Factors that Moderate Parent’s Experience of Ambiguous Loss in Families with Gender Incongruent Youth

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Accessibility
Factors that Moderate Parent’s Experience of Ambiguous Loss in Families with Gender Incongruent Youth

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A Thesis in the Field of Psychology
for the Degree of Master of Liberal Arts in Extension Studies

Harvard University
November 2021
Abstract

Ambiguous loss is an identified type of loss that occurs when a loved one is here but not here; they are physically there but different from how you have known them. This study investigated feelings of ambiguous loss (AL) experienced by parents of gender incongruent children after the discovery or disclosure of their child's perceived gender identity. It examined (i) the correlation between AL and stress, anxiety, and depression levels and (ii) moderating effects of avoidant coping, the personality trait openness to experience, and perceived social support. Given the scarcity of available research on counseling strategies in family systems of transgender children, this study aims to bridge this gap and provide evidence to develop counseling procedures to reduce symptoms of depression, anxiety, and stress and acknowledge parents' feelings of AL. The study hypothesized that the characteristics low openness to experience, high avoidant coping, and insufficient perceived social support predict higher stress, anxiety, and depression levels in parents experiencing AL. Participants were recruited at the Check-in counseling practice for children and adolescents with gender quests in the Netherlands. A self-report questionnaire format was used to capture participants' experience of AL; stress, anxiety, and depression symptoms; coping; personality; and social support. The results showed that near half of the parents experience AL, more mothers than fathers experienced AL, and mothers reported a significantly higher level of experienced AL. Furthermore, this study provides initial evidence suggesting a significant role of perceived social support and avoidant coping in reporting stress symptoms. Perceived social support also
moderated anxiety and depression levels. Future longitudinal studies should be undertaken to better understand the mechanism of action and the predictive effect of these variables on AL.
Dedication

I dedicate this thesis to my mom & dad; you know why!
Acknowledgments

I want to express my deepest gratitude to my thesis advisor, Dr. Amy Tishelman, my research advisor, Dr. Dante Spetter, and my academic advisor, Dr. Chuck Houston, for their patient guidance and support. See you soon in Utrecht Chuck! Kathryn Bean, thank you for helping me out with the GDPR struggle. Christy Desire, thanks for untangling my Denglish and Saskia van den Eerenbeemt for being my questionnaire queen. You are the most supportive friends and helped me troubleshoot through every stage of my research project.
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Chapter I
Introduction

Although a growing body of research shows that a child's gender diversity affects everyone in their family, little research has been published on the specific experiences of the parents of gender-incongruent children after the discovery or disclosure of their child's perceived gender identity (Betz & Thorngren, 2006; Coolhart, Ritenour, & Grodzinski, 2018; Ellis & Eriksen, 2002; Emerson, 1996; McGuire, Catalpa, Lacey, & Kuvalanka, 2016; Norwood, 2012; Wahlig, 2015; Zamboni, 2006). Gender identity refers to the feeling of being female or male, being in between, or neither of these poles. "Gender incongruence" is the term used when a person's gender expression or gender identity differs from what society associates with their physical characteristics. Additionally, gender dysphoria refers to a distressing sense of incongruence (Hembree et al., 2017; Kuyper & Wijsen, 2014).

When an individual gives birth, they both consciously and unconsciously create a picture of their life with their child. This picture often involves gendered expectations associated with the child's assigned gender at birth. However, not all children identify with their assigned gender. Clark et al. (2014) reported that 1.2% of high school students identified as transgender, while 2.5% reported being unsure about their gender.

While gender-incongruent children may feel free to express who they are for the first time when they come out, their parents often describe the loss of dreams after the discovery or disclosure of their child's perceived gender identity. In Coolhart et al.'s
(2018) study, parents expressed grief, the loss of dreams and rites of passage, and the feeling that they had lost their child despite their physical presence. Moreover, McGuire et al. (2016) found that parents of transgender children described feelings of simultaneously having a physically present child and having lost their son or daughter. Consequently, parents must develop an alternative vision of the future (Beeler & Diprova, 1999). Boss (1999) described this type of loss that occurs when a loved one is here but not here and developed the theory of ambiguous loss (AL). Among clinicians, a lack of understanding of emotional processing models in the context of gender-incongruent children's parents has led the objectification, mislabeling, and mistreatment of families who have sought counseling (Coolhart et al., 2018; Ehrensaft, 2011; Zamboni, 2006).

Ambiguous Loss

Loss and grief have been extensively studied. A well-known model of loss and grief is that of Kübler-Ross (1969), who described five stages of grief: denial, anger, bargaining, depression, and acceptance (Kübler-Ross, 1969; Mahmood, 2006). However, Nowinski (2011) suggested that modern medicine has changed how people experience grief. He identified a pattern of grief experienced by families who face the loss of a loved one, which includes the following stages: crisis, unity, upheaval, and using the gift of time. The stages of grief that Kübler-Ross and Nowinski described are based on a clear and recognizable form of loss: the death of a loved one. The death of a child is an identifiable and clear form of loss. This type of loss is publicly recognized and acknowledged; parents receive support from their community. Prescribed rituals exist for a funeral, at which friends and family members gather. Such support and rituals can help
parents.grieve.and.find.closure.

Unlike the loss of a loved one, parents of gender-incongruent children have described feeling like they have lost their son or daughter while still having their child physically present (McGuire et al., 2016). There are many examples of the physical or psychological loss of family members or loved ones that cannot be identified as concretely as the death of a loved one. Boss (1999) developed the theory of AL, which occurs when a loved one is here but not here. Boss began to study unclear losses in the 1970s and developed a theory based on the experience of unclear losses within families of missing Vietnam war pilots and veterans diagnosed with Alzheimer's disease (Caron, Boss, & Mortimer, 1999; Boss, 2016). In a 1977 study, Boss conducted structured interviews with 47 families of servicemen who were missing in action. Data was obtained through self-report and interviewer assessments. The results suggested that AL predicts family dysfunction (Boss, 1977). A follow-up study on the wives of servicemen who went missing in action was conducted in 1980. During the analysis, Boss only used data from a subsample of 37 wives: those who had not remarried. The findings from this study bolstered the prediction of family dysfunction in families with AL (Boss, 1980). In 1990, Boss, Caron, Horbal, and Mortimer (1990) studied caregivers of dementia patients. They conducted semi-structured interviews with 70 primary caregivers, primarily female spouses. Their results indicated that AL was significantly related to a caregiver's depression level, whereas the severity of the patient's dementia was not (Boss, Caron, Horbal, & Mortimer, 1990). Based on her research, Boss (1999) argued that AL predicts family conflict and personal symptoms of depression and anxiety. She concluded that grief is not resolved without official verification of death, possibility of closure, and
Western society tends to hold a binary view of sex and gender. Sex is viewed as a biological construct that refers to genetics and physiological characteristics to categorize people as male or female (Institute of Medicine, 2011, p. 25). However, gender is a cultural construct to which society assigns certain expectations of attitudes, feelings, and behavior as "masculine" or "feminine." In Western society, sex and gender are considered to be naturally aligned. Based on the appearance of an individual's external genitalia, which is determined by medical personnel or observers of an infant's birth, gender is assigned, and specific gender role behavior and expression are expected (Wahlig, 2015). Accordingly, parents have learned to view the world through this lens. Many factors shape their expectations regarding gender identity and expression, including family values, political beliefs, ethnicity, and religion. Society has historically viewed gender-incongruent feelings as pathology. Being confronted with transgender identities challenges people's own identities concerning gender and their notions of gender and related gender roles (Zamboni, 2006). Therefore, the parents of gender-incongruent children sometimes have a strong emotional response to the discovery or disclosure of their child's perceived gender identity. They may experience shock, betrayal, anger, fear, depression, and grief (Coolhart & Shipman, 2017; Lesser, 1999; Zamboni, 2006).

