

## Affirmation-support, parental conflict, and mental health outcomes of transgender and gender diverse youth

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### ABSTRACT

**Background:** Transgender and gender diverse young people (TGDY) are at higher risk of psychosocial distress relative to their cisgender counterparts. TGDY rely heavily on their parents to support their desired affirmation and to facilitate access to legal and medical affirmation. While it is well understood that parent conflict negatively impacts the well-being of children and young people, little is known about how parental conflict and parental affirmation support are related to TGDY well-being.

**Aims:** The aim of the present study was to (1) explore affirmation experiences of TGDY, as reported by their parents, focusing in particular on parental support for affirmation and barriers to affirmation, and (2) test whether parental support and aspects of the coparenting relationship predicted TGDY mental health outcomes.

**Method:** A sample of 63 parents (Mage = 45.71 years) of TGDY (aged 11 to 17 years) completed an online survey.

**Results:** Almost 90% of the TGDY reported on had socially affirmed their gender, though fewer had taken steps to legally or medically affirm their gender. Parental support for affirmation was generally very high, and reported discrepancies between coparents were generally low; however, discrepancies were greatest for medical affirmation. Finally, parent support for affirmation was a strong predictor of lower TGDY depressive symptoms, though parental conflict did not predict TGDY mental health.

**Conclusion:** Results highlight the important role of parental support for gender affirmation. Further research is needed to track the role of parental support and affirmation on TGDY well-being over time, and to ensure that such research is completed with more diverse samples.

### KEYWORDS

coparenting; gender affirmation; gender diverse; gender dysphoria; parental conflict; transgender; non-binary; youth

Transgender is an umbrella term referring to those whose gender identity differs from their sex assigned at birth (Bockting et al., 2013; Kozee et al., 2012), while cisgender refers to those with a gender identity consistent with sex assigned at birth. Increasing numbers of children and young people across the world identify as transgender, including those who identify outside of the gender binary (i.e. woman/man, girl/boy), or as gender diverse (Handler et al., 2019; Telfer et al., 2018; Tollit et al., 2023). While varied terminology is used, here we use the term transgender and gender diverse youth (TGDY). It is currently estimated that around 2 to 3% of young people in Australia and around the world identify as transgender or gender diverse (Strauss et al., 2021) though there are difficulties in quantifying this due to differences in definitions, changes in

terminology, and the limitations of national census data (Australian Bureau of Statistics, 2022).

There have been significant shifts in how gender diversity is viewed in society, particularly in relation to children and young people. Gender diversity is increasingly being seen as part of the natural spectrum of human diversity (Coleman et al., 2022). The rates of TGDY presenting to gender services has increased in recent years (Tollit et al., 2023; Zucker, 2019), likely due to increased societal acceptance leading to more TGDY ‘coming out’ earlier and accessing gender-affirming healthcare.

### TGDY mental health and gender affirmation

TGDY are more vulnerable to poor mental health, and present with a far higher incidence of

suicidality, self-harm, depression, and anxiety compared with their cisgender peers (Reisner et al., 2015), and these mental health disparities can appear at 10 years of age and younger (Becerra-Culqui et al., 2018). In the past, this was considered to be associated with the gender diversity itself and viewed through a pathological lens (Cohen-Kettenis & Pfäfflin, 2010). However, it is now understood that distress associated with the mismatch between one's assigned and actual gender, as well as exposure to minority stressors, such as discrimination, social exclusion, bullying, victimization, and violence, contribute to elevated rates of psychological distress (Durwood et al., 2017; Reisner et al., 2015; Telfer et al., 2018).

There is a growing recognition that TGDY require gender-affirmative care (Carlile et al., 2021; Hidalgo et al., 2013; Riggs, 2019). Affirmation for TGDY can take a number of forms depending on the age of the child, ranging from social transition for pre-pubertal children (e.g. using the correct name and pronouns, wearing attire that affirms one's gender identity), puberty blockers once children reach early puberty, and administration of gender-affirming hormones (e.g. testosterone, oestrogen) later in adolescence (Hidalgo et al., 2013; Telfer et al., 2018). Although there are established protocols in place (Telfer et al., 2018), TGDY affirmation is neither linear nor universal (Coleman et al., 2022; Temple Newhook et al., 2018) and relies on understanding the specific affirmation each TGD young person desires (Telfer et al., 2018).

Social affirmation can be achieved with the support of family, legal affirmation relies on the law, and medical affirmation relies on access to gender-affirming care, typically requiring the knowledge and consent of both parents to proceed (Ouliaris, 2022). Requirements for legal and medical gender-affirmation vary depending on the jurisdiction. In Australia, the process for accessing legal affirmation of gender as a minor (e.g. changing the gender marker listed on a birth certificate) varies according to State-based requirements (Telfer et al., 2018). The process for accessing medical affirmation has varied over time, with court approval sometimes being required depending on whether the young person, medical practitioners, and parents/legal guardians, are in agreement on

the proposed treatment (e.g. gender-affirming hormones; Ouliaris, 2022; Kelly et al., 2022).

