how long it has been since they came out, and your responses.
- Also, we will ask about your confidence in caring for a Rainbow/LGBTQIA+ child, the beliefs you may have about Rainbow/LGBTQIA+ people, your experiences within your parent-child relationship, and how your ethnicity and spirituality may influence the way you parent.
- Lastly, we will ask you about your perspective regarding your's and your child's or children's general well-being and the resources you have accessed or would like to access in your journey of accepting and supporting your Rainbow/LGBTQIA+ child or children.

Once the survey is completed, you will be given the opportunity to enter a prize draw to win one of ten $40 gift vouchers and indicate if you would like to receive a summary of the research findings. If you wish to enter the draw and/or receive a summary of this project's findings, anonymity will be maintained by using a separate survey to collect your contact details (this will be the only time such personal information will be asked for) and is completely optional.

What your responses will be used for

We hope that learning more about primary caregivers' responses to their Rainbow/LGBTQIA+ children will expand current understandings and inform new resources and services that seek to support caregivers of Rainbow/LGBTQIA+ children. For example, a current research grant in the lab seeks to create a support group for caregivers of Rainbow/LGBTQIA+ young people, and we plan to use the results from this study to inform the design of that support group. We plan to share the results of this study with others through peer-reviewed articles and conference presentations, as well as online via social media.

What will happen to the information you share

This research is anonymous and confidential. We will not ask for your name or your child's name, and will only present research findings in aggregate (i.e., we will not share any individual participant's responses). All information you share will be kept securely on a Massey University Cloud server indefinitely, which is only accessible to this study's research team. No other Massey staff or students will have access to the raw survey data. If you choose to participate in our prize draw or request a summary of the results, we will ask you for your email address. This information will be stored separately from the rest of your answers in a secure, password-protected file, and will be destroyed at the end of the study when the prize draw is complete.

Your rights as a participant

- If you change your mind about participating in the survey, please do not submit it. Once the survey is completed and submitted, it will not be possible to withdraw your survey responses from the project because the survey is anonymous, and we won't be able to identify which survey response is yours.
- You can decline to answer any question for any reason. The only exceptions are the questions regarding eligibility (e.g., your age, child's age, whether you live in Aotearoa New Zealand, and if you are fluent in English). We need all participants to answer these questions in order to determine whether you are eligible for this study.
- You can ask any questions about this study at any time — you can email me or my supervisor using the contact details below.

What else you need to know

While we hope that participating in this project will be a positive experience, we realise that there is a possibility that reflecting on your experiences might cause mild discomfort. If doing so tends to be upsetting for you, while completing the survey, please consider having a support person in easy reach if you need them. At the end of the survey, we will provide some details for places you can contact if you feel you need some support.

Who can you contact with any questions or problems

If you have any questions about this research now or in the future, you can contact Ilana at i.seagervandyk@massey.ac.nz

In case they are useful, here is a list of mental health support resources you may access:

- OUTline: 0800 688 5463 (0800 OUTLINE)
- 1737 – Need to talk?: Free call or text 1737 for support from a trained counsellor

- Massey Health and Counselling Centre (for Massey Students and Staff Only): https://www.massey.ac.nz/massey/student-life/services-and-resources/health-counselling-services/counselling/counselling_home.cfm
- A full list of mental health crisis teams in NZ is available here: https://www.health.govt.nz/your-health/services-and-support/health-care-services/mental-health-services/crisis-assessment-teams

In addition, here is a list of resources for caregivers of Rainbow/LGBTQIA+ young people: https://docs.google.com/document/d/1tXNrUu20IuJMENg5TslcZm1acUIsvK0o/edit?usp=sharing&ouid=104225820221667402611&rtpof=true&sd=true

This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 2, Application OM2 24/16. If you have any concerns about the conduct of this research, please contact the Chairperson, Massey University Human Ethics Ohu Matatika 2, email humanethics2@massey.ac.nz.