Emerson (1996) was among the first researchers to interview family members of transgender people to better understand about their emotional experiences. The data was not formally analyzed; instead, the descriptions of family members' adjustment processes were based on content analysis. Emerson's proposed model was an adaptation of Kübler-Ross's model (1969); it included the stages of denial, anger, bargaining, depression, and
acceptance. Subsequently, Ellis and Eriksen (2002) expanded Emerson's model (1996). They analyzed informal stories written by family members of transgender people and described their experiences after they became aware of their child's perceived gender identity via discovery or disclosure. In their analysis, the researchers found that successful adaptation progressed beyond acceptance to pride. Their model includes six stages: possible posttraumatic reaction, anger and feelings of loss, seeking support, feelings of change within themselves, acceptance of the transgender loved one, and feelings beyond acceptance, such as being proud of their child's gender transition (Ellis & Eriksen, 2002).

Various adverse family situations with a loved one being there but not there have been related to Boss's AL theory. Golish and Powell (2003) used this model to discuss various emotions related to grief among parents of premature babies. Additionally, O'Brien (2007) described this kind of grief among families of children with autism spectrum disorders.

Much of the work that investigates family adjustment to a gender nonconforming child originates from either clinician reports or small, qualitative studies. Norwood (2013) was the first researcher to explain the experiences of families of transgender loved ones based on AL. She interviewed 37 family members, primarily parents, who were grieving the transition of their transgender loved one. The participants were recruited via personal contacts, support groups, and support websites. Participants said that the concepts of male and female were incompatible; one person cannot be both and must be one or the other. Norwood suggested that this apparent incongruity could generate a sense of AL during gender transition. Participants experienced the transition of their loved one
as a living death, with the transgender person being perceived as simultaneously present and absent and the same and different. Norwood found that the meaning that participants attached to transition were related to sex, gender, and the understanding of the self. In Norwood's study, all participants experienced feelings of AL (Norwood, 2013). In addition, Coolhart and Shipman (2017) described a model that validated parents' emotional experiences of fear and loss; it was also based on clinical work rather than empirically analyzed data.

Coolhart et al. (2018) conducted the first empirical study on the experiences of parents of transgender youth. The inclusion criteria were that participants had to be a family member of a transgender child and that the disclosure or discovery of the child's perceived gender identity occurred before age 21. Six parents participated: three mothers and three step-fathers, all parents of transgender boys. Then, semi-structured, in-depth interviews were conducted. Coolhart et al. (2018) found that all the mothers and one father in the sample described feelings of AL. They reported the loss of dreams and feelings of losing their child's envisioned future. Others stated that the child they once had was now deceased; although they still had a child, they were not the same as before. Coolhart et al. (2018) stated that some parents consistently prioritized their child when coping with feelings of confusion. It is arguable that in the two fathers who did not express feelings of loss, this mechanism of focusing on the child’s needs was unconsciously a way of coping with their own feelings, a way to suppress their feelings of AL (avoidant coping).

Boss's (1999) theory of AL was not developed to address the loss that parents of gender-incongruent children experience after the discovery or disclosure of their child's
perceived gender identity. However, as Norwood (2012) showed, given that the family members of transgender people struggle most with reconciling their child's simultaneous presence and absence and sameness and difference, the AL theory fits these family members' experiences.

Psychological Symptoms in People Who Experience Ambiguous Loss

According to Boss (2016), AL is the most stressful type of loss because it is not formally recognized; therefore, no closure occurs. Living with someone who is perceived as both absent and present is a bizarre human experience; individuals may experience a number of symptoms, including depression and anxiety, identity issues, and stress-related illness (Boss, 2006, 2016; Boss & Yeats, 2014).

Kennedy, Deane, and Chan (2019) reviewed the literature on psychological responses among family members of missing people. They found that the most consistent psychological symptoms were depression, anxiety, posttraumatic stress, and prolonged grief reactions. In ten studies that measured depression and anxiety symptoms, the elevated prevalence of depressive symptoms was reported in five studies, ranging from 39% to 88%. Anxiety symptoms were reported in five studies, ranging from 48% to 65% (Kennedy, Deane, & Chan, 2019). Lenferink, de Keijser, Wessel, de Vries, and Boelen (2019) identified five studies that reported prevalence rates for depression and anxiety among the loved ones of missing people. These showed varying prevalence rates for depression (3–88%) and anxiety (1–65%). The variability in prevalence rates was attributed to several factors related to the quality of available quantitative literature (Lenferink, de Keijser, Wessel, de Vries, & Boelen, 2019).

Although the circumstances of these study groups differ from those of parents of
Gender-incongruent children after the discovery or disclosure of their child's perceived gender identity, both fit the pattern of a parent's AL of a child as described by Boss (Boss, 1980). Therefore, it is expected that a substantial percentage of parents of gender-incongruent children would also show symptoms of depression, anxiety, and stress after the discovery or disclosure of their child's perceived gender identity. To the researcher's knowledge, no prevalence rates of depression, anxiety, and stress symptoms have been reported for this group. If depression, anxiety, and stress are not recognized and adequately addressed, they can seriously undermine coping and resilience, eroding psychological well-being (Strada, 2019).

Boss (2016) showed the relationship between AL, available resources, and level of stress and trauma in a contextual model of family stress. In this model, AL is the stressor and resources are included as moderating factors that can influence the degree of stress and trauma (Boss, 2016). The amount and effectiveness of available resources, such as coping skills, personality traits, and social support, differ for each individual and family. Clarifying potential differences in strategies for coping with loss is necessary to facilitate an understanding of how parents who experience AL may be provided with the most effective support (Kennedy et al., 2019).

Coping

Coping strategies refer to people's behavioral and psychological efforts to master, tolerate, or reduce stress. They play a crucial role in moderating adjustments to stressful life events (Bonanno & Kaltman, 1999). Two general coping strategies have been distinguished in the coping literature: problem-solving and emotion-focused coping.
strategies (Folkman & Lazarus, 1980). An additional distinction has been made between active and avoidant coping strategies. Active coping strategies are responses that aim to change the nature of the stressor or how one appraises "the threat." Conversely, avoidant coping strategies may involve avoiding situations and stimuli that are reminders of the loss to reduce its emotional impact (Bonanno & Kaltman, 1999). Active coping strategies are considered a better way to address stressful events than avoidant coping strategies. Holahan and Moos (1987) suggested that avoidant coping strategies are a psychological risk factor when facing stressful life events.

In research on posttraumatic stress, avoidant coping has consistently been implicated as a mechanism that drives posttraumatic stress disorder symptoms. Pineles et al. (2011) interviewed 55 assault survivors. All participants completed posttraumatic stress disorder diagnostic interviews and a self-report coping measure, the Coping Strategies Inventory (CSI). Avoidant coping was associated with progressive symptoms of posttraumatic stress over time (Pineles et al., 2011). Holahan and Moos (1986) analyzed 245 men and 248 women to assess stress-resistance factors in coping to predict psychological and physical outcomes in one year. They showed that a disinclination to use avoidant coping and the availability of family support protected individuals from the negative psychological consequences of life stressors (Holahan & Moos, 1986). Moreover, Lund et al. (1986) studied 192 bereaved older people in a two-year longitudinal study. They identified recently bereaved people over the age of 50 through local newspaper obituaries in the Salt Lake City metropolitan area. Data analysis was based on the responses of 138 respondents at both three to four weeks and two years after the deaths of their spouses. A computed coping scale was used to identify specific
characteristics associated with coping difficulties. The researchers found that coping difficulties at two years were significantly greater among participants who demonstrated avoidant coping behavior (Lund et al., 1986).

Kennedy, et al. (2019) reviewed the literature on people with missing loved ones. In a systematic review of 42 studies, they found that people who experienced an unclear feeling of loss often reported the use of avoidant coping strategies. Therefore, a high prevalence of using avoidant coping strategies is expected among parents of gender-incongruent children. Different coping styles can influence the different ways in which parents make sense of their child's gender role transition. This study hypothesizes that using avoidant coping is associated with more difficulties than using other coping strategies.

Personality traits

Carver, Scheier, and Weintraub (1989) showed that personality variables are only weakly correlated with coping strategies. However, personality traits have been associated with coping efficacy (Bonanno et al., 2002). To date, no consistent findings regarding personality traits that protect people from the effects of grief have been identified.

Openness to experience is a personality trait characterized by flexibility of thought, open-mindedness, creativity, and divergent thinking (McCrae & Costa, 1986). As previously described, the parents of gender-incongruent children often express feelings of loss after the discovery or disclosure of their child's perceived gender identity. Considering McGuire et al.'s (2016) argument that the experience of AL due to a loved
one's gender transition is due to society's cisgender normative views, it is arguable that openness to experience could be a helpful trait for this study's population. Adjusting one's existing framework to reduce stress requires flexibility of thought and liberal views. Therefore, we believe that the parents of gender-incongruent children who score highly on openness to experience would sustain a lower level of AL after the discovery or disclosure of their child's perceived gender identity.