Standards of Care (Coleman et al., 2022; Telfer et al., 2018) and researchers (Pullen Sansfaçon et al., 2023) outline how access to affirming care is an important contributor to TGDY well-being. Consistent with this proposition, in a sample of  $n=73$  TGDY who had been able to socially transition, Olson et al. (2016) found no difference in depression, and only a slight increase in anxiety, when compared to age matched controls. Similarly, Durwood et al. (2017) found that TGDY who had socially transitioned displayed mental health outcomes equivalent to their cisgender peers. The improved wellbeing of TGDY who had affirmed their gender stands in stark contrast to the body of research showing high rates of psychological distress and behavioral problems among TGDY who had not affirmed their gender.

### **Family support and affirmation**

Family support and affirmation is an important factor that contributes to TGDY well-being (Olson et al., 2016). For instance, family rejection is associated with higher suicidality, substance use and overall psychological distress (Fuller & Riggs, 2018; Klein & Golub, 2016), whereas parental acceptance and support for TGDY has been associated with improved outcomes (Grossman et al., 2021; Hidalgo et al., 2017). The perception of parents as supportive and accepting is a significant protective factor associated with healthy adolescent development among TGDY (Grossman et al., 2021). Indeed, TGD individuals whose families provide more gender-related support display less distress, whereas those reporting gender-related discrimination from family report more distress (Fuller & Riggs, 2018).

The views of parents are directly related to access to care (Ouliaris, 2022; Riggs et al., 2020) which often requires powerful and persistent advocacy from parents (Carlile et al., 2021) to confront systemic barriers to affirmation and acceptance. These barriers include restrictive laws regarding consent for affirming treatment (Ouliaris, 2022), long waiting-lists for gender affirming care in the public system (Eade et al., 2018), restricted private options for gender-

affirming care due to limited workforce capacity (Wiggins, 2022), and alarmist coverage in the media about gender-affirming care (Garcia & Badge, 2021). The impact of these barriers can be that gender-affirming care is controlled, denied or delayed (Hill et al., 2021). However, the importance of family support is such that even when affirmative care is available and accessible, disapproval and/or rejection from family remains a significant factor that prevents affirmation and undermines TGDY well-being.

### **Parent conflict and disagreement**

It is well established that interparental conflict has negative outcomes on the wellbeing of children (Stallman & Ohan, 2016; Westrupp et al., 2015) particularly when the conflict is related to child-rearing or a matter concerning the child (Sturge-Apple et al., 2012). The harmful nature of inter-parental conflict is not limited to separated or divorced families; regardless of the family type, children exposed to inter-parental conflict tend to have poorer emotional well-being than those whose parents have a non-conflictual relationship (Baxter et al., 2011).

High rates of family conflict and relationship breakdown have been identified in families with TGDY presenting to health services (Kozłowska et al., 2021). Outcomes for TGDY are worse when participants report a lack of family support (Strauss et al., 2017), and poor family functioning is associated with more internalizing symptoms among TGDY (Munroe et al., 2020). Further, many TGDY are limited in how much their gender identities are supported by their parents, and negative responses are common among both mothers and fathers, at least initially (Grossman et al., 2021), with heterosexual fathers being most likely to have difficulty supporting or affirming a transgender child (Ishii, 2018; Riggs & Due, 2015). However, little is known about the impacts of coparenting quality, conflict, and the presence of an effective and coherent coalition between parents, on TGDY well-being.

Even when a TGD young person is deemed ‘Gillick competent’ or competent to consent to medically affirming treatment (Ouliaris, 2022), they require parental consent from both parents

in Australia (Kelly et al., 2022). The majority of TGDY who access gender affirming care have at least one parent who is supportive of their gender diversity and desire to medically affirm their gender (Tollit et al., 2023). However, parents in conflict are more likely to include one parent who is less supportive or who opposes affirmation, and this leads to barriers to affirmation in the form of delay or denial of medical care (Kimberly et al., 2018; Riggs et al., 2020). Parents opposing affirmation are most commonly seen in research where the parents are separated, but opposition and conflict can also occur when families are not separated (Riggs & Due, 2015). Further, disagreements about how to support TGDY can contribute to increased conflict, including enmeshment between the supportive parent and the TGD young person, which can have negative impacts on the coparenting relationship (Aramburu Alegria, 2018).

### **The present research**

TGDY are at greater risk of poor mental health, and this appears to be exacerbated by barriers to gender affirmation, and minority stressors, including family rejection and a lack of family support. Conflict between parents about children is known to have particularly deleterious impacts on well-being, and the presence of parent conflict has been found to affect decision making for their TGDY children, often resulting in barriers to affirmative care. However, less is known about how the coparenting relationship, including conflict relating to support for TGDY affirmation, affects TGDY well-being.