By agreeing to participate in this study, you are confirming that you have reviewed the information above and agree to participate in this study. Do you agree to participate?

- Yes
- No

Appendix E: Survey

Eligibility Screener

What is your current age (in years)? _____

Do you live in Aotearoa New Zealand?

Yes

No

Are you fluent in English?

Yes

No

Are you a primary caregiver of a Rainbow/LGBTQIA+ child under the age of 30 years? (If your Rainbow child is now an adult, are they currently under age 30?)

Yes

No

General Demographics

What is your gender? _____

When we describe who participated in our study, which of these *sexual orientation-related* categories would you like us to include you in?

A Rainbow/sexual "minority" category (usually refers to people who identify as lesbian, gay, bisexual, pansexual, takatāpui, asexual or some other non-heterosexual sexual orientation)

A heterosexual/straight category (usually refers to people who are attracted exclusively to others of a different gender)

Neither Rainbow/sexual "minority" or heterosexual describe me because: _____

Unsure because: _____

When we describe who participated in our study, which of these *gender-related* categories would you like us to include you in?

A trans/transgender category (usually refers to people who were assigned a gender and/or sex label at birth that does not accurately represent them)

A cisgender category (refers to people who are the same gender and/or sex they were assigned at birth)

Neither cisgender nor transgender describe me because: _____

Unsure because: _____

And which of these other *gender-related* categories would you like us to include you in?

Binary (someone who identifies as completely a man/male or woman/female)

Nonbinary (someone who has an identity other than completely woman/female or man/male)

Neither binary nor nonbinary describe me because: _____

Unsure because: _____

Which ethnic group or groups do you belong to? (Select all that apply)

New Zealand Māori

New Zealand European/Pākehā

Cook Island Māori

Chinese

Indian

Niuean

Samoan

Tongan

Another group, e.g., Dutch, Japanese, Fijian. Please specify: _____

I don't know

What level of education have you achieved/completed?

Some high school

High school

Some tertiary

Bachelor's degree

Postgraduate qualification

Something else. Please specify: _____

Thinking of your household's total income, how well is your household able to make ends meet?

With great difficulty

With difficulty

With some difficulty

Fairly easily

Easily

Very easily

Caregiving Demographics

What is the relationship between you and your Rainbow/LGBTQIA+ child [cgp_1]

Biological parent / whaea, matua
Step-parent / matakēkē
Adopted parent / mātua whāngai
Foster parent/ mātua whāngai
Biological grandparent / tipuna
Step-grandparent / tipuna whakaangi
Adopted grandparent / tipuna whāngai
Foster grandparent / tipuna whāngai
Biological aunt or uncle / whaea kēkē, matua kēkē
Step-aunt or uncle / whaea/matua kēkē whakaangi
Adopted aunt or uncle / whaea/matua kēkē whāngai
Foster aunt or uncle / whaea/matua kēkē whāngai
Close family friend
I prefer another word to describe this relationship. Please specify: _____

Do you parent/caregive with another adult?

Yes
If yes, please specify how many co-caregivers you parent with: _____
No

What is the relationship between your Rainbow/LGBTQIA+ child and your co-caregiver(s)? Please tick all that apply.

Not applicable – I do not parent/caregive with another adult.
Biological parent / whaea, matua
Step-parent / matakēkē
Adopted parent / mātua whāngai
Foster parent/ mātua whāngai
Biological grandparent / tipuna
Step-grandparent / tipuna whakaangi
Adopted grandparent/ tipuna whāngai
Foster grandparent / tipuna whāngai
Biological aunt or uncle / whaea kēkē, matua kēke
Step-aunt or uncle / whaea/matua kēkē whakaangi

Adopted aunt or uncle / whaea/matua kēkē whāngai

Foster aunt or uncle / whaea/matua kēkē whāngai

Close family friend

I prefer another word to describe this relationship. Please specify: _____

Does your co-caregiver(s) know about your Rainbow/LGBTQIA+ child/children's Rainbow/LGBTQIA+ identity?