Perceived Social Support

Wahlig (2015) showed that there are no cultural guidelines for understanding, coping with, or talking about the gender transition of a child. Therefore, parents may feel as though they do not have the right to experience grief since their child is still alive. Unlike loss from death, the AL has no official verification of loss because the "missing" person is still present. AL is an unclear loss without rituals or closure (Boss & Yeats, 2014). The AL is unacknowledged; thus, parents are denied the right to grieve (Betz & Thorngren, 2006). Many parents at the Check-in Coaching practice report that they feel family members and friends don’t understand the complexity of having a gender-incongruent child. Due to a lack of resources and stigma, shame, and ignorance about transgender issues, parents often struggle with who and even how to tell others about their child's transgender identity, which leads to a sense of isolation (Lesser, 1999; Norwood, 2012; Wren, 2002). They may be reluctant to reach out to others for support, and social support may be complicated for the family to find (Boss, 1999). However, receiving support is essential for parents to adjust to their child's transgender identity (Zamboni, 2006).

Positive psychology states that perceived social support could be effective in
minimizing the negative outcomes associated with adversity, and stress theory predicts that social support have a buffering effect on the impact of bereavement (Folkman, 1984). In a longitudinal study, W. Stroebe, M. Stroebe, Abakoumkin, and Schut (1996) followed 60 recently widowed older people to assess the role of social support in adjustment to bereavement. They showed that bereaved individuals who perceived their social support as high reported fewer depressive symptoms. Moreover, Anjum (2017) studied 150 fathers of missing people and found perceived social support to be positively related to posttraumatic growth.

Based on this research, it is expected that parents who perceive sufficient social support experience less stigma, shame, and isolation. Therefore, we hypothesize that parents who perceive sufficient social support experience less AL. In our opinion, this is an important variable to assess since therapists can facilitate social support through measures such as facilitating peer focus groups either onsite or online.

The current literature on family members of gender-incongruent children and adolescents provides various models of emotional processing based on clinical work and experience rather than research. It is crucial to investigate which perceptions and resources are relevant to parents of transgender children and thus specify their needs to develop therapeutic interventions for this specific population. The AL framework allows therapists to normalize AL for parents of transgender children as an understandable response to their child’s transitioning (McGuire et al., 2016). Parents' feelings of AL should be addressed to reduce potential depression, anxiety, and stress symptoms. When clinicians know what coping strategies to focus on, what social support to offer, and what
personality traits to strengthen, they can acknowledge parents' feelings of loss through the AL theory.

Significance of Study

The international literature shows that an increasing number of minors and adolescents are turning to health professionals at an increasingly young age for counseling and treatment in the context of gender identity services throughout Europe and North America. For example, Shields et al. (2013) assessed over 2,700 middle schoolers from 22 public schools in San Francisco. They found that 1.3% of middle school students identified as transgender. In Finland, Kaltiala-Heino and Lindberg (2019) found that the annual number of gender-incongruent youth increased five-fold from 2011 to 2017. In their study of 135,760 Finnish adolescents under 21 years of age, they found that 0.6% of participants identified as the opposite sex and 3.3% identified as both boy and girl or neither, or said that their perception of their gender varied. In addition, Kuyper and Wijsen (2014) studied the prevalence of gender dysphoria in a Dutch sample of participants aged 15–70 years old. They found that 4.6% of the participants who were assigned men at birth and 3.2% of the participants who were assigned female at birth identified as the opposite sex; moreover, 1.1% and 0.8% reported gender incongruence, respectively. In 2018, the U.S. Center for Disease Control and Prevention’s Division of Adolescent and School Health published data collected among high school students in Grades 9–12 to assess the prevalence of transgender identity and suicide risk. Nearly 2% reported identifying as transgender, and 35% had previously attempted suicide (Center for Disease Control and Prevention’s Division of Adolescent and School Health, 2018). Despite the rising prevalence of gender-diverse youth, research on gender-
incongruent children and their families has shown that most parents had never heard of
gender-incongruent children before their first-hand experience with them (Gregor,
Hingley-Jones, & Davidson, 2015). Successfully raising a child is a challenge;
successfully raising a child who is different can pose even more of a challenge. Having a
gender-incongruent child—a phenomenon that is poorly understood by society—can
entail immense challenges for parents, not only for their child but also for themselves as
individuals. Many of these challenges were not considered as possibilities before they
presented themselves to unsuspecting parents. Therefore, parents may be unaware of how
to name the experience or how to behave and talk about gender-identity questions or
perceived gender with their child (Gregor et al., 2015). Thus, they often experience
feelings of guilt, embarrassment, worry, impotence, anger, and grief (Dierckx & Platero,
2018).

The well-being of parents is not only of importance to the parents themselves; it is
also of extreme importance to the well-being of their gender-incongruent child and can
thus be lifesaving (Riggs, Bartholomaeus, & Sansfaçon, 2019). In the literature, there is
evidence that family support is pivotal for the mental health of gender-incongruent
children. Parents’ psychological state and reaction to gender-incongruent children is
likely to significantly influence the child's development (Wren, 2002). Research has
identified a relationship between gender incongruency in youth and an increased
incidence of mood and anxiety disorders, self-harm, and suicidal ideation. Additionally,
the literature suggests that psychopathology in gender-incongruent children may be
primarily linked to their family's negative reactions (Kaltiala-Heino, Bergman,
Työläjärvi, & Frisen, 2018; Westwater, Jason, Riley, Elizabeth, & Peterson, 2019). There
is broad variability in how parents respond to the discovery or disclosure of their child's perceived gender (Ludici & Orczyk, 2021). Family boundaries may become blurred or rigid, significantly impacting the dynamics in the family-system and impacting relationships. It is essential to be aware of the signs of AL and, instead of attributing symptomology to dysfunction or pathology, searching for and acknowledging it. Counseling parents can provide in need to normalize and validate parents' emotional processes after the discovery or disclosure of their child's perceived gender identity.

Studies have confirmed the fundamental importance of family support for improving the mental health of gender-incongruent children (Simons, Schrager, Clark, Belzer, & Olson, 2013). Olson, Durwood, DeMeules, and McLaughlin (2016) showed that gender-incongruent children and adolescents who are supported by their parents have only slight elevations in levels of anxiety and depression compared to cisgender youth.

The current literature on family members of gender-incongruent individuals is based on clinical work and experience rather than research. In the context of trans family systems, the AL framework can increase understanding of the nature of relational rupture (McGuire et al., 2016). It can also provide a new lens for intervention by clinicians (Boss, 2016).

Empirically exploring ideas increases knowledge. Thus, therapists can benefit from research in their work with family systems of transgender individuals (Coolhart et al., 2018) to improve family relationships, the emotional health of family members, and the healthy development of gender-incongruent children.
Study Aims and Hypotheses

This study aims to better understand parents' coping and adjustment to having a gender-incongruent child. It focuses on the following aims:

Aim 1

This study aims to identify the percentage of parents of gender-incongruent children who experience AL (AL+) after the discovery or disclosure of their child's perceived gender. Hypothesis 1 states that the percentage of parents who experience AL after disclosure or discovery is greater than the percentage of those who do not.

Aim 2

This study aims to show that experiencing AL is correlated with higher levels of the psychological symptoms of stress, depression, and anxiety. Hypothesis 2 states that parents who experience AL after the discovery or disclosure of their child's perceived gender (AL+) have significantly higher levels of stress, depression, and anxiety than parents who do not experience AL after the discovery or disclosure of their child's perceived gender (AL−).

Aim 3

This study aims to show the moderating effects of the coping mechanism (avoidance), the personality trait of openness, and perceived social support on levels of stress, depression, and anxiety symptoms in parents who experience AL after the discovery or disclosure of their child's perceived gender. Therefore, the following hypotheses were tested:
Hypothesis 3: Among parents who experience AL after the discovery or disclosure of their child's perceived gender, a low score in the personality trait of openness to experience predicts higher (a) stress, (b) anxiety, and (c) depression levels.