In a sample of parents of TGDY, the aim of the present research was to explore rates of affirmation, support for and barriers to affirmation, and aspects of the coparenting relationship. As this component of the study was largely descriptive, specific hypotheses were not outlined.

In relation to parenting factors and TGDY mental health outcomes, we hypothesized the following:

1. Parental support for TGDY affirmation would predict greater TGDY well-being (parent-reported).

2. High coparental conflict (high coparent undermining and low coparent agreement) would predict poorer TGDY well-being (parent-reported).

## Method

### Participants

Participants were 63 parents ( $M_{age} = 45.71$  years) of TGDY aged 11–17 years old. Table 1 displays demographic characteristics of the sample. Almost

**Table 1.** Demographic characteristics of the sample.

Variable	<i>n</i> (%)
Participant gender	
Woman/trans woman	56 (88.9)
Man/trans man	3 (4.8)
Genderqueer	2 (3.2)
Non-binary	1 (1.6)
Agender	1 (1.6)
Sex assigned at birth	
Male	3 (4.8)
Female	60 (95.2)
Sexual orientation	
Straight	38 (60.3)
Gay or Lesbian	6 (9.5)
Bisexual	9 (14.3)
Pansexual	4 (6.3)
Queer	4 (6.3)
Asexual	2 (3.2)
Other	1 (1.6)
Prefer not to say	1 (1.6)
Co-parent gender	
Woman/trans woman	6 (9.5)
Man/trans man	55 (87.3)
Genderqueer	1 (1.6)
Non-binary	1 (1.6)
Ethnicity	
White/Caucasian	58 (92.1)
Asian	2 (3.2)
Pacific Islander	1 (1.6)
Multiracial	1 (1.6)
Other	2 (3.2)
Education	
Secondary/high school or lower	5 (7.9)
Non-university tertiary (e.g. TAFE)	12 (19)
University (undergraduate)	15 (23.8)
University (postgraduate)	30 (47.6)
Family structure	
Single parent living with children	15 (23.8)
2 or more parents living with children	39 (61.9)
Parent, step-parent and children	8 (12.7)
Living alone, children with other parent	1 (1.6)
Gender of TGD child	
Girl/trans girl	22 (34.9)
Boy/trans boy	19 (30.2)
Non-binary	17 (27)
Gender fluid	3 (4.8)
Genderqueer	2 (3.2)
Agender	1 (1.6)
Sex assigned at birth for TGD children	
Male	27 (42.9)
Female	36 (57.1)

Note: Some percentages may add up to over 100% for questions where participants could select multiple responses (i.e. 'select all that apply').

90% were women, and about 60% listed their sexual orientation as 'straight'. In terms of coparenting relationships, most reported being currently in a relationship with their coparent (relationship length  $M=22.08$  years,  $SD=6.5$ ), while just under 40% were separated or divorced (length of separation  $M=7.91$  years,  $SD = 4.13$  years); one participant had never been in a relationship with their coparent. Most participants lived in a major city, though about a third of the sample lived outside of major cities. More than 70% of the sample had a university qualification.

Participants had between 1 and 4 children ( $M=2.2$ ,  $SD = .87$ ), and most ( $n=56$ , 88.89%) had one TGD child. The mean age of TGDY was 14.28 years ( $SD=2.14$ ). About a third were girls, approximately 30% were boys, and the remainder were non-binary or gender diverse. Participants reported first becoming aware that their child's gender identity did not match the sex they were assigned at birth at around 10.5 years of age (TGDY  $M$  age = 10.51,  $SD=4.37$ ).

### Power analysis

Required sample size was calculated using G\*Power based on a linear regression model (in line with the key hypotheses) with an effect size of  $f^2 = .20$ , with power of .80,  $\alpha = .05$ , and 2 predictors; the required number of participants was 52.

## Materials

### Demographics

Participants responded to demographic questions including age, gender, ethnicity, location, education, relationship status and family structure.

### TGDY affirmation

Participants were asked if their TGD child had ever wanted to affirm their gender (yes vs. no) in specific ways (*Affirmation Desire*): (1) socially (i.e. change their name/pronouns or gender presentation); (2) legally (i.e. change their legal name or gender markers on identification documents); and (3) medically (i.e. puberty blockers, hormone therapy, gender-affirming surgeries). They were then asked whether their child had accessed these forms of affirmation (yes vs. no).

### Barriers to affirmation

Barriers to affirmation were measured using questions from the Writing Themselves In 4 Report (Hill et al., 2021) which assessed experiences of autonomy in the gender affirmation process. Participants were asked if their child's social, legal, and medical affirmation had been: (a) controlled (i.e. your child wanted to affirm their gender but there were barriers to doing so); (b) denied (i.e. your child wanted to affirm their gender but was prevented by someone else); (c) delayed (i.e. your child wanted to affirm their gender but had to wait longer than they wanted to); and (d) supported (i.e. your child was able to affirm their gender socially at the time and manner they wished to). Participants could select multiple response options. Participants were also asked whether their child's legal and medical affirmation had been delayed, controlled, or denied due to (a) laws (for legal affirmation only); (b) treatment access issues (for medical affirmation only); and (c) parental disagreement.