Not applicable – I do not parent/caregive with another adult.

Yes

No

I don’t know

For how many children are you the primary caregiver?

1

2

3

4

5

6

7

8

9

10

How many of the children for whom you are the primary caregiver identify as Rainbow/LGBTQIA+?

1

2

3

4

5

6

7

8

9

10

Thinking of only your rainbow/LGBTQIA+ identifying child/children, please answer the following question. If you have more than one rainbow/LGBTQIA+ child, please note that you will be asked these questions for each of your rainbow/LGBTQIA+ children.

Does your Rainbow/LGBTQIA+ child live at the same address as you?

Yes, fulltime

Yes, part-time

No

Parent Response Indicators

Scale:

1) Strongly disagree
2) Disagree
3) Somewhat disagree
4) Neither agree nor disagree
5) Somewhat agree
6) Agree
7) Strongly agree

Negative indicators:

My child and I get into disagreements related to their Rainbow/LGBTQIA+ status.

I feel sad that my child came out as Rainbow/LGBTQIA+.

My child coming out as Rainbow/LGBTQIA+ feels like the loss of the child I once had

My relationship with my child has gotten worse since my child came out as Rainbow/LGBTQIA+.

I feel shame for my child being Rainbow/LGBTQIA+.

Positive Indicators:

I feel accepting towards my Rainbow/LGBTQIA+ child.

I plan to ensure my child has social support to cope with some of the challenges of being Rainbow/LGBTQIA+.

I plan to support my child by educating myself to understand my child and the Rainbow/LGBTQIA+ community better.

I plan to support my child by showing my support for the Rainbow/LGBTQIA+ community (e.g., by getting involved in activism and Rainbow/LGBTQIA+ rights campaigns, and joining Rainbow/LGBTQIA+ groups).

My relationship with my child has improved since my child came out as Rainbow/LGBTQIA+.

Time and Age

1. How long has it been since you first became aware of your child's Rainbow/LGBTQIA+ identity?
   Less than six months
   Six months to one year
   One to two years
   Three to five years
   More than five years

2. What age was **your child** when you first became aware of your child's Rainbow/LGBTQIA+ identity? _____

3. What age were **you** when you first became aware of your child's Rainbow/LGBTQIA+ identity? _____

Child's Rainbow Identity

Thinking of only your rainbow/LGBTQIA+ identifying child/children, please answer the following questions. If you have more than one rainbow/LGBTQIA+ child, please note that you will be asked these questions for each of your rainbow/LGBTQIA+ children.

What is your child's current age? _____

Which of the following sexual orientation-related categories best describes your child?

A Rainbow/sexual "minority" category (usually refers to people who identify as lesbian, gay, bisexual, pansexual, takatāpui, asexual or some other non-heterosexual sexual orientation)
A heterosexual/straight category (usually refers to people who are attracted exclusively to others of a different gender)
Neither Rainbow/sexual "minority" or heterosexual describe me because: _____
Unsure because: _____

Which of the following gender-related categories best describes your child?

A trans/transgender category (usually refers to people who were assigned a gender and/or sex label at birth that does not accurately represent them)
A cisgender category (refers to people who are the same gender and/or sex they were assigned at birth)

Neither cisgender nor transgender describe my child because: _____

Unsure because: _____

Which of these other gender-related categories would help describe your child?

Binary (someone who identifies as completely a man/male or woman/female)

Nonbinary (someone who has an identity other than completely woman/female or man/male)

Neither binary nor nonbinary describe my child because: _____

Unsure because: _____

Is your child intersex/Does your child have a variation of sex characteristics?

Yes, they are intersex/have a variation of sex characteristics

No, they are not intersex/have a variation of sex characteristics

I don't understand the question

I don't know

What sex was your child assigned at birth?

Female

Male

Indeterminate

Caregiver Attachment Style

The following statements ask you to think about how you see (or understand) the relationship between yourself and your LGBTQIA+ child. Please show your agreement with the following.