Hypothesis 4: Among parents who experience AL after the discovery or disclosure of their child's perceived gender, high avoidant coping predicts higher (a) stress, (b) anxiety, and (c) depression levels.

Hypothesis 5: Among parents who experience AL after the discovery or disclosure of their child's perceived gender, insufficient perceived social support predicts higher (a) stress, (b) anxiety, and (c) depression levels.

The significance of this study, the relevant literature, and the research questions have been highlighted in Chapter I. Chapter II describes the study's methods, and Chapter III presents its results. Finally, Chapter IV discusses the results and main conclusions, outlines the study's limitations, and provides recommendations for further research.
Chapter II

Methods

The study was conducted using hard-copy questionnaires. The target sample consisted of 90 participants who were recruited when visiting the Check-in Coaching practice. Check-in Coaching is a private practice for children and adolescents with gender identity questions. A multidisciplinary team of multiple child psychologists, a psychiatrist, a medical doctor and gender therapist, a social worker-experience expert, and a speech-therapist counsel children, adolescents, and their families in their search for the child's identity and in finding what they need in that process, for instance a social gender role transition, help with their coming out at school, or a medical transition. When a referral for medical transition is indicated, Check-in Coaching has a collaborative referral network with the internally renowned gender expertise team at Amsterdam's University Medical Center (AUMC). Currently, Check-in Coaching is actively counseling 193 families.

Participants

All parents who visit the Check-in Coaching practice are parents of a gender-incongruent child or adolescent who seek counseling after disclosure or discovery of their child's perceived gender identity. Therefore, they were all potential subjects for the study. The inclusion criteria were as follows: all participants had to be the parents of a gender-incongruent child or adolescent, the disclosure or discovery of their child's perceived gender identity must have occurred before age 21, and the child or family had to be registered as patients at the practice. Participants were excluded if they had insufficient
knowledge of the Dutch language or were counseled by the principal investigator (PI). The PI screened patients scheduled for the day regarding the inclusion and exclusion criteria. Then, the PI provided a list of parents who fulfilled the inclusion criteria to the administrative personnel. When entering the Check-in Coaching waiting room, the listed parents received an information letter about the study.

A total of 157 parents received the information letter with an invitation to participate, and 98 parents entered the study. Parents could take home the questionnaires to answer them and return them on their next visit. Twenty-one parents opted to immediately fill out the questionnaires in an office space provided at the Check-in Coaching practice. After data collection, participants were excluded if their responses were incomplete. This resulted in sample data that comprised 78 fully completed questionnaires from 48 mothers (61.5%) and 30 fathers (38.5%).

Measures

The study protocol included measures to capture AL, psychological distress, and possible moderating factors, such as coping strategy and personality traits.

Measure of Ambiguous Loss

There is no known research tool for measuring the level of experienced AL. To indicate levels of AL, we developed an AL Likert scale. On the AL questionnaire, the concept of AL was explained and participants were asked to report their personal experience of AL on a seven-point Likert scale:

"Some parents easily embrace their child's new identity after the discovery or the disclosure of their child's true gender identity. Other parents may struggle with the changes it brings. Sometimes parents describe feelings of
having lost their son or daughter, which can feel confusing because they still have their child physically present. They can feel confused, stressed, guilty, lonely, helpless, or sad. Several parents of gender-incongruent children explicitly state that they have feelings of grief.

Grieving for someone who is still around but different is called ambiguous loss. It is believed to be the most stressful type of loss. There is not a clear moment of the loss. There is no social or religious ritual to deal with these kinds of losses. There is little or even no recognition from the outside world, which means there is no usual support for mourning through death. Parents can feel judged over time for not being able to find closure. Please indicate whether you recognize the feeling of ambiguous loss and to what extent you experience it after the discovery or disclosure of your child's perceived gender. This can be in different domains in your life (e.g., friends, workplace, family relationships)."

Participants were asked whether they experienced AL and, if so, how often. A seven-point Likert scale was chosen to this end, since it has been shown that seven points are more accurate than five points, and a better reflection of a subject's true evaluation. Thus, a seven-point Likert scale could capture the intensity of the participants' experienced AL; it appeared to be the best solution for the questionnaire (Finstad, 2010).

Measure of Psychological Distress

To understand which parents to focus on in counseling, we wanted to determine which parents experienced elevated stress, anxiety, and depression levels to prevent further decline in their mental state. This study sought to identify increased symptoms of negative emotion rather than make a diagnosis of disorders.

The Depression Anxiety Stress Scale (DASS-21) is based on a dimensional rather than categorical conception of psychological problems. It scores the intensity of symptoms that a subject experiences rather than establishing diagnostic cutoff points. Since the DASS was developed with non-clinical samples, it is suitable for screening normal adults (Henry & Crawford, 2005). De Beurs, Van Dyck, Marquenie, Lange, and
Blonk (2001) studied the psychometric properties of the Dutch translation of the DASS. The results showed the scale's reliability to be adequate, and its validity was supported. Therefore, depression, anxiety, and stress symptoms were measured in this study's cohort using the DASS-21. The DASS-21 distinguishes three symptom groups: depression, anxiety, and stress. It comprises 21 questions answered on a four-point scale, ranging from "0 = Not at all or never applicable" to "3 = Most definitely or usually applicable."
The total score and the subscale scores are calculated by determining the sum of the constituent items. The score is then converted into a seven-point scale that ranges from very low to very high compared to the normal group. Reliability and validity were examined using 49 non-clinical volunteers and 212 clinical patients with a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis (e.g., panic disorder, obsessive compulsive disorder, social phobia, specific phobia, or major depressive disorder). Antony, Bieling, Cox, Enns, and Swinson (1998) found that the DASS-21 appropriately distinguishes between symptoms of depression, physical arousal, and psychological tension and agitation. Internal consistency and concurrent validity were found to be acceptable to excellent.

Measures of Moderating Factors

The Utrecht Coping List (UCL) is a self-report questionnaire that measures respondents' coping styles. It was initially conceived in 1988 in Dutch. Therefore, it is well-suited to this study's cohort (Sanderman & Ormel, 1992). The Dutch version of the UCL is widely used to measure coping styles (Rotman et al., 2018). In a population of cardiac illness and general practice patients, the UCL's internal consistency, as measured by Cronbach's α, was found to be .43–.88 in the seven subscales (Sanderman & Ormel,
1992). Turner, Bryant-Waugh, Peveler, and Bucks (2012) conducted a psychometric evaluation of the English version of the UCL and found strong internal consistency. Five of the seven subscales had good test-retest reliability. Except for the expression of emotion subscale in men, concurrent validity with the Coping Orientation to Problems Experienced subscales was found to be good (Turner, Bryant-Waugh, Peveler, & Bucks, 2012). The UCL comprises 47 questions answered on a four-point scale from "1 = rarely or never" to "4 = very often." The seven subscales are as follows: active approach, palliative reaction, avoidance, seeking social support, passive reaction pattern, expression of emotions, and reassuring thoughts. All items are assessed on a four-point scale consisting of "rarely or not," "sometimes," "often," and "very often."

The Big Five personality traits are neuroticism, extraversion, openness to experience, altruism, and conscientiousness. The Neuroticism-Extraversion-Openness Inventory (NEO) assessment is the most widely accepted means of analyzing these traits. The NEO Five-Factor Inventory (NEO-FFI) is a self-report questionnaire on the Big Five personality traits. It is a shortened version of the NEO Personality Inventory (NEO-PI). The NEO-FFI contains 60 questions answered on a five-point scale that ranges from "1 = Strongly disagree" to "5 = Strongly agree." Subjects receive a score on each of the five factors. Raw scores are then converted to T scores. Retest reliability is uniformly high and ranges from .86–.90 for the five scales, while internal consistency ranges from .68–.86 (McCrae & Costa, 2004).

The Social Support List – Discrepancies (SSL–D) measures the extent to which the social support received by the respondents meets their needs. This measure was developed for Dutch studies and was the only Dutch self-report instrument for measuring
perceived social support available at the time of our study. The SSL-D comprises 34 items related to six subscales: everyday emotional support, emotional support for specific problems, valuation aid, instrumental support, social partnership, and informative support concerning the behavior of the person involved. Answers are scored on a four-point scale that ranges from "1 = I miss; I would like more" to "4 = happens too often; it would be nice if it happened less often." Both subscale scores and the total score are calculated. A high score indicates the subject perceives a lack of social support. In a standard group of people who need social support, the SSL-D was found to have a Cronbach's α of .95 (Van Sonderen, 2012).