### Affirmation support

Participants responded to three items measuring their degree of support for their child's gender affirmation (social, legal, and medical). Specifically, they were asked to rate the extent to which they agreed or disagreed with the following statement: "I support my child in affirming their gender [socially; legally; or medically]". They then completed the same three items in relation to their child's other parent: "My child's other parent supports our child in affirming their gender [socially; legally; or medically]". Participants responded on a 7-point Likert scale ranging from 1 (*Strongly Disagree*) to 7 (*Strongly Agree*). There was also the option to indicate that a particular item did not apply to their child. The mean *Affirmation Support* score reflects the average level of support across the three forms of affirmation (for the participant and coparent), thus scores range from 1 to 7. As would be expected, internal consistency was high for both the participant ( $\alpha = .95$ ) and coparent ( $\alpha = .94$ ) *Affirmation Support* scores. Finally, *Support Discrepancy* was calculated by subtracting the coparent total support from the participant's total support and converting to positive values; values range from 0 to 6.

### Coparenting and conflict

The 35-item Coparenting Relationship Scale (CRS; Feinberg et al., 2012) assesses parents' relationship and conflict. Example items include "My coparent and I have the same goals for our child" and "My coparent undermines my parenting". Participants indicate the extent to which each statement is reflective of their relationship on a 7-point Likert scale ranging from 0 (*Not true of us*) to 6 (*Very true of us*). Here we used the two subscales most relevant to the aims of the current study, namely *Coparenting Agreement* and *Coparenting Undermining*, as indicators of coparent agreement and conflict. We also formed a composite variable, *Coparenting Conflict*, which comprised coparenting undermining (50%) and (reversed) coparenting agreement (50%) for the regression model. The original scale refers to 'my partner'; we modified this to 'my coparent' to ensure that the question was applicable both to those who were in intact and separated coparenting relationships. The CRS is a reliable and valid measure ( $\alpha = .91$  to  $.94$ ; Feinberg et al., 2012), and demonstrated high internal consistency in the present sample ( $\alpha = .83$  to  $.91$ ).

### TGDY well-being

Depressive symptoms were measured using the parent report version of the 13-item Short Mood and Feelings Questionnaire (SMFQ; Angold et al., 1995). Parents were asked to indicate the extent to which each statement was true of their child over the previous two weeks, with response options of 0 (*Not true*), 1 (*Sometimes*) and 2 (*True*). A total score was calculated, with higher scores indicating increased symptom severity. Items were modified to use they/them pronouns instead of the original s/he and him/her. Examples include "They felt miserable or unhappy" and "They thought nobody really loved them". The SMFQ has demonstrated high internal consistency ( $\alpha = .90$ ) (Angold et al., 1995), which was also high in the present sample ( $\alpha = .94$ ).

### Procedure

Ethics approval was obtained from the La Trobe University Human Research Ethics Committee. Australian parents of TGD children aged 11–17

who share parenting with a coparent, either in an intact or separated family, were eligible to participate. Internet based recruitment was chosen given the presence of significant and active online parent support groups. Posts were made within these private support groups with the approval of administrators, and on the public facing accounts of these groups on both Facebook and Twitter. Announcements were also forwarded to TGD community Facebook pages, Twitter accounts, and LinkedIn profiles. Participants were informed the questionnaire would take between 20–30 min. The advertisements contained a link to the questionnaire which was hosted on QuestionPro. We followed recommended guidelines to prevent and detect survey bots (e.g. including a brief open-ended response option, reviewing timestamps and response patterns, and use of identical questions at different points in the study; Xu et al., 2022).

## Results

The Software Statistical Package for Social Sciences v29 was used for all analyses. Frequencies were calculated to explore desire for social, legal, and medical affirmation (i.e. parent reports of their TGDY's affirmation desire) and actual affirmation (i.e. parent reports of their TGDY having accessed affirmation of that specific type). As shown in Table 2, more than 90% of participants indicated their child desired social affirmation, and most had proceeded with social affirmation. However, only about half of those with the desire to legally affirm their gender had done so, and just under two thirds of those with the desire to medically affirm their gender had done so.

As shown in Table 3, over 60% of participants reported their children had experienced barriers to their desired social affirmation (i.e. that it had

been either controlled, denied, or delayed), while two thirds also reported that it had been supported. Just over a quarter of participants reported that their child's desired legal affirmation had been denied, and while rates of denial of desired medical and social affirmation were lower, participants also reported these types of affirmation had been denied. As shown in Figure 1, when the barriers were broken down to explore the underlying reasons, laws were somewhat more frequently endorsed as delaying ( $n=17$ , 27%) or controlling ( $n=15$ , 23.8%) desired legal affirmation compared with parent disagreement. Similarly, issues with access to medical treatment appeared more likely to delay ( $n=25$ , 39.7%) or control ( $n=10$ , 15.9%) desired medical affirmation than parent disagreement.