Scale:

1) Strongly disagree
2) Disagree
3) Somewhat disagree
4) Neither agree nor disagree
5) Somewhat agree
6) Agree
7) Strongly agree

Anxious attachment subscale:

I worry that my child won't care about me as much as I care about them.

My desire to be very close sometimes scares my child away.

I need a lot of reassurance that I am loved by my child.

I find that my child does not want to get as close as I would like.

I get frustrated if my child is not available when I need them.

Avoidant attachment subscale:

I am nervous when my child gets too close to me.

I try to avoid getting too close to my child.

I usually discuss my problems and concerns with my child. [reverse coded]

It helps to turn to my child in times of need. [reverse coded]

I turn to my child for many things, including comfort and reassurance. [reverse coded]

Secure attachment subscale:

I feel confident that my child will be there for me when I need them.

I find it relatively easy to get close to my child.

I feel confident about relating to my child.

I am confident that my child likes and respects me.

Caregiver Parenting Style

Scale:

1) Never
2) Rarely
3) Sometimes
4) Often
5) Always

Authoritative subscale:

I know the names of my child's friends.

I am aware of the problems or concerns about my child in school.

I give praise when my child is good.

I explain the consequences of my child's behaviour.

I give my child reasons why rules should be obeyed.

I emphasise the reasons for rules.

I take into account my child's preferences in making plans for the family.

I allow my child to give input into family rules.

I take my child's desires into account before asking my child to do something.

I am easy-going and relaxed with my child.

I show patience with my child.

I joke and play with my child.

Authoritarian subscale:

I raise my voice when my child misbehaves.

I argue with my child.

I manage my child's behaviour by taking away privileges with little explanation.

I manage my child's behaviour by putting my child somewhere alone with little explanation.

I tell my child what to do.

I criticise to make my child improve.

Permissive subscale:

I allow my child to interrupt others.

I appear confident about my parenting abilities. [reverse-coded]

I allow my child to annoy others.

I appear unsure of how to solve my child's misbehaviours.

Caregiver Perceived Religious Acceptance of Rainbow People

Do you consider yourself a religious or spiritual person?

Yes

No

If yes, do you affiliate with an organised religion?

Yes; please specify: _____

No

How often do you attend religious services?

Not applicable — I have no religious affiliation

Daily

Weekly

Only on special occasions (e.g., primary holy days, main holidays, special events)

Rarely

Never

How closely do you identify with your religion?

Not applicable — I have no religious affiliation

0 (Not at all)

1

2

3

4

5 (Very much)

Does your religion accept Rainbow/LGBTQIA+ individuals?

Not applicable — I have no religious affiliation

0 (Not at all)

1

2

3

4

5 (Very much)

How much do you agree with your religion's views on Rainbow/LGBTQIA+ individuals?

Not applicable — I have no religious affiliation

0 (Not at all)

1

2

3

4

5 (Very much)

Caregiver Perceived Ethnic Acceptance of Rainbow People

The following questions ask about your perspective on your ethnicity's responses to Rainbow/LGBTQIA+ individuals.

How accepting of Rainbow/LGBTQIA+ individuals is your ethnic group or groups **in private**?

0 (Not at all)

1

2

3

4

5 (Very much)

How accepting of Rainbow/LGBTQIA+ individuals is your ethnic group or groups **in public**?

0 (Not at all)

1

2

3

4

5 (Very much)

How much do you **agree** with your ethnic group or group's views on Rainbow/LGBTQIA+ individuals?

