Raising Rural Rainbows: How Rural Contexts Shape Caregiver Wellbeing, Responses, and Youth Wellbeing in Aotearoa.

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Abstract

Rainbow youth in Aotearoa New Zealand experience disproportionately high rates of mental distress compared to their non-rainbow peers. Emerging evidence highlights the decisive role of caregivers in shaping these outcomes through their wellbeing and responses in diverse sociocultural contexts. However, little research has examined how these family processes operate across rural and non-rural contexts. This quantitative cross-sectional study addressed this gap through a nationwide survey of 152 caregivers of rainbow youth under 30 years of age. Participants reported their own wellbeing, their young persons' wellbeing, caregiving responses, experiences of affiliate stigma, and access to rainbow-affirming resources.

Analyses compared rural (*n* = 20) and non-rural (*n* = 132) caregivers. Although mean level differences between rural and non-rural caregivers were minimal, patterns of association revealed meaningful contextual variation. Across the sample, greater caregiver wellbeing was associated with greater youth wellbeing, with tentative evidence that this relationship was stronger in rural contexts. Greater caregiver wellbeing was associated with fewer negative caregiver responses across contexts and with more positive caregiver responses only in rural contexts. Negative caregiver responses were associated with lower youth wellbeing across rural and non-rural contexts, whereas positive caregiver responses were associated with greater youth wellbeing only in rural contexts. Affiliate stigma was associated with lower caregiver and youth wellbeing as well as fewer positive and more negative caregiver responses across both rural and non-rural contexts. Accessing rainbow-affirming resources was associated with fewer negative caregiver responses in rural contexts only.

This thesis provides one of the first quantitative comparisons between rural and non-rural caregivers of rainbow youth in Aotearoa. Findings position caregiver wellbeing as an important correlate of rainbow youth wellbeing, and highlight caregiver responses as a potential mechanism through which rural contexts may enhance wellbeing outcomes for rainbow young people. While longitudinal research is needed to establish temporal

relationships, findings extend minority stress theory by positioning caregivers as active agents that shape youth outcomes. Practically, this thesis underscores the need to strengthen caregiver wellbeing and ensure equitable access to affirming resources, particularly for rural families, where resources remain limited yet profoundly impactful.

Keywords: Rainbow youth, caregiver wellbeing, caregiver responses, affiliate stigma, resource access, minority stress theory, rural, Aotearoa, New Zealand.

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Table of Contents

List of Tables

List of Figures

Researcher Positionality

As a cisgender, gay, Pākehā man who grew up in rural Aotearoa, my personal, professional, and cultural experiences have deeply informed the way in which I have approached this thesis. My childhood was shaped by the unique strengths and challenges of rural life. Although this rural context facilitated a profound connection with and respect for the natural world, it was also embedded within a sociocultural milieu that constrained my rainbow identity. This complexity informed my understanding of rurality as not all good or all bad but as a multifaceted context that can amplify the effects of both acceptance and rejection.

I have lived my entire life in Aotearoa and uphold the principles of Te Tiriti o Waitangi as the foundation for ethical psychological research and practice in Aotearoa. As a Pākehā researcher, I recognise the responsibilities this entails by engaging with rurality and wellbeing through a lens that embraces situated knowledges and resists colonial narratives of what constitutes healthy and successful families. I chose this thesis topic because wellbeing is inherently contextual, particularly for young people, who have limited control over the contexts and systems in which they are embedded. I resist narratives and epistemologies that situate distress solely within the decontextualised individual, especially for those embedded in harmful systems and contexts. My perspective is shaped by the belief that what is often labelled as an individual pathology, particularly in rainbow young people, might instead be an understandable response to a harmful and rejecting environment.

My lived experience as a rainbow young person who grew up in rural Aotearoa, combined with my professional work as a mental health clinician supporting rural rainbow youth and their families, has informed my dual lens as both an insider and an outsider to this topic. Although I have grown up as a rainbow young person in a rural environment, I have not experienced the perspective of being a caregiver to a rainbow child. I also recognise that the social and technological context of growing up in rural Aotearoa has changed since my youth in the 2000s, with todays' families navigating both new challenges and opportunities that were absent when I was younger.

I see this research as both a contribution to the limited body of knowledge on rural rainbow experiences in Aotearoa, and as an act of advocacy. As rural families are often underrepresented and under-theorised in the literature on rainbow wellbeing, my goal is to respectfully and reflectively elevate their voices, with a particular emphasis on the situated strengths, meanings, and knowings of rural people and communities. While one cross-sectional study cannot encompass all rural rainbow experiences in Aotearoa, I hope that this work will contribute to a growing body of knowledge that continues to explore these experiences more deeply and expansively to improve the wellbeing of rainbow youth and their families.

Statement of Contribution

This thesis is part of the *Raising Rainbows* project, a broader study conducted by PrideLab at Massey University and led by Dr. Ilana Seager van Dyk. The overall project, including the development of research aims and overarching questions, survey design, measure selection, and recruitment materials, was conducted in collaboration with Dr Ilana Seager van Dyk, Adriana Westerbaan, Grey Woods, and myself.

Regarding this thesis, I was responsible for all stages, including the development and refinement of the research questions and predictions specific to this thesis, the execution of statistical analyses, and preparation and writing of the thesis document. Data cleaning of the primary dataset was performed by Adriana Westerbaan, and ethics approval was obtained by Dr. Ilana Seager van Dyk. All other aspects of this thesis represent my independent work under the supervision of Dr. Ilana Seager van Dyk and Dr. Kealagh Robinson.

A Note on Terminology

In this thesis, the term *'rainbow'* refers to the collective spectrum of identities and experiences related to diverse sexual orientations (e.g., gay, lesbian, bisexual, pansexual, asexual, takatāpui, queer), gender identities and expressions (e.g., transgender, trans, takatāpui, whakawahine, tangata ira tāne, fa'afafine, fa'afatama, genderqueer), and sex characteristics (e.g., takatāpui, intersex, people born with innate variations to sex characteristics). Although the acronym LGBTQIA+ features prominently in the international literature when referring to this collective, *rainbow* tends to be preferred in Aotearoa, as it reflects culturally important terms (e.g., takatāpui, whakawahine) that acknowledge the unique social, cultural, and historical contexts of Aotearoa.

For the purposes of this thesis, the term 'non-rainbow' refers to identities that fall outside the rainbow spectrum, such as those who identify as both cisgender *and* heterosexual. It is important to note that some people who identify as heterosexual may still fall under the rainbow umbrella, such as transgender individuals whose sexual orientation is heterosexual, but whose gender identity is transgender. The use of *rainbow* and *non-rainbow* aims to be inclusive while also recognising the complexity of identity.

The term *wellbeing* refers to the interconnected state of health across the physical, mental, emotional, social, and spiritual domains. This conceptualisation of wellbeing was chosen as a focal construct for this thesis because it provides a holistic framework for understanding how participants' experiences are situated within interconnected social, cultural, historical, and environmental contexts and systems. This holistic model also aligns with te ao Māori perspectives of *wellbeing*, which view *wellbeing* as arising from balance and connection across these domains, making it an appropriate approach for research within Aotearoa. Additionally, *wellbeing* also emphasises a model of health that extends beyond categorical conceptions and understandings of illness and disease. While this thesis uses *wellbeing* to reflect this broader view, much of the existing health literature utilises categorical definitions of illness, such as *anxiety* and *depression*. When this study describes

previous research that indirectly assed wellbeing by focusing on categories of illness, those terms will be retained to contextualise the evidence more accurately.

The terms *young person* and *youth* are used to refer to individuals under the age of 30. This age range aims to be inclusive, acknowledging that many young people remain connected to their families in ways that meaningfully shape their experiences beyond adolescence and into emerging adulthood. It is worth noting that much of the existing international literature on *rainbow youth* focuses exclusively on adolescents (13 – 18 years old). When this thesis draws from studies that focus on a more specific developmental stage (e.g. children, adolescents, young adults), those terms will be retained to contextualise the evidence more accurately.

The term '*caregiver*' refers to individuals who occupy a primary carer role in a young person's life. This includes biological parents, stepparents, grandparents, aunts, uncles, or others who hold primary responsibility for the wellbeing of a young person. This framing acknowledges the diverse forms that families might take beyond the conventional Western model of the nuclear family.

The terms *rural* and *non-rural* refer to the geographic settings in which people live. *Rural* settings are shaped by varied and overlapping social, cultural, and geographic factors, which make a standardised definition difficult. In the current study, *rural* participants were identified based on rural delivery addresses drawn from New Zealand's postal classification system. Conversely, *non-rural* participants were identified as those who did not live in an area with rural delivery postcodes. In the broader literature, terms such as *regional* or *urban* are often used to describe *rural* and *non-rural* contexts, respectively. When this thesis draws from studies that use these classifications, those terms will be retained to contextualise the evidence more accurately.

Chapter One: Introduction

Human wellbeing is profoundly shaped by the social, cultural, and historical contexts people inhabit (Marks et al., 2021). Globally, wellbeing is increasingly understood as a product of dynamic and interconnected individual, interpersonal, and structural processes, rather than as a discrete and self-contained state (Bronfenbrenner & Morris, 2006; World Health Organization, 2024). Social belonging, family connections, and access to supportive environments have consistently emerged as central determinants of health across the lifespan (Helliwell et al., 2023). From this systems perspective, wellbeing emerges through the interaction between an individual and their contexts. For young people, whose social worlds and identities are still developing, these interactions are especially formative. Both relational and geographic contexts profoundly shape how youth wellbeing is supported or constrained.

Adolescence and emerging adulthood are developmental periods during which these relational contexts are particularly important. During this period, caregivers serve as a primary source of guidance and security, supporting young people in developing autonomy, seeking belonging, and navigating their identities (Branje, 2018; Smetana & Rote, 2019). Extensive research across the general population has shown that close, supportive caregiver-youth relationships foster emotional security, resilience, and adaptive development (Branje, 2018; Pinquart & Silbereisen, 2002; Steinberg, 2001). In contrast, critical and rejecting caregiver-youth relationships have been found to increase the risk of distressing internalising and externalising behaviours (Branje, 2018; Pinquart & Silbereisen, 2002; Steinberg, 2001). These findings highlight that families, particularly caregivers, play a decisive role in shaping young people's wellbeing.

Caregiver dynamics are even more significant for rainbow youth, who experience disproportionately high rates of mental distress and diminished wellbeing compared to their non-rainbow peers both in Aotearoa and internationally (e.g., Hatzenbuehler & Pachankis, 2016; Marshal et al., 2011; Sutcliffe et al., 2024; Tan et al., 2023; Tan et al., 2022; Wilson & Cariola, 2020). While such inequities reflect global trends, their domestic expression is

shaped by Aotearoa's unique sociocultural, historical, and geographic contexts. Within such contexts, the caregiver-youth relationship often serves as the first and most influential site of acceptance or rejection of a young person's rainbow identity. Here, positive caregiver responses characterised by acceptance and support buffer against the harmful effects of discrimination, while negative caregiver responses characterised by rejection and judgement increase psychological distress (Clark et al., 2022; Ryan et al., 2009). Despite these well-documented effects, much of the existing research in this area continues to centre rainbow youth as the primary targets of investigation, situating caregivers as background figures rather than key agents of support and constraint within the family system.

Geographic context further shapes these caregiver-youth dynamics. Rural environments in particular, may intensify both protective and risk factors for rainbow families. Caregivers in rural areas often face reduced access to rainbow-affirming information, support services, and peer networks (Deane et al., 2019; Easpaig et al., 2022; Stevenson et al., 2024), making it more difficult for them to provide informed, affirming support to their rainbow young person. Simultaneously, rural contexts may provide unique strengths, such as a slower pace of life, less environmental stress, and access to natural landscapes (Ladry et al., 2024). Approximately 16.0% of Aotearoa's population live in rural areas (Environmental Health Intelligence New Zealand, 2018), highlighting the importance of understanding how rurality interacts with family processes to shape the wellbeing of both caregivers and rainbow young people.

Despite these intersecting influences, research exploring the interactions between caregiver wellbeing, responses, and rurality remains limited, particularly in Aotearoa. Existing Aotearoa studies have largely examined rainbow youth outcomes in urban or generalised contexts (e.g., Deane et al., 2019; Easpaig et al., 2022; Nixon, 2024), with few directly comparing rural and non-rural families or examining caregivers as relational agents of wellbeing in their own right. Consequently, health professionals, educators, and policymakers lack the evidence base required to support rural caregivers in providing affirming and accepting environments for their rainbow youth.

This thesis addresses this gap in knowledge. Drawing on a nationwide survey of caregivers of rainbow young people in Aotearoa, this thesis investigates how caregiver responses, caregiver and youth wellbeing, affiliate stigma, and access to affirming resources relate and differ across rural and non-rural contexts. In doing so, this thesis positions caregivers not merely as contextual factors but as active relational agents whose wellbeing both shapes and reflects the environments they inhabit. By integrating relational, contextual, and geographic perspectives, this thesis offers one of the first quantitative comparisons between rural and non-rural caregivers of rainbow youth in Aotearoa, offering novel insights for practice, policy, and future research.

Chapter Two provides a pragmatic review of the existing literature on this subject, beginning with an overview of the mental health disparities experienced by rainbow young people, minority stress theory, caregiver relationships, caregiver wellbeing, affiliate stigma, resource access, and finally, rurality. Chapter Three outlines the current study, its aims, rationale, and the specific research questions and predictions that emerge from the literature review. Chapter Four outlines the methodology, including ethical considerations, participant characteristics, measures, and analytical strategy of the current study. Chapter Five presents the results organised by three key research questions. Finally, Chapter Six integrates these findings with the existing literature to highlight the theoretical and practical implications, discussing the strengths and limitations of the current study, and suggesting potential future research directions.

Chapter Two: Literature Review

Decades of research have shown that rainbow youth experience disproportionately poor mental health outcomes, with these disparities increasingly linked to systemic and contextual factors rather than individual pathologies (e.g., Fergusson et al., 1999; Hatzenbuehler & Pachankis, 2016; Russell & Fish, 2016; Wilson & Cariola, 2020). In Aotearoa, these disparities are particularly pronounced, with rainbow youth more likely to experience anxiety, depression, and substance use issues compared to their non-rainbow peers (Steers et al., 2021; Tan et al., 2023; Tan et al., 2022). National data shows that rainbow youth are up to three times more likely to experience bullying and twice as likely to attempt suicide and engage in self-harm compared to non-rainbow youth (Koh et al., 2024; Lucassen et al., 2014; Roy et al., 2021; Sutcliffe et al., 2024). Beyond a higher prevalence, the *severity* of mental distress is also elevated among rainbow young people in Aotearoa (Sutcliffe et al., 2024; Tan et al., 2023). The heightened distress experienced by rainbow young people highlights the importance of understanding the social systems and contexts that create and maintain these outcomes.

Consequently, research has started to shift from individual explanations of distress in rainbow youth towards frameworks that locate their wellbeing within their broader structural and social contexts (Hatzenbuehler & Pachankis, 2016). Increasingly, researchers are looking beyond individual level explanations of mental distress towards the social, structural, and place-based contexts that can shape mental health outcomes for rainbow youth (Amos et al., 2023; Smith et al., 2014). Such perspectives are particularly salient for youth, as they typically have less control over the systems, structures, and environments that shape their lives compared to adults (Marks et al., 2021). Youth wellbeing therefore depends, not only on individual coping, but also on the quality of the interpersonal contexts in which young people are embedded. Within these contexts, experiences such as stigma, rejection, and bullying can be internalised by rainbow youth, increasing their distress and adversely affecting their wellbeing. This evolving body of work sets the theoretical scene for understanding and

exploring the relational and structural influences on mental health disparities among rainbow youth.

Together, these patterns highlight how *structural and relational* forces, rather than individual deficits, drive rainbow youth mental health disparities. Accordingly, contemporary research is moving away from explanations of youth distress based on the decontextualised individual and towards relational and contextual understandings of distress that foreground caregiver relationships and place (Clark et al., 2022; Seager van Dyk et al., 2024).To this end, the evidence is clear: rainbow young people flourish when embraced by accepting and supportive families, schools, and community systems (Fenaughty et al., 2019; Rituparna et al., 2021), yet their wellbeing can suffer when these systems are unsupportive, rejecting, and stigmatising (Rituparna et al., 2021). Such differences reflect not only individual-level factors but also broader contextual-level factors, such as discrimination, victimisation, and exclusion, which collectively influence mental health outcomes in rainbow young people (Mustanski et al., 2016; Rentería et al., 2025). Based on these processes, mental health disparities among rainbow youth are increasingly understood to result from *minority stress*, reflecting a shift toward contextualised understandings of wellbeing that emphasise the role of families, communities, and social systems as active agents of change rather than passive backdrops to the individual experience (Rentería et al., 2025; Shangani et al., 2020).

Minority Stress Theory

Minority stress theory explains how stressors unique to minoritised groups, such as discrimination, harassment, and victimisation, contribute to poor health outcomes in these populations (Brooks, 1981; Hatzenbuehler & Pachankis, 2016; Meyer, 1995; Meyer, 2003). Typically, these stressors are categorised into two types, distal and proximal, which together generate chronic and excessive stress, resulting in adverse health outcomes (Brooks, 1981; Meyer, 1995; Meyer, 2003). Distal refers to contextual and systemic stressors, such as interpersonal victimisation and structural discrimination. In contrast, proximal stressors refer to an individual's subjective conflicts and 'states of mind', such as shame, internalised stigma, and hypervigilance, often resulting from exposure to distal stressors (Lazarus &

Folkman, 1984; Meyer, 2003). Minority stress theory emphasises that these stressors are chronic and socially derived, occurring in *addition* to general life stressors and compounding to disproportionately diminish the wellbeing of minoritised groups (Meyer, 2003). This framework provides a foundation for exploring how systemic forces translate into lived psychological distress for minoritised groups.

Minority stress theory is especially relevant for understanding the mental health of rainbow young people. Applied to this group, minority stress theory highlights how systems-level factors, such as family, school, and geographic context, can contribute to the internal conflicts from which mental distress arises and is amplified (Meyer, 2003). Here, minority stress theory provides a crucial framework for understanding how distal stressors, such as negative caregiver responses, can amplify experiences of mental distress for rainbow young people, while simultaneously highlighting how environments founded on positive caregiver responses can improve wellbeing for this group (Clark et al., 2022; Seager van Dyk et al., 2024). In doing so, minority stress theory situates caregiver responses as a core mechanism through which distal stressors impact rainbow youth through the caregiver-youth relationship. Understanding the influence of caregiver responses is especially important during adolescence, a developmental period during which young people negotiate identity formation, autonomy, and peer relationships.

Experiences of minority stress during adolescence can disrupt key developmental tasks, compounding the ordinary stressors of this period and leading to enduring mental health challenges (Gibbs & Rice, 2016; Radkowsky & Siegel, 1997). Adolescents already navigate pressures around autonomy, identity, and belonging; minority stress adds additional burdens, such as stigma, discrimination, identity concealment, and internalised homophobia. Importantly, these stressors are experienced differently by rainbow youth compared to rainbow adults, as youth are often embedded within compulsory systems like home and school where they have little control compared to rainbow adults (Goldbach & Gibbs, 2017). In geographically isolated areas, these compulsory systems may further increase vulnerability, as smaller schools and closer-knit communities mean fewer alternatives and

greater visibility for rainbow youth. Consequently, rainbow youth are less able to avoid distal stressors, such as parental rejection and school bullying, resulting in proximal stressors, such as the concealment of sexual identity and internalised stigma (Goldbach & Gibbs, 2017). Severe parental rejection can even result in homelessness (Clatts et al., 2005), and studies suggest that up to 90% of rainbow youth experience school-based victimisation (Berlan et al., 2010; Mustanski et al., 2016; Mustanski et al., 2011). As rainbow young people have little control over these contexts, caregiver responses become a critical determinant of whether stress is buffered or amplified, situating caregivers as an important target for interventions aimed at ameliorating the adverse effects of minority stress on this group (Goldbach & Gibbs, 2017; Hatzenbuehler, 2011). Despite its utility in understanding the unique developmental challenges faced by rainbow young people, minority stress theory is not without its limitations, particularly in its treatment of intersecting identities.

Although minority stress theory provides a valuable theoretical lens, scholars have criticised its limited engagement with intersectionality and structural power (e.g., Frost & Meyer, 2023; Schmitz et al., 2020; Zhang et al., 2025). Critics have noted that the framework tends to emphasise sexual orientation at the expense of the complex intersections of gender, race, socioeconomic status, and geographic location (Schmitz et al., 2020; Zhang et al., 2025). While recent extensions have attempted to include intersectional perspectives (Schmitz et al., 2020; Tan et al., 2020), much of the literature continues to emphasise the cumulative impact of multiple minoritised identities, neglecting the reality that an individual's identities are not isolated factors but rather interact and conflict within a hegemonic society that marginalises certain identities while privileging others (Few-Demo, 2014). This limits the ability of minority stress theory to fully explain how structural power and privilege impact the wellbeing of rainbow youth and their caregivers (Few-Demo, 2014; Zhang et al., 2025). Recognising these critiques invites a more relational application of minority stress theory, one that centres the family as a relational site where social stress is both reproduced and transformed.

Despite its limitations, minority stress theory remains a powerful lens for conceptualising how additional stress is produced and transmitted through social contexts to rainbow youth. By situating caregivers within this framework, it becomes possible to examine how systemic and contextual forces, such as social norms, stigma, and resource access, are metabolised within the family and embodied in daily interactions between caregivers and rainbow youth. In this way, caregivers serve as both interpreters and transmitters of minority stress, influencing how rainbow youth experience distal stressors in their daily lives. Recognising this relational conduit not only extends minority stress beyond its individualised focus, but also positions caregiver relationships as a developmental crucible for rainbow youth, where stress and resilience are shaped. Building on this theoretical foundation, the following section explores the developmental importance of caregiver relationships during adolescence, a period when these dynamics are particularly impactful, and when caregivers' capacity to buffer or amplify minority stress can profoundly shape wellbeing outcomes for rainbow young people.

Role of Caregivers in Adolescent Development

Adolescence is a crucial developmental period during which young people begin to form autonomous identities while still relying on caregivers for emotional support, security, and guidance (Branje, 2018; McConnell et al., 2016). During this time, adolescents often desire independence more rapidly than they can develop their self-regulation skills (Branje, 2018). Consequently, this period is often characterised by increased conflict between caregivers and adolescents (Pinquart & Silbereisen, 2002). While some level of conflict is normal and supportive of adolescent autonomy and individuation (Steinberg, 2001), persistently high levels of caregiver conflict, criticism, judgement, and rejection can lead to unhelpful internalising and externalising behaviours that increase mental distress and disrupt the achievement of developmental milestones (Mills-Koonce et al., 2018; Tucker et al., 2003). Given that adolescence is such a formative period, these findings suggest that it is the *quality* of the caregiver-youth relationship that is decisive in determining whether young

people experience this developmental period as a time of growth or vulnerability, a distinction that is particularly pronounced for rainbow young people.