Next, we examined participants' reports of their own and their coparent's support for their child's social, legal, and medical affirmation. As shown in Table 4, total affirmation support was high, as was support for the specific subtypes of affirmation. A paired-sample *t-test* was conducted to investigate the difference between participants ratings of their own support and coparents' support. There was a significant difference between ratings of own support and coparent support ( $t(53) = -4.893$ ,  $p < .001$ ), such that participants reported higher levels of their own support than they did for their coparents. Discrepancies between participants own support and ratings of coparent support spanned the full range (0–6), though discrepancies were generally low (mean discrepancy ratings ranged from 1.31 to 1.51). Discrepancies were greatest for support for medical affirmation, suggesting this is an area where disagreements between parents may occur more frequently. Figure 2 presents a visual representation of these patterns. More participants reported strongly agreeing that they are supportive of their children's desired affirmation of all forms, and their reports of coparent support were more likely to be supportive than not supportive.

**Table 2.** Frequencies for affirmation desire & action.

Affirmation type	Desire	Action
Social affirmation	58 (92.1%)	55 (94.8%) <sup>a</sup>
Legal affirmation	45 (71.4%)	25 (55.5%) <sup>a</sup>
Medical affirmation	44 (69.8%)	28 (63.6%) <sup>a</sup>
Puberty blockers		17 (27%) <sup>b</sup>
Gender-affirming hormones		19 (30.2%) <sup>b</sup>
Gender-affirming surgery		4 (6.3%) <sup>b</sup>

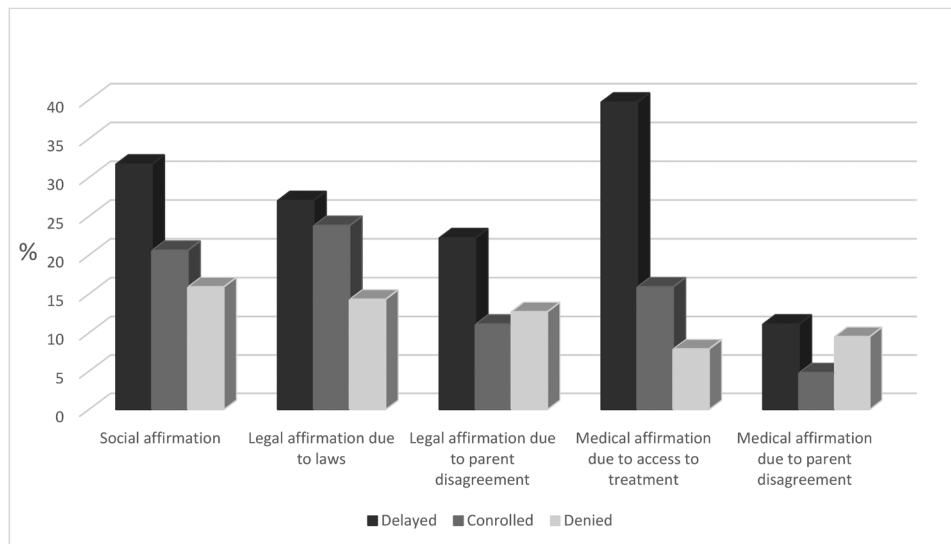
<sup>a</sup>Percentage of those who desired this form of affirmation.

<sup>b</sup>Percentage of full sample.

**Table 3.** Frequencies for support and barriers to affirmation.

Type of affirmation	Controlled	Denied	Delayed	Supported
Social affirmation	13 (20.6%)	10 (15.9%)	20 (31.7%)	42 (66.7%)
Legal affirmation	18 (28.6%)	16 (25.4%)	25 (39.7%)	24 (38.1%)
Medical affirmation	10 (15.9%)	7 (11.1%)	27 (42.9%)	21 (33.3%)

Note: Figures add to over 100% as participants could select multiple responses (i.e. 'select all that apply').