0 (Not at all)

1

2

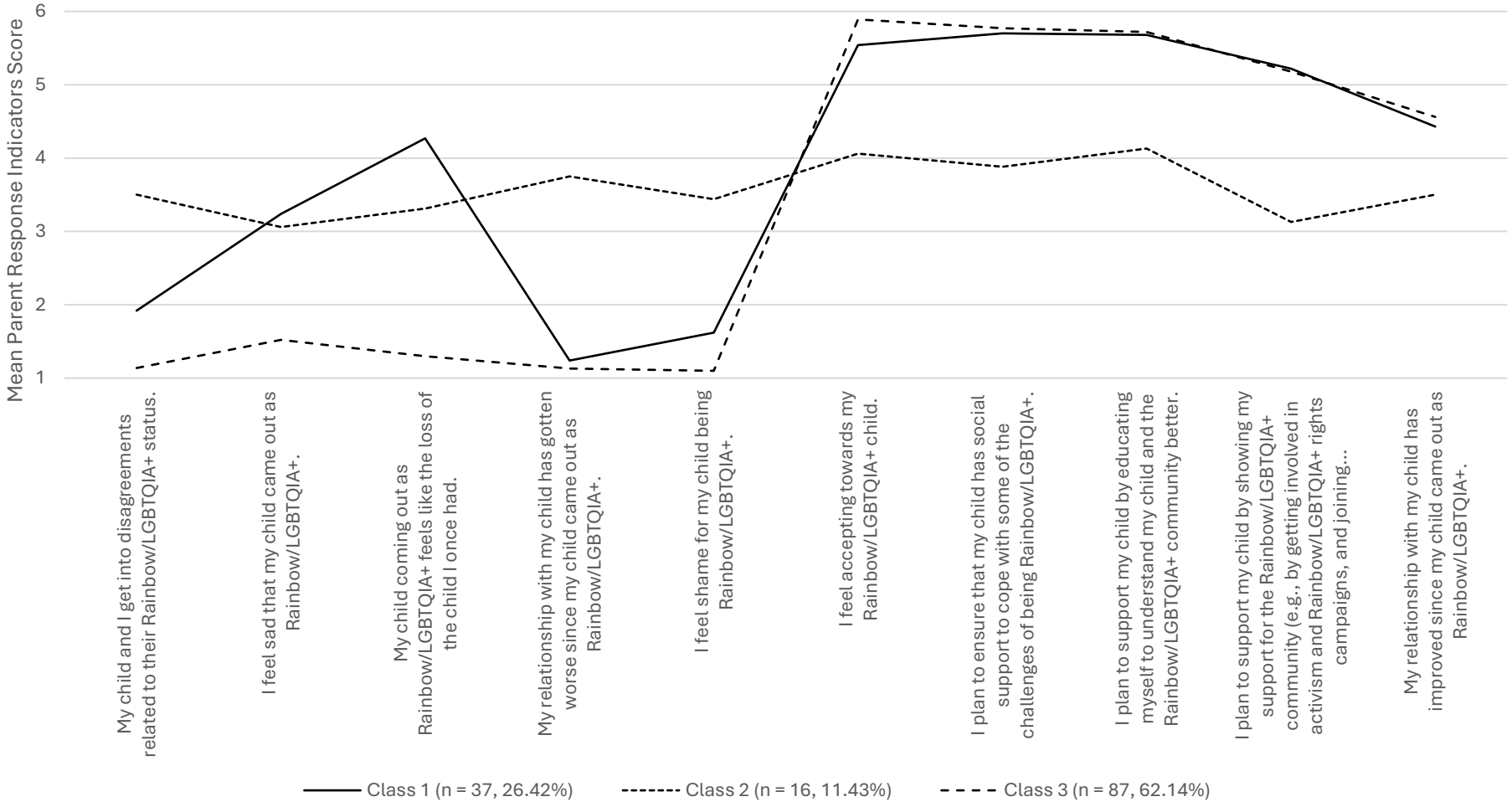
3

4

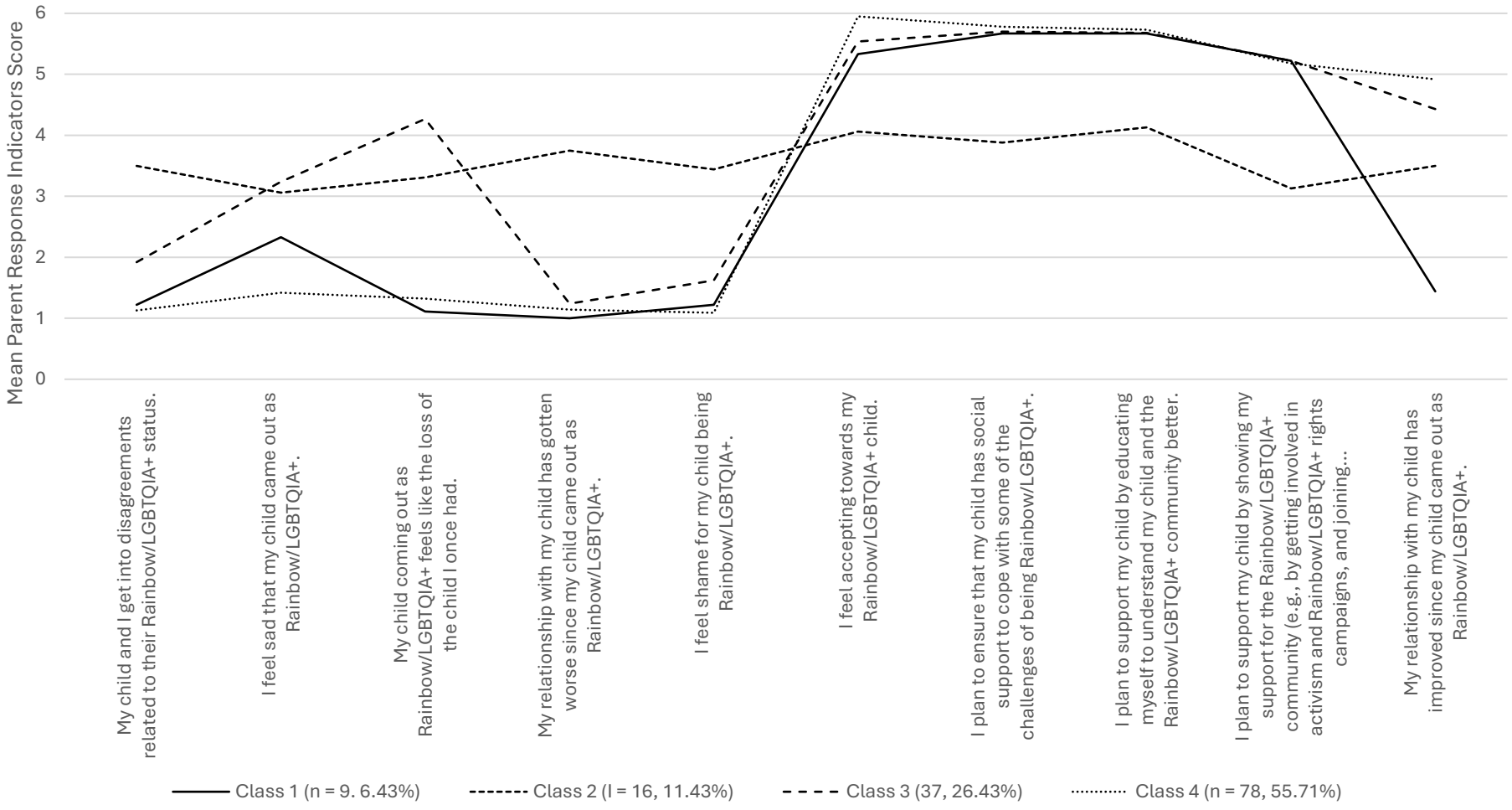
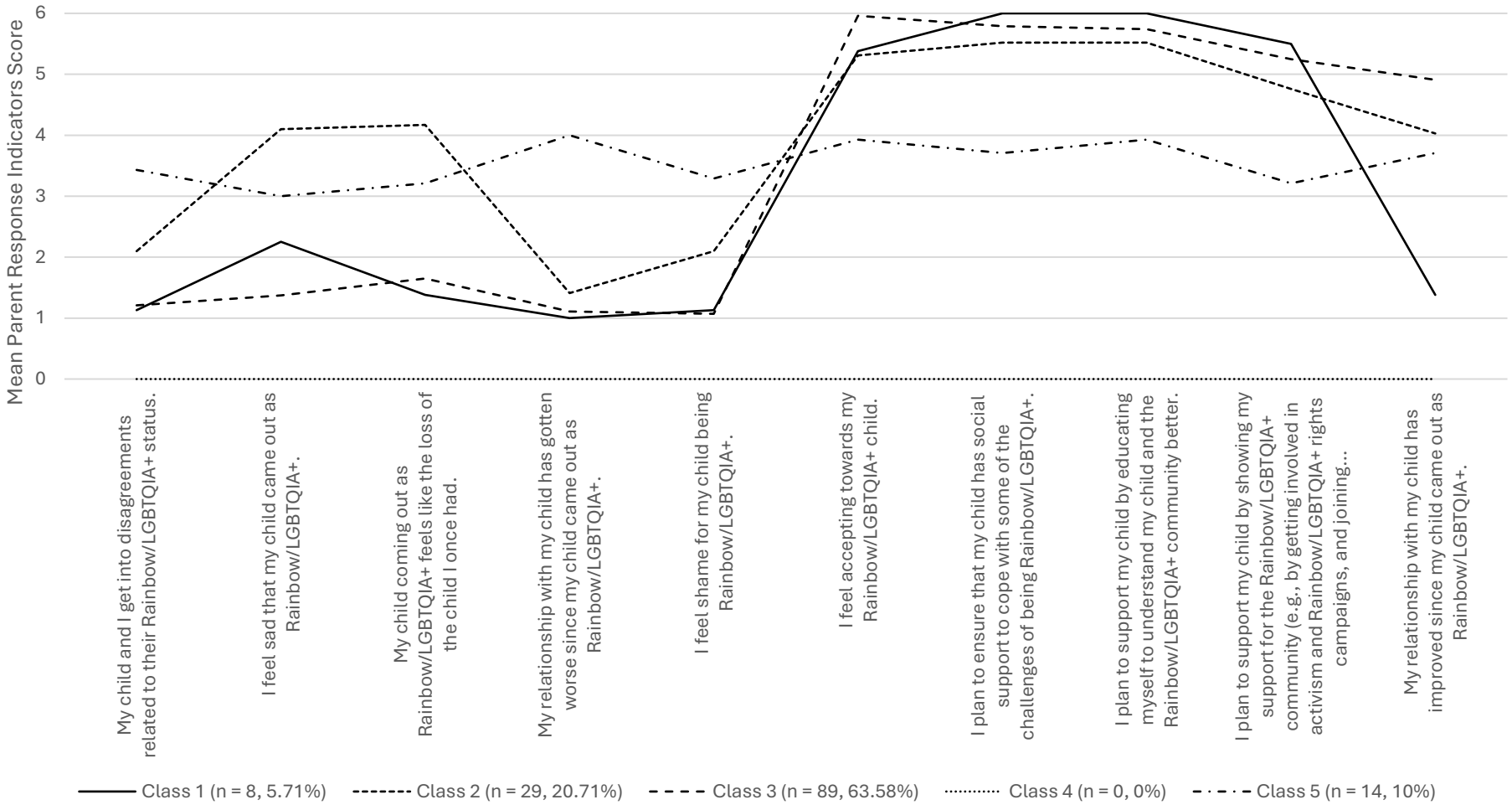
5 (very much)

Appendix F: Three, Four, and Five-Class Models

Three-Class Model of Latent Profiles of Caregiver Response to Their Rainbow Child



Four-Class Model of Latent Profiles of Caregiver Response to Their Rainbow Child



Five-Class Model of Latent Profiles of Caregiver Response to Their Rainbow Child