Supportive and secure caregiver-youth relationships are consistently associated with improved adolescent development (Smetana & Rote, 2019). Close, affirming caregiver relationships can buffer rainbow young people from the stress associated with navigating a minoritised identity during a developmental period defined by intense social comparison and identity formation. Identity formation during this period often involves navigating tensions between belonging versus alienation, and identity cohesion versus confusion (Newman & Newman, 2022). For rainbow youth, these developmental tasks are further complicated by processes, such as 'coming out' as rainbow, which often occur against a backdrop of uncertainty around potential rejection from caregivers (Gibbs & Rice, 2016; Goldbach & Gibbs, 2017). When caregivers respond to their young person's rainbow identity disclosure with acceptance and validation, such as by using their preferred name and pronouns and engaging in open and supportive communication, the young person's wellbeing is enhanced, and distress is reduced (Clark et al., 2022; Ryan et al., 2010; Seager van Dyk et al., 2024). Ultimately, supportive caregiver relationships provide rainbow youth with the tools they need to begin exploring their identities without fear, enabling them to integrate their identities within affirming family systems.

Affirming caregiver responses also underpin longer term developmental processes. Although longitudinal studies on this topic are limited, the existing literature suggests that supportive caregiver relationships have enduring benefits for rainbow young people that persist into adulthood. Prospective and cohort follow-up research indicates that caregiver acceptance during adolescence predicts lower rates of depression and suicidality, greater self-esteem, and better general health into adulthood (e.g., Ryan et al., 2010; Snapp et al., 2015; Teasdale & Bradley-Engen, 2010; Ueno, 2005). In the five-and-a-half year 'Family Matters' study, rainbow youth with the highest level of family support maintained the lowest psychological distress (McConnell et al., 2016). Critically, rainbow youth, whose family relationships improved over time, showed significant declines in distress, approaching the

high support group by early adulthood (McConnell et al., 2016). Large clinical and survey datasets echo these findings, showing that caregiver support halves the odds of recent suicidality among rainbow youth in primary care (DelFerro et al., 2024). Importantly, even *one* supportive caregiver confers measurable benefits, especially to transgender youth, among whom a single strongly supportive caregiver is linked to dramatically reduced suicide risk and near-normal levels of internalising behaviour (Olson et al., 2016; Vandermorris, 2023). Evidence from Aotearoa supports this, with the Youth19 survey finding that family acceptance is one of the strongest predictors of emotional wellbeing among rainbow youth (Koh et al., 2024). Over time, these supportive caregiver and family dynamics can reinforce self-acceptance, belonging, and resilience, which can mitigate the effects of minority stress on rainbow young people and promote flourishing across their lifespan.

Caregiving Approaches to Rainbow Youth

Initial research suggests that established parenting strategies that are beneficial for the general adolescent population may not be as beneficial for rainbow young people, whose developmental contexts differ markedly from those of their non-rainbow peers (DeVore & Ginsburg, 2005; Kincaid et al., 2012). For example, while general parenting strategies, such as monitoring and open communication, are typically associated with improved outcomes for young people, their impact on rainbow youth appears to be more variable (DeVore & Ginsburg, 2005; Kincaid et al., 2012). Some studies suggest that these strategies can support the wellbeing and sexual health of rainbow youth, while others highlight that, when delivered in non-rainbow-affirming or hetero- and cis-normative ways, these strategies can feel intrusive, critical, and invalidating (Mustanski et al., 2017; Thoma & Huebner, 2014). In these ways, findings underscore that the success of caregiving approaches depends not only on *what* caregivers do but also on *how* they do so. Accordingly, the quality and tone of caregiving responses in conveying safety, openness, and affirmation, rather than the strategies themselves, most strongly shape the wellbeing of rainbow youth.

Across the literature, affirmation and acceptance emerge as the foundations upon which caregiving approaches either foster resilience or amplify distress among rainbow young people (e.g., Eisenberg & Resnick, 2006; Feinstein et al., 2014; Gillig et al., 2022; Newcomb et al., 2019; Pearson & Wilkinson, 2013; Ryan et al., 2009; Ryan et al., 2010; Thoma & Huebner, 2014). Affirming caregiver responses, characterised by warmth, validation, and support, enhance rainbow young peoples' wellbeing, while negative caregiver responses, characterised by rejection, criticism, and avoidance, reduce rainbow young peoples' wellbeing (Clark et al., 2022; Ryan et al., 2009; Ryan et al., 2010; Seager van Dyk et al., 2024). Without an affirming and accepting relational basis, even well-intentioned caregiving practices may inadvertently reinforce stress and identity concealment for rainbow youth (e.g., The Trevor Project, 2022; U.S. Centres for Disease Control and Prevention, 2024). Consequently, acceptance and affirmation serve as vehicles for all effective caregiving approaches for rainbow young people. Together, these findings have prompted researchers to look beyond discrete caregiving practices toward the relational qualities of caregiver responses and how these affect rainbow youth across contexts.

Caregiver responses are typically conceptualised along three broad dimensions – affirming, rejecting, and mixed–each associated with distinct wellbeing outcomes for rainbow youth (Seager van Dyk et al., 2024). As previously discussed, affirming responses are associated with significantly improved wellbeing for rainbow youth (McConnell et al., 2016; Ryan et al., 2009; Ryan et al., 2010), while rejecting responses are associated with increased psychological distress and negative developmental outcomes (Clark et al., 2022; Ryan et al., 2009; Ryan et al., 2010). Notably, many caregiver responses occupy an ambiguous, middle ground. Mixed or ambivalent responses, where support coexists alongside avoidance or silence, reflect the complex processes that many caregivers undergo when navigating their young people's rainbow identities (Seager van Dyk et al., 2024). This partial acceptance, such as 'I love you, but let's not talk about it', or 'It's just a phase', can leave young people uncertain about the security of their relationship with their caregiver, undermining the relational consistency and clarity that is essential for adaptive development

(Perrin et al., 2004; Seager van Dyk et al., 2024). Thus, caregivers' emotional ambivalence can be as impactful as overt rejection, particularly when it is situated within broader social, cultural, and environmental pressures.

Negative or ambivalent caregiver responses are especially consequential for rainbow youth, who face additional stress within a cis- and hetero-normative sociocultural backdrop that positions them as outsiders (Goldbach & Gibbs, 2017; Meyer, 2003; Mills-Koonce et al., 2018). Unlike many other minoritised populations, rainbow youth typically do not share their minoritised status with their caregivers, promoting a kind of 'status asymmetry' that can heighten conditional acceptance, misunderstanding and rejection (Goldbach & Gibbs, 2017). Such asymmetry often fuels feelings of anticipatory rejection and identity concealment, with many rainbow youth learning to hide aspects of themselves or expecting rejection even before disclosure of their rainbow identity (Baiocco et al., 2015; Clark et al., 2022; Pearson & Wilkinson, 2013). These internalised expectations can create tension and strain within the caregiver-youth relationship long before the young person comes out, contributing to less close caregiver-youth relationships compared with non-rainbow peers (Teasdale & Bradley-Engen, 2010; Ueno, 2005). Viewed through a minority stress lens, such relational ruptures illustrate how distal stress can be transmitted into the family system, magnifying the stress burden on rainbow youth.

Minority stress dynamics within families are further intensified when caregivers are under-resourced and under-supported, limiting their capacity to provide affirmation and support to their rainbow young people (Frost & Meyer, 2023; Hatzenbuehler & Pachankis, 2016; Seager van Dyk et al., 2024). Caregivers embedded in geographic communities with few affirming resources or high levels of stigma may struggle to access information and supportive networks, perpetuating cycles of misunderstanding and distress (Frost & LeBlanc, 2014; Frost & Meyer, 2023). Within these contexts, distal stressors (e.g., social exclusion and community conservatism) create and compound proximal stressors (e.g., caregiver shame and anxiety), creating relational dynamics that restrict open dialogue and emotional safety. Dynamics such as these emphasise how caregiver responses are not formed in

isolation but emerge within layered contextual milieus of stress and support. Thus, the capacity for caregivers to provide affirming responses depends as much on the sociocultural and geographic contexts surrounding them as on material resource access.

Cultural norms and individual-level factors can shape caregiver responses, influencing whether families respond to rainbow identities with rejection, ambivalence, or affirmation. Culturally situated standards of masculinity and expectations of extended family co-residence, for example, have been associated with more negative family responses in some contexts (Gattamorta et al., 2019; LaSala & Frierson, 2012). Conversely, many Indigenous relational values, such as the te ao Māori notions of *whanaungatanga*[1] and *manaakitanga*[2], place a high value on family, loyalty, empathy, and meaningful connections, which have been associated with more positive family responses in certain contexts (Abreu, Gonzalez, et al., 2020; Abreu, Riggle, et al., 2020; Hamley et al., 2025). At the individual level, high religious fundamentalism, low parental satisfaction, low education, and low cognitive flexibility have been associated with negative caregiver responses, whereas high empathy, female gender, rainbow identity, and high prior awareness of rainbow issues have been associated with more positive responses (Morgan et al., 2022; Rosenkrantz, 2018; Rosenkrantz et al., 2020). These intersecting influences illustrate that caregiver responses to their rainbow youth are situated within multi-layered sociocultural and environmental systems, where individual beliefs, cultural norms, and community worldviews jointly shape the emotional climate of the caregiver-youth relationship.

Together, these findings position caregiver responses as both products and transmitters of the wider sociocultural environments that they and their families inhabit. In other words, *caregiver responses matter* and occur within structural, interpersonal, and cultural milieus, all of which have profound implications for the wellbeing of rainbow youth.

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[1] *Whanaungatanga* refers to the te ao Māori value of connection, kinship, and relationship – emphasising the responsibilities, mutual care, and sense of belonging that arise from being in relationship with others.

[2] *Manaakitanga* refers to the te ao Māori value of care, respect, and hospitality shown toward others – the practice of uplifting others *mana* (dignity, integrity, and spiritual authority) through generosity, empathy, and reciprocity.

Within these systems and structures, caregivers are a primary relational conduit through which broader sociocultural norms of gender and sexuality are internalised, interpreted, and enacted within the family (Newcomb et al., 2019). Recognising caregiver responses as a contextually situated process invites a closer examination of caregivers themselves, their wellbeing, stress, and coping abilities, all of which can shape how they respond to their rainbow young people over time.

Caregiver Wellbeing

Having a child 'come out' and disclose a rainbow identity can be an emotionally complex journey that affects the wellbeing of caregivers themselves (de Bres & Morrison-Young, 2023, 2024). Although numerous studies have linked caregiver responses to the wellbeing of rainbow youth, comparatively little research has explored the wellbeing of caregivers themselves and the mechanisms that shape it (Newcomb et al., 2019). This oversight is unfortunate, as for many caregivers, the process of negotiating the disclosure of their young person's rainbow identity can adversely affect their wellbeing (Newcomb et al., 2019). Minority stress theory provides valuable insight into the factors influencing this process for caregivers, highlighting how sociocultural norms that privilege non-rainbow identities create contexts in which caregivers may grieve heteronormative expectations for their rainbow youth, fear for their youth's wellbeing, and feel disconnected from them, resulting in feelings of shame, anxiety, and grief for caregivers (Hatzenbuehler & Pachankis, 2016; Meyer, 2003; Rith, 2017; Shangani et al., 2020; Shilo & Mor, 2014). This distress can reverberate through the family system, with implications for the quality of the caregiver-youth relationship and the wellbeing of both parties.

Caregiver wellbeing is particularly vulnerable in systems that stigmatise rainbow identities. Caregivers may face judgement and rejection because of their connection with their rainbow young person (Moss-Racusin et al., 2024), while limited access to affirming resources, especially in geographically isolated rural communities, can heighten feelings of disconnection and discourage help-seeking (Deane et al., 2019; Easpaig et al., 2022; Rosenkrantz et al., 2017; Warren et al., 2015). As peer relationships are a key source of

support for caregivers, exclusionary social systems can compound the negative effects of under-resourced geographical contexts, adversely impacting caregiver wellbeing, and further straining the caregiver-youth relationship (Easpaig et al., 2022; Stevenson et al., 2024; Wienke & Hill, 2013). Consequently, both the youth and the caregiver may suffer, reinforcing relational patterns of rejection and diminished wellbeing. Thus, strengthening caregiver support and resourcing is a central pathway for improving outcomes for *both* caregivers and rainbow youth.

Caregiver wellbeing is deeply intertwined with youth wellbeing (Johnston, 2024; Newcomb et al., 2019). When caregivers of rainbow youth feel supported and have access to rainbow-affirming resources, their wellbeing improves, and they are better able to provide affirming and supportive care to their rainbow young people (Huei & Nie, 2023; Newcomb et al., 2019). Such support can take many forms, including connections with other parents of rainbow youth, access to affirming community networks, and engagement with inclusive counselling and education. Accessing and engaging with such support can reduce feelings of isolation, normalise the caregiver journey, and build caregivers' confidence in affirming their rainbow young person. Conversely, caregivers who feel unsupported and isolated often experience worse wellbeing, making it difficult for them to support their rainbow young people, whose wellbeing suffers as a result (Carone et al., 2025; Huei & Nie, 2023). Importantly though, when caregivers have access to rainbow-affirming resources, they can experience a period of personal growth and improved wellbeing, even after an initial period of distress and uncertainty (Gonzalez et al., 2013). For these caregivers, access to resources can facilitate a shift toward acceptance of their rainbow young person, leading to closer relationships between caregiver and young person, more positive emotions for both, and a greater sense of purpose for caregivers (Gonzalez et al., 2013). This illustrates that caregiver wellbeing is both a socially influenced outcome *and* a relational resource that can buffer or risk the wellbeing of rainbow young people. Such interdependence between caregivers and youth suggests that interventions that bolster caregiver wellbeing are

important leverage points for improving the wellbeing of rainbow youth, particularly in contexts in which broader resources and affirmation are scarce.

Caregiver wellbeing is best understood not only as an outcome but also as a dynamic relational process shaped by caregivers' sociocultural environments. Caregivers' experiences of support or strain often represent the broader narratives of acceptance and stigma present in their communities. In affirming community contexts, caregivers are more likely to feel confident and connected, whereas in environments marked by prejudice, they may experience stress, shame, and isolation. These contextual pressures can mirror minority stress processes that affect rainbow youth, demonstrating how systemic stigma can permeate family systems and directly affect caregivers.

Affiliate Stigma

One key mechanism linking caregiver wellbeing to broader social contexts is affiliate stigma, the stigma caregivers experience through association with their rainbow young person (Robinson, 2014; Stewart, 2002). Affiliate stigma encompasses both distal experiences, such as overt discrimination or social rejection due to having a rainbow child, and proximal experiences, including worries about the prejudice that their child might face and shame or guilt about their child's rainbow identity (Clark et al., 2024; Robinson, 2014). For example, caregivers may experience overt discrimination or subtle exclusion from their extended family or community simply because of their young person's rainbow identity. These negative social responses can erode caregivers' wellbeing, leading to a cycle in which external stressors feed internalised stigma and strain the caregiver-youth relationship. These processes suggest that stigma is not confined to rainbow youth themselves, but can extend to those closest to them, shaping the wellbeing of the family system in complex ways.

Although stigma has long been recognised as a determinant of rainbow youth wellbeing (e.g., Clark et al., 2024; Frost & LeBlanc, 2014; Hatzenbuehler & Pachankis, 2016; Meyer, 2003; Salway et al., 2018; Schmitz et al., 2020; Stevenson et al., 2024), its impact on caregivers has only recently begun to receive attention (Clark et al., 2024). Emerging evidence highlights that caregivers of rainbow young people frequently experience increased

rates of stress, depression, and anxiety, as a result of affiliate stigma (Chan et al., 2022; Clark et al., 2024; Rith, 2017). Together, these findings suggest that the distal and proximal minority stress processes long studied in rainbow youth may also extend to their caregivers (Martin et al., 2025), providing a framework for understanding how experiences of affiliate stigma shape caregiver responses and family wellbeing. Understanding how stigma operates within the caregiver-youth relationship is crucial for explaining why some caregivers adapt with resilience while others experience distress.

Caregiver responses appear to play a key role in shaping the effects of affiliate stigma in the caregiver-youth relationship. Chan et al. (2022) reported that caregivers who responded positively to their rainbow young person experienced less stigma associated mental distress, making caregiver's acceptance of their rainbow youth a protective factor for caregivers themselves (Chan et al., 2022). One explanation for this negative association between positive caregiver responses and experiences of stigma is that acceptance consolidates caregivers' role identity and reduces shame proneness, thereby weakening the adverse psychosocial consequences of stigma (Gonzalez et al., 2013). In contrast, caregivers who respond negatively to their rainbow young person appear to internalise stigma more deeply, which has been linked to worse mental health outcomes for this group (Martin et al., 2025; Rusu et al., 2024). Here, positive caregiver responses may foster a stronger sense of identity coherence and security for the caregiver, buffering against the adverse effects of affiliate stigma, whereas negative responses may compound the caregiver's shame and distress. Importantly, these processes emerge within a broader sociocultural context that can both constrain and support caregivers' capacities to affirm their rainbow youth.

The degree to which caregivers encounter affiliate stigma is strongly shaped by the social and cultural contexts in which they live. Caregivers situated within inclusive and accepting social environments tend to report less affiliate stigma, whereas those embedded within more conservative communities often report higher levels of stigma and stress (Clark et al., 2024). Such contextual differences show that affiliate stigma is not a problem of the

decontextualised individual, but a socially patterned process that reflects the norms, values, and resources of one's environment (Gajek, 2025; Siegel et al., 2022). Ultimately, patterns of affiliate stigma demonstrate that caregiver wellbeing cannot be disentangled from the sociocultural milieus in which caregivers inhabit, where collective attitudes towards gender and sexuality shape the everyday realities of acceptance, rejection, shame, and connection for rainbow young people and their families. Recognising affiliate stigma as socially produced invites reflection on how these insights might translate into practical forms of support and change.

Understanding affiliate stigma as a contextually influenced process allows for more targeted interventions aimed at supporting caregivers and youth. Interventions that challenge stigma must also address the social and cultural narratives that create and sustain it, promoting visibility, understanding, and solidarity. In this sense, affiliate stigma is both a challenge and an opportunity, as it reveals how deeply intertwined caregiver wellbeing is with the systems they are embedded in, while also pointing to the transformative power of supportive and affirming networks, services, and resources.

Resource Access

Access to affirming resources is a distinct yet interconnected contextual factor that influences how rainbow families cope with minority stress. Here, resource access refers to a caregiver's ability to locate, reach, and engage with affirming networks, services, and information that can validate and support their own and their young person's identities and wellbeing (Tan et al., 2023; Tan et al., 2022). Within the minority stress framework, these resources form a part of the caregiver's structural milieu, which can either buffer or amplify minority stress. When resources are scarce or inaccessible, their absence itself can be a form of structural stigma, constraining coping, amplifying isolation and negative caregiver responses, and intensifying the adverse effects of affiliate stigma (Deane et al., 2019; Easpaig et al., 2022). Understanding where and why gaps in resource access occur requires an examination of the multiple ecological layers that shape these dynamics.

Barriers to resource access occur at multiple ecological levels, reflecting systemic inequities in health, education, and community support. At the structural level, inequities in health and social service provision can limit the availability of rainbow-oriented practitioners and family level support (Fraser et al., 2022; Seager van Dyk et al., 2024). At the organisational level, a lack of affirming staff training and policies can reduce the visibility and safety of existing services, discouraging caregivers from engaging. At the interpersonal level, fear of gossip and judgement can deter help-seeking, even when support is available (Rosenkrantz et al., 2017; Warren et al., 2015). Together, these layers highlight that resource access is not only a logistical issue, but is embedded within wider systems of power, visibility, and belonging. Despite these barriers, evidence suggests that when caregivers *are* able to engage with affirming resources, the benefits extend beyond practical supports to relational and emotional transformation.

Engaging with affirming resources can profoundly enhance caregivers' confidence, understanding, and ability to provide supportive care to their rainbow youth. Caregivers who access affirming networks and educational support often report an improved understanding of their young person's rainbow identity, reduced uncertainty and fear, and greater confidence in providing an accepting and supportive relational space (Gonzalez et al., 2013; Huei & Nie, 2023; Newcomb et al., 2019). For example, interventions that intentionally integrate caregiver education and community connections, such as family support programs for parents of transgender youth (Chesters et al., 2025; Hatzenbuehler, 2011; Hatzenbuehler & Pachankis, 2016), reduce parental anxiety, increase caregiver acceptance, and improve mental health outcomes for youth. These findings situate resource access as a protective factor that can interrupt the feedback loop between stigma, stress, and negative caregiver responses to their rainbow young person. To conceptualise these dynamics more broadly, ecological and minority stress frameworks offer insights into how resource access operates as a moderating force within family systems.

Within ecological and minority stress frameworks, resource access can be conceptualised as a community-level influence that shapes how caregivers and their families

adapt to stress and stigma (Bronfenbrenner & Morris, 2006; Meyer, 2003). Just as individual interpersonal support can buffer against caregiver distress, access to affirming resources constitutes part of a broader ecology that can support caregivers' ability to cope, providing practical opportunities for accessing affirming care, connection, and support (Hatzenbuehler, 2011). When affirming resources are visible, credible, situated, and reachable, caregivers are better equipped to reinterpret stigmatising narratives, foster acceptance of their rainbow young person, and model resilience within their families. When resource access is restricted, caregivers and their youth are more vulnerable to distress. Such theoretical and conceptual links clarify how access to affirming resources functions not only as a form of external support, but also as a structural influence on caregiver youth relationships. In confluence, these findings position resource access as a measure of social equity and community investment in rainbow wellbeing.

Ultimately, access to affirming resources represents more than a practical concern; affirming resources signal the extent to which societies prioritise equity, belonging, and systemic care. Strengthening resource access, especially in geographically isolated or conservative rural communities, can mitigate the cumulative adverse impacts of stigma and foster communities in which rainbow youth and their families thrive. Importantly, the availability and meaning of such support is deeply shaped by place. Rural environments in particular, reveal how geography, community norms, and relational processes intertwine to influence caregivers' experiences of stigma, wellbeing, and connection, highlighting the need to understand resource access not only as a structural issue, but also as a process embedded in everyday relationships, values, and environments.

The Rural Context

Rurality represents a core contextual dimension in understanding how caregivers respond to rainbow young people in Aotearoa, where 16.0% of the population lives in rural areas (Environmental Health Intelligence New Zealand, 2018). This is especially true considering that rural communities in Aotearoa often exhibit characteristics associated with higher rates of rejecting attitudes toward rainbow young people, such as conservatism,

religious fundamentalism, and rigid cis- and hetero-normative social standards (Bergh et al., 2015; Campbell & Bell, 2000; Greaves et al., 2017; Rosenkrantz, 2018; Satherley et al., 2020; Sibley & Wilson, 2007). Statistically, rurality in Aotearoa is often described in terms of lower population densities and smaller settlements, often including regions surrounded by farmland, forests, or conservation areas (Statistics New Zealand, 2021). *Degrees* of rurality are often delineated by population sparsity and commute times, with a sparser population and longer commute indicating a higher degree of rurality (Statistics New Zealand, 2021). Importantly, these features form a contextual backdrop in which broader patterns of wellbeing emerge, with implications for caregivers and their rainbow youth navigate their daily lives.