Procedures

The study was conducted using three main protocols: recruitment, study, and data collection and cleaning protocols.

Recruitment

During the recruitment period, the principal investigator (PI) screened Check-in Coaching patients who were scheduled for the day. The administrative personnel were notified about potential participants. When entering the Check-in Coaching waiting room, potential participants received an information letter about the study. The letter explained the study and its aims, the voluntary nature of participation, the tasks that participants would complete and the total duration of the survey. At the end it included an invitation for them to join the study. Then, interested parents were introduced to the PI to provide them with an opportunity to ask questions about the study.
Study Protocol

Interested participants initially gave consent through a hard-copy consent form, which provided more information about the general purpose of the study, the voluntary nature of participation, the tasks that they would complete, the total duration of the survey, the confidentiality of their responses, and who to consult in case of distress after taking the survey. After they provided consent, participants were given a sealed envelope containing six hard-copy questionnaires. A separate room was provided at the Check-in Coaching practice to allow participants to complete the questionnaires in silence and in private.

All participants were asked to complete a demographic questionnaire, which assessed age, number of children, the respondent's relationship to the child, marital status, alignment with their partner on the child's gender quest, sexual identification, gender identification, educational level, habitation type, psychological history, feelings at the moment of discovery or disclosure of child's perceived gender identity, doubts, peer contacts, counseling on gender identity questions, and degree of religiousness. Next, participants were asked to complete four hard-copy standardized questionnaires. All standardized questionnaires were available in Dutch: the UCL, NEO-FFI, SSL-D, and DASS-21. Finally, they were asked to complete an AL questionnaire. After completing all study measures, participants were directed to deposit all hard-copy materials in a sealed mailbox in the Check-in Coaching practice. The PI collected the completed questionnaires from the mailbox.

The median time that participants took to complete the study protocol was approximately 26 minutes.
Data Collection and Cleaning Protocol

The PI scored the hard-copy questionnaires. The answers and scores were transferred to an SPSS Statistics file. After data collection in SPSS Statistics was complete, specific procedures were followed to clean the data. Variables were checked for outliers, which were excluded. Any duplicate data entries and incomplete responses were also excluded.

Data Analysis

The data analysis stage began with a general statistical analysis of the data distribution. Data analyses were then conducted separately according to each study aim, followed by an exploratory analysis.

Aim 1

To investigate the percentage of parents of gender-incongruent children who experienced AL after the discovery or disclosure of their child's perceived gender, we examined the frequencies of AL levels and calculated the percentage of parents who experienced AL (AL+).

We generated cross-tabulations with a chi-square test for a between-group comparison between AL− and AL+ for further information. We examined whether a significant difference existed between the percentages of mothers in each group. We then conducted an independent sample t-test for equality of means to determine whether a significant difference existed in the level of experience of AL between mothers and fathers.
Aim 2

To evaluate if experiencing AL is correlated with higher levels of the psychological symptoms of stress, depression, and anxiety a between group analyses was conducted. A one-way ANOVA was used to evaluate the difference in stress, depression, and anxiety levels between the two groups, AL− and AL+.

Aim 3

A logistic linear regression model was used to show the moderating effects of openness to experience, an avoidant coping style, and perceived insufficient social support. We calculated R-squared to determine the extent to which the variance of stress, depression, or anxiety levels (i.e., the independent variables) was explained by our model by AL, openness to experience, an avoidant coping style, and perceived insufficient social support (i.e., the dependent variables).

In addition, we examined the percentage of parents who knew other parents with a gender-incongruent child. Then, we compared the number of parents who knew other parents with a gender-incongruent child in the AL− and AL+ groups.
Chapter III

Results

From the recruited sample of 98 parents, a total of 20 participants were excluded (20.4%). Within the excluded sample, 35% of participants were mothers and 65% were fathers. Thus, the final sample included 78 participants, 61.5% of which were mothers and 38.5% were fathers. All fathers included in the final sample were part of the same family as one of the mothers. Table 1 shows the characteristics of the final sample.

Experience of Ambiguous Loss

The descriptive analysis revealed the percentages of different scores on levels of AL: 47.4% of participants did not recognize the described feeling of AL, 7.7% understood the described feeling but had not experienced it themselves, 20.5% had experienced the feeling of AL a few times, 7.7% had experienced AL a few times per month, 11.5% had experienced AL a few times per week, and 5.1% had experienced AL daily. Two groups were created for further analyses. Group 1 consisted of parents who had not experienced AL (AL−; 55.1%), and Group 2 consisted of parents who had experienced AL (AL+; 44.9%); see Figure 1 for sample characteristics.

To further explain differences between the groups (AL+ and AL−), we analyzed the characteristic of being surprised at the discovery or disclosure of the child's perceived gender identity. In the final sample, we found that 33.3% of parents in this study cohort were surprised by the disclosure or discovery of their child's perceived gender identity. Additionally, we analyzed the difference in the percentage of parents who were surprised in each group (AL− versus AL+); the results are shown in Table 2.
Table 1.

Characteristics

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mothers</th>
<th>Fathers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents: total n (%)</td>
<td>48 (61.5%)</td>
<td>30 (38.5%)</td>
</tr>
<tr>
<td>Age (years): mean (SD)</td>
<td>Mothers 47.0 (5.5)</td>
<td>Fathers 51.3 (7.4)</td>
</tr>
<tr>
<td>Number of children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time of disclosure or discovery: total n (%)</td>
<td>&lt;1 year ago 15 (19.2%)</td>
<td>1–2 years ago 20 (25.6%)</td>
</tr>
<tr>
<td></td>
<td>&gt;2 years ago 43 (55.1%)</td>
<td></td>
</tr>
<tr>
<td>Surprised: total n (%)</td>
<td>No 20 (25.6%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Somewhat 32 (41%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes 26 (33.3%)</td>
<td></td>
</tr>
<tr>
<td>Completed education: total n (%)</td>
<td>Secondary school 3 (3.8%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bachelor's degree 13 (16.7%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Master's degree 62 (79.5%)</td>
<td></td>
</tr>
<tr>
<td>Habitation type: total n (%)</td>
<td>Urban 21 (26.9%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Suburban 30 (38.5%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rural 26 (33.3%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Remote 1 (1.3%)</td>
<td></td>
</tr>
<tr>
<td>Gender identity: total n (%)</td>
<td>Cisgender 76 (97.4%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other 2 (2.6%)</td>
<td></td>
</tr>
</tbody>
</table>
Sexual orientation: total n (%)  

<table>
<thead>
<tr>
<th>Sexual orientation</th>
<th>Heterosexual</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>75 (96.2%)</td>
<td>3 (3.8%)</td>
</tr>
</tbody>
</table>

Peer parents* : total n (%)  

<table>
<thead>
<tr>
<th>Peer parents</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>42 (53.8%)</td>
<td>36 (46.2%)</td>
</tr>
</tbody>
</table>

Note: This table presents the characteristics of the final sample group. *Peer parents” means that the respondent knows other parents with a gender-incongruent child.

Figure 1. Percentages of AL− and AL+

Note: This figure displays the percentages of parents who did not experience AL (AL−) versus those who did experience AL (AL+).
### Table 2.

**Being Surprised**

<table>
<thead>
<tr>
<th>AL group</th>
<th>Count</th>
<th>No</th>
<th>Somewhat</th>
<th>Yes</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>AL−</td>
<td></td>
<td>16</td>
<td>19</td>
<td>8</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>37.2%</td>
<td>44.2%</td>
<td>18.6%</td>
<td>100.0%</td>
</tr>
<tr>
<td>AL+</td>
<td></td>
<td>4</td>
<td>13</td>
<td>18</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>11.4%</td>
<td>37.1%</td>
<td>51.4%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>20</td>
<td>32</td>
<td>26</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>25.6%</td>
<td>41.0%</td>
<td>33.3%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Note: This table presents the number and percentages of parents who were surprised by the discovery or disclosure of their child's perceived gender identity, versus those who were somewhat or not surprised by the discovery or disclosure of their child's perceived gender identity.

