

A Study of Parents of Sexual and Gender Minority Children: Linking Parental Reactions With Child Mental Health

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In this study of parents of sexual and/or gender minority (SGM) children, we derived a typology of parental responses to their children's SGM identities and documented associations between these response classes and child's recent mental health (e.g., depression) and related social difficulties (e.g., bullying). Parents with an SGM child younger than 30 years old ($N = 205$) completed an online survey assessing their relationship with their child and their child's mental health. Latent profile analysis classified parents based on 5 positive and 5 negative indicators of parental responses to their SGM child. We examined associations between parental response classes, parent and child sociodemographic characteristics, and child's recent (last 6 months) mental health problems. Uncovered parental classes were negative response (Class 1; 15.1%), mixed response (Class 2; 10.7%), and positive response (Class 3; 74.1%). Parent and child sociodemographic profiles differed across response classes. Adjusted logistic regression models showed that parents classified as negative response versus positive response reported that their SGM children experienced substantially greater odds of recent anxiety/worry (adjusted odds ratio [AOR] = 3.91, $p < .01$), depression (AOR = 2.73, $p < .10$), substance use (AOR = 12.79, $p < .01$), and bullying (AOR = 6.74, $p < .01$). Parents classified as mixed response versus positive response reported that their SGM children experienced substantially more recent bullying (AOR = 6.74, $p < .01$). These findings can identify parents requiring additional support navigating the significant process of accepting their child's SGM identity to improve SGM youth's mental health.

Public Significance Statement

This study suggests that there are distinct subgroups of parents defined by how they respond to their sexual or gender minority (SGM) child, and these subgroups are associated with SGM children's recent mental health and social difficulties. We identify parents who might require additional support navigating the significant process of accepting their child's SGM identity to improve SGM youth mental health.

Keywords: sexual orientation, gender identity, parenting, latent class analysis, parent–child relationship

The substantial mental health disparities affecting sexual and gender minority (SGM) individuals emerge in childhood, making SGM youth a priority population for research and affirmative pediatric clinical practice (Dowshen & Ford, 2019; Russell & Fish, 2016). SGM is an umbrella-term encompassing both sexual minority (i.e., those who identify as lesbian, gay, or bisexual or have same-gender

attraction or sexual behaviors) and gender minority individuals (i.e., those whose gender identity does not align with their assigned sex at birth; Coulter et al., 2019). SGM youth are vulnerable to poor mental health at least in part because they must negotiate typical stressors of youth and adolescence alongside coming to terms with an SGM identity, which can include managing exposure to stigma-related stressors even from within their own families (Baams et al., 2015; Earnshaw et al., 2016; Ryan et al., 2010).

Unlike several other minority populations (e.g., racial minorities, religious minorities, individuals from lower socioeconomic backgrounds), SGM youth typically do not share the same sexual or gender identity as their parents. How a parent reacts to their child's SGM identity can strongly determine their child's mental health, even across the life span (Ryan et al., 2009; Ryan et al., 2010). For instance, parental rejection of a child's SGM identity is associated with elevated rates of depression, suicidality, and substance use (D'Amico & Julien, 2012; Russell & Fish, 2016; Ryan et al., 2009), while parental support serves as a strong buffer against depressive symptoms and is associated with higher life satisfaction (Ryan et al., 2010; Simons et al., 2013). At the same time, many parental reactions, rather than

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being outright rejecting or fully accepting, are likely mixed (LaSala, 2000; Phillips & Ancis, 2008; Savin-Williams & Dubé, 1998). For instance, some parents might largely ignore the identity, subtly distance themselves from their child, feel guilty or blame themselves, or grieve the “loss” of their presumed heterosexual or cisgender child (Pachankis et al., 2018; Phillips & Ancis, 2008; Savin-Williams & Dubé, 1998).

Although the association between parental responses to a child’s SGM identity and the child’s mental health has been established across numerous studies, several methodological features hamper conclusions that can be drawn and therefore their clinical utility. For instance, most prior studies on parental reactions toward their SGM children have relied on youth self-reports, often retrospectively (D’Amico & Julien, 2012; Feinstein et al., 2014; Padilla et al., 2010; Ryan et al., 2009; Ryan et al., 2010; Samarova et al., 2014). This approach can introduce same-source reporting bias and known confounds between mental health and perceptions of social support (Meyer, 2003). On the other hand, studies that assess parental responses from parents themselves can inform clinicians’ capacity to support parents in accepting their SGM child’s identity, yet such studies are rare, and of those that do exist, a majority are qualitative with small samples (Ben-Ari, 1995; Goodrich, 2009; Lee & Lee, 2006; Phillips & Ancis, 2008; Trahan & Goodrich, 2015).