People living in rural Aotearoa are more likely to experience poorer wellbeing than their non-rural counterparts, leading to higher mortality rates among rural individuals (Nixon, 2024; Nixon et al., 2023). These disparities are reflected across a range of wellbeing indicators, including lower educational achievement, lower vaccination rates, reduced access to mobile phones and internet, and significantly lower access to quality hospitals and specialist care (Hauora Taiwhenua: Rural Health Network, 2024). Rural communities in Aotearoa also experience twice the level of socioeconomic deprivation as non-rural communities and much higher rates of mental distress and suicide; factors which are more pronounced for rural Māori than their peers (Hauora Taiwhenua: Rural Health Network, 2024). Despite this, rural expertise and lived experiences are frequently undervalued in national policy discussions (Nixon, 2024). Contributing to a systemic bias toward non-rural expertise and knowledge, these patterns have been described as ‘geographical narcissism’ (Fors, 2018), a dynamic that leaves rural communities underserved and slow to see the results of national initiatives aimed at improving health outcomes in Aotearoa (Nixon et al., 2023). Within this broader landscape of inequity, rural rainbow youth and their caregivers often face additional challenges and opportunities that are unique to rural contexts.

For rainbow young people, rural settings can magnify both structural and interpersonal forms of minority stress. Rural rainbow youth often encounter elevated distal

stressors, such as reduced access to affirming resources, higher rates of discrimination and peer victimisation, oppressive heteronormative school cultures, and higher visibility due to the tight-knit nature of rural communities (Campbell & Bell, 2000; D'Augelli, 2006; Rickard & Yancey, 2018; Stevenson et al., 2024; Wienke & Hill, 2013). These distal stressors often translate into proximal stressors, such as internalised homophobia and transphobia, identity concealment, and hypervigilance (Agueli et al., 2022; Deane et al., 2019; Wienke & Hill, 2013). Here, the combination of social conservatism, reduced anonymity, and limited access to rainbow-affirming spaces can compound the experiences of distress for rainbow young people (Easpaig et al., 2022; Rickard & Yancey, 2018). In these ways, rural environments can both intensify existing stress processes and restrict the availability of affirming supports. Importantly though, alongside these disadvantages, many rural environments contain strengths and resources that can foster resilience and wellbeing in rainbow young people and their caregivers.

Rural lives and rural environments are not uniformly negative. For many rainbow youth and their caregivers, rural environments offer distinctive sources of strength that support wellbeing, especially when family relationships are already accepting and affirming (Ladry et al., 2024). Studies have highlighted that rural life can foster close-knit family and community ties, a slower pace of life, less environmental stress, and regular access to natural landscapes, all of which can nurture wellbeing (Ladry et al., 2024; Wienke & Hill, 2013). These ecological and social features can act as protective factors, offering respite from urban stressors (e.g., higher population density, elevated cost of living, social competition, social comparison, and fast-paced lifestyles; Elliott et al., 2022; Rosenkrantz et al., 2017). For caregivers, these unique qualities of rural life can promote wellbeing and stress resilience, supporting their capacity to self-regulate, and provide warmth and affirmation to their rainbow young people (Hartig et al., 2014; Pearson & Wilkinson, 2013). For rainbow young people, rural qualities, such as regular access to natural spaces, can foster greater self-reflection, meaning, and belonging (Fine et al., 2025; Hamley et al., 2025; Ladry et al., 2024). Ultimately, rural contexts may operate as amplifiers of relational

dynamics, magnifying both the strengths that arise from affirming caregiver-youth relationships and the vulnerabilities that emerge in their absence. However, despite the potential advantages of such situated understandings, empirical research on the experiences of caregivers of rainbow youth in rural Aotearoa remains scarce.

Within the intersecting complexities of place and sociocultural context, caregivers of rainbow youth occupy a unique and nuanced position that research is only beginning to explore (Deane et al., 2019; Easpaig et al., 2022; Movement Advancement Project, 2024). Preliminary research suggests that caregivers of rainbow young people in rural areas often face higher levels of visibility, scrutiny, and affiliate stigma, often due to the fact that there are fewer people, so those who are different can 'stick out' more (Henriquez & Ahmad, 2021; Movement Advancement Project, 2024). Caregivers of rainbow young people in rural areas also tend to experience heightened levels of social isolation compared to caregivers of non-rainbow children in similar contexts, making it difficult for them to connect with other families experiencing similar challenges, limiting options for accessing their own emotional and social support, and increasing their mental distress (McAweeney & Farr, 2024; Power et al., 2014). This lack of support undermines caregivers' wellbeing and constrains their ability to support their rainbow young person. Compounding this, conservative social norms that champion conformity can produce internal conflicts for caregivers who wish to affirm their young person's identity yet fear social repercussions (McAweeney & Farr, 2024; Stevenson et al., 2024; The Trevor Project, 2021). Given the strong connection between caregiver and youth wellbeing, these patterns highlight the need for rural-specific research and intervention.

These complex and often contradictory processes demand a research approach that emphasises and elevates the situated knowledges, beliefs, and experiences of rural rainbow families. Rather than asking just *what* struggles rural rainbow youth and their caregivers face, research must examine *how* place and social norms inform context-dependent forms of connection, silence, and resilience in rural communities. The strength of many rural families lies in what is often overlooked, such as deep interdependence and connection to nature, facilitating grounded lifeworlds that can foster and protect wellbeing. Importantly, these

strengths cannot be properly understood through non-rural knowledges and worldviews. Just as rural communities are shaped by unique histories, geographies, and sociocultural milieus, so too must be the research aimed at supporting these communities. Failing to do so risks missing the very conditions of rural communities that are most crucial to improving outcomes for rainbow young people and their families. Caregivers are central here, serving as translators of place into the daily relational milieus that shape the wellbeing of rainbow youth. Despite this need, the lived realities of rural rainbow families remain only partially understood in the existing literature, and even less so in Aotearoa, calling for closer empirical attention to these contexts and complexities.

Gaps in Current Knowledge

Although research on rainbow young people and their caregivers is expanding, the preceding review highlights an existing knowledge base that is fragmented and urban-centric. Most empirical studies in this area have explored rainbow youth outcomes in general terms of minority stress and family rejection and acceptance, while typically assuming, either implicitly or explicitly, a non-rural backdrop where affirming resources, diverse peer groups, and rainbow role models are often more visible and accessible (e.g., Deane et al., 2019; Easpaig et al., 2022; Newcomb et al., 2019). This knowledge gap is especially pronounced in Aotearoa, where there is currently little to no quantitative comparative research directly comparing rural and non-rural rainbow families, and minimal research exploring caregiver wellbeing and affiliate stigma in these settings (for review, see Deane et al., 2019). Existing work, while valuable, has been primarily qualitative or small-scale (e.g., Easpaig et al., 2022) and has not systematically tested associations between caregiver responses, affiliate stigma, and resource access. Moreover, studies that do address caregivers often position them as secondary informants of their rainbow young person's wellbeing, rather than as subjects of enquiry in their own right (Chan et al., 2022; Clark et al., 2024; Newcomb et al., 2019). When caregivers are studied directly, the focus tends to be on individual-level attitudes or grief processes, without linking caregivers to broader place-based and system-level processes, such as affiliate stigma and resource access.

Research that does consider geography tends to frame rural settings as uniformly disadvantageous to rainbow young people and their families (Campbell & Bell, 2000; D'Augelli, 2006; Stevenson et al., 2024). This oversimplification risks homogenising the heterogeneous situated strengths of rural life, such as the slower pace of life and easy access to natural landscapes, which can improve the wellbeing of rainbow youth and their caregivers and buffer against minority stress (Ladry et al., 2024; Wienke & Hill, 2013). Simultaneously, the lived experiences of rural caregivers, who often face heightened visibility and exposure to conservative social norms, remain poorly theorised and under-explored in quantitative work, *especially* in Aotearoa (Deane et al., 2019; Easpaig et al., 2022; Nixon, 2024). Consequently, much of what is known about the impact of caregiver relationships on rainbow youth has been extrapolated from non-rural international samples, leaving it unclear how rurality influences the risks and resilience of rural rainbow youth and their families in Aotearoa.

Furthermore, while there is ample literature exploring minority stress theory as it applies to the outcomes of rainbow youth, this theory has rarely been extended to explore the dynamics underpinning caregiver wellbeing and how caregivers metabolise community stigma (Frost & Meyer, 2023; Schmitz et al., 2020). Although affiliate stigma has been identified as a process that undermines caregiver wellbeing and responses (Chan et al., 2022; Clark et al., 2024; Clark et al., 2022), few studies have explored how it interacts with resource access and rural sociocultural milieus. Similarly, while resource access is widely acknowledged as protective of caregiver and youth wellbeing, research seldom explores the nuances of unmet desire for resources (i.e., those who want support but are unable to obtain it), especially in rural contexts where practical barriers and social risk can intertwine, and where resources themselves are often based on non-rural knowledges and worldviews that do not align with rural realities.

Finally, and most importantly, very little research has integrated the strands of caregiver and youth wellbeing, caregiver responses, affiliate stigma, and resource access into a single analytic frame that considers how rural contexts interact with these processes.

Existing studies rarely test how caregiver wellbeing relates to caregiver responses in different geographies, or how affiliate stigma and resource access shape these pathways. Without this integration, interventions aimed at supporting rural family's risk being designed based on urban-centric assumptions, leaving rural families underserved and their situated strengths invisible. In Aotearoa, this gap is particularly acute, as there is no nationally relevant, contextually anchored data that explores how rural caregivers of rainbow youth respond to their young people and experience affiliate stigma and resource access. Accordingly, the purpose of this research is not to simply measure these processes, but to build an understanding of how they interact and influence the lives of caregivers and their rainbow young people. Here, repositioning rural caregivers as active meaning-makers rather than passive recipients of non-rural-derived models of support is essential if research is to inform practice and policy that benefits rainbow families in rural Aotearoa. Such repositioning demands that rurality not be understood as a condition of deficit but as a context that both constrains and supports, one rich in situated knowledges, worldviews, and capacities that remain underrepresented in the current literature.

In combination, these gaps demonstrate a need for research that: (1) situates caregivers as relational agents of wellbeing: - (2) maps how minority stress processes, in particular, affiliate stigma, are moderated by geography: - and (3) recognises rurality as both protective and constraining. The current study directly responds to this need by systematically comparing rural and non-rural caregivers across their own wellbeing and that of their young person, caregiver responses, and testing the interconnected influences of resource access and affiliate stigma. In doing so, this study extends beyond decontextualised notions of individual pathology and towards an understanding of caregivers as active meaning makers who navigate their roles within contexts that can simultaneously offer support and stress, connection, and constraint. This thesis positions rural caregivers not as passive recipients of sociocultural norms, but as active translators of place, individuals whose responses are shaped by, and in turn shape, the relational conditions of their communities. By recognising these dynamics, this study aims to contribute crucial

insight into how caregiver responses, wellbeing, and environment interact to influence the wellbeing of rainbow youth in rural and non-rural Aotearoa.

Building on the conceptual and empirical gaps identified in the preceding review, Chapter Three outlines the aims and rationale of the current study, detailing the research questions and associated predictions that structure the statistical analyses that follow.

Chapter Three: The Current Study

Building on the gaps identified in the preceding literature review, the current study aimed to address three primary research questions designed to clarify how caregiver and youth wellbeing, caregiver responses, and contextual processes vary across rural and non-rural contexts in Aotearoa. These research questions and their associated predictions were designed to explore the relationships among these constructs and to identify patterns of strength and stress in rural and non-rural family systems. Chapter Two outlined disparities in rainbow youth wellbeing, introduced minority stress theory to explain how distal and proximal stressors shape these outcomes, and highlighted the central role of caregiver responses and wellbeing. The review then examined affiliate stigma and resource access, situating them within the rural context, forming the conceptual and empirical foundation for the three research questions explored below.

The current study comprised a cross-sectional survey of rural and non-rural caregivers of rainbow youth under 30 years of age. Participants reported their own wellbeing, their young persons' wellbeing, caregiving responses, experiences of affiliate stigma, and access to rainbow-affirming resources. The current study foregrounds caregivers' perspectives as windows into how family and contextual processes interact. By drawing from caregiver reports collected at a single point in time, this research was designed to offer a snapshot of interactions as they occur within real-world sociocultural settings. These aims and boundaries were defined to balance analytic clarity and feasibility with the breadth necessary to capture key contextual influences.

For ease of interpretation, predictions are discussed below in narrative form. Appendix A provides all 19 original predictions in list version, organised by research question.

Research Question 1: How Do Caregiver and Youth Wellbeing Differ Between Rural and Non-Rural Contexts?

Prior international research has shown that caregivers of rainbow youth often experience increased distress following the disclosure of their young person's rainbow

identity, particularly in environments marked by conservatism, stigma, and reduced support (de Bres & Morrison-Young, 2024; Easpaig et al., 2022; Newcomb et al., 2019). Rural caregivers, in particular, frequently report reduced access to rainbow-affirming services, greater social scrutiny, and heightened isolation (Deane et al., 2019; Rosenkrantz et al., 2017).

Accordingly, it is predicted that rural caregivers will report lower overall wellbeing than non-rural caregivers. Because caregiver wellbeing is closely linked with youth wellbeing, especially in contexts where support is scarce (Johnston, 2024; Mustanski et al., 2011; Newcomb et al., 2019), rural rainbow youth were expected to have lower wellbeing than their non-rural peers. Moreover, as caregiver wellbeing consistently been positively associated with youth wellbeing (Ryan et al., 2009; Ryan et al., 2010), lower caregiver wellbeing was expected to be associated with lower youth wellbeing, with this association being stronger in rural contexts.

Research Question 2: How Do Caregiver Responses Toward Their Rainbow Youth Differ Across Rural and Non-Rural Contexts?

Caregiver responses to rainbow young people are known to cluster into affirming, rejecting, or mixed forms, with affirming responses linked to improved youth outcomes and rejecting responses associated with poorer outcomes (e.g., Clark et al., 2022; Seager van Dyk et al., 2024). In rural environments, where conservative norms are often more entrenched and rainbow-affirming resources are less available (Deane et al., 2019; Sibley & Wilson, 2007), caregivers were expected to report more negative responses to their rainbow youth than non-rural caregivers. Conversely, non-rural caregivers were expected to report more positive responses than their rural peers, reflecting their typically greater exposure to affirming resources, supports, and attitudes.

At the relational level, distressed caregivers may find it harder to provide positive responses, making caregiver wellbeing a predictor of caregiver responses (Newcomb et al., 2019). Therefore, lower caregiver wellbeing was expected to be associated with more negative caregiver responses, particularly in rural contexts, where affirming resources are

scarce, whereas higher caregiver wellbeing was expected to be associated with more positive responses overall. Importantly, while higher caregiver wellbeing was expected to predict more positive caregiver responses overall, it remains possible that this effect is shaped by the rural context, suggesting an avenue for exploration.

These dynamics are expected to extend to youth outcomes (Ryan et al., 2009; Ryan et al., 2010): more negative caregiver responses are expected to be associated with lower youth wellbeing, particularly in rural contexts, whereas more positive caregiver responses are expected to be associated with higher youth wellbeing, especially in non-rural contexts (McConnell et al., 2016; Rith, 2017; Siegel et al., 2022). Collectively, these predictions assess the patterns of association between caregiver wellbeing, response style, and youth wellbeing across rural and non-rural contexts.

Research Question 3: Do Contextual Factors Influence the Relationship Between Caregiver Responses and Wellbeing?

Building on the earlier focus on wellbeing and relational dynamics, this research question examined whether contextual influences, specifically affiliate stigma and resource access, influenced the relationship between caregiver responses and wellbeing outcomes. Affiliate stigma, the stigma experienced by caregivers through association with their rainbow young person, has been shown to reduce caregiver wellbeing and increase the likelihood of negative responses to their rainbow young person (Chan et al., 2022; Clark et al., 2024; Siegel et al., 2022). In rural contexts, where rainbow families are more visible and social norms are often less accepting, caregivers were expected to report higher levels of affiliate stigma than their non-rural peers.

Access to rainbow-affirming resources is another contextual factor that has implications for caregiver and youth wellbeing. Studies have shown that access to and engagement with affirming resources and services can increase caregiver wellbeing and help facilitate positive responses (Gonzalez et al., 2013; Huei & Nie, 2023). Notably, such resources are often scarcer in rural contexts, meaning that a greater proportion of rural

caregivers were expected to report not accessing resources, and among those who do, rural caregivers were expected to draw on a smaller range of resource types.

Higher levels of affiliate stigma were expected to be associated with lower caregiver and youth wellbeing, with stronger associations in rural environments, where stigma is less buffered by affirming resource access. Conversely, caregivers who access affirming resources were expected to report higher wellbeing for both themselves and their youth. At the relational level, affiliate stigma was expected to be associated with more negative caregiver responses, whereas not accessing affirming resources was expected to be associated with more negative responses, with both associations expected to be especially pronounced in rural settings. Finally, recognising that access and desire are not the same, this study also explored whether caregivers who are not currently accessing affirming resources nevertheless wish to do so. It was expected that a higher proportion of rural caregivers will report such unmet desire compared to non-rural caregivers, reflecting barriers to resource access rather than a lack of motivation.

Taken together, these three research questions aim to provide an integrated analysis of how individual, relational, and contextual factors combine to shape the wellbeing of caregivers and rainbow youth across rural and non-rural Aotearoa. By examining caregiver and youth wellbeing, caregiver responses, and the moderating effects of resource access, affiliate stigma, and rurality, this study sought to map the interplay between stress and strength within families of rainbow youth embedded in different geographic contexts. In doing so, it identifies not only potential risks, but also pathways of resilience within rural contexts.

Chapter Four outlines the methodological approach used to examine these research questions. It describes the research context and design, ethical and methodological considerations, participant characteristics, measures employed, and the analytic strategy used to test predictions.

Chapter Four: Methodology

This study used a subset of survey data drawn from the *Raising Rainbows* project, a broader project exploring caregiver-youth relationships in rainbow families across Aotearoa. This study quantitatively compared rural and non-rural primary caregivers of rainbow youth under 30 years of age on measures of youth wellbeing, caregiver responses, affiliate stigma, and access to rainbow-affirming resources.

This study employed a cross-sectional, anonymous, online survey design to capture a snapshot of the variables influencing caregiver responses to their rainbow youth at a single point in time. This design was selected because it is particularly suited to exploratory research involving hard-to-reach groups (Oliveri et al., 2021), such as rural families of rainbow youth (Guillory et al., 2018), as it allows efficient, wide-reaching, and anonymous recruitment (Murdoch et al., 2014). Cross-sectional surveys are also well suited to exploring regional (e.g. rural vs. non-rural) differences in minority stress and wellbeing, as they allow for the recruitment of large, geographically dispersed samples (Morandini et al., 2015).

Ethical Considerations

Massey University Human Ethics Ohu Matatika 2 granted approval for the overall *Raising Rainbows* project (OM2 24/16). Given that this project explored caregiver responses to rainbow youth, a group that includes individuals and families who frequently face discrimination, marginalisation, and stigmatisation, the ethical considerations for this project emphasised three key domains: protecting confidentiality, minimising participant distress, and ensuring cultural safety for both rainbow and Māori communities.

Confidentiality was safeguarded by collecting survey responses anonymously, de-identifying the data, and presenting the results as an aggregate. Contact details (provided optionally by those wishing to enter the prize draw or receive a summary of research results) were stored separately from the primary dataset and were permanently deleted once those activities were complete. Participants indicated their consent to participate in the study by clicking ‘yes’ at the end of the information sheet (see Appendix B) prior to beginning the survey. A brief early logic error in Qualtrics that permitted access to the survey without

clicking ‘yes’ was corrected immediately. Per the information sheet, submission of the survey inferred informed consent, and the two submissions that occurred with this error were permitted on that basis. All data was stored on password-protected servers accessible only to the research team. To maintain separation between participant incentives and research outcomes, a PrideLab member external to the core Raising Rainbows research team conducted the voucher draw for the participants.

Potential distress was mitigated through informed consent procedures (i.e., via a participant information sheet with a clear description of the research context and aims and an overview of the survey content; see Appendix B) and the provision of a curated list of rainbow-affirming support services, which included contact details for the research supervisor, a clinical psychologist with experience in supporting rainbow communities.

Finally, the research aims and survey items were screened and reviewed by cultural advisors to ensure appropriateness for both the rainbow and Māori communities. It was noted that several measures were developed and validated in international populations and required minor language adjustments to reflect the Aotearoa context. Prior to submission to Massey University’s ethics committee, the Raising Rainbows project was peer-reviewed by Massey’s PrideLab (i.e., a multicultural research collective focused on scholarship related to gender and sexual identities, development, and emotional wellbeing) to ensure the safety and appropriateness of the survey content.

Methodological Considerations

The very characteristics that define rural areas pose unique challenges for researchers investigating rural experiences. Conventional approaches, such as distributing flyers, conducting interviews, or running focus groups, are often hindered by the geographic remoteness and low population density of rural communities (Whitehead et al., 2022). These challenges can be intensified when exploring rural rainbow experiences, as participants and their families may be reluctant to engage due to fears of being ‘outed’ and ‘losing face’ in small, tight-knit communities where privacy is limited (Warren et al., 2015). Although online recruitment and data collection can provide the benefit of anonymity, they can suffer from a

self-selection bias that overlooks the experiences of those who are not comfortable with rainbow identities, have limited access to the internet, and are not connected to rainbow networks where flyers might be displayed or posted (Warren et al., 2015). Given these issues, rural rainbow individuals and their families have been described as 'doubly hidden' in the literature, owing to the intersection of their rural and rainbow identities and the impact of this on research recruitment and participation (Warren et al., 2015). Finally, research on rural rainbow experiences often does not distinguish or explore them specifically, rendering these voices particularly underrepresented in the literature (Deane et al., 2019; Easpaig et al., 2022).

In light of these issues, careful consideration was given to the operationalisation of rurality in this thesis. A balance had to be struck between the anonymity provided by an online survey and the need to gather sufficient location data to classify participants meaningfully. Postcodes were selected as the most viable method to achieve these outcomes, providing enough information to differentiate between rural and non-rural participants without requiring potentially identifying information, such as a physical address. However, this added further complexity regarding what postcodes should be classified as rural. Both Statistics New Zealand (2021) and researchers such as Whitehead et al. (2022) conceptualise rurality on a continuum, recognising multiple degrees of rurality. While theoretically appealing, this approach was not feasible for this study because the mesh block data required for such distinctions did not align with postcode boundaries, and collecting more precise data would have compromised anonymity. Consultation with rural mental health scholars in Aotearoa indicated that, although distinguishing between degrees of rurality can be informative when exploring health outcomes, when collapsed into a rural/non-rural binary, findings are generally comparable across conceptualisations (Payne, 2024). Given that most of this study's predictions were related to the geographically isolating nature of rural contexts, the use of rural delivery postcodes (i.e., areas of population sparsity and geographical remoteness) was considered a pragmatic and ethically sound method of differentiating rural and non-rural participants (Land Information New Zealand, 2018).

Participants

Participants were primary caregivers of rainbow young people. Eligibility criteria for the broader project required that the caregiver reside in Aotearoa, be fluent in English, and that the rainbow youth they cared for was under the age of 30. This participant group was selected for its relevance to the broader Raising Rainbows project aim of exploring family responses to rainbow youth in Aotearoa. See Appendix C for survey items establishing eligibility.