In the AL+ group, we found that significantly more ($p = .003$) participants in the AL+ group were surprised at the discovery or disclosure of their child's perceived gender identity (51.4%) compared to participants in the AL− group (18.6%; see Table 2).

As shown in Table 3, we also found that more mothers than fathers experienced AL (AL+). This finding was significant at the .10 level ($p = .082$) but not at the .05 level. An additional analysis was conducted to examine differences in the level of experienced AL between fathers and mothers. Mothers experienced significantly higher levels of AL (mean = 3.54) than fathers (mean = 2.50; $t = 2.38; p = .02$; see Table 4).

Given this finding, we wanted to analyze whether time elapsed since the discovery or disclosure of the child's perceived gender influenced the level of expressed
AL by examining the number of months since this event (see Figure 2). However, the distribution of months was too widespread and the sample was too small to have sufficient power to validate this analysis.

Table 3.
Differences in Experience of Ambiguous Loss Between Mothers and Fathers

<table>
<thead>
<tr>
<th>Relationship to child</th>
<th>AL group</th>
<th>AL−</th>
<th>Count</th>
<th>%</th>
<th>Father</th>
<th>%</th>
<th>43</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AL−</td>
<td></td>
<td>23</td>
<td>53.5%</td>
<td>20</td>
<td>46.5%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>AL+</td>
<td></td>
<td>25</td>
<td>71.4%</td>
<td>10</td>
<td>28.6%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Note: This table presents the number and percentage of mothers versus fathers in the AL− and AL+ groups.

Table 4.
Mean level of experienced Ambiguous Loss between Mothers and Fathers

<table>
<thead>
<tr>
<th>Relationship to the child</th>
<th>n</th>
<th>Mean</th>
<th>Std. deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of AL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>48</td>
<td>3.54</td>
<td>1.901</td>
</tr>
<tr>
<td>Father</td>
<td>30</td>
<td>2.50</td>
<td>1.852</td>
</tr>
</tbody>
</table>

Note: This table presents the mean levels of experienced ambiguous loss among mothers versus fathers.
Levels of Stress, Anxiety, and Depression

In confirmation of our second hypothesis, we found that parents who experienced AL had significantly higher levels of stress, anxiety, and depression (see Figure 3). The ANOVA analyses revealed significant differences in levels of stress ($F = 18.419, p = .000$), anxiety ($F = 10.663, p = .002$), and depression ($F = 10.399, p = .002$) between the AL− and AL+ groups (see Table 5).

After running descriptive statistics, we compared the mean scores for stress (12),
depression (8), and anxiety (4) in the AL+ group to the DASS-21 questionnaire's severity ratings (see Figure 3). For stress and depression, the mean scores were above average compared to the normal population (Fischer & Corcoran, 2007; Lovibond & Lovibond, 1995).

Table 5.
Differences in levels of stress, anxiety, and depression between the AL− and AL+ groups

<table>
<thead>
<tr>
<th></th>
<th>Sum of squares</th>
<th>df</th>
<th>Mean square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>174.655</td>
<td>1</td>
<td>174.655</td>
<td>10.66</td>
<td>.002</td>
</tr>
<tr>
<td>Between groups</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Within groups</td>
<td>1244.832</td>
<td>76</td>
<td>16.379</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1419.487</td>
<td>77</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress</td>
<td>763.312</td>
<td>1</td>
<td>763.312</td>
<td>18.41</td>
<td>.000</td>
</tr>
<tr>
<td>Between groups</td>
<td></td>
<td></td>
<td></td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Within groups</td>
<td>3149.560</td>
<td>76</td>
<td>41.442</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3912.872</td>
<td>77</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>427.249</td>
<td>1</td>
<td>427.249</td>
<td>10.39</td>
<td>.002</td>
</tr>
<tr>
<td>Between groups</td>
<td></td>
<td></td>
<td></td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Within groups</td>
<td>3122.546</td>
<td>76</td>
<td>41.086</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3549.795</td>
<td>77</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: This table displays the difference in the levels of stress, anxiety and depression among parents who didn’t experience ambiguous loss versus parents who did experience ambiguous loss.
Moderating Effects of the Personality Trait Openness of Experience, Avoidant Coping, and Perceived Social Support

First, we analyzed the moderating factors of openness to experience, avoidant coping, and perceived social support on levels of stress. Table 6 displays the results from the regression analysis. They showed that 34.6% of the variability of stress was explained by the model ($r = .588$, R-square = .346). A significant moderating role was found for avoidant coping ($p = .031$, Beta = .211) and insufficient social support ($p = .004$, Beta = .303). However, the personality trait of openness to experience did not play a significant moderating role on level of stress in this model ($p = .828$, Beta = .021).

![Figure 3](image.png)

Figure 3. Mean levels of depression, anxiety, and stress in the AL− versus AL+ group

Note: This figure displays the mean levels of depression, anxiety, and stress symptoms among parents who didn’t experience ambiguous loss versus parents who did experience ambiguous loss, with a 95% confidence interval for the means.
Secondly, we analyzed the effects of the moderating factors on level of anxiety. Overall, 20% of the variability of anxiety was explained by the model ($r = .452$, R-square $= .204$). The regression showed a significant moderating role for insufficient social support ($p = .002$, Beta $= .365$). However, openness to experience ($p = .474$, Beta $= .079$), and avoidant coping ($p = .474$, Beta $= .079$) did not play significant moderating roles on level of anxiety in this model (see Table 7).

Table 6.
Model summary for the level of stress

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized coefficients</th>
<th>Standardized coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. error</td>
</tr>
<tr>
<td>1</td>
<td>(Constant)</td>
<td>−10.986</td>
</tr>
<tr>
<td></td>
<td>Ambiguous loss</td>
<td>1.272</td>
</tr>
<tr>
<td></td>
<td>Insufficient social support</td>
<td>0.149</td>
</tr>
<tr>
<td></td>
<td>Openness to experience</td>
<td>0.020</td>
</tr>
<tr>
<td></td>
<td>Avoidant coping</td>
<td>0.440</td>
</tr>
</tbody>
</table>

Note: This table displays the role of the different variables in explaining the variability of the level of stress symptoms.
Finally, we analyzed the effects of the moderating factors on level of depression (see Table 8). The model explained 31.5% of the variability of depression ($r = .561$, $R$-square = .315). The results showed a significant moderating role for insufficient social support ($p = .001$, Beta = .382). However, openness to experience ($p = .622$, Beta = -.495) and avoidance ($p = .139$, Beta = .153) did not play significant moderating roles in this model (see Table 8).

Table 7.
Model summary for the level of anxiety

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized coefficients</th>
<th>Standardized coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. error</td>
</tr>
<tr>
<td>2</td>
<td>(Constant)</td>
<td>-7.558</td>
</tr>
<tr>
<td></td>
<td>Avoidant coping</td>
<td>.100</td>
</tr>
<tr>
<td></td>
<td>Ambiguous loss</td>
<td>.305</td>
</tr>
<tr>
<td></td>
<td>Insufficient social support</td>
<td>.108</td>
</tr>
<tr>
<td></td>
<td>Openness to experience</td>
<td>.045</td>
</tr>
</tbody>
</table>

*Note: This table displays the role of the different variables in explaining the variability of the level of anxiety.*

In conclusion, the results showed that insufficient social support was a significant
moderator for levels of stress, anxiety, and depression. In addition, we wanted to evaluate whether this effect was different on mothers and fathers. However, we had insufficient power to examine whether the importance of social support was different for mothers or fathers or similar for both.

To further explain the effect of insufficient social support, we analyzed the effect of knowing a peer parent (i.e., another parent with a gender-incongruent child). In this study cohort, 53.8% of participants did know any peer parents (see Table 9). In addition, no significant difference was found between the number of participants who knew peer parents in the AL− and AL+ groups ($p = 0.06$; see Figure 4). In the AL+ group, we found that there were more participants who knew a peer parent than those who did not (see Figure 4). Knowing other parents with a gender-incongruent child did not seem to counter the effects of having insufficient support.