**Figure 1.** Parent-reported barriers to affirmation.

**Table 4.** Means and standard deviations for affirmation variables.

Variable	M (SD)	Observed range	Reference range
Affirmation support (participant)	6.01 (1.64)	1–7	1–7
Social	6.34 (1.57)	1–7	1–7
Legal	6.12 (1.66)	1–7	1–7
Medical	5.57 (1.93)	1–7	1–7
Affirmation support (co-parent)	4.75 (1.96)	1–7	1–7
Social	5.25 (1.97)	1–7	1–7
Legal	4.82 (2.07)	1–7	1–7
Medical	4.18 (2.21)	1–7	1–7
Support discrepancy	1.41 (1.64)	0–6	0–6
Social	1.31 (1.71)	0–6	0–6
Legal	1.40 (1.72)	0–6	0–6
Medical	1.51 (1.74)	0–6	0–6

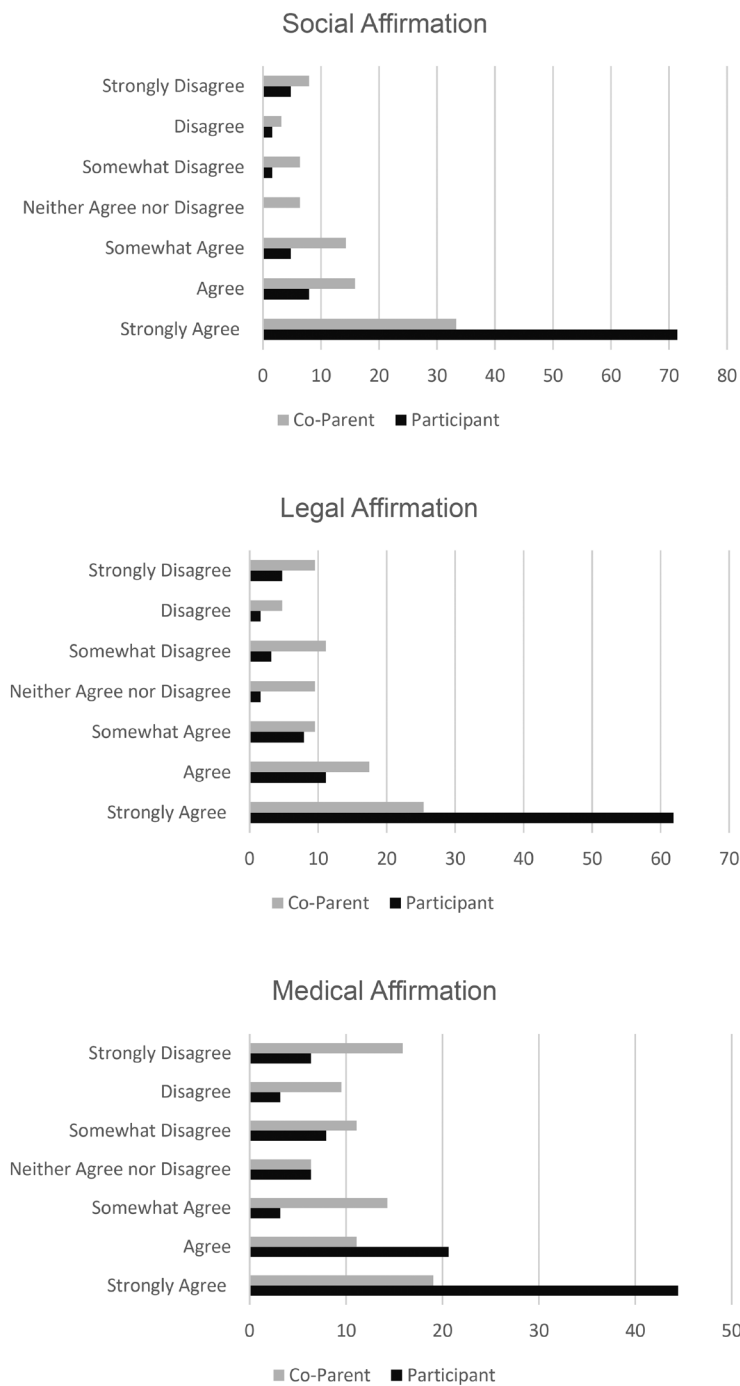
Finally, we examined associations between coparenting agreement, coparenting conflict, affirmation support and support-discrepancies between parents with TGDY mental health. As can be seen in Table 5, the coparenting conflict composite score, as well as the undermining and agreement subscales, correlated in expected directions with support discrepancy. There were no significant correlations between coparenting agreement/conflict, or support discrepancy, with TGDY mental health. Rather, the only factor that was significantly related to TGDY mental health was total affirmation support.

As coparenting undermining and agreement were highly correlated (Table 5), we used the composite score, *coparenting conflict*—comprised of coparenting agreement and undermining—in the regression analysis to deal with issues of multicollinearity. We conducted a linear regression with coparenting conflict

and total affirmation support as the predictors, and TGDY mental health as the outcome variable. The regression model was significant ( $F(2,49) = 7.23, p = .002$ ) and results converged with the correlations observed above. Specifically, affirmation support ( $\beta = -0.42, p = .002$ ) predicted fewer TGDY depressive symptoms, whereas parental conflict ( $\beta = .22, p = .088$ ) did not. The model explained 22.8% of the variance in TGDY depressive symptoms ( $R^2 = .228$ ).