The final sample comprised 152 caregivers (*n* = 20 rural, *n* = 132 non-rural; see Appendix D for a visual representation of the geographic distribution of participants). Caregivers were aged from 25 to 66 years (*M* = 47.26, *SD* = 8.06). Most caregivers were biological parents (88.2%), with a smaller proportion of stepparents (1.2%), adoptive parents (2.6%), grandparents (2.0%), aunts or uncles (2.7%), close whānau or family friends (2.0%), and caregivers who preferred another descriptor (1.3%). The majority of caregivers identified as cisgender woman (78.3%), followed by cisgender men (5.9%), and gender-diverse individuals (0.8%; including transgender, non-binary, genderqueer, agender, and neutrois). Sexual orientation was most commonly reported as heterosexual/straight (63.6%), with 26.5% of caregivers reporting a rainbow/sexual minority identity (e.g., lesbian, gay, bisexual, pansexual, etc.), with 6.0% indicating that neither heterosexual/straight or rainbow/sexual minority described them, and 4.0% responding as unsure. Ethnic identification was primarily New Zealand European/Pākehā (82.9%), followed by New Zealand Māori (13.8%), Cook Island Māori (3.3%), Tongan (2.6%), Indian (2.0%), Samoan (1.3%), Chinese (1.3%), and Niuean (.7%). Sixteen participants (10.5%) identified as belonging to other ethnic groups (e.g., Dutch, Fijian, Japanese), with one participant (0.7%) indicating that they were unsure of their ethnicity. Educational attainment in the sample was high, 84.6% of participants reported having completed some kind of tertiary qualification, and 38.3% had a postgraduate qualification. See Appendix E for survey items exploring demographics.

A post-hoc sensitivity analysis was conducted using G*Power to estimate whether the final sample provided sufficient statistical power. Across the planned analyses, the

largest recommended sample size was 128 participants to detect a medium effect (d = 0.5, f^2 = .15, w = .30) with 80% power at α = .05. The final sample (*n* = 152) exceeded this overall. However, the rural subgroup was considerably smaller (*n* = 20) than the non-rural subgroup (*n* = 132), which substantially reduced the detectable effect size for between-group comparisons. Sensitivity analyses revealed that with this uneven split, the study had 80% power to detect only large effects (d $\geq$ .87) but was underpowered to detect small-to-medium effects. In contrast, regression models with the full sample (*n* = 152, 3 predictors) had 80% power to detect small-medium effects ($f^2 \geq .07$). Therefore, results comparing rural to non-rural caregivers should be interpreted with caution (see Chapter Six for a greater discussion regarding statistical power).

Measures

Rural Status

Rural status was determined using rural delivery (RD) postcodes (New Zealand Post, 2025), which indicate whether an address is serviced by a rural delivery contractor route rather than a standard urban street delivery (Land Information New Zealand, 2018). This postal definition reflects logistical and operational criteria that align with this project's research questions (e.g., low population density, dispersed dwellings, and differentiation from urban centres).

Postcodes are often used as *intermediary* geographic identifiers in Aotearoa-based research and national surveys, providing a pragmatic means of linking participant data with area-level variables that can be used to approximate geographic location for geocoding and to stratify participants by region (Atkinson et al., 2024; Swerdloff et al., 2023; Yang et al., 2024).

Participants were asked to provide their postcode in an open text box, and postcodes were then linked to New Zealand Post Classifications to determine their rural status (New Zealand Post, 2025). Participants were then categorised as either Rural (1) or Non-Rural (0).

Caregiver and Youth Wellbeing

Caregiver and youth wellbeing were measured using a shortened version of the Hua Oranga Scale (see Appendix F; Kingi, 2002). The Hua Oranga is grounded in te ao Māori perspectives of health and wellbeing, spanning four domains: physical (taha tinana), social (taha whānau), mental/emotional (taha hinengaro), and spiritual (taha wairua; Kingi, 2002). The full version comprises 16 items (four per domain), each rated on a 5-point Likert scale, with tangata whaiora, whānau, and practitioner versions (Te Rau Ora, 2024). Similar to previous studies (Elder, 2013), the shortened version of the measure used in this study included one item per wellbeing domain, with caregivers rating their own wellbeing (e.g., *'At present, I feel my physical [tinana] health is…'*) as well as their rainbow youth's wellbeing (e.g., *'At present, I feel my rainbow child's physical [tinana] health is…'*). Items were rated on a 5-point Likert scale ranging from 1 (Very Bad) to 5 (Extremely Good). Composite scores were created separately for caregiver and youth wellbeing measures by averaging across the four items of each scale

Research on the 16-item version of the Hua Oranga demonstrates good face and content validity, and moderate construct validity (Elder, 2013; Harwood et al., 2012; Kingi, 2002). While comprehensive testing of the shortened measure is ongoing, early data suggests acceptable internal consistency (Elder, 2013; Kingi, 2002). Zero-order correlations among the four items indicated moderate positive associations across both caregiver (r = *.31–.41*) and youth wellbeing (r = *.3 6–.54*), suggesting adequate internal reliability.

Caregiver Responses

Caregiver responses to their young person's rainbow identity were measured using the *Parental Responses to Children's Sexual Orientation and Gender Identity Scale* (PRI; Clark et al., 2022; see Appendix F). The scale was developed from qualitative research with parents of rainbow young people (Clark et al., 2022) and consists of 10 items across two subscales. Five items assess negative caregiver responses (e.g., *'I feel shame for my child being rainbow/LGBTQIA+'*) and five items assess positive caregiver responses (e.g., *'I feel accepting towards my rainbow/LGBTQIA+ child'*). Each item was revised to include 'rainbow'

to better reflect the terminology used in Aotearoa to describe this population. Items were rated on a 6-point Likert scale ranging from 1 (*Strongly Disagree*) to 6 (*Strongly Agree*), with higher scores indicating higher levels of either positive or negative responses. Composite scores were created by averaging the five items of each subscale.

Confirmatory factor analysis was conducted to assess the two-factor structure of the PRI, which comprised positive and negative caregiver responses. The model demonstrated adequate standardised loadings for all items (p <.001), ranging from .36 to .91, and a strong negative correlation between the two latent factors (r = -.83, p <.001). Model fit indices indicated some misfit, χ^2 (34) = 119.0, p <.001, Comparative Fit Index (CFI) = .83, Tucker-Lewis Index (TLI) = .77, Standardised Root Square Mean Residual (SRMR) = .08, Root Mean Square Error of Approximation (RMSEA) = .13. Importantly, the original two-factor structure remained conceptually and empirically congruent with the original scale. Therefore, consistent with previous research (Seager van Dyk et al., 2024), the theoretical distinction between positive and negative caregiver responses was retained as a valid measure of the two latent constructs of the scale. Internal consistency was good for both subscales (α= .67 for positive responses, α= .77 for negative responses).

Affiliate Stigma

Caregiver affiliate stigma was assessed using the 17-item Lesbian, Gay, Bisexual Affiliate Stigma Measure (LGBAS; Robinson, 2014; see Appendix F). The LGBAS comprises 17 items across three subscales: public discrimination/rejection (e.g., *'I worry about being rejected if people in my religious/spiritual community find out that my child is rainbow/LGBTQIA+'*), vicarious stigma (e.g., *'I worry that my child will be rejected for being rainbow/LGBTQIA+'*), and public shame (e.g., *'I feel embarrassed that I have a child who is rainbow/LGBTQIA+*). Each item was revised to include 'rainbow' to better reflect the terminology used in Aotearoa to describe this population. Additionally, as the focus of the project was on caregivers of rainbow youth, items were modified to focus on this group (e.g., changing 'family member or close friend' to 'child'). Items on the LGBAS were rated on a 7-

point Likert scale (0 = *Not Applicable*, 1 = *Strongly Disagree*, 6 = *Strongly Agree*), with higher scores indicating higher levels of affiliate stigma. Composite scores were created by averaging the 17 items on the scale, with 'not applicable' responses excluded to ensure means captured only relevant responses.

Confirmatory factor analysis was conducted to assess the construct validity of the LGBAS using a unidimensional model that reflected overall affiliate stigma. Model fit was acceptable, but somewhat below conventional thresholds, χ^2 (119) = 265.4, p <.001, CFI = .86, TLI = .83, SRMR = .09, RMSEA = .10. These indices indicate that while the model did not meet all criteria, the items were sufficiently coherent to justify the use of a total affiliate stigma score, consistent with previous research (Clark et al., 2024; Yao et al., 2021). Internal consistency for the full scale was excellent (α = .86).

Caregiver Resources

Caregiver access to rainbow-affirming resources was assessed using three items adapted from Seager van Dyk et al. (2024; see Appendix F) The measure first asked whether caregivers had ever accessed rainbow-affirming resources (response options: *yes* or *no*). If participants answered yes to this question, they were then asked which of eight resources they had accessed (*books*, *pamphlets*, *in-person or online support groups*, *websites*, *counselling*, *friends and family*, or other resources specified in an open text box). Finally, all participants were asked whether they were interested in accessing resources in the future (response options: *yes*, *maybe*, or *no*). The total number of resources accessed was calculated by summing the number of resource types selected by each caregiver. Responses to the open text box were reviewed but did not introduce any new resource types; therefore, they were excluded from the total.

Categorical checklist measures of the types of resources accessed are common in the literature (e.g., Evans et al., 2017; Kidd et al., 2024; Lawlis et al., 2020), supporting their use in this study.

Procedure

Recruitment and Data Gathering

Given the methodological challenges of recruiting rural caregivers of rainbow young people, an anonymous online survey format was selected to balance accessibility, efficiency, and confidentiality (Andrews et al., 2003; Dillman et al., 2014; Van Selm & Jankowski, 2006; Warren et al., 2015). The survey was created and hosted using Qualtrics. Prior to beginning the survey, participants were presented with information on the project's aims, provided informed consent, and were introduced to the research team through a short written whakawhanaungatanga. Data was collected between August and October 2024.

Participant recruitment took place between August and October 2024. Using a snowball sampling approach, invitations were distributed through social media posts, e-mail lists, organisational networks, and via word of mouth. Recruitment materials (see Appendix G for recruitment material used in this study) were widely disseminated, including to parenting groups, Rainbow services, medical centres, schools, rural hubs, and community notice boards. During the final weeks of recruitment, a targeted effort was made to increase rural representation by contacting rural schools and medical centres and posting flyers on online and physical rural community noticeboards. Recruitment ended when the target sample size (n = 150) for the overall project was reached.

Participants were offered the opportunity to enter a draw to win one of ten $40 gift cards. Both participants and services were invited to receive a summary of the results once the research was completed. During data gathering, the primary Raising Rainbows research team met regularly to review responses, verify eligibility, and remove invalid responses. Invalid responses included duplicate entries, incomplete entries, responses from IP addresses outside of Aotearoa, caregivers under the age of 18, caregivers with rainbow youth over the age of 30, caregivers not fluent in English, and entries completed in under 5 minutes. In total, 104 entries were removed prior to the final analyses.

Data Analyses Plan

Analyses were performed using IBM SPSS (Version 30). Statistical significance was set at p <.050, with p <.100 considered a statistically significant trend for the predicted effects only.

Little's Missing Completely at Random test indicated data was likely missing completely at random (MCAR), $X^2(160) = 137.69$, $p = .898$. The proportion of missing data per variable ranged from 3.2% to 9.7% ($M = 6.5\%$). Given that data were MCAR and <10% was missing, the decision was made to use listwise deletion across analyses (Allison, 2002; Little & Rubin, 2019; Pepinsky, 2018; Tabachnick et al., 2019)[3].

Continuous variables and composites were assessed for normality using skewness, kurtosis, and visual inspection of histograms and Q-Q plots. While most variables approximated normal distributions, some displayed minor deviations. While parametric tests are generally robust to *minor* departures from normality (Little & Rubin, 2019), to provide robust estimates where deviations are present, all analyses (except for chi-squared tests), used a bias-corrected bootstrapped confidence interval with 5000 resamples. For *t*-tests, homogeneity of variances was assessed using Levene's test. Multicollinearity in the regression models was assessed using variance inflation factors (VIF) and tolerance values, which indicated no concerns (VIF <5, tolerance >.2). Residuals from the regression models were examined for normality and found to be acceptable. Linearity and homoscedasticity were examined using scatter plots of standardised residuals against standardised predicted values, which showed no clear violations.

Pearson's and Spearman's correlations assessed the zero-order associations between the variables of interest. Paired sample *t*-tests assessed within-participant differences across (a) caregiver and youth wellbeing scores, and (b) positive and negative

[3] Comparisons of descriptive statistics across retained and excluded cases, as well as across listwise, pairwise, expectation-maximisation, and regression estimation methods revealed negligible differences, supporting the robustness of the listwise dataset. As a sensitivity analysis, multiple imputation (fully conditional specification with 50 imputations at 100 iterations per dataset) was conducted and across all analyses produced results were substantively identical to those obtained by listwise deletion, supporting the robustness of listwise results.

caregiver responses. Independent sample *t*-tests compared Rural and Non-Rural caregivers on caregiver and youth wellbeing indices, positive and negative caregiver responses, affiliate stigma, and resource access. Chi-squared tests examined Rural and Non-Rural differences in categorical indicators of resource access, while simple linear regression analysis assessed whether rural status predicted future interest in resource access.

Hierarchical multiple linear regression models were used to explore unique associations and moderations. Specifically, this study tested predictions using the following regression models:

a) Youth wellbeing as a predictor of caregiver wellbeing, moderated by rural status.
b) Caregiver wellbeing as a predictor of positive and negative caregiver responses, moderated by rural status.
c) Positive and negative caregiver responses as predictors of youth wellbeing, moderated by rural status.
d) Affiliate stigma as a predictor of caregiver wellbeing, youth wellbeing, and negative caregiver responses, moderated by rural status.
e) Resource access as a predictor of negative caregiver responses, caregiver wellbeing, and youth wellbeing, moderated by rural status.

During analysis, it became clear that affiliate stigma and resource as predictors of positive caregiver responses, moderated by rural status, was relevant to this study's aims. This additional analysis was added and thus should be considered exploratory.

Within each regression model, rural status was entered into Block One, followed by the primary predictor variable(s). An interaction term between rural status and the predictor variable(s) was created and entered in Block Two to test predicted moderation effects. Where significant interactions were detected, follow-up simple slopes analyses were conducted to explore how the relationship between the predictor variable(s) and the outcome differed by rural status.

Demographic variables were not included as covariates in these regression models to preserve the degrees of freedom in a modest sample and to maintain an analytical focus on the theoretically specified predictors of interest. All continuous predictor variables were mean-centred before creating interaction terms to reduce multicollinearity and to aid in the interpretation of the main effects. Effect sizes are reported as Hedges' *g* for *t*-tests, ϕ for chi-squared tests, R^2 for simple linear regression analyses, *r* for Pearson's correlations, and β for hierarchical multiple linear regression analyses.

Chapter Five presents the results of these analyses, organised by the three research questions outlined in Chapter Three.

Chapter Five: Results

Descriptive statistics and zero-order correlations for the main study variables are presented in Table 1. Caregiver and youth wellbeing scores spanned the full scale and were endorsed to a similar extent by participants, $t(129) = 0.39$, $p = 0.702$, $g = 0.03$. As predicted, caregiver and youth wellbeing were positively correlated.

Caregivers reported substantially higher levels of positive than negative responses, $t(140) = 25.93$, $p < .001$, $g = 2.12$, indicating that positive responses were more common than negative responses. Positive and negative caregiver responses were strongly inversely related. Affiliate stigma scores clustered around the mid-point of the scale (3 = '*somewhat disagree'*), suggesting that overall, participants experienced low levels of affiliate stigma regarding their rainbow young person. Higher levels of affiliate stigma were associated with lower wellbeing for both caregivers and youth.

On average, caregivers accessed four types of resources, with most (77.5%) having accessed at least one. Interest in future access was also high (56.5%). Total resources accessed showed a small positive correlation with positive responses but was otherwise unrelated to other study variables.

Research Question 1: How Do Caregiver and Youth Wellbeing Differ Between Rural and Non-Rural Contexts?

To test whether caregiver and youth wellbeing differ in rural and non-rural contexts, mean-level group comparisons were conducted to determine whether overall levels of caregiver and youth wellbeing differed by rural status. Contrary to predictions, caregiver wellbeing did not differ between rural ($M = 3.39$, $SD = 0.75$) and non-rural caregivers ($M = 3.52$, $SD = 0.61$), $t(128) = 0.82$, $p = .478$, $g = 0.20$, 95% BCa CI [-.17, .42]. Likewise, counter to predictions youth wellbeing was also similar across geographic contexts (Rural: $M = 3.39$, $SD = 0.94$; Non-Rural: $M = 3.49$, $SD = 0.70$), $t(129) = 0.51$, $p = .608$, $g = 0.13$, 95% BCa CI [-.30, .54].

Table 1

Descriptive Statistics and Zero-Order Correlations for Key Study Variables

Variable	*M*	*SD*	Scale Range	1.	2.	3.	4.	5.	6.
1. Caregiver wellbeing	3.54	0.65	1-5	—	.38**	.21*	−.26**	−.38**	.01
2. Youth wellbeing	3.51	0.70	1-5		—	.10	−.27**	−.31**	−.10
3. Positive caregiver responses	5.31	0.68	1-6			—	−.59**	−.18	.23*
4. Negative caregiver responses	1.80	0.89	1-6				—	.37**	−.15
5. Affiliate stigma	3.00	0.70	1-6					—	.18
6. Total resources accessed	3.66	1.46	0-8						—

Note. Zero-order Pearson correlations are below the diagonal; two-tailed tests. **p < .010, *p < .050.

Next, a hierarchical multiple linear regression was conducted to examine how caregiver wellbeing and rural status predicted youth wellbeing (see Table 2 for parameter estimates). Caregiver Wellbeing and Rural Status were entered at Step 1 and explained 14.9% of the variance in youth wellbeing, $F(3, 126) = 7.33$, $p < .001$, *Adj.* $R^2 = 0.13$. Consistent with predictions, greater caregiver wellbeing was uniquely associated with greater youth wellbeing ($\beta = 0.28$, $p = .002$), although rural status showed no association. The addition of the Caregiver Wellbeing × Rural Status interaction at Step 2 showed a statistical trend (ΔF (1, 126) = 3.07, $p = .082$, $\Delta R^2 = 0.02$), providing tentative evidence that Rural Status moderates the relationship between caregiver wellbeing and youth wellbeing, though the interaction term itself only showed a statistical trend. Follow up simple slopes analysis demonstrated that the positive association between caregiver and youth wellbeing was stronger for rural caregivers ($b = 0.76$, $p < .001$) than non-rural caregivers ($b = 0.33$, $p = .003$; see Figure 1). Together, results suggest that while overall levels of wellbeing did not differ by rural status, the positive association between caregiver and youth wellbeing was amplified in rural contexts.

Table 2

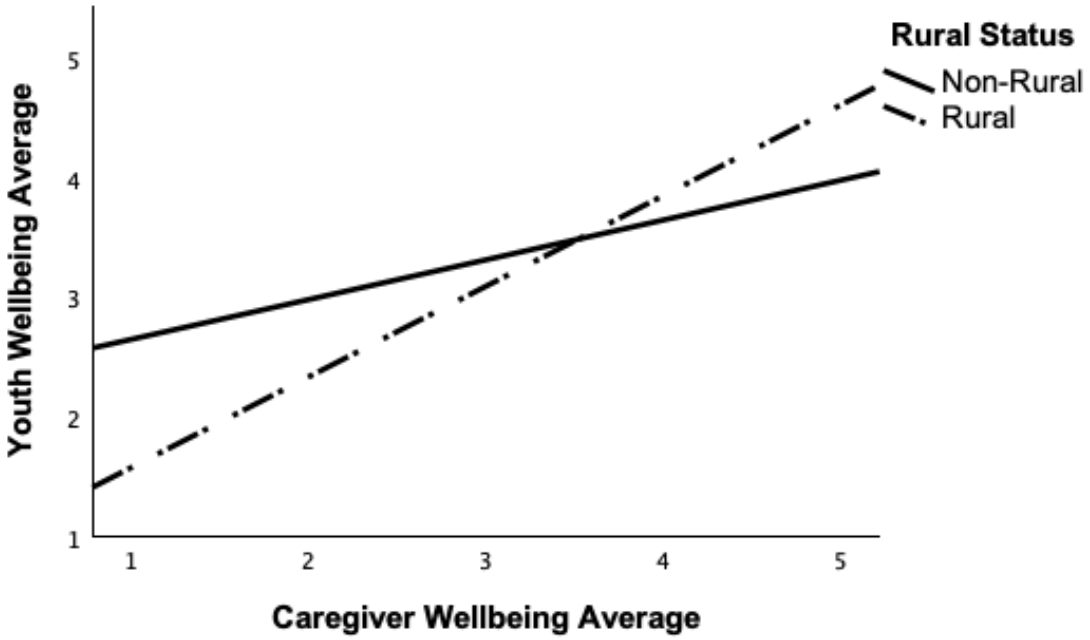
Caregiver Wellbeing and Rural Status as Predictors of Youth Wellbeing

Predictor	*β*	95% CI	*p*
Youth Wellbeing			
Step One			
Caregiver Wellbeing	0.28	0.12, 0.55	.002
Rural Status	-0.004	-0.35, 0.33	.958
Step Two			
Caregiver Wellbeing × Rural Status	0.16	-0.06, 0.90	.082

Note. Confidence intervals are bias-corrected and accelerated based on 5,000 resamples. Outcome variable is bolded for clarity.

Figure 1

Interaction Between Caregiver Wellbeing and Rural Status in Predicting Youth Wellbeing



Research Question 2: How Do Caregiver Responses to Their Rainbow Youth Differ Between Rural and Non-Rural Contexts?

To explore whether rural status shaped caregiver responses, mean-level group comparisons were first conducted. Counter to predictions, negative responses were similar for rural (M = 1.88, SD = 1.24) and non-rural caregivers (M = 1.82, SD = 0.91), $t(139)$ = -0.26, p = .799, g = 0.06, 95% BCa CI [-.73, .49]. Similarly, counter to predictions positive

responses were comparable across rural (M = 5.18, SD = 0.98) and non-rural caregivers (M = 5.21, SD = 0.73), $t(140) = 0.18$, $p = .857$, $g = 0.04$, 95% BCa CI [-.44, .53].

To extend these comparisons, a series of three hierarchical multiple linear regression analyses were conducted to examine whether caregiver wellbeing predicted positive and negative caregiver responses, before considering whether this relationship was moderated by rural status (see Table 3 for parameter estimates for all models). In the first regression model, Caregiver Wellbeing and Rural Status were entered at Step 1, explaining 4.6% of the variance in Negative Caregiver Responses $F(2, 125) = 3.022$, $p = .053$, $Adj.\ R^2 = 0.02$. Partially consistent with predictions, greater Caregiver Wellbeing was uniquely associated with fewer Negative Caregiver Responses, while Rural Status was not. The addition of a Caregiver Wellbeing x Rural Status interaction term at Step 2 did not improve model fit (ΔF (1, 124) = 0.23, $p = .392$, $\Delta R^2 = 0.01$), indicating that greater levels of caregiver wellbeing were associated with fewer negative caregiver responses in a similar manner across both rural and non-rural contexts.