In conclusion, the results of the current study refuted Hypothesis 1 and showed that only around half of participants in the study population experienced AL. However, Hypothesis 2 is supported by the finding that participants who experienced AL after the discovery or disclosure of their child's perceived gender had significantly higher levels of stress, depression, and anxiety than parents who did not experience AL. Additionally, the results showed that low openness to experience did not predict higher levels of stress, anxiety, and depression among parents who experienced AL. Therefore, Hypotheses 3a, 3b, and 3c are refuted. The results supported Hypothesis 4a, which states that high avoidant coping predicts higher stress levels; however, they refuted Hypotheses 4b and 4c. Finally, Hypothesis 5 was fully supported by this study, which showed that
insufficient perceived social support predicted higher levels of stress, anxiety, and depression among participants who experienced AL.

Table 8.
Model summary for the level of depression

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized coefficients</th>
<th>Standardized coefficients</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Std. error</td>
<td>Beta</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>(Constant)</td>
<td>-9.386</td>
<td>5.770</td>
<td>-1.627</td>
</tr>
<tr>
<td>Avoidant coping</td>
<td>.303</td>
<td>.203</td>
<td>.153</td>
<td>1.497</td>
</tr>
<tr>
<td>Ambiguous loss</td>
<td>.629</td>
<td>.379</td>
<td>.180</td>
<td>1.659</td>
</tr>
<tr>
<td>Insufficient social support</td>
<td>.178</td>
<td>.049</td>
<td>.382</td>
<td>3.619</td>
</tr>
<tr>
<td>Openness to experience</td>
<td>-.046</td>
<td>.092</td>
<td>-.050</td>
<td>-.495</td>
</tr>
</tbody>
</table>

Note: This table displays the role of the different variables in explaining the variability of the level of depression.
Table 9.

Percentage of parents who knew peer parents

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>42</td>
<td>53.8</td>
<td>53.8</td>
</tr>
<tr>
<td>No</td>
<td>36</td>
<td>46.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>78</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

*Note: This table displays the percentage of parents that knew other parents with a gender-incongruent child.*

Figure 4. Number of parents who knew peer parents in group AL− versus AL+

*Note: This figure displays the number of parents who knew other parents with a gender-incongruent child in AL− versus AL+.***
Chapter IV
Discussion

This study aimed to better understand parents' experiences of AL at the discovery or disclosure of their child's perceived gender identity. When therapists know which moderators to focus on, they can develop better counseling procedures to reduce their clients' symptoms of depression, anxiety, and stress and acknowledge their feelings of AL. First, the percentage of parents who experienced AL (AL+) and those did not experience AL (AL−) was calculated. Secondly, different characteristics of the AL+ and AL− groups were compared to identify potential factors that could explain differences in participants' reactions to the discovery or disclosure of their child's perceived identity. This study also explored levels of stress, anxiety, and depression in both the AL+ and AL- groups and aimed to capture the relevance of effective counseling programs for parents who experience AL. Finally, this study aimed to examine moderating factors for AL to identify focus points for the development of counseling strategies for parents who experience AL. The most prominent finding to emerge from this study is that therapists must increase social support systems for parents of gender-incongruent children who experience AL. The results further support the idea that counseling should focus on replacing avoidant coping with a more helpful coping strategy.

Coolhart et al. (2018) provided evidence that family members of transgender children and adolescents expressed AL. Most participants in their study expressed AL, while the mothers all expressed AL. In line with Coolhart et al.'s findings, we hypothesized that most parents would experience AL at the discovery or disclosure of their child's perceived gender identity. The analysis showed that approximately half of
the parents experienced AL after the discovery or disclosure of their child's perceived gender. A notable finding was that only 33.3% of participants in this study cohort were surprised by the discovery or disclosure of their child's perceived gender identity. Families of transgender children often do not recognize that their children experience difficulties as they become aware of their gender identity, although some become aware of their child's gender quest as young as age 3 (Morrow & Messinger, 2006). Knowing or suspecting that their child has a gender identity quest might open communication on the subject between parents and their child. Knowing or suspecting can give parents enough time to come to terms with the situation, to prepare themselves by educating themselves on the subject and on how to support their child, or to identify where to turn for help. Having this time provides parents with the opportunity to develop an alternative vision of the future ahead of time and reduces the shock of the revelation. It is expected that parents who were able to have this adaptation period would experience less or no AL at their child's disclosure of the perceived gender identity. In our study population, two thirds of participants suspected the upcoming disclosure of their child's perceived gender identity quest. Therefore, we may have recruited a larger group than expected of parents who did not experience AL.

This consideration was confirmed by an apparent difference between the AL+ and AL− groups: the percentage of parents who were surprised by the discovery or disclosure of their child's perceived gender identity in the AL+ group was significantly higher than the percentage of parents who were surprised by the discovery or disclosure of their child's perceived gender identity in the AL− group (69.2% vs. 20%). This finding shows that the high percentage of parents who suspected the upcoming disclosure on their
child's perceived gender identity quest tempered the percentage of parents who reported feelings of AL in this study.

Furthermore, we found that more mothers than fathers experienced AL. This finding aligns with a substantial body of research that demonstrates that women are the more emotionally expressive gender. Emotions of sadness are believed to be more characteristic of women than men (Kelly & Hutson-Comeaux, 1999). Moreover, Bradley, Codispoti, Sabatinelli, and Lang (2001) reported that men display less emotion than women. One explanation could be normative expectations, as men are expected to be less emotional and express fewer emotions. In the literature on parents of transgender children, the discrepancy between the reactions of mothers and fathers has been attributed to the paternal anxiety that the child's gender incongruence could reflect on their masculinity. Moreover, fathers tend to need more time to accept the disclosure of their child's perceived gender identity (Gregor et al., 2015; Kane, 2006). Therefore, it is possible that fathers are less forthcoming about or willing to acknowledge and report their feelings about their child's gender quest.

Additionally, we found that the level of experienced AL was higher for mothers than for fathers. A factor to consider in explaining this difference is that women sometimes process emotions differently than men. For instance, men may minimize emotional coping mechanisms and maximize intellectual coping mechanisms (Montagne, Kessels, Frigerio, de Haan, & Perrett, 2005). Other explanations derive from neuro-anatomical research, which has shown differences in the structures responsible for affective processing between men and women. The limbic system is the part of the brain that is involved in behavioral and emotional responses (Rajmohan & Mohandas, 2007). A
study by George, Ketter, Parekh, Herscovitch, and Post (1996) showed that women activate a significantly larger proportion of their limbic system than men when experiencing sadness, which may explain differences in emotional expression between men and women.

We showed that parents who experienced AL had significantly more stress, anxiety, and depression (see Figure 3). Mean scores for stress and depression were above average compared to the normal population, which indicates that the effects of experiencing AL after the discovery or disclosure of a child's perceived gender identity significantly affected participants' lives. These results are consistent with previous studies on AL in families with missing people (Kennedy et al., 2019) and Boss's (2016) description of AL as the most stressful type of loss because of a lack of formal recognition for it and, as a result, a lack of closure. Living with someone who is perceived as both "here and at the same time gone" is a bizarre human experience; individuals may manifest symptoms such as depression and anxiety (Boss, 2006, 2016; Boss & Yeats, 2014). These findings support the importance of developing better counseling methods for parents of gender-incongruent children who experience AL to reduce symptoms of stress and depression.

Coping strategies play a crucial role in moderating adjustments to stressful life events (Bonanno & Kaltman, 1999). Kennedy et al. (2019) found that people reported the use of an avoidant coping strategy when they experienced a feeling of unclear loss, such as that described in situations of AL. Avoidant coping behavior includes avoiding places or situations, such as school or social events. Moreover, it might refer to avoiding specific thoughts that create stress or even anxiety. This is in line with the behavior
observed among many parents at the Check-in Coaching practice. Parents of gender-incongruent children often witness forms of social discrimination or other stressors directed toward them or their child (Dierckx & Platero, 2018). At Check-in Coaching, many parents reported missing family get-togethers to avoid difficult questions after the discovery or disclosure of their child's perceived gender identity. They might feel social judgments of their decision to allow their child to explore their gender in non-traditional ways or decide not to inform friends about their child's situation because they expect them to reject them or their child. Parents of gender-incongruent children describe a deep sense of loss in response to their child's transition to a different gender identity. Although the child that they once knew is gone (Norwood, 2013), a physical death has not occurred. Parents struggle to adjust to this stressful, life-changing new situation.