## Discussion

The aims of the present research were twofold: (1) to explore affirmation experiences for TGDY, as reported by their parents, focusing in particular on parental support for affirmation and barriers to affirmation; and (2) to test whether parental support and aspects of the coparenting relationship predicted TGDY mental health outcomes. Regarding the exploratory component of the present research (Aim 1), results revealed more than 90% of participants indicated their child desired social affirmation, and almost all had proceeded with this. However, of those who desired legal and medical affirmation, only about 56% and 64%, respectively, had taken steps to affirmation in these domains. Parental support for affirmation was generally very high, and discrepancies between participants own support and ratings of coparent support were generally low. Support discrepancies were greatest for medical affirmation. In relation to Aim 2, hypotheses



Note: Values are percentages.

**Figure 2.** Participant and co-parent support for social, legal, and medical affirmation.  
Note: Values are percentages.

were partially supported. Specifically, parent support for affirmation was a strong predictor of lower TGDY depressive symptoms, though coparenting conflict did not significantly predict TGDY mental health. The model explained 22.8% of the variance in TGDY mental health.

### ***TGDY affirmation, parental support, and well-being***

Almost 95% of the TGDY who desired social affirmation had proceeded with this, but far fewer who wished to legally or medically affirm their gender had done so. Social affirmation is often the first step in affirming gender, though parents



**Table 5.** Descriptive statistics and correlation matrix for variables of interest.

Variable of interest	Mean (SD)	1	2	3	4	5	6
1. Coparenting agreement	3.23 (1.69)	–					
2. Coparenting undermine	1.76 (1.79)	–0.82***	–				
3. Coparenting conflict <sup>a</sup>	2.27 (1.66)	–0.95***	0.96***	–			
4. Affirmation support (total)	5.36 (1.59)	0.08	–0.04	–0.06	–		
5. Support discrepancy	1.41 (1.64)	–0.67***	0.56***	0.65***	–0.33*	–	
6. TGDY-depression	7.71 (6.82)	–0.24	0.24	0.25	–0.43**	0.03	–

<sup>a</sup>Coparenting conflict is a composite variable comprised of coparenting undermining (50%) and (reversed) coparenting agreement (50%).

\* $p < .05$ ; \*\* $p < .01$ ; \*\*\* $p < .001$

reported substantial barriers to their TGDY accessing desired affirmation of all types. Barriers related to restrictive laws, and delays in gaining access to gender-affirming medical care, were high, constituting important obstacles for this cohort. Results are broadly consistent with those presented in national surveys of LGBTQA + young people (Writing Themselves In 4 Report; Hill et al., 2021) in terms of desire for each type of affirmation. Participants in the current sample were far less likely to report their children had accessed specific forms of medical affirmation, such as hormone therapy (30.2%) or surgical intervention (6.3%), likely due to the age of the present sample and age-related barriers to some forms of affirmation, such as surgical intervention (Coleman et al., 2022).

Parent and coparent support for their TGDY's gender affirmation was generally very high, which is consistent with prior qualitative and thematic evidence of parents' perspectives on gender affirmation (e.g. Horton, 2023). Discrepancies between participants own support for gender affirmation, and their reports of their coparents' support, were also generally very small. There has been a dearth of research pertaining to parental support for gender affirmation, though the current sample reported more support for their children's affirmation, and fewer barriers to affirmation, compared with those reported in studies directly assessing young people (Hill et al., 2021). It is plausible that this might reflect differences in parent and child ideas about affirmation, as well as potential gaps between a parent's intended support and the impact or perception of this support reported by the young person. However, evidence suggests varied parental attitudes toward TGDY (e.g. Elischberger et al., 2016; Grossman et al., 2005; Hill et al., 2021; Hill and Menvielle, 2009), and

the findings of overall high parental support in the present study cannot be assumed to generalize to the broader population. As the sample was partially recruited from online support groups for parents of TGDY, the present sample may display more support than what would be found in the general population. Nonetheless, although support was, on average, higher in the current study, there is no compelling reason to expect that associations between parental support and mental health outcomes would differ, even when mean scores are lower.

The TGDY reported on in this study did not show high levels of distress, according to their parents, which is in stark contrast to much of the research pertaining to TGDY mental health (Strauss et al., 2021; Tollit et al., 2023). There are a few possibilities as to why distress appeared lower in the current sample. First, although we used a well-validated parent-report scale of youth mental health, some studies have found differences between self-reports of wellbeing by TGDY and parent reports (e.g. Kuper et al., 2019). There is a need for research that includes both parent-reports and TGDY self-report measures of each of the variables assessed in the current study. Second, this sample was largely drawn from parent support groups, and support for affirmation was generally high in the current sample, which might also explain the lower rates of distress. Finally, almost all TGDY who wanted to socially affirm their gender had done so (94.8%), and it is plausible that this could also contribute positively to their mental health.