In the second regression model, Caregiver Wellbeing and Rural Status were entered in Step 1, accounting for a small non-significant variance in Positive Caregiver Responses, $F(2, 126) = 2.38$, $p = 0.097$, $Adj.\ R^2 = 0.04$. Neither Caregiver Wellbeing nor Rural Status were uniquely associated with Positive Caregiver Responses. Adding the Caregiver Wellbeing x Rural Status interaction at Step 2 showed a statistical trend toward explaining more variance in Positive Caregiver Responses (ΔF (1, 125) = 3.81, $p = .053$, $\Delta R^2 = 0.03$). This overall improvement to model fit provides tentative evidence that Rural Status moderates the relationship between caregiver wellbeing and positive caregiver responses. Follow up simple slopes analysis showed that caregiver wellbeing was significantly associated with positive responses among rural caregivers ($b = .64$, $p = .007$) but not non-rural caregivers ($b = .23$, $p = .275$; see Figure 2). This result was partially consistent with predictions, suggesting that greater caregiver wellbeing is associated with more positive caregiver responses only in rural contexts.

Table 3

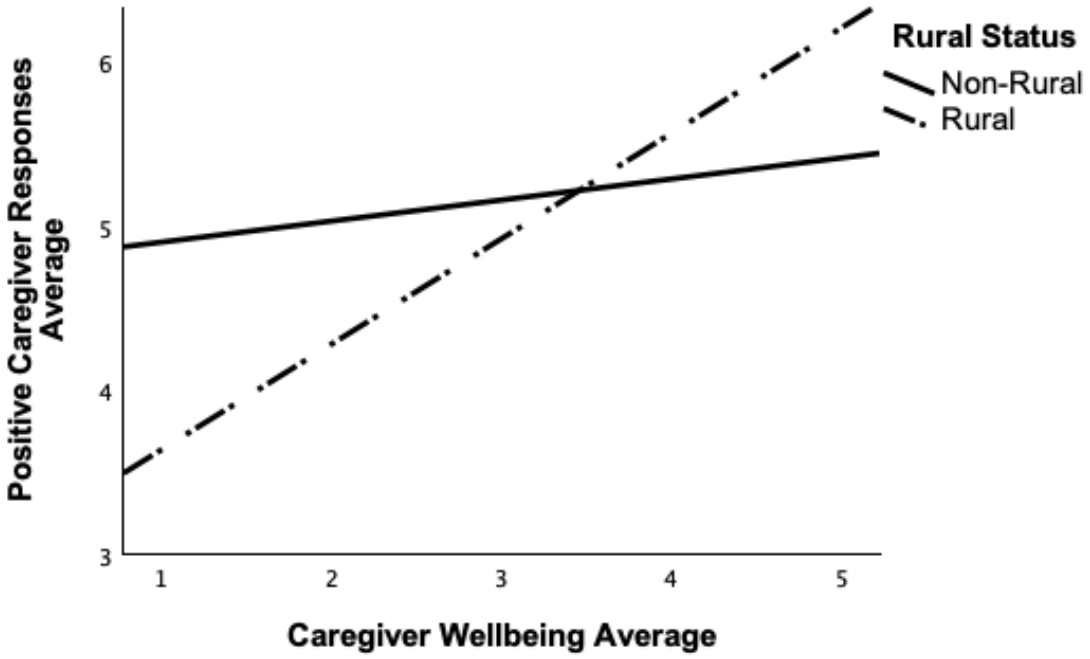
Caregiver Wellbeing and Rural Status as Predictors of Caregiver Responses, and Caregiver Responses and Rural Status as Predictors of Youth Wellbeing

Predictor	*β*	95% CI	*p*
Negative Caregiver Responses			
Step One			
Caregiver Wellbeing	-0.18	-0.61, 0.06	.073
Rural Status	-0.01	-0.52, 0.65	.939
Step Two			
Caregiver Wellbeing × Rural Status	-0.09	-1.75, 0.24	.392
Positive Caregiver Responses			
Step One			
Caregiver Wellbeing	0.11	-0.06, 0.31	.275
Rural Status	0.01	-0.43, 0.39	.908
Step Two			
Caregiver Wellbeing × Rural Status.	0.19	-0.07, 1.40	.053
Youth Wellbeing			
Step One			
Negative Caregiver Responses	-0.30	-0.39, -0.08	.009
Positive Caregiver Responses	0.09	-0.34, 0.07	.413
Rural Status	-0.04	-0.50, 0.34	.606
Step Two			
Negative Caregiver Responses × Rural Status	0.31	-0.24, 1.01	.240
Positive Caregiver Responses × Rural Status	.51	-0.41, 1.71	.010

Note. Confidence intervals are bias-corrected and accelerated based on 5,000 resamples. Outcome variables are bolded for clarity.

Figure 2

Interaction Between Caregiver Wellbeing and Rural Status in Predicting Positive Caregiver Responses

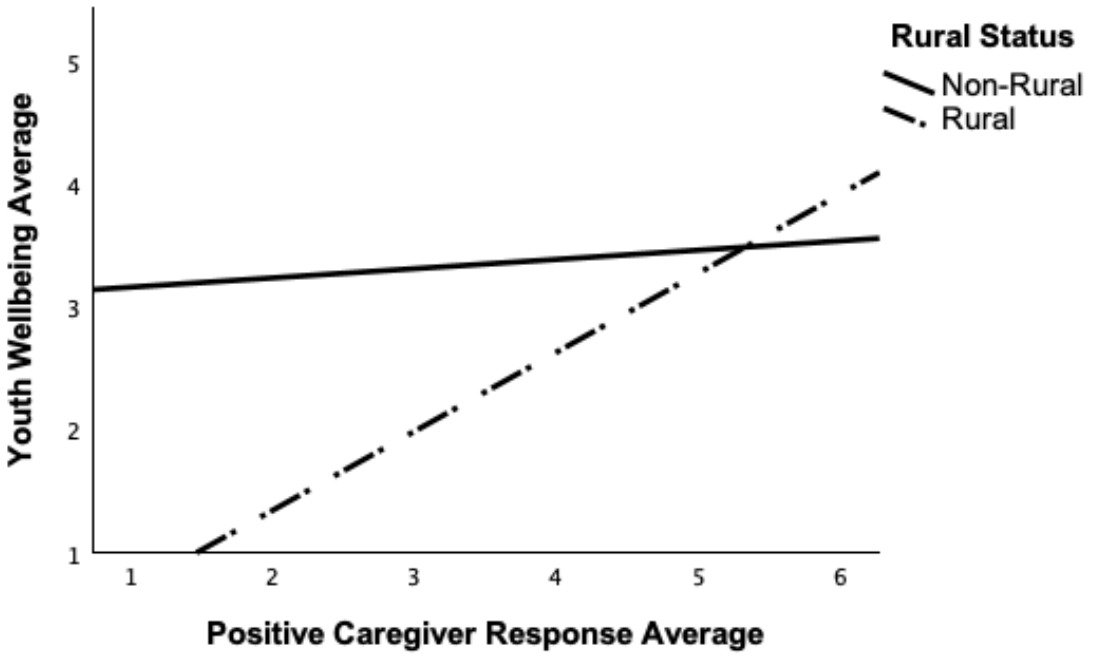


A final hierarchical multiple linear regression model examined whether both positive and negative caregiver responses uniquely predicted youth wellbeing, and whether this association varied across rural and non-rural contexts. Positive Caregiver Responses, Negative Caregiver Responses, and Rural Status were entered at Step 1, explaining 8.9% of the variance in Youth Wellbeing, $F(3, 125) = 4.05$, $p = .009$, *Adj.* $R^2 = 0.07$. Greater levels of Negative Caregiver Responses were uniquely associated with lower Youth Wellbeing, while Positive Caregiver Responses and Rural Status were not. The addition of both Positive Caregiver Responses x Rural Status and Negative Caregiver Responses x Rural Status interaction terms at Step 2 explained significantly more variance in Youth Wellbeing ($\Delta F(2, 123) = 6.99$, $p = <.001$, $\Delta R^2 = 0.07$). The Positive Caregiver Responses × Rural Status interaction was significant, while the Negative Caregiver Responses × Rural Status interaction was not. These results indicate that rural status moderates the relationship between positive caregiver responses and youth wellbeing. Follow up simple slopes analysis showed that positive caregiver responses were positively associated with youth wellbeing in

rural contexts (b = .64, p < .001) but not in non-rural contexts (b = .08, p = .416; see Figure 3). Together, these findings indicate that greater levels of caregiver wellbeing are associated with fewer negative caregiver responses across contexts and with more positive responses only in rural contexts. In turn, negative responses were associated with lower youth wellbeing across contexts, whereas positive caregiver responses were associated with greater youth wellbeing only in rural contexts.

Figure 3

Interaction Between Positive Caregiver Responses and Rural Status in Predicting Youth Wellbeing



Research Question 3: Do Contextual Factors Influence the Relationship Between Caregiver Responses and Wellbeing?

Finally, the potential role of affiliate stigma and resource access as contextual influences on caregiver responses and caregiver and youth wellbeing were considered. Mean-level group comparisons were conducted to determine whether levels of affiliate stigma and accessing rainbow affirming resources differed between rural and non-rural contexts. Contrary to predictions, affiliate stigma did not differ by rural status (Rural: M = 2.94, SD = 0.68; Non-Rural: M = 2.99, SD = 0.72), t(136) = 0.27, p = 0.786, g = 0.06, 95%

BCa CI [-.29, .39]. Likewise, counter to predictions accessing affirming resources did not differ by rural status (Rural: M = 3.15, SD = 1.21; Non-Rural: M = 3.75, SD = 1.47, t(102) = 1.39, p = 0.169, g = 0.41, 95% BCa CI [-.17, .99]). Counter to predictions, the proportion of caregivers who accessed at least one affirming resource was also similar across groups (68.4% Rural vs. 79.0% Non-Rural), χ^2(1, N = 138) = 1.05, p = 0.312, φ = - 0.09, and interest in accessing resources in the future did not differ by rural status F(1, 136) = 0.39, p = .540, $R^2 \leq 0.01$, 95% BCa CI [-.42, .22].

To examine how contextual factors, such as affiliate stigma and accessing affirming resources, shape caregiver and youth outcomes, a series of four hierarchical multiple linear regression analyses were conducted (see Table 4 for parameter estimates of all models). These models extended on previous models by testing whether affiliate stigma and resource access predicted caregiver and youth wellbeing and caregiver responses, and whether these relationships were moderated by rural status.

The first model assessed whether affiliate stigma and accessing affirming resources was associated with caregivers' own wellbeing before considering whether this differed by rural status. Affiliate Stigma, Resource Access, and Rural Status were entered at Step 1 and explained 11.8% of the variance in Caregiver Wellbeing, F(3, 126) = 5.63, p = .001, *Adj.* R^2 = .10. Greater Affiliate Stigma was uniquely associated with lower Caregiver Wellbeing, while Rural Status and Resource Access were not. The addition of the Affiliate Stigma x Rural Status and Resource Access x Rural Status interaction terms did not improve model fit (ΔF (2, 124) = 0.47, p = .630, ΔR^2 = 0.01). The lack of improvement to overall model fit suggests that Rural Status did not moderate the relationship between Affiliate Stigma, Resource Access and Caregiver Wellbeing. These findings were largely consistent with predictions, indicating that greater levels of affiliate stigma were associated with lower levels of caregiver wellbeing across rural and non-rural contexts, while accessing affirming resources was unrelated to caregiver wellbeing.

Table 4

Affiliate Stigma, Resource Access, and Rural Status as Predictors of Caregiver and Youth Wellbeing and Caregiver Responses

Predictor	β	95% CI	*p*
Caregiver Wellbeing			
Step One			
Affiliate Stigma	-0.31	-0.42, -0.11	.001
Resources Accessed	.14	-0.07, 0.51	.137
Rural Status	-0.13	-0.54, 0.59	.933
Step Two			
Affiliate Stigma × Rural Status	-0.82	-0.67, 0.26	.385
Resources Accessed x Rural Status	-0.10	-0.90, 0.47	.536
Youth Wellbeing			
Step One			
Affiliate Stigma	-0.32	-0.51, -0.14	.001
Resources Accessed	0.09	-0.18, 0.49	.372
Rural Status	-0.09	-0.84, 0.48	.592
Step Two			
Affiliate Stigma × Rural Status	0.08	-0.31, 0.78	.397
Resource Access x Rural Status	0.06	-0.67, 0.95	.728
Negative Caregiver Responses			
Step One			
Affiliate Stigma	0.34	0.22, 0.67	<.001
Resources Accessed	0.08	-0.21, 0.53	.378
Rural Status	0.37	-0.39, 2.83	.020
Step Two			
Resources Accessed × Rural Status	-0.41	-3.14, 0.15	.014
Affiliate Stigma × Rural Status	0.07	-0.34, 1.04	.424
Positive Caregiver Responses			
Step One			
Affiliate Stigma	-0.17	-0.38, 0.01	.062
Resources Accessed	0.01	-0.31, 0.36	.880
Rural Status	-0.12	-1.12, .25	.211
Step Two			
Affiliate Stigma × Rural Status	-0.0	-0.81, .33	.407
Resources Accessed × Rural Status	-0.21	-.30, 1.37	.206

Note. Confidence intervals are bias-corrected and accelerated based on 5,000 resamples. Outcome variables are bolded for clarity. Resources accesses was a binary variable coded as 0 = No, 1 = Yes.

Building on this, the second model examined youth wellbeing to determine whether similar associations extended to young people and whether they were moderated by rural status. Affiliate Stigma, Resource Access, and Rural Status were entered at Step 1 and explained 9.5% of the variance in Youth Wellbeing, $F(3, 127) = 4.23$, $p = .007$, *Adj.* $R^2 = 0.07$.

Greater Affiliate Stigma was significantly associated with lower Youth Wellbeing, while Rural Status and Resource Access were not. The addition of the interaction terms did not improve model fit $\Delta F(2, 125) = 0.37$, $p = .690$, $\Delta R^2 = 0.01$, suggesting that Rural Status did not moderate the relationships between Affiliate Stigma, Resource Access and Youth Wellbeing. As with caregiver wellbeing, these results suggest that greater levels of affiliate stigma were associated with lower levels of youth wellbeing across rural and non-rural contexts, while accessing affirming resources was unrelated to youth wellbeing.

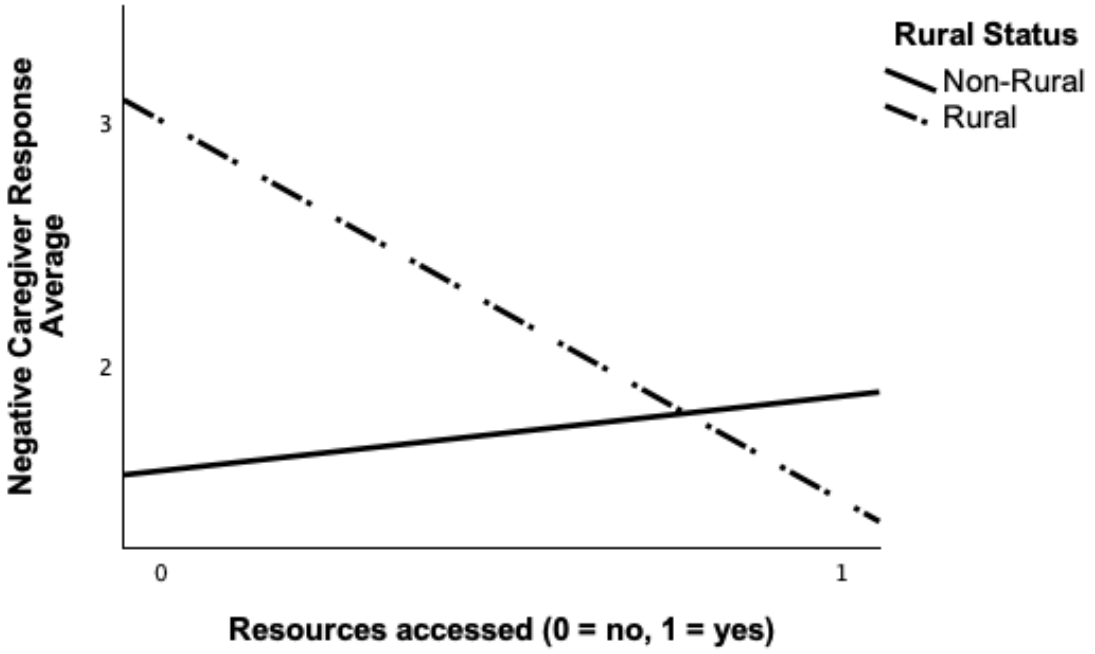
The next analysis explored negative caregiver responses, extending the focus from wellbeing outcomes to the relational dynamics within caregiver-youth relationships. The first regression model explored whether affiliate stigma and resource access predicted negative caregiver responses, and whether these relationships were moderated by rural status. Affiliate Stigma, Resource Access and Rural Status were entered at Step One, accounting for 15.9% of the variance in Negative Caregiver Responses, $F(3, 132) = 7.97$, $p < .001$, *Adj.* $R^2 = 0.13$. Greater Affiliate Stigma was uniquely associated with more Negative Caregiver Responses, while Resource Access and Rural Status were not associated. The addition of the Affiliate Stigma x Rural Status and Resource Access x Rural Status interaction terms explained significantly more variance in Negative Caregiver Responses ($\Delta F(2, 130) = 4.44$, $p = .014$, $\Delta R^2 = 0.05$). The Resource Access x Rural Status interaction was significant while the Affiliate Stigma x Rural Status interaction was not. Follow up simple slopes analysis showed that for rural caregivers, accessing affirming resources was associated with significantly fewer negative responses ($b = -1.14$, $p = .012$; see Figure 4). Together, these results suggest that affiliate stigma was associated with greater levels of negative caregiver responses overall, whereas accessing affirming resources was associated with fewer negative caregiver responses in rural contexts only.

Finally, a fourth model tested whether affiliate stigma and resource access predicted caregivers' use of positive responses across rural and non-rural contexts. Affiliate Stigma, Resource Access, and Rural Status were entered at Step 1 and demonstrated a statistical

trend, explaining 5.2% of the variance in Positive Caregiver Responses, $F(3, 133) = 2.41$, $p = .069$, *Adj.* $R^2 = 0.03$. Greater Affiliate Stigma was showed a trend level association with fewer Positive Caregiver Responses, while Resource Access and Rural Status were not associated. The addition of both the Affiliate Stigma x Rural Status and Resource Access x Rural Status interaction terms at Step 2 did not improve model fit ($\Delta F(2, 131) = 1.50$, $p = .232$, $\Delta R^2 = 0.02$).

Figure 4

Interaction Between Resource Access and Rural Status in Predicting Negative Caregiver Responses



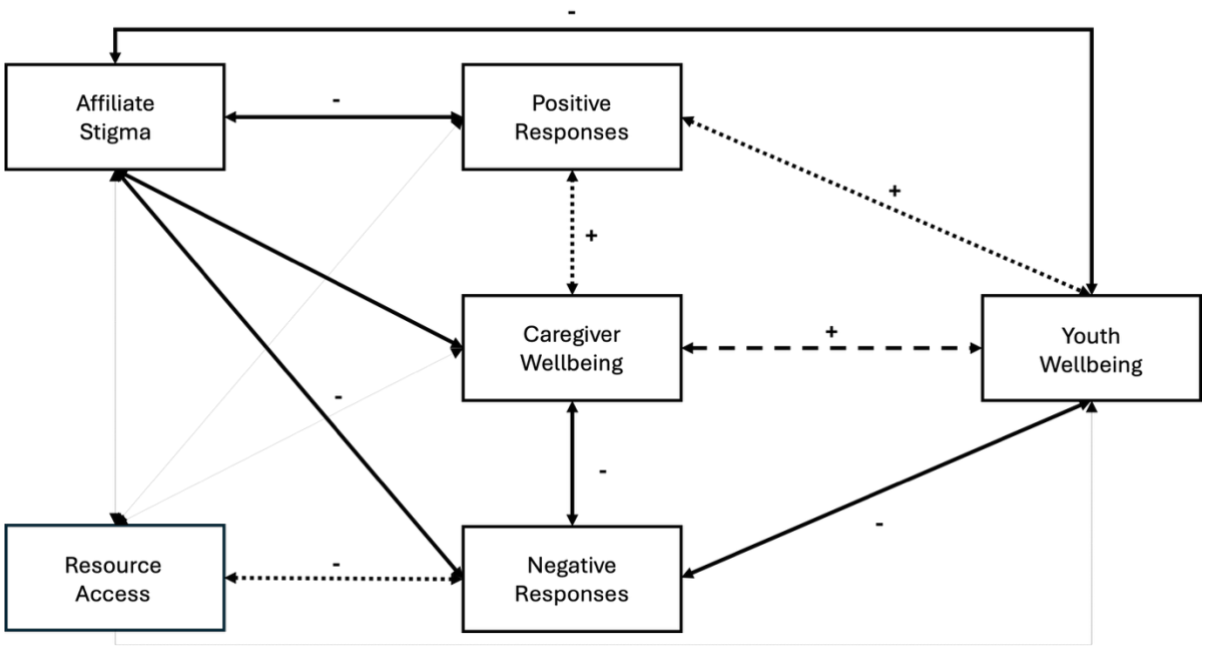
Chapter Six: Discussion

The present study investigated the relationship between caregiver and youth wellbeing across rural and non-rural contexts in Aotearoa, before considering how caregiver responses, affiliate stigma, and resource access may help explain these associations. For ease of interpretation, findings are visually summarised in Figure 5. Collectively, findings position caregivers as potentially pivotal agents in the wellbeing of their rainbow youth, with rural status shaping the magnitude of associations.

Caregiver wellbeing was positively associated with youth wellbeing, with the strength of this relationship amplified in rural contexts. While overall levels of wellbeing and caregiver responses did not differ across rural and non-rural contexts, rural status influenced several relationships.

Figure 5

Conceptual Diagram Summarising the Study's Findings



Note. Black lines indicate significant associations. Dotted lines indicate associations only in rural contexts, while dashed lines indicate that the association is magnified within rural contexts. Grey lines indicate non-significant associations.

Specifically, greater caregiver wellbeing predicted more positive caregiver responses only in rural contexts, and positive caregiver responses predicted greater youth wellbeing only in rural contexts. By contrast, negative responses were associated with poorer wellbeing outcomes across contexts.

Affiliate stigma emerged as a broadly corrosive influence, associated with lower caregiver and youth wellbeing, more negative caregiver responses, and fewer positive ones, regardless of rural status. Conversely, accessing affirming resources appeared to be only protective in rural contexts, where it corresponded with fewer negative caregiver responses. Taken together, these findings posit that rural status is not an inherent risk but an amplifying context, one that can magnify the strengths already present in rural environments.

Interconnected Caregiver and Youth Wellbeing Across Contexts

Caregiver and youth wellbeing were positively associated across rural and non-rural contexts, with this association stronger in rural contexts. This finding indicates that when caregivers experienced greater levels of wellbeing, their rainbow young people tended to do so too – especially in rural contexts. While the amplifying effect of rural status was unexpected, the overall positive association between caregiver and youth wellbeing echoes prior international and Aotearoa-based research (e.g., Barnes, 2024; Mansoor, 2024; McConnell et al., 2016; Mortier et al., 2025; Ryan et al., 2009; Ryan et al., 2010; Seager van Dyk et al., 2024), reflecting a relational synchrony that is well recognised in family systems theory (Paley & Hajal, 2022). In this context, wellbeing can be understood as something that is co-constructed within families, rather than originating solely within the individual. Accordingly, the emotional tone and regulatory patterns established by caregivers form a backdrop that can support or constrain young people in developing their sense of identity, security, self-worth, and belonging (Paley & Hajal, 2022; Su et al., 2024).