Consequently, parents of gender-incongruent children might use avoidance as a coping strategy after the discovery or disclosure of their child's perceived gender identity. Holahan and Moos (1987) suggested that avoidant coping strategies are a psychological risk factor when facing stressful life events. A short period of avoidance (denial) may be helpful to provide an opportunity to gain personal resources in the initial phase of coping with an overwhelming new situation. However, when a person continues to rely on avoidant coping, psychological dysfunction is likely to occur (Holahan & Moos, 1987). In working toward better counseling for parents of gender-incongruent children, we wanted to analyze whether avoidant coping moderated increased stress, anxiety, and depression levels to identify areas of interest in counseling.

This study corroborates findings from previous research, which suggested that avoidant coping is associated with higher levels of stress symptoms when experiencing
In this study, we found a trend towards higher levels of anxiety and depression among parents who scored high on avoidant coping. However, this was not a statistically significant result. The lack of statistical significance in this analysis could be due to the small sample size, since we did observe a trend.

Personality is an essential concept in the discussion of stress, anxiety, and depression. Personality may affect reactivity to stressful situations and psychological outcomes (Bolger & Zuckerman, 1995). Among existing concepts of personality, the Big Five model is considered to be the most universal. In the Big Five model, personality consist of five dimensions: openness to experience, extraversion, neuroticism, agreeableness, and extraversion. Openness to experience refers to a tendency to positively evaluate life experiences. People who score highly on openness to experience are more curious, tolerant of novelty, and relate to divergent thinking (Pollak, Dobrowolska, Timofiejczuk, & Paliga, 2020). Baumgartner and Schneider (2020) found that openness to experience was associated with more positive stress responses and Williams, Rau, Cribbet, and Gunn (2009) described greater stress resilience and lower vulnerability to stress among people who scored highly on openness to experience.

Adjusting one's existing framework to reduce stress requires flexibility of thought and liberal views. Thus, parents of gender-incongruent children must change their framework for how they perceive their child and their child's gender and create a new vision of the future.

However, the results of this study were inconsistent with the idea that openness to experience would have a buffering effect on levels of stress, anxiety, and depression among parents of gender-incongruent children who experienced AL. Baumgartner and
Schneider (2020) stated that, although some personality traits influence stress responses, different situations can also affect stress responses over and above personality. Being surprised by the discovery or disclosure of a child's perceived gender identity could be the type of situation that Baumgartner referred to. Thus, future research should include other personality traits and attitudes. These constructs could amplify explanations of the relationship between personality traits and psychological symptoms among parents of gender-incongruent children. Furthermore, Lincoln (2008) suggested that social support could moderate the effects of personality on psychological distress.

Understanding how social influences affect mental health is vital in identifying targets of intervention. Lincoln's (2008) findings suggested that both social support and negative interactions have statistically significant associations with psychological distress, even after controlling for the influence of personality. Parents at the Check-in Coaching practice have reported many examples of negative interactions that they have had, such as teachers who were not affirming of their child’s gender identity, family members who gave them the cold shoulder, or friends who ridiculed them or their child. These negative interactions took place within their own social networks. Therefore, it was clear that parents of gender-incongruent children perceived insufficient social support.

To establish target points for future counseling, this study analyzed whether perceived insufficient social support influenced levels of stress, anxiety, and depression among parents of gender-incongruent children who experienced AL. The results were consistent with Lincoln's (2008) suggestion that mental health was positively associated with having social resources (Lincoln, 2008). The current study found that the perception of insufficient social support was the most potent moderator for explaining the variability
in stress, anxiety, and depression levels among parents of gender-incongruent children who experienced AL. Hence, it lends supports to the idea that perceived social support should be a focus point in better counseling for parents; clinicians could help them with their described problems, overcome their reluctance to reach out to others for support, and enable them to find social support for their family (Boss, 1999). These results corroborate Zamboni’s (2006) statement that receiving support is essential for parents to adjust to their child's transgender identity.

Proposals for amplifying perceived social support for parents at Check-in Coaching have been made, such as parents peer support groups to help parents of gender-incongruent children meet similar peers to share their experiences. However, findings from the current study showed that more than half of participants already knew other parents with a gender-incongruent child. Against our expectations, most of the participants who reported knowing peer parents were in the AL+ group. This finding shows that in time of adversity, different relationships, i.e., friendship versus family relationships, can lead to different outcomes in psychological distress. As Lincoln (2008) showed in her analysis, social support from relatives reduced distress, but distress was unaffected by social support from friends. Family members are often identified as close and intimate members of a person's network who can provide long-term support. In counseling parents of gender-incongruent children, it would appear that the focus should be on improving social support within family systems.

Conclusions

In light of the lack of available research on the prevalence of AL and moderating factors among parents after the disclosure or discovery of their child's perceived gender,
this study provides initial data on differences between parents who experience AL and those who do not. The results suggest that counseling should be actively offered to parents of gender-incongruent children since half of the participants experienced AL, especially mothers. When parents experience AL, levels of stress, anxiety, and depression increase to the extent that they negatively affect their lives. More broadly, this study suggests the development of counseling strategies that target coping behavior and perceived social support for parents after the discovery or disclosure of their child's perceived gender identity, such as establishing parent support groups in line with the Alzheimer Society's manual for supporting clients through AL and grief. According to the manual, belonging to a support group is key to recognizing, understanding, and coping with grief and loss and taking better care of one's own needs (Alzheimer Society of Canada, 2019). However, in general, the main focus when counseling parents of gender-incongruent children should be enhancing family relationships.

Limitations and Future Directions

While the findings of this study suggest that social support and avoidant coping strategies play a role in levels of stress, anxiety, and depression among parents of gender-incongruent children who experience AL, it is essential to understand the limitations of these findings. First, the selection of participants at the Check-in Coaching practice was convenience-based. Sampling was restricted to families known at Check-in Coaching, which may have led to a particular bias in parental experiences, since these families were already seeking professional help with their children. Therefore, the data could be skewed by self-selection bias. The pool of participants may not have accurately represented the Dutch population. For example, parents who do not experience stress or anxiety upon the
discovery or disclosure of their child’s perceived gender may have a lower chance of experiencing AL. Moreover, the study excluded parents who did not speak Dutch fluently. This requirement may have introduced possible threats to the study's validity. Therefore, this study is not generalizable to parents of gender-incongruent children in the Netherlands, let alone worldwide.

Second, the participants were not randomly assigned; therefore, this quasi-experiment created a selection threat to the study's internal validity. Third, the essential and valuable findings and implications for practice must be tempered by the fact that the study had a relatively small sample size after the exclusion of partially completed questionnaires. The small sample size resulted in reduced power, which limited the ability to detect effects among the differences in the subject group, i.e., whether insufficient social support effected mothers more than fathers, or whether time elapsed since the discovery or disclosure of the child's perceived gender influenced the level of expressed AL. Therefore, conducting a similar study with more participants could be beneficial for identifying key differences in parents who do experience AL versus parents who don’t experience AL through a more statistically substantial analysis.

Additionally, a drawback of the current approach is that a detailed assessment of parents' experiences of AL or the development of AL over time could not be made. The simplicity of the measurements did not adequately capture the complexity of experiences of AL. More detailed measures should include other expected moderators of the experience and duration of AL. It is very likely that some characteristics of the gender-incongruent child themselves may influence experiences of AL among parents, such as the child's age at the time of the discovery or disclosure of their perceived gender
identity, their assigned gender at birth (male or female), and whether the child's gender identity is exclusively masculine or feminine or, for example, non-binary, agender, or gender-fluid. Therefore, these aspects should be included in future studies.

Finally, it is essential to mention that all results obtained from this study only indicate potential correlations between coping, personality, social support, and levels of anxiety, stress, and depression among parents of gender-incongruent children who experience AL; they do not infer any causation. The novel findings from this study require further replication and thorough validation in future studies. It is essential to conduct longitudinal studies to better understand the mechanism of action of any of the abovementioned variables and their actual predictive effect on AL and levels of stress, anxiety, and depression. Longitudinal studies can capture a more comprehensive array of factors over multiple periods and assess the variables' effect on AL and stress, anxiety, and depression levels. Future studies should control for these factors by randomizing parents of gender-incongruent children and include a more extensive, nationally representative sample before drawing any firm conclusions.
References