### **Coparenting quality, parental support, and TGDY well-being**

Participants in the current study reported greater coparenting conflict and lower coparenting

agreement than has been found in prior studies (Feinberg et al., 2012). Although affirmation-support discrepancies between participants and coparents were small in magnitude, there was still variation in parent support for affirmation which might, at least in part, explain these higher rates of coparenting difficulties. It is, however, important to also note that the current study included a balance of intact and separated/divorced families, which likely also explains the higher rates of inter-parental conflict and hostility found here (Baxter et al., 2011).

Parent support for gender affirmation was a strong predictor of lower TGDY depression, which is consistent with evidence that parental acceptance and gender-related support is associated with more positive outcomes among TGDY (Fuller & Riggs, 2018; Grossman et al., 2021). Given that the views of parents are directly related to access to gender affirming care for TGDY (Kelly et al., 2022; Ouliaris, 2022), it is not surprising that parent support for affirmation emerged as an important predictor of TGDY mental health, and highlights the importance of parental support for TGDY. It is, however, important to note that parental support for affirmation is complex and multifaceted. In the present study we obtained self-report ratings of overall support for each form of affirmation (social, legal, and medical), though it is reasonable to expect that assessing for behaviorally-specific indicators of affirmation support, ideally from both parents and TGDY given the potential for discrepancies in ratings, might better capture the nuances of affirmation support. For instance, behaviorally-specific indicators of support for social affirmation might include a parent using correct pronouns, or shopping for gender-appropriate clothing. It would be helpful for future research to investigate affirmation support as a multifactorial construct comprised of a range of specific behaviors, as rated by parents and TGDY, and to test the associations of these behaviors with TGDY mental health. Future research would also benefit from examining the influence of TGDY age when investigating factors associated with affirmation support and wellbeing given that some factors, including access to medical affirmation, are likely to be affected by age.

Coparenting quality was unrelated to TGDY mental health. This was unexpected given the large body of research demonstrating links between inter-parental conflict and reduced wellbeing in children (Stallman & Ohan, 2016; Sturge-Apple et al., 2012), including research demonstrating that this association is not limited to separated or divorced families (Baxter et al., 2011). It is possible that when included alongside parental affirmation support, parental agreement and conflict do not contribute as strongly to TGDY mental health and thus do not predict unique variance. However, bivariate correlations also suggest that coparent agreement and conflict are not significantly related to TGDY mental health. Nonetheless, it is clear that parental affirmation-support is associated with less psychological distress among TGDY.

### **Limitations and future directions**

There are some limitations of the present research that should be acknowledged. First, the cross-sectional nature of the study means that causation and directionality cannot be definitively established. Second, the research relies on parent reports which is both a strength and limitation. Specifically, although parent-reports provide a more direct measure of parental perceptions of conflict and affirmation-support, it provides a less direct measure of TGDY depressive symptoms. Further, it is important to consider that a child may or may not be aware of any parental conflict, and that a parent's perception of how supportive they are may be quite different from how it is experienced by the child. Similarly, gaining child reports of their own mental health would clearly be an advantage. Longitudinal research that includes both parents and their TGD child is needed to assess these perceptions and track the determinants of TGDY well-being over time.

Third, although this study includes a good proportion of participants from both urban and regional locations, the sample does consist largely of white mothers with high levels of education who were, overall, quite supportive of their TGD children's gender affirmation. Thus, the extent to which these findings can be generalized to the broader population, or to other cultures and ethnicities, remains unclear. Many of the participants

in the present research were recruited from online support groups for parents of TGDY. As a result, many participants may be more likely to be supportive and engaged with the needs of their TGDY given the opportunities for learning and emotional support provided in such groups (Hillier & Torg, 2019). Future research should consider how to recruit a more diverse sample of parents, particularly when many may be reluctant to participate in such studies. Further, given that prior research has found that heterosexual fathers may be less likely to be supportive (Ishii, 2018; Riggs & Due, 2015), future research should ensure this group is represented in such studies in order to gain a more complete picture of the role of parental support, conflict, and TGDY well-being.

As mentioned earlier, in the present study we assessed affirmation support as an overall rating for each of the three forms of affirmation (social, legal, and medical). Although this is a parsimonious indicator of parents' perceptions of overall support for the three forms of affirmation, future research should test for behaviorally-specific indicators of affirmation support to gain a more nuanced understanding of the role that affirmation support may have on TGDY mental health. Although the present study was adequately powered to detect medium to large sized effects, it is possible that very small effects went undetected due to the size of the sample. Future research is needed with larger sample sizes for this reason. Future research should consider how to recruit a more diverse sample of parents, particularly when many may be reluctant to participate in such studies, and to include both parents and TGDY to ensure the voices of TGDY are heard and form part of the body of research.

### Ethical approval and informed consent

The present research was approved by the La Trobe University Human Research Ethics Committee and all procedures were performed in accordance with 1964 Helsinki declaration and its later amendments/comparable ethical standards. Informed consent was obtained from all individual participants included in the study.

### Disclosure statement

The authors declare that there are no competing interests to declare.

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