When caregivers are emotionally regulated, available, and attuned, they are better able to be a steady relational resource that their rainbow young person can rely on to interpret, manage, and navigate the stressors of daily life and identity development (Seager van Dyk et al., 2024). Thus, the family system can function as a shared emotional foundation

in which experiences of safety, warmth, and wellbeing can reinforce one another over time. These findings are also consistent with theoretical perspectives which emphasise supportive caregiver-youth relationships founded on co-regulation and reciprocal empathy as building blocks of adaptive emotional development in young people (e.g., DelFerro et al., 2024; Feinstein et al., 2014; McCurdy et al., 2023; Pearson & Wilkinson, 2013; Ryan et al., 2009; Ryan et al., 2010; Su et al., 2024; Thoma & Huebner, 2014).

In contrast, when caregiver wellbeing is constrained or depleted, youth wellbeing also tends to decline. This downward synchrony reflects the same relational mechanisms operating in reverse; when caregivers are distressed, their reduced capacity for attunement can unsettle the family's emotional balance (DePasquale, 2020). In practical terms, this means that when a caregiver's wellbeing is low, this strain can ripple through the household, unsettling the caregiver-youth relationship that young people fundamentally rely on (Shih et al., 2019). For rainbow youth, who may already face external pressures related to identity, instability and strain in this primary attachment can be particularly costly. This relationship uncertainty can leave rainbow youth unsure when, how, or if affirming support will be available, prompting withdrawal or heightened vigilance that can mirror their caregivers' own unease (Stettler & Katz, 2017). Over time, these small disruptions can accumulate, narrowing the space for open communication, mutual reassurance, and validation (Rusu et al., 2025). What emerges here is not always overt conflict, but a gradual loss of rhythm in the family system, where moments of connection become less frequent and more fragile (Rusu et al., 2025; Sousa et al., 2024).

Ultimately, rather than a one-way flow from caregiver to youth, wellbeing may operate as a reciprocal feedback loop, where changes in one reflect and reinforce changes in the other, consistent with the strong positive association between caregiver and youth wellbeing observed in this study. Although these dynamics may operate bidirectionally, caregivers typically hold greater control over the household environment and the relational climate. Therefore, caregiver wellbeing is a particularly powerful and important lever for shaping a family's emotional climate more broadly. When it falters, the emotional and relational

scaffolding that supports youth wellbeing can weaken (Carr, 2015; Qin et al., 2025), and when it strengthens, the family system as a whole can recalibrate toward safety, acceptance, and belonging.

Underpinning these reciprocal family dynamics are shared biological and environmental foundations that give rise to the co-occurrence of caregiver and youth wellbeing. Twin and family studies have consistently shown that approximately one-third of the variance in subjective wellbeing is heritable, with the remainder explained by environmental context and gene-environment interactions (Bartels, 2015; Nes & Røysamb, 2015). Families, therefore, tend to share not only inherited predispositions, but also the social worlds that influence how these predispositions manifest (Martínez-Levy et al., 2025). In this sense, inherited traits linked to stress sensitivity or emotional regulation are not fixed outcomes but temperamental tendencies that take shape through the interaction between people and their environments. In supportive, well-resourced households, these sensitivities can become sources of attunement and insight, whereas in strained or chaotic households, these sensitivities may heighten distress and avoidance (Ellis et al., 2011).

A differential susceptibility framework helps to interpret these gene-environment interactions (e.g., Belsky et al., 2007; Belsky & van Ijzendoorn, 2017; Ellis et al., 2011; Kelly & Sullivan, 2023; Pluess, 2017), illustrating how the same biological predispositions can yield different outcomes depending on a person's context. Within this framework, caregiver wellbeing can function as a key contextual influence, such that when caregivers are well within themselves, this wellness can provide them with the internal resources required to respond in ways that can buffer genetic vulnerabilities and foster adaptive functioning in their youth. Conversely, when caregivers are distressed and unable to respond to their young person with attunement and warmth, those same genetic vulnerabilities are more likely to be activated (Homberg & Jagiellowicz, 2022; Kelly & Sullivan, 2023). Biology therefore sets the scene but does not determine the performance; rather, it offers potentialities that unfold within the dynamic theatre of family life, where every day emotional exchanges shape which possibilities take form.

Looking beyond biological contributions, family wellbeing is also shaped through learned emotional patterns that are woven into the routines of daily life. Caregivers model coping, communication, and self-regulation strategies that gradually become the family's implicit language for handling stress and connection (Paley & Hajal, 2022). These relational patterns continuously interact with the biological system of the body. Chronic family stress, for instance, can desensitise the hypothalamic-pituitary-adrenal axis, constraining how individuals respond to and recover from emotional challenges, where nurturing and affirming caregiver-youth interactions can recalibrate these systems toward greater flexibility (Bush et al., 2025). This interplay between environment and physiology underpins what is now understood as epigenetic plasticity (e.g., Bush et al., 2025; Herrero-Roldán et al., 2021; Meaney, 2010; Metrailer et al., 2025; Peña, 2025; Sullivan et al., 2023) - the capacity for supportive environments and systems to shape gene expression related to stress and emotion regulation. In this sense, caregiving is not simply a *response* to potentially inherited differences in young people but something that can biologically remodel how those differences manifest (Gunnar et al., 2019; Provenzi et al., 2020). Over time, consistent warmth and attunement can downregulate stress-response genes, whereas persistent stress and strain can heighten their activation, reinforcing cycles of distress and wellbeing across generations (Ryan et al., 2024). Crucially, the presence of plasticity indicates that these patterns are not fixed. Here, even modest improvements in caregiver wellbeing can potentially set off a cascade of restorative processes that ripple through behaviour and biology (Oren et al., 2025), re-establishing synchrony with the family system.

Minority stress theory helps contextualise how this interplay between caregiver and youth wellbeing may unfold among rainbow families, situating caregiver wellbeing as a fulcrum in which minority stress processes turn. From this perspective, the wellbeing of minoritised individuals is shaped by the continual exchange between distal structural stressors and proximal internal processes (Meyer, 2003). The present findings extend this framework by positioning caregivers as both translators and transformers in minority stress processes within their family systems. When caregivers are well, they can act as buffers,

filtering, and metabolising the pressures of stigma and structural stressors before they reach the young person. When their wellbeing falters, this protective barrier may thin, allowing external stressors to reverberate through the family system and reinforce strain. Therefore, the synchrony between caregiver and youth is not just an emotional resonance, but also a system of relational co-creation where minority stress is either metabolised or magnified. It is within this relational circuitry that structural inequality becomes embodied or, conversely, undone. Biological sensitivities, intergenerational learning, and daily patterns of co-regulation intertwine here, showing that wellbeing is both inherited and created. Through this lens, caregiver wellbeing emerges as a potentially core process in the mechanism of minority stress, the relational hinge through which societal pressures are metabolised in family life, and crucially, into resilience.

Critcially, this study's findings demonstrated that the association between caregiver and youth wellbeing was markedly stronger in rural contexts, despite no differences in the average level of wellbeing across rural and non-rural settings. The absence of average differences suggests that the core dynamics of family wellbeing discussed above, such as co-regulation and reciprocal empathy, are broadly similar across contexts (Li & Zhou, 2025; Paley & Hajal, 2022). What may differ is not necessarily *whether* these dynamics exist, but *how* they operate in each context. In non-rural contexts, external supports such as peers, community Pride spaces, and affirming services may help distribute the 'relational load', supporting wellbeing through multiple pathways (Deane et al., 2019). By contrast, in rural contexts, where structural and systems level supports are often sparse (Deane et al., 2019; Easpaig et al., 2022), families can be more self-contained and self-reliant, meaning that young people end up relying more heavily on their caregivers and family systems for emotional support, acceptance, and belonging (Kemmerer et al., 2025; Lyons et al., 2015; Wike et al., 2022). Consequently, when alternative forms of affirmation are limited, the family system can become a primary arena in which rainbow young people negotiate safety, and identity. In this way, rural families may operate as more enclosed emotional ecosystems, concentrating the reliance of youth on their caregivers, and potentially magnifying the

strengths and strains of this relationship. Ultimately, rural contexts may not influence overall levels of wellbeing as much as shape how wellbeing circulates within families, serving as a kind of relational conductor that might amplify the flow of wellbeing within families and between family and place.

In addition to shaping the breadth of the emotional support available to rainbow youth and their caregivers, the natural spaces inherent in many rural environments can carry their own restorative and regulatory qualities. An eco-psychological perspective is informative here, highlighting how connection with natural environments can restore and regulate wellbeing. Eco-psychological research points to the therapeutic effects of open spaces, quietude, and sensory immersion in nature (e.g., Bowers et al., 2021; Capaldi et al., 2015; Knez & Eliasson, 2017; Legrand et al., 2022; Passmore & Krause, 2023; Pinós, 2025; Sudimac et al., 2022; Wilson, 2011). Here, a soft sense of awe and wonder at the natural landscape can restore wellbeing (Zhou et al., 2025), representing a kind of ‘biophilic pull’ that can reduce physiological arousal and help people to embody a slow internal rhythm aligned with the pace of natural environments (Pinós, 2025). These environmental-regulatory affordances may, in turn, heighten synchrony between caregiver and youth wellbeing by supporting both self- and co-regulation (Al Sayyed & Al-Azhari, 2025; Wright et al., 2024). In other words, when the rural environment itself fosters calm and regulation, it may strengthen the emotional resonance between caregivers and their young people, such that their wellbeing is more tightly coupled in these rural contexts (Marchi et al., 2023; Medina-Maldonado et al., 2025; Michael et al., 2022). Such sensory and physical scaffolding enables families to recover together after stress and adapt to change (e.g.,Capaldi et al., 2015; Legrand et al., 2022; Sudimac et al., 2022; Zhou et al., 2025), potentially reinforcing and enriching the close-knit interpersonal ties that can characterise family relationships in rural settings.

A transpersonal psychological perspective is also relevant to interpreting and contextualising these findings. Echoing te ao Māori perspectives of wellbeing, this framework highlights dimensions of connection and meaning that extend beyond the individual to

encompass connection with land, seasonal rhythms, and community, as part of a wider web sacred connection (e.g., Davis, 2011; Jaye et al., 2022; Knez & Eliasson, 2017; Passmore & Krause, 2023; Wilson, 2011). From this perspective, the caregiver-youth dynamic does not exist in isolation from context, but participates in a living ecology of meaning and consciousness that includes natural environmental cycles, shared histories, and collective identities (Cunningham, 2022; Davis, 1998). Rural life, often characterised by its closeness to nature and its adaptive, self-sustaining communities, provides fertile grounds for such experiences (Bowers et al., 2021). The quiet of a familiar valley, the repetition of seasonal tasks, or the subjective sense of being held within a small community can each evoke a subtle awareness of interconnectedness that nourishes wellbeing (Bowers et al., 2021; Passmore & Krause, 2023; Wilson, 2011). In a transpersonal sense, these moments reflect a movement of awareness beyond the personal self (Passmore & Krause, 2023), where wellbeing is sustained through connection with something larger and enduring (Wilson, 2011).

In combination, the interplay between concentrated rural social networks, and the restorative natural environments of rural areas may help explain why the link between caregiver and youth wellbeing was more pronounced in rural contexts. When wellbeing arises within a network that includes both people *and* places, its effects can resonate through every layer of that ecology. Rural contexts, therefore, are not merely geographic backdrops to family life, but active participants in the regulation and meaning-making that sustain it.

Caregiver Responses to Their Rainbow Youth Across Contexts

For both rural and non-rural caregivers, positive caregiver responses were more frequently endorsed than negative ones. Overall, this finding suggests that those who chose to participate in this study were a relatively affirming group. It is likely that caregivers who already hold supportive attitudes toward their rainbow young people felt more comfortable or motivated to participate in this study, while those with more rejecting attitudes were less inclined to do so (Meyer & Wilson, 2009; Potter & Potter, 2020). Further, in this study, 26.5%

of participating caregivers identified as rainbow themselves, compared with approximately 5.0% of the general population of Aotearoa who identify as rainbow (Statistics New Zealand, 2023). This overrepresentation may have further contributed to the predominance of positive caregiver responses in this study. In this sense, the overall balance between positive and negative caregiver responses likely reflects those who felt drawn to participate.

Nevertheless, it is important to recognise that positive and negative responses are not simply opposite ends of a spectrum but rather different relational dynamics that can co-occur (Mazursky, 2025; Seager van Dyk et al., 2024). While positive responses reflect, curiosity, openness, and a willingness to learn, negative responses are more closely tied to fear, shame, or stress (Clark et al., 2022; Niedlich et al., 2022; van Bergen et al., 2021). In this way, even among a generally affirming sample, caregivers simultaneously reported a mixture of positive and negative responses, emphasising a nuanced interpretation of the relational processes that underlie both response types (Seager van Dyk et al., 2024). Crucially, these distinct relational pathways may also help explain the differing patterns of association observed in this study, where negative responses were associated with lower wellbeing outcomes across contexts, while positive responses were associated with higher wellbeing outcomes only in rural contexts. From this perspective, understanding positive and negative caregiver responses as divergent yet overlapping ways of relating can provide a clearer foundation for interpreting these responses within the broader mechanisms of minority stress.

Contrary to predictions, rural and non-rural caregivers reported similar levels of negative responses. Prior Aotearoa-based research has reported higher levels of conservative norms among those living in rural contexts compared to those living in non-rural contexts (e.g., Bergh et al., 2015; Crawley, 2024; Greaves et al., 2017; Satherley et al., 2020; Sibley & Wilson, 2007). Informed by minority stress theory (Meyer, 2003), this led to this study's prediction that rural caregivers would report more negative responses, given their potential exposure to a higher level of constraining conservative norms which have been associated with more rejecting attitudes toward rainbow identities (Rosenkrantz, 2018).

This focus on the negative impacts of distal stressors may have overlooked how the unique strengths of rural life, such as close-knit family ties and access to natural spaces, might attenuate negative caregiver responses (LeBlanc et al., 2015; Li & Zhou, 2025). For example, in rural contexts, this attenuation may rely more on the close-knit bonds of the family itself, with caregivers' wellbeing and the relational closeness within the family acting as circuit breakers that transmute structural stress before it manifests as negative responses (Kemmerer et al., 2025; Meanley et al., 2021). Conversely, in non-rural contexts, the same buffering may occur through broader structures of inclusion and affirmation such as formal community supports, Pride events, and institutional initiatives that diffuse structural stress collectively rather than privately (Miller, 2022). These findings suggest that while minority stress theory can be useful in identifying potential sources of stress, it may underestimate the place-based strengths and buffering processes that shape how minority stress unfolds in everyday family life, especially in rural environments where unique strengths and challenges can intersect to further shape outcomes (Kemmerer et al., 2025). In this way, the finding of similar levels of positive and negative caregiver responses across contexts points not to a contradiction of minority stress theory, but to a need for a more contextualised understanding of how minority stress processes are influenced by place.

Critically, the association between caregiver wellbeing and caregiver responses differed by response valence. More negative caregiver responses were associated with lower caregiver and youth wellbeing in both rural and non-rural contexts. Negative caregiver responses, such as caregivers experiencing sadness and shame toward their young person's rainbow identity, can emerge as reactive defaults (Shaw & Starr, 2019) that are easily cued by stress and constraining cis- and hetero-normative sociocultural scripts. These negative responses, irrespective of rural status, can erode wellbeing across caregivers and youth alike, reflecting the family system level processes of emotional synchrony discussed earlier (Paley & Hajal, 2022; Su et al., 2024).

In contrast, more positive caregiver responses were associated with greater caregiver and youth wellbeing only within rural contexts. Positive caregiver responses,

characterised by caregivers feeling accepting and supportive of their rainbow young people, tend to reflect deliberate acts of attunement that draw more heavily on internal resources, such as regulation, empathy, and openness (Leerkes et al., 2020). In rural contexts, where alternative sources of affirmation may be fewer, and social networks more tightly bound, these deliberate responses may carry greater emotional reach, fostering youth wellbeing through strengthened co-regulation and belonging (Paley & Hajal, 2022). From a family systems perspective, such deliberate positive responses require the caregiver to 'hold steady' under pressure (Fitzgerald et al., 2020), and to remain present, curious, and accepting toward their rainbow youth when uncertainty arises (Li & Zhou, 2025; Paley & Hajal, 2022). This work is easier to sustain when caregivers are well within themselves and regulated (Bridgett et al., 2015). Accordingly, caregiver wellbeing may provide the foundation from which positive responses emerge, with the relational climate shaped by those responses, especially in rural contexts, extending outward to nourish the wellbeing of rainbow youth.

In rural settings, where the social world is smaller, more visible, and tightly interwoven (Wike et al., 2022), the caregiver-youth relationship can become the primary site in which the wellbeing and identity of rainbow young people are supported or constrained. With fewer alternative affirming mirrors, positive caregiver responses founded on acceptance and support can become quietly courageous acts (de Bres & Morrison-Young, 2023, 2024; Tang et al., 2025). This visibility can 'raise the cost' of positive responses, increasing their demand on psychological resources. Part of this demand may result from the need to act against intergenerational patterns rooted in conservative social norms, which often privilege restraint and emotional composure over explicit warmth and affirmation (Miller, 2022; Rosenkrantz, 2018). In such contexts, responding positively may require caregivers to override longstanding emotional and relational patterns that have been learned and reinforced over time (Bridgett et al., 2015; Fitzgerald et al., 2020; Leerkes et al., 2020; Shaw & Starr, 2019). Wellbeing may therefore provide caregivers with the emotional resources required for that override, supporting their capacity to observe their distress without over-

identifying with it (Su et al., 2024), to stay attuned to their rainbow youth even when others are watching, and to choose congruence with their young person's rainbow identity over conformity to constraining normative social scripts. Rural contexts may therefore intensify the need for and effect of caregivers' internal resources, amplifying the reach of each positive response within the dense relational fabric of rural lifeworlds.

Findings suggest that in rural contexts, caregiver wellbeing may cascade through several layers of the caregiving system, such that when caregivers are well, their capacity for positive responses strengthens, and in turn, those positive responses appear to nurture youth wellbeing. From an eco-psychological perspective, natural environments can support regulated caregiving through qualities of quiet, rhythm, and sensory spaciousness that can reduce arousal and widen attention (Pinós, 2025; Zhou et al., 2025). These same natural environments can also support young people's wellbeing directly (Bowers et al., 2021), enriching the beneficial effects of their caregivers' positive responses. Beyond these restorative effects, connection with nature can evoke a transcendent sense of belonging (Naor & Mayseless, 2020) and a sense of participating in something larger than the self. This wider sense of belonging may invite caregivers to respond from a more compassionate and accepting state, which can ripple through the family system, allowing young people to experience not only the benefits of positive caregiver responses but also a shared sense of belonging with their caregiver to something larger than themselves (Bowers et al., 2021; Knez & Eliasson, 2017; Passmore & Krause, 2023). Within this milieu, positive responses can reflect an expression of integrity with the larger whole, nurturing both giver and receiver within a shared atmosphere of belonging (White, 2013).

Collectively, these associations indicate a consistent asymmetry in how care and stress are transmitted within families, where negative caregiver responses appear to be detrimental to wellbeing overall, while positive responses appear to generate context-specific gains to wellbeing. This asymmetry also reflects the understanding that rather than being 'one or the other', positive and negative caregiver responses represent distinct relational

dimensions, each with different emotional and regulatory requirements (Seager van Dyk et al., 2024).

Considering the above, the context-specific effects of rural settings may unfold in two stages. First, higher caregiver wellbeing may enable caregivers to respond more positively under conditions of greater social scrutiny and constraint. Second, these positive responses, once enacted, may in turn enhance youth wellbeing, creating a context-specific relational cascade in which caregiver wellbeing and positive responses together reinforce youth wellbeing. In rural contexts, these positive responses may carry further within the tighter relational webs of rural life, where positive responses to rainbow identities are often rarer, and thus resonate more deeply with young people. In this way, the same mixture of rural advantages that facilitate the translation of caregiver wellbeing into positive responses may also strengthen the association between these responses and youth wellbeing. Rural contexts can therefore heighten both the cost of positive responses *as well as their reach*. When caregivers are well, they may be better able to align their inner resources with positive actions, and this alignment could not only improve their own wellbeing but also extend outwards to strengthen the wellbeing of their rainbow young person, recalibrating the emotional tone of the family itself.

Together, these findings offer a potential extension to minority stress theory, suggesting that an over emphasis on distal and proximal stressors neglects how placed-based relational and ecological contexts can shape the translation of stress into lived family experiences. To this end, a place-based sequential pathway was proposed where the unique strengths of rural contexts facilitate the movement of wellbeing through the family system. Here, minority stress in rural environments unfolds not simply through a process of compounding exposure to stressors, but through intersecting relational and contextual pathways that can shape how caregivers and their families interpret and metabolise that exposure.

Affiliate Stigma and Resource Access Across Contexts

Affiliate stigma and resource access were considered together, as they reflected distinct contextual factors that can influence the wellbeing of caregivers and their rainbow youth (Kemmerer et al., 2025). Across rural and non-rural contexts, higher affiliate stigma was associated with lower caregiver wellbeing, lower youth wellbeing, more negative caregiver responses, and tentatively with fewer positive caregiver responses. Average levels of affiliate stigma did not differ by rural status, nor did accessing affirming resources or future interest in accessing affirming resources. While accessing affirming resources was not associated with either caregiver or youth wellbeing, it was associated with fewer negative caregiver responses in rural contexts only. Collectively, these findings suggest that stigma directed at rainbow identities is not just a distal burden carried only by rainbow young people but something that can also encumber their caregivers, shaping their thoughts and feelings in ways that impact daily life through their responses (LeBlanc et al., 2015). Additionally, these findings suggest that, in rural contexts only, even modest engagement with affirming resources may carry greater weight, offering a sense of validation to caregivers that can reduce their negative responses to their rainbow youth.

Findings extend emerging research (Li & Zhou, 2025), highlighting that minority stress is not only an individual experience, but also a relational one, where stigma absorbed from the societal level can become embodied at the family level. As part of this process, caregivers can internalise structural stigma resulting in shame, worry, and self-surveillance, which can then constrain their wellbeing and deplete the resources available for them to respond to their rainbow young person with attunement and acceptance (Gajek, 2025; Moss-Racusin et al., 2024; Rusu et al., 2024). Over time, rainbow youth can absorb caregivers' emotional constriction, lowering their own wellbeing (Hatzenbuehler & Pachankis, 2016; Lyons et al., 2015; Stevenson et al., 2024). Thus, these reciprocal caregiver-youth dynamics are embedded within broader structural contexts, where via self-reinforcing loops of emotional synchrony and co-regulation, distal stressors such as stigma can constrain the wellbeing of both caregivers and youth (LeBlanc et al., 2015; Li & Zhou, 2025).

Counter to predictions, average levels of affiliate stigma did not differ between rural and non-rural contexts. From a minority stress perspective, rural caregivers were expected to report higher levels of affiliate stigma, given that rural environments are often characterised by greater social scrutiny, conservative norms, and fewer visibly affirming structural supports (e.g., Easpaig et al., 2022; Fine et al., 2025; Kemmerer et al., 2025; Lyons et al., 2015; Rickard & Yancey, 2018; Rosenkrantz et al., 2017; Stevenson et al., 2024). However, this pattern may be better understood in light of this study's sample composition. Across the study, caregivers reported significantly more positive than negative caregiving responses toward their rainbow young people, with around one-quarter of participating caregivers identifying as rainbow themselves. Collectively, these factors likely contributed to a sample that was already more affirming, informed, and connected to rainbow communities compared to the broader caregiver population. Accordingly, the similarity in affiliate stigma scores across contexts may not suggest that rural context is irrelevant to the experience of stigma; rather that affirming caregivers across Aotearoa, regardless of where they live, may share comparable outlooks. Indeed, caregivers' participation in this study may reflect a shared disposition toward acceptance through their willingness to engage in rainbow-oriented research in the first place. Critically, even within a generally affirming sample, these findings suggest that affiliate stigma can still exert a corrosive effect on caregivers' wellbeing and responses.

From a family systems perspective, affiliate stigma may influence families through emotional translation processes. When caregivers internalise stigma, absorbing its messages about what is acceptable and what is not, they can carry that tension into their emotional lives and belief systems, and from there, into their relationships with their rainbow young people (Tan et al., 2022; Trahan & Goodrich, 2015). The first movements in this process are psychological and emotional, where internalised shame and social vigilance erode caregivers' wellbeing, narrowing their window of tolerance and capacity for regulation. As their emotional bandwidth contracts and distress increases, it becomes difficult for caregivers to stay attuned to and co-regulate with their young people (Paley & Hajal, 2022;

Su et al., 2024). In these states, caregivers may shift their attention from connection to impression management (Jordan et al., 2024), seeking to protect the family's public image rather than its internal safety. Rainbow youth may then perceive this emotional withdrawal as a subtle rejection or judgement, responding with their own withdrawal or concealment. Over time, these recursive exchanges can transform external stressors into internalised relational patterns, as stigmatising distal narratives are re-enacted in everyday family life (Li & Zhou, 2025). Caregivers who feel judged may grow guarded, and youth who sense this 'closing off' may pull away in return, eventually internalising this distance from their caregiver as a reflection of their own self-worth (Frazer, 2022; Li & Zhou, 2025; Paley & Hajal, 2022; Su et al., 2024). Through these mechanisms, stigma is thought to migrate from wider structural social contexts into the emotional fabric of the family system. This cascade may help explain why affiliate stigma was associated with lower caregiver and youth wellbeing across contexts. Ultimately, in the background hum of Aotearoa's 'neighbourly' culture, even subtle disapproval can find its way through these relational pathways (Nakhid et al., 2025; Nakhid et al., 2022; Taylor, 2023), potentially reshaping family life and the outcomes of rainbow young people within it.

Contrary to predictions, rural and non-rural caregivers reported comparable levels of access to rainbow-affirming resources. This finding contradicts previous international and domestic research (e.g., Deane et al., 2019; Easpaig et al., 2022; Imig, 1983; Kemmerer et al., 2025; Lyons et al., 2015; Rickard & Yancey, 2018; Wienke & Hill, 2013). Again, this finding may reflect the composition of the sample, which consisted of largely affirming caregivers who were likely already engaged with, or curious about, rainbow wellbeing. In this way, the overall sample may represent caregivers more proactive in seeking and engaging with affirming resources, irrespective of rural context. Also of note is the changing landscape of resource access, where online networks and social media have broadened the reach of affirming resources, possibly softening traditional geographic divides with respect to resource access (Escobar-Viera et al., 2022; Jonas et al., 2024; McInroy et al., 2019).

Even so, these findings invite attention to what *constitutes* resource access in Aotearoa. An apparent similarity in access does not mean that support is experienced or mobilised in the same way across contexts. In rural communities, support often flows through existing relational lines, including trusted GP's, teachers, sports coaches, or neighbours who have 'been there and done that' (Kemmerer et al., 2025). Here, conversations unfold in ordinary settings, such as leaning on a gate while the milk-tanker collects the milk, while getting the cows in, walking along the beach, or waiting to 'pick the kids up' from the bus stop. In these contexts, support is often offered through presence rather than procedure, and it carries cultural credibility precisely because it is local and familiar. This may reflect the enduring ethos of 'Number-8-Wire' resourcefulness and the 'we look after our own' mentality that frequently underpins rural self-reliance in Aotearoa (e.g., Judd et al., 2006; Kaukiainen & Kõlves, 2020; Pal et al., 2025; Wright, 2022). Within these social worlds, turning outward to formal services can feel unnecessary, or even alien. By receiving affirming support through trusted, everyday relationships, rural caregivers may fulfil the same underlying psychological need for validation and belonging that non-rural caregivers meet through more formal pathways (Cavarra et al., 2025; Nakhid et al., 2025). In this light, even though average levels of reported access did not differ across contexts, potential differences in the mechanisms underpinning resource access remain important to understand and explicate.

The influence of accessing affirming resources differed by rural status. In rural contexts, accessing affirming resources was associated with fewer negative caregiver responses, whereas no such association was found in non-rural areas. This finding suggests that the value of accessing affirming resources may not lie in its frequency or availability but in the way it resonates contextually (Ashford, 2007; Gluckman et al., 2021). In rural contexts, where social lives are often close-knit, and family systems operate as more self-contained emotional ecosystems, even modest access to affirming resources can travel further within the relational field. Suggested here is that each instance of accessing affirming resources stands out more distinctly against the backdrop of rural reserve (Kemmerer et al., 2025),

gaining symbolic weight through contrast. For caregivers experiencing shame, grief, or uncertainty about the young person's rainbow identity, such encounters can be quietly transformative (McAweeney & Farr, 2024; Medina-Maldonado et al., 2025). Within these smaller rural ecologies, accessing affirming resources may help validate caregivers' emotions, highlighting that is 'okay to feel unsure' (Dakin et al., 2020). Rather than directly fostering new positive responses, this process may instead decrease negative responses by reducing the mental distress that can accompany the alienating feelings of shame and grief which underlie negative caregiver responses (Masten, 2021; Meanley et al., 2021; van Bergen et al., 2021). In this way, moving from a sense of alienation toward one of belonging may ease the distress based protective vigilance that often facilitates negative caregiver responses (Baiocco et al., 2015; McAweeney & Farr, 2024). When caregivers feel reconnected to community, to other caregivers with similar experiences, or simply to a sense that their experience is valid, negative responses may be softened (L'Heureux et al., 2022). In rural contexts, where broader affirming structural supports may be less visible, accessing these resources may be especially potent (Elliott et al., 2022; Fine et al., 2025; Jonas et al., 2024; Warren et al., 2015). Here, what is diffused in larger systems becomes more focused and resonant in smaller ones, thereby allowing affirming resources to reconnect caregivers with a sense of belonging and validity.

Te ao Māori perspectives can also help explain why the association between accessing resources and fewer negative caregiver responses was only significant in rural contexts. Māori make up a larger proportion of rural populations in Aotearoa (Statistics New Zealand, 2021), with te ao Māori frameworks of wellbeing emphasising whakapapa[4] as the living web that connects whānau, wairua, and whenua[5], together serving as a foundation of balance and harmony from which wellbeing arises (Mead, 2003; Valentine et al., 2017). From this perspective, wellbeing arises from the 'right relationship' between people and

[4] *Whakapapa* refers to genealogy or lineage. The intergenerational connections that link people to their ancestors, to each other, and to place.
[5] *Whenua* refers to land, and placenta. Reflects deep connection between people and land as source, sustenance, and identity.

place, with distress reflecting a disruption in the mauri[6] connecting these dimensions of life (Mark et al., 2022; Rolleston et al., 2022). When viewed through this lens, accessing affirming resources can be seen as a means of restoring mauri and strengthening mana[7], reconnecting caregivers to supportive relational networks that can reaffirm belonging to whānau and whenua (Mark et al., 2022; Reweti et al., 2023). In minority stress terms, such resource engagement may buffer distal pressures by re-embedding caregivers in collective meaning systems rather than isolating them within rupturing stress responses. In rural environments, where social and spiritual life may be especially intertwined with land and community, these restorative effects may settle more deeply and ripple further through the interconnected dimensions of wellbeing.

Thus, te ao Māori perspectives can help clarify why accessing affirming resources was associated with fewer negative caregiver responses in rural contexts only, even though average levels of wellbeing, affiliate stigma, and resource access are comparable across contexts. Here, the effects of resource access are amplified in rural contexts through relational and place-based reciprocity, rather than individual change alone (Angeli-Gordon, 2024; Reweti, 2023). In this way, Indigenous, eco-psychological, and transpersonal models converge with each describing wellbeing as a restoration of connection and flow across the nested systems of family, community, environment, and history. Rural contexts, by virtue of their heightened relational interdependence and enduring links to whenua, may therefore act as magnifiers of these restorative processes (Mead, 2003; Reweti et al., 2023). In confluence, these perspectives suggest that what begins as a moment of reconnection and restoration, such as a conversation, a gesture, or accessing an affirming resource, can initiate deeper shifts in how caregivers see themselves, their young people, and their place within their contexts. In essence, the same relational and spiritual currents that restore mauri and balance in te ao Māori, and that sustain ecological and transpersonal harmony, can also

[6] *Mauri* refers to the life force or vital essence that sustains wellbeing and balance.
[7] *Mana* refers to the authority, dignity, and spiritual strength derived from connection to others, to land, and to one's lineage.

be understood as catalysts of inner transformation. At the same time, these relational and restorative processes unfold within sociocultural milieus that can constrain or support caregivers, making it important to consider how structural pressures such as affiliate stigma interact with these processes.

Together, these contextual dynamics point back to the broader role of affiliate stigma as a structural pressure that may influence caregivers' wellbeing and responses. From this perspective, a picture emerges in which affiliate stigma may act as a distal stressor that can filter down from the structural context caregivers are embedded in to infiltrate the family system where they shape caregiver and youth wellbeing and caregiver responses (Clark et al., 2024; Corrigan & Miller, 2004; Favina et al., 2025; Moss-Racusin et al., 2024; Rusu et al., 2024). This interpretation aligns with minority stress and family systems theories (Li & Zhou, 2025; Meyer, 2003; Paley & Hajal, 2022), which propose that distal societal stigma can become internalised, constraining caregiver wellbeing and narrowing their window of tolerance and ability to connect, attune, and respond positively to their rainbow young person. Consequently, rainbow youth may feel subtly rejected, reproducing stress within the family system and within the rainbow young people themselves (Meanley et al., 2021; Ryan et al., 2009). Within this framework, accessing affirming resources may function as a distal form of social anchoring, providing caregivers with a tangible reminder that affirmation exists within the wider world (Snapp et al., 2015). In rural contexts, where social visibility is high and family systems are closely intertwined (Kemmerer et al., 2025; Wike et al., 2022), this anchoring may carry greater symbolic weight, offering a sense of inclusion and confidence that reinforces caregivers' capacity to regulate before responding, reducing their negative responses to their rainbow young people. Ecologically, these distal and proximal processes coexist within nested systems, such as family, community, and culture, each capable of transmitting or transforming minority stress (Bronfenbrenner & Morris, 2006). Viewed in this way, the context-specific effect of resource access in rural contexts can be understood as evidence that even small shifts at the individual and community levels can reverberate

through these smaller, denser social systems, cascading from structure, to relationship, and finally, to wellbeing.

In a broader sense, this study's resource access and affiliate stigma findings help illustrate a psychological ecosystem in which structural, relational, and environmental factors are interwoven rather than independent. Here, structural stigma creates pressure that can be filtered into family life through affiliate stigma, while in rural contexts accessing affirming resources may validate caregivers, fostering a sense of belonging that reduces their negative responses. When caregivers can engage with these resources and begin to reinterpret stigmatising social scripts, small but durable shifts can occur in how they respond to their rainbow young person. Transpersonal, eco-psychological, and Indigenous perspectives help to explain why these shifts might hold more firmly in rural contexts, where a slow pace of life, routine contact with the natural environment, and close community ties can provide a setting that supports reflection and growth.

Strengths

While this study is not without its limitations, four key strengths enhance confidence in its findings and its contribution to the field.

First, this study advances the novel conceptualisation of rurality as an intensifier rather than a deficit. By reframing rural environments as amplifiers of resilience, this study challenges the non-rural centric bias that often pathologizes rural places (Nixon, 2024). This conceptual strength lies in recognising that the characteristics of rural environments, such as slower pace of life, connection to nature, and refuge from non-rural stressors, can magnify the benefits of supportive and affirming caregiving on rainbow youth. Rather than assuming that rurality is uniformly harmful to caregivers and their youth, this framing highlights the complexity and transformational potential of rural environments. This perspective resists the 'geographical narcissism' of non-rural epistemologies and contributes a distinctly Aotearoa-based understanding of rural rainbow wellbeing.

Second, this study used a holistic and culturally embedded conceptualisation of wellbeing. Whereas much psychological research defines wellbeing narrowly as the absence

of illness or distress (e.g., Christopher & Hickinbottom, 2008; Kirmayer et al., 2011; Lomas et al., 2021), this study adopted a holistic lens encompassing emotional, social, spiritual, and physical dimensions of wellbeing. This approach aligns with ecological and Indigenous models of health in Aotearoa, which emphasise balance, connection, relational interdependence, and spirituality, such as *Te Whare Tapa Wha* (Durie, 1985) and *Te Weke (Pere, 1997)*. By operationalising wellbeing in this way, this study contributes to a growing body of research that resists reductionist or illness-focused framing of psychological health, positioning wellbeing as a relational and contextually situated phenomenon. This pluralistic framing also directly aligns with this study's aim to explore wellbeing within rural contexts, where social, environmental, and cultural contexts are inseparable from family (Judd et al., 2006; Kemmerer et al., 2025; Wilson et al., 2015). In doing so, this study models how wellbeing can be understood not as an abstract psychological state but as a lived, situated process that reflects the dynamic interaction between people and their contexts.

Third, recruiting caregivers through an anonymous online survey enabled participation from individuals who might otherwise be unwilling or unable to engage, such as those for whom participation could risk unwanted visibility or social repercussions (Meyer & Wilson, 2009). Previous research describes rural rainbow families as 'doubly hidden' from the evidence base, as their experiences are often obscured both by the geographic isolation of rural life and by fears of being 'outed' within close-knit rural communities where privacy is often limited and reputational stakes are high (Warren et al., 2015). For rural caregivers, in particular, anonymity can reduce anxiety around social scrutiny, social backlash, or inadvertently exposing their young person's rainbow identity, thereby creating a safe pathway to share their perspectives (Meyer & Wilson, 2009; Potter & Potter, 2020). In this way, the methodological decision to recruit anonymously online directly supported the study's rural rainbow focus by reducing barriers to participation for those whose perspectives are frequently absent from research in this area.

Finally, this study's focus on caregivers represents a timely contribution to the literature, as research and policy are increasingly recognising families as key sites for

reducing minority stress and improving outcomes for rainbow youth (Li & Zhou, 2025; Stettler & Katz, 2017). While existing research has primarily focused on rainbow youth themselves, this study positions caregivers as active agents of change rather than as background figures. By foregrounding caregiver wellbeing and responses, this study highlights a leverage point that has profound implications for intervention and policy. Caregivers often hold greater influence over the relational climates in which rainbow youth develop, meaning that their wellbeing and attitudes can shape outcomes far beyond what youth can independently control. Caregivers are also important in and of themselves, as their wellbeing forms part of the overall health of the family system, influencing patterns of communication, emotional regulation, and attachment that extend across generations (Bridgett et al., 2015; Leerkes et al., 2020; Shaw & Starr, 2019). Supporting caregivers therefore not only contributes to youth outcomes but to intergenerational resilience and the ongoing transmission of adaptive relational knowledge within families and communities (Fitzgerald et al., 2020; Masten, 2021). In this way, the study expands the scope of minority stress research from individual centred frameworks to include whole family systems (Li & Zhou, 2025), highlighting caregivers as both central to the ecology of stress and the ecology of support.

Limitations

Although this study provides new insights into understanding rainbow families in Aotearoa, six key limitations should be considered when interpreting its findings.

First, the study's statistical power was constrained by the small number of participants, especially rural participants (n = 20). Although the proportion of rural caregivers in this study's sample (13.2%) broadly maps onto the estimates of the general rural population distribution in Aotearoa (Environmental Health Intelligence New Zealand, 2018), the small sample size limited the precision of between-group comparisons and required testing predictions with separate regression models rather than with one structural equation model that could assess for unique associations among all study variables simultaneously. Although bootstrapping procedures were used to improve the robustness of the estimates,

the reduced rural subgroup size increased the likelihood of Type II errors, meaning that some meaningful differences might not have reached statistical significance. Similar challenges have been noted in other rural health studies in Aotearoa, where small, dispersed populations can make it difficult to obtain large representative samples (Ranta et al., 2021; Teale, 2023). As a result, findings, particularly with regard to between-group comparisons, should be interpreted with caution, as they may reflect insufficient statistical power rather than true equivalence across groups.

Second, rurality was operationalised through self-reported rural delivery postcodes, a practical method consistent with large-scale population research (e.g., Ross et al., 2017; The University of Melbourne, 2025). However, this binary measure cannot fully capture the complexity of rural life. Rural Aotearoa encompasses a spectrum of communities from remote farming regions and forestry towns to coastal and lifestyle-based areas, each with distinct social and cultural norms. In these ways, using postcodes to differentiate rural and non-rural participants risked flattening these diverse realities into a reductive binary. Contemporary health and wellbeing research in Aotearoa increasingly recognises that rurality is best understood as a dimensional construct rather than as a rural-urban binary (Payne, 2024; Whitehead et al., 2022). Framing rurality as a multidimensional geographical and social construct would more accurately capture variations in accessibility, infrastructure, and community context, positioning place as dynamic and relational rather than fixed or categorical.

Third, as highlighted previously, the study's voluntary participation likely introduced a self-selection bias, which is common in rainbow-oriented research (Meyer & Wilson, 2009; Potter & Potter, 2020). Studies involving rainbow families often attract participants who are already affirming, reflective, and connected to supportive networks, thereby producing samples that may overrepresent positive family dynamics (e.g., Fish & Russell, 2018; Meyer & Wilson, 2009; Potter & Potter, 2020; Warren et al., 2015). In this way, less-affirming caregivers, particularly those in rural areas who face stigma, visibility concerns, or limited digital access, are likely to be underrepresented. Part of this issue also stems from this

study's assumption that caregivers were aware of their young person's rainbow status. Caregivers who hold strongly negative views may be absent from the sample simply because their young person has not disclosed their rainbow identity to them, effectively making their participation impossible. As a result, these self-selection biases likely created an overly optimistic picture of caregiver-youth dynamics, obscuring hidden demand and unmet needs among caregivers (and their young people) who are isolated or less comfortable engaging with rainbow affirming spaces (Power et al., 2010). These dynamics underscore a core challenge of conducting rainbow-oriented research that authentically captures the full spectrum of caregiver and youth perspectives, especially of those most in need of support.

Fourth, relying on caregiver self-reports for both caregiver *and* youth wellbeing introduces shared method variance. Caregivers who perceive their relationship with their rainbow youth positively may overinflate their reports of youth wellbeing, whereas those under stress may underreport both their and their youth's wellbeing. In this study, caregivers completed the Hua Oranga (Kingi, 2002), which assesses wellbeing across mental, physical, social, and spiritual domains. While some of these observations include more subjective perceptions (e.g., mental and spiritual wellbeing), others reflect more observable aspects of functioning (e.g., physical and social wellbeing). As a result, caregivers may infer parts of their young persons' wellbeing from outward behaviour, introducing a potential bias in youth ratings. Research comparing caregiver and youth reports often finds such discrepancies, particularly when youth wellbeing is assessed only through caregiver perceptions (De Los Reyes et al., 2015; Makol et al., 2021; Ringoot et al., 2015). As such, incorporating youth perspectives into future studies would offer a more balanced account of family dynamics.

Fifth, although the validated measures used in this study were adapted to reflect terminology used in Aotearoa, they may not have fully captured the cultural and relational nuances of caregiving in this country. In Aotearoa, concepts such as affiliate stigma and caregiver responses are likely shaped by cultural epistemologies that include Māori and Pacific understandings of family, gender, and sexuality (Lapsley et al., 2020; Ran et al.,

2021). Although consultations with cultural advisors informed measurement decisions, future measure development should explicitly embed local ontologies and language of care to ensure cultural fit and relevance.

Finally, the cross-sectional design of this study limits the ability to infer causal or temporal relationships among the phenomena of interest. Consistent with theoretical and developmental models of family systems (e.g., Bornstein & Bradley, 2014; Bouris et al., 2010; Clark et al., 2022; Feinstein et al., 2014; Mills-Koonce et al., 2018; Seager van Dyk et al., 2024; Smetana & Rote, 2019), this study's predictions and interpretive framing assumed that caregiver responses and wellbeing influence youth wellbeing. This study also considered how this relationship may operate in reverse, with youth wellbeing influencing caregiver wellbeing (e.g., Lengua et al., 2025; Narvaez et al., 2021). However, it is likely that this relationship is also influenced by third variables that shape *both* caregiver and youth wellbeing. For instance, socioeconomic deprivation could independently affect caregiver wellbeing, responses, and youth outcomes (Katsantonis & McLellan, 2023; Robinson et al., 2017). The amount of time since a young person disclosed their rainbow identity to their caregiver could also independently shape caregiver and youth wellbeing, as families further in the adjustment process may report higher wellbeing and more positive caregiver responses than those at the beginning of the process (Narvaez et al., 2021; Ryan et al., 2009; Ryan et al., 2010). Unfortunately, the cross-sectional nature of this study meant that it was not possible to disentangle the potential mechanisms that create caregiver and youth wellbeing.

Collectively, these limitations illuminate the deeper question of how research can meaningfully represent the experiences of caregivers of rainbow youth, particularly in rural contexts. Recruiting participants from diverse geographic contexts, measuring relational processes, and capturing the subtleties of identity and place are complex undertakings shaped by visibility, access, and the willingness to be seen. These challenges are not unique to this study but reflect broader methodological challenges facing rainbow-oriented research, such as, how can the voices of caregivers who are less affirming, or unaware of their young

person's rainbow identity, be meaningfully represented when they are least likely to participate in research of this nature (for further discussion, see Biancotto et al., 2023; Blair, 2024; Reczek & Bosley-Smith, 2021). At this point in time, the solution to these issues remains unclear. Importantly though, such uncertainty serves as a reminder that researching families navigating sexual and gender diversity is complex and evolving work which requires creativity, reflexivity, and collaboration with the very communities it seeks to understand.

Implications

Building on the observed associations between caregiver wellbeing, caregiver responses, and youth outcomes, the current findings invite a shift beyond urban-centric, deficit-based framings of rural environments. Rather than presuming rural environments inherently harm rainbow youth or constrain their caregivers, this study points to context-dependent patterns in which features of rural life interact with family systems to shape resilience. Across Aotearoa and internationally, rurality is not a single construct, but a constellation of communities, each with unique histories, social scripts, and understandings of gender and sexuality. Recognising this diversity invites conceptual models that privilege rural people's knowledge and move beyond assumptions derived from non-rural knowings and worldviews.

These findings also carry system-level implications. If rural wellbeing is shaped by place-based meanings and relationships, then approaches grounded in rural knowledges would be expected to influence broader rural cultures of gender and wellbeing, not just rainbow-specific outcomes. Normative sociocultural milieus of rural life, particularly those shaped by agricultural values of masculinity, can constrain everyone, not just rainbow people (Campbell & Bell, 2000; Robinson, 2020). Cultivating community-led conversations about care, belonging, and emotional expression, may loosen these constraints and generate more expansive ways of being. In this sense, situated rural interventions are not merely remedial but also *generative*, with the potential to shift rural life toward greater authenticity, connection, and collective wellbeing. By reframing rurality as an amplifier of relational

strengths rather than an inherent risk to rainbow wellbeing, this study extends minority stress and family systems frameworks to incorporate place-based conceptions of wellbeing.

Ultimately, findings suggest that improving outcomes for rural rainbow youth and their families may depend more on leveraging the strengths of rural environments than on addressing assumed rural deficits.

Applications

Findings suggest that caregiver wellbeing may be a core correlate of youth wellbeing, underscoring its potential as a primary lever for fostering supportive and affirming family environments. As such, interventions that specifically target caregiver wellbeing have the potential for cascading benefits, as improving caregivers' wellbeing may enable them to respond to their youth with more positive responses and fewer negative responses. In turn, these responses may be especially impactful for rural rainbow youth. In other words, supporting caregivers is not an optional adjunct to rainbow youth wellbeing, but a potentially central mechanism for enhancing both caregiver *and* youth wellbeing. Policymakers and service providers must ensure that support for rainbow youth does not stop at the young person but instead extends to the wider social and geographical contexts in which rainbow youth and their families are embedded.

In rural areas, where geographic isolation can compound stress, resource design and access must be situated, flexible, and informed by local epistemologies. Existing frameworks, such as *Access and Choice, Hauora Taiwhenua,* and *Te Whatu Ora's Rural Strategy* (Hauora Taiwhenua: Rural Health Network, 2024; New Zealand Government, 2023; Te Whatu Ora, 2023) offer structural footholds for embedding rainbow-affirming caregiver support into everyday practice in rural communities. To achieve this, rainbow-inclusive care must be understood as a routine part of rural wellbeing rather than as a non-rural concern. Existing rural structures such as local marae, Men's Sheds, and rural supply stores could serve as natural wellbeing hubs for rainbow caregivers if equipped with the right tools that work best for their unique local contexts.

Existing examples from Aotearoa illustrate how such visibility and affirmation can be cultivated in ways that feel both familiar and locally embedded. Rainbow Youth's *I Am Local* initiative (Rainbow Youth, 2025), which distributes affirming resources to rural schools, libraries, and medical centres, challenges the narrative that rainbow identities are an 'urban thing' by embedding messages of belonging and acceptance directly into rural communities. Similarly, InsideOUT's school resources (InsideOUT, 2025) and the Mental Health Foundation's *More than Alright* and *Manly As* (Mental Health Foundation, 2025a, 2025b) campaigns reframe gender and sexual identity through rural-accessible imagery and local storytelling. Such resources offer rural caregivers alternative narratives to those embedded in agricultural-based gender mythologies (Campbell & Bell, 2000). They may also enable caregivers to move from shame and secrecy to visibility and pride and from rigid gender binaries to multiple legitimate ways of being. In these ways, small interventions can provide powerful signals of safety and belonging to caregivers of rainbow youth and to rainbow youth themselves. Collectively, these initiatives demonstrate that resources for rural caregiver can be both subtle and transformative, shifting narrative from 'we handle our own' to 'we *care* for our own'.

Future Research Directions

Future research should work toward more inclusive and multidimensional conceptions of rurality that capture gradients of remoteness, socioeconomic conditions, and cultural settings, reflecting not only geography, but also sociocultural and historical diversity. This could include multidimensional measures of rural and place-based identities, as well as integrating situated, community-defined understandings of what it means to be 'rural' in Aotearoa. Studies adopting this approach will be better equipped to determine how hidden forms of rural life produce distinct strengths, challenges, and meanings of wellbeing for rainbow families. Integrating the perspectives of young people themselves is also crucial, as their experiences of affirmation, belonging, and identity development may differ markedly from those of their caregivers (e.g., De Los Reyes et al., 2015; Makol et al., 2021; Ringoot et al., 2015).

To better capture the complexity of family dynamics and the temporality of associations, longitudinal and multi-informant research designs are needed. Longitudinal studies can help clarify how caregiver wellbeing and responses develop over time as caregivers navigate their young persons' rainbow identity, while multi-informant approaches can illuminate where caregivers' and youths' perceptions align and diverge. Together, these designs would allow future research to move beyond cross-sectional snapshots toward a deeper understanding of change, reciprocity, and resilience within rainbow family systems.

Complementing this, mixed-method (Goodman, 2023) and participatory approaches may further enrich understandings by placing situated rural knowledges, meanings, and realities at the centre stage. Participatory action research (Medina-Maldonado et al., 2025), narrative enquiry (Sonn et al., 2016), and visual methods (Hodgetts et al., 2010) may be particularly effective in capturing local forms of meaning-making and co-producing knowledge *with* rural caregivers rather than about them. Recruitment approaches should also extend beyond established rainbow networks to include general community channels such as local radio stations, rural supply stores, and sports centres to ensure broader representativeness. This shift from externally defined, deficit-based perspectives of rurality to strengths-based, co-constructed, and contextually grounded understandings of rural life reflects an important reorientation in inquiry from 'what is missing' in rural contexts to 'what is already working and how can we leverage this?'

Instead of retrofitting non-rural interventions, future research should develop, and rigorously evaluate, rural-led interventions that support caregiver wellbeing, recognising its central role in shaping both caregiver responses and youth wellbeing. Programs designed to enhance caregivers' confidence, connection, and acceptance of rainbow identities may have cascading effects across their family systems, especially in rural contexts where social networks are close-knit and visibility high. Grounding these programmes in rural epistemologies situated in place-based identities can help resist the geographical narcissism of non-rural knowledge, offering a more nuanced framework for understanding how rainbow identities are lived and supported outside urban strongholds. Designing interventions for

these communities should begin by asking what matters to rural families, what support looks like in these communities, and how wellbeing is already being nurtured. Effective models must therefore be co-created and led by rural caregivers, particularly those already engaged in rainbow allyship and embedded within their rural communities. Identifying and equipping these caregivers as local touchstones of affirming care can help interventions grow organically from *within* rural cultures. Rural radio, agricultural shows, and local papers can serve as culturally congruent mediums for dissemination, amplifying affirming narratives through familiar channels.

Conclusion

This thesis frames rurality not as a deficit, but as an amplifier that can intensify resilience in the lives of rainbow young people and their families. Across rural and non-rural contexts, caregiver wellbeing was positively associated with youth wellbeing, with this association notably stronger among rural caregivers. In rural contexts only, higher caregiver wellbeing was linked to more positive caregiver responses. Positive caregiver responses, in turn, were associated with higher youth wellbeing only in rural contexts, suggesting that the unique strengths of rural life may magnify the influence of caregiver wellbeing and positive responses on rainbow youth. These findings highlight that, while rainbow families across Aotearoa have many similarities, the relational dynamics of care and connection may take on a greater intensity in rural contexts.

Affiliate stigma was associated with lower caregiver wellbeing, lower youth wellbeing, more negative caregiver responses, and fewer positive caregiver responses. In turn, accessing affirming resources was associated with fewer negative caregiver responses in rural contexts only. Here, stigma and resource access can be seen as opposing levers within the family system, one transmitting constraint and silence and the other transmitting new languages of safety, belonging, and validity. Together, these results indicate that caregiver wellbeing, caregiver responses, and contextual moderators, such as affiliate stigma and resource access, work in concert to shape rainbow youth outcomes. The interaction between rurality and these processes reflects how rural settings contain both strengths as well as

challenges, revealing the power that place can have in shaping family dynamics. Collectively, these findings contribute novel quantitative evidence linking caregiver wellbeing and responses to youth outcomes across rural and non-rural contexts in Aotearoa, clarifying where caregiver-youth dynamics can be most consequential, and why targeting caregiver wellbeing is a credible leverage point for improving outcomes for rainbow youth.

These insights have clear implications for future research, practice, and policy. Supporting rainbow youth requires supporting their caregivers, particularly in rural settings where affirming supports can be scarce and visibility heightened. When caregivers are affirmed and resourced, they can become a powerful source of safety, support, and resilience in young people's lives. Efforts to reduce stigma and increase access to affirming resources must, therefore, be embedded within rural systems and created *from* rural systems. By meeting rural families where they are and valuing their own ways of knowing, interventions can take root and create meaningful and enduring changes.

The theoretical contributions of this thesis also provide important directions for future research. Rather than relying on simplified rural and non-rural binaries, future studies should capture the full spectrum of rural experiences, including variations in remoteness, community structure, culture and history. Mixed-method, participatory, and co-led approaches are particularly well suited to this task, as they allow researchers to *collaborate* directly with caregivers of rainbow youth to uncover how place shapes wellbeing, belonging, and identity. Such approaches will not only deepen the understanding of these important issues, but also ensure that the knowledge generated is grounded, relational, and useful for the communities it seeks to serve.

If rurality amplifies what already exists, then the potential for positive change is immense. When caregivers are supported to challenge stigma and access new narratives of acceptance and affirmation, the potential for transformation extends beyond the family to the wider community. These shifts can loosen restrictive social norms, expand possibilities for connection, and create environments where difference can be lived with pride rather than

fear. This is not merely about reducing harm but about *cultivating possibility*, about rural families becoming co-creators of affirming cultures where everyone can flourish.

By recognising caregivers as essential, rurality as complex, and advocacy as central, this thesis calls for a world where all rainbow young people can grow up safe, supported, and celebrated, and where the love of their families is amplified by communities and systems that affirm and embrace who they are.

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Appendix A

Original Research Questions and Predictions

Research Question 1: How does the wellbeing of caregivers and youth compare in rural vs non-rural contexts?

P1a: Rural caregivers will report lower overall wellbeing than non-rural caregivers.

P1b: Rural youth will be reported to have lower overall wellbeing than non-rural youth.

P1c: Lower caregiver wellbeing will be positively associated with lower youth wellbeing and this effect will be stronger in rural contexts.

Research Question 2: How do caregiver responses to their children compare in rural vs non-rural contexts?

P2a: Rural caregivers will report more negative caregiver responses to their rainbow youth compared to non-rural caregivers.

P2b: Non-rural caregivers will report more positive caregiver responses to their rainbow youth compared to rural caregivers.

P2c: Lower caregiver wellbeing will be positively associated with negative caregiver responses, and this effect will be stronger in rural contexts.

P2d: Higher parent wellbeing will be positively associated positive caregiver responses.

P2e: Higher levels of negative caregiver responses will predict lower youth wellbeing and this effect will be stronger in rural contexts.

P2f: Higher levels of positive caregiver responses will predict higher youth wellbeing and this effect will be stronger in non-rural contexts.

Note. P2d was initially phrased as a simple linear regression prediction. However, in the later stages of analyses rural status was added as a moderator via hierarchical multiple linear regression. This moderation was treated as exploratory as it was not part of the initial predictions.

Research Question 3: What changes/moderates the relationship between wellbeing and parent response?

a. Affiliate stigma b. Access to resources/supports

P3a: Rural caregivers will report higher levels of affiliate stigma than non-rural caregivers.

P3b: A higher proportion of rural caregivers will report not accessing resources compared to non-rural .

P3c: Of caregivers that access rainbow affirming resources, rural caregivers will access a smaller range of resources than non-rural caregivers.

P3d: Higher levels of caregiver affiliate stigma will be negatively associated with caregiver wellbeing and this effect will be stronger in rural contexts.

P3e: Higher levels of caregiver affiliate stigma will be negatively associated with youth wellbeing and this effect will be stronger in rural contexts.

P3f: Caregivers who access rainbows affirming resources will report a higher level of parent wellbeing than caregivers who do not access those resources.

P3g: Caregivers who access rainbows affirming resources will report a higher level of child wellbeing than caregivers who do not access those resources.

P3h: Higher levels of affiliate stigma will predict more negative caregiver responses and this effect will be stronger in rural contexts.

P3i: Not accessing resources will predict more negative caregiver responses to their youth and this effect will be stronger in rural contexts'.

P3j: Exploratory. Of the caregivers who don't access resources a higher proportion of rural caregivers will report interest in access affirming resources than non-rural.

Appendix B

Information Sheet for Participants

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

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 and your child's or children's general wellbeing 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 C

Eligibility Screener

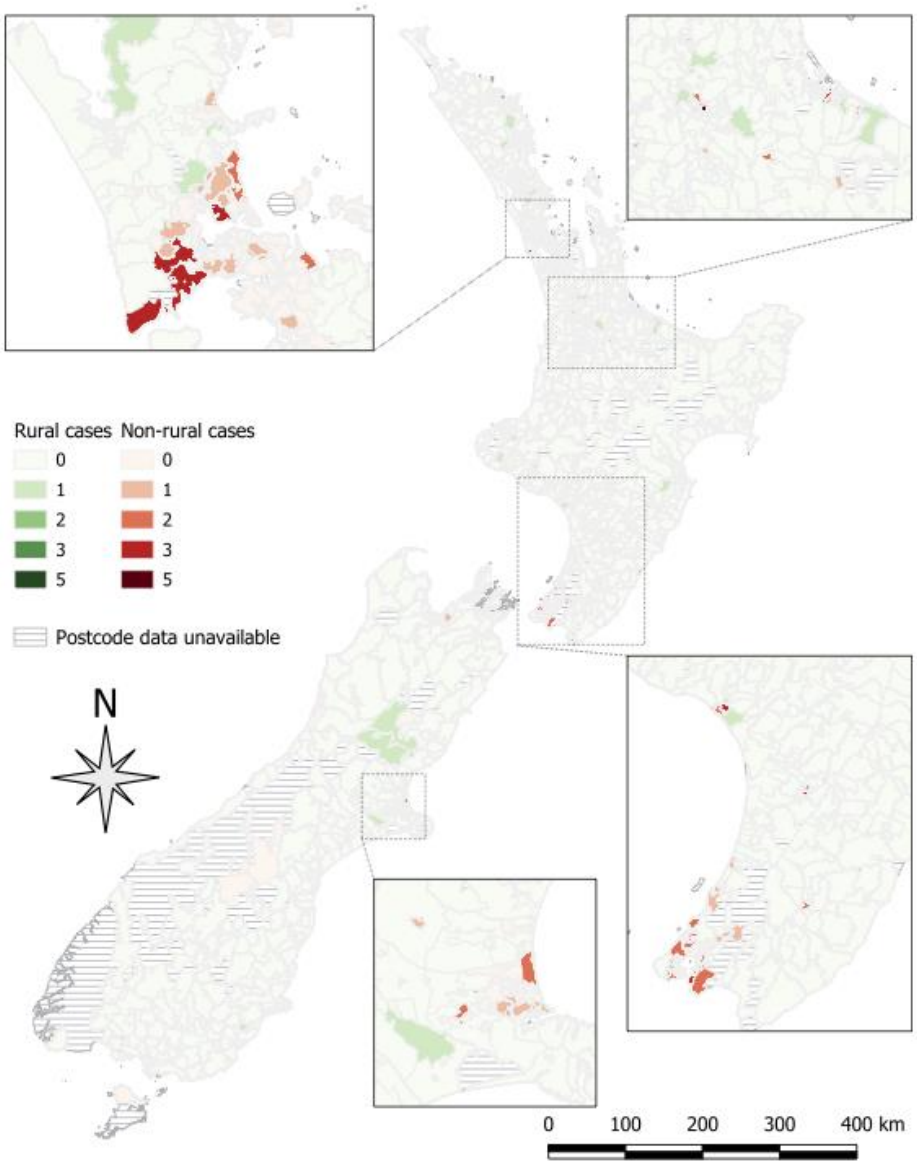
Eligibility Screen

1) What is your current age (in years)?
2) Do you live in Aotearoa New Zealand?
    a) Yes
    b) No
3) Are you fluent in English?
    a) Yes
    b) No
4) 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?)
    a) Yes
    b) No

Eligibility Note. Participants were discontinued from the survey if any of the following applied: under 18 years of age, not living in Aotearoa New Zealand, not fluent in English, or not a primary caregiver of a Rainbow/LGBTQIA+ child under the age of 30.

Appendix D

Visual Representation of Geographic Distribution of Participants by Rural Status



Note. Postcode shapefile adapted from Giffney, S. (2025). "*Open NZ postcodes*." https://github.com/s01ipsist/open_nz_postcodes?tab=readme-ov-file#readme. New Zealand outline modified from Statistics New Zealand (2025). "*Urban rural 2025 clipped*." https://datafinder.stats.govt.nz/layer/120964-urban-rural-2025-clipped/.

Appendix E

Survey Items Establishing Demographic Data

What is your sexual orientation?

What is your gender?

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

   a) 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)

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

   c) Neither Rainbow/sexual “minority” or heterosexual describe me because:

   d) Unsure because:

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

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

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

   c) Neither cisgender nor transgender describe me because:

   d) Unsure because:

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

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

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

c) Neither binary nor nonbinary describe me because:

d) Unsure because:

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

e) With great difficulty

f) With difficulty

g) With some difficulty

h) Fairly easily

i) Easily

j) Very easily

4) What is your postcode? (This information is being asked so that we can determine the size of the population where you live — we won't use it for any other purpose)

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

a) New Zealand Māori

b) New Zealand European/Pākehā

c) Cook Island Māori

d) Chinese

e) Indian

f) Niuean

g) Samoan

h) Tongan

i) Another group, e.g., Dutch, Japanese, Fijian. Please specify

j) I don't know

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

a) Biological parent / whaea, matua

b) Step-parent / matakēkē

c) Adopted parent / mātua whāngai

d) Foster parent/ mātua whāngai

e) Biological grandparent / tipuna

f) Step-grandparent / tipuna whakaangi

g) Adopted grandparent / tipuna whāngai

h) Foster grandparent / tipuna whāngai

i) Biological aunt or uncle / whaea kēkē, matua kēkē

j) Step-aunt or uncle / whaea/matua kēkē whakaangi

k) Adopted aunt or uncle / whaea/matua kēkē whāngai

l) Foster aunt or uncle / whaea/matua kēkē whāngai

m) Close family friend

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

What level of education have you achieved/completed?

a) Some high school

b) High school

c) Some tertiary

d) Bachelor's degree

e) Postgraduate qualification

Something else. Please specify: _____

Appendix F

Measures

Caregiver Response Measure

Scale

a) Strongly disagree

b) Disagree

c) Somewhat disagree

d) Somewhat agree

e) Agree

f) Strongly agree

Negative Responses

1. My child and I get into disagreements related to their Rainbow/LGBTQIA+ status
2. I feel sad that my child came out as Rainbow/LGBTQIA+.
3. My child coming out as Rainbow/LGBTQIA+ feels like the loss of the child I once had
4. My relationship with my child has gotten worse since my child came out as Rainbow/LGBTQIA+.
5. I feel shame for my child being Rainbow/LGBTQIA+

Positive Responses

1. I feel accepting towards my Rainbow/LGBTQIA+ child
2. I plan to ensure my child has social support to cope with some of the challenges of being Rainbow/LGBTQIA+
3. I plan to support my child by educating myself to understand my child and the Rainbow/LGBTQIA+ community better.
4. 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).
5. My relationship with my child has improved since my child came out as Rainbow/LGBTQIA

Affiliate Stigma

Scale:

a) Not applicable

b) Strongly disagree

c) Disagree

d) Somewhat disagree

e) Somewhat agree

f) Agree

g) Strongly agree

1. I feel worse about myself because my child is Rainbow/LGBTQIA+.
2. Work/school colleagues may discriminate against me because I have a child who is Rainbow/LGBTQIA+.
3. I worry my child may be rejected for being Rainbow/LGBTQIA+.
4. People from my religious/spiritual community may discriminate against me because I have a child who is Rainbow/LGBTQIA+.
5. I worry about being rejected by work/school colleagues if they find out that my child is Rainbow/LGBTQIA+.
6. I feel embarrassed that I have a child who is Rainbow/LGBTQIA+.
7. I worry the stigma my Rainbow/LGBTQIA+ child faces will affect their physical health.
8. I worry about being rejected if people in my religious/spiritual community find out that my child is Rainbow/LGBTQIA+.
9. I feel shame for my child being Rainbow/LGBTQIA+.
10. I worry my child may be verbally harassed if others learn my child is Rainbow/LGBTQIA+.
11. People at work/school would look down on me if they knew my child is Rainbow/LGBTQIA+.

12. Telling work/school colleagues my child is Rainbow/LGBTQIA+ is risky.

13. It bothers me that many things in life will be harder for my child because my child is Rainbow/LGBTQIA+.

14. I worry that my child might receive negative attention for being Rainbow/LGBTQIA+.

15. Work/school colleagues' attitudes towards me may turn sour if they find out my child is Rainbow/LGBTQIA+.

16. I worry that my Rainbow/LGBTQIA+ child might experience emotional pain from being stigmatised.

17. I worry that my child might be physically harmed for being Rainbow/LGBTQIA+.

Caregiver Resources

1) Have you accessed any type of resource to support you as the primary caregiver of a Rainbow/LGBTQIA+ child?
    a) Yes
    b) No
2) Please select the types of resources you have accessed.
    a) Books
    b) Pamphlets
    c) In-person support group
    d) Online support group
    e) Websites
    f) In-person one-on-one counselling/support
    g) Online one-on-one counselling/support
    h) Friends or family who have a child that is LGBTQIA+
    i) Something else. Please specify: _____

3) Are you interested in accessing any resources to support you as the primary caregiver of a Rainbow/LGBTQIA+ child?

a) Yes

b) No

c) Maybe

Caregiver and Youth Wellbeing

Scale

a) Very bad

b) Not good

c) Just okay

d) Good

e) Very Good

Caregiver Wellbeing

1) At present, I feel that my physical health (tinana) is
2) At present, I feel that my mental health (hinengaro) is
3) At present, I feel that my social wellbeing (whānau) is
4) At present, I feel that my spiritual wellbeing (wairua) is

Youth Wellbeing

1) At present, I feel that my Rainbow child's physical health (tinana) is
2) At present, I feel that my Rainbow child's mental health (hinengaro) is
3) At present, I feel that my Rainbow child's social wellbeing (whānau) is
4) At present, I feel that my Rainbow child's spiritual wellbeing (wairua) is

Appendix G

Recruitment Materials for Organisations

Kia ora

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 wellbeing, it is crucial that research contributes to the improvement of wellbeing 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.

Follow up E-mail to Organisations

Tēnā koe,

I hope this message finds you well.

I wanted to touch base regarding the email we sent a couple of weeks ago about our research project at Massey University. We're aiming to better understand 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.

Understanding that everyone has a lot on their plate, it's entirely possible that our initial request might have slipped through the cracks. I just wanted to gently remind you about our

survey and the possibility of sharing our recruitment flyer with your contacts.

If you've already taken action on this, I truly appreciate your support. If not, and you're able to assist, it would mean a lot to our team and the broader community we're hoping to reach.

Here's the survey link for easy reference: **tinyurl.com/RaisingRainbows**

Thank you once again for considering our request amidst your busy schedule. If there's any additional information or support you need from our end, please don't hesitate to let me know.

Ngā mihi nui,

Flyers


Are you a caregiver for a Rainbow/LGBTQIA+/takatāpui person under 30?
Do you live in Aotearoa NZ?
Complete our survey and be in to win a $40 gift voucher!
Interested? Find out more at [LINK]
Questions? Email
i.seagervandyk@massey.ac.nz


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

CONTACT US - PRIDELABNZ@GMAIL.COM