A notable exception is a recent survey of 1,195 parents of sexual minority youth that assessed parents’ negative attitudes about having a sexual minority child. This study found that African American and Latinx parents, parents with older children, and the child’s more recent coming out were associated with parents’ self-reported negative attitudes. Despite representing one of the first and largest quantitative investigations of parental responses to youth’s sexual minority identities, this study assessed negative attitudes through a single item (i.e., “On a scale of 1 to 5, how hard is it for you, knowing that your son or daughter is gay, lesbian, or bisexual?”) that the authors noted could be interpreted as either assessing parental rejection or might simply indicate concern for their child’s well-being (Huebner et al., 2019). In fact, beneficent worry about one’s SGM child’s well-being is a common parental response that differs from rejecting responses (Beeler & DiProva, 1999; Bernstein, 1990; Phillips & Ancis, 2008; Robinson & Brewster, 2016). Similarly, most other studies rely on a one- or two-item measure to assess parental acceptance, and from the perspective of the SGM youth (Feinstein et al., 2014; Pachankis et al., 2018; Samarova et al., 2014). Recently, some studies have sought to develop measures assessing different domains of perceived parental support (e.g., parental attitudes toward transgender children’s gender expansiveness; Hidalgo et al., 2017), but these approaches are limited to assessing the perceptions of SGM youth. Although important, such approaches are incapable of capturing more nuanced parental responses, often neither wholly negative nor positive, that have been documented as prevalent through qualitative research (Freedman, 2008; Savin-Williams & Dubé, 1998).

A full quantitative typology of parental responses along the negative-to-positive continuum remains unavailable, precluding knowledge of how distinct parental responses, including responses composed of a mix of rejection and support, co-occur. Further, no known study has linked such a typology to SGM youths’ mental health. Deriving specific profiles of parental responses and linking them to youths’ mental health and related social difficulties (i.e., bullying) would help clinicians identify particularly at-risk families

and potentially guide unaccepting parents through navigating—and ultimately accepting—their child’s identity to improve mental health.

With the purpose of improving understanding of parental responses toward their SGM children, we sought to assess the perspective of parents themselves. We then quantitatively identified distinct profiles of parental responses to an SGM child and linked these profiles to reports of their child’s mental health problems. By drawing on a sample of parents of SGM youth and utilizing a novel analytic approach incorporating numerous elements of parental responses to their child’s SGM identity, findings from this study can provide a nuanced understanding of parental responses to SGM youth, thus advancing the mental health profession’s capacity to support parents of SGM youth as they navigate the important process of accepting their child’s SGM identity (Dowshen & Ford, 2019).

Method

Study Sample

Participants were recruited to participate in a web-based survey that invited parents of SGM youth to answer questions related to their relationship with their child and their child’s mental health. Inclusion criteria were having at least one SGM child younger than 30 and residing in the United States. Participants with more than one SGM child were advised to keep one child in mind while answering the survey questions. Participants were recruited through online advertisements (Facebook, Google), listservs, and community flyers. Participants provided informed consent and were offered a \$10 gift card for participation. Responses were screened for logical inconsistencies (e.g., parent reporting their own age as younger than their child’s age) and random patterns of responding to quantitative or open-ended qualitative items as agreed upon by two independent coders; 264 valid responses were included in the final sample.

The present analyses were limited to parents of SGM youth who themselves identified as heterosexual and cisgender ($N = 205$). Most parents in the sample were female (78.5%), had attained at least a 4-year college education (62.9%), identified as White (83.9%), and were affiliated with a religion (75.1%; see Table 1). The average age of parents was 47 years old. Children of parents in the sample were approximately 19 years old and disclosed their SGM identity to their parent at approximately age 16; a majority identified as gay or lesbian (58.1%), were assigned female sex at birth (55.1%), and were cisgender (59.0%). This study was approved by the University of Maryland Institutional Review Board.

Measures

Demographics

Parents reported their age, gender, education level, race/ethnicity, religious affiliation, whether their religion is accepting of SGM individuals, whether their coparent knows about their child’s sexual or gender identity, and their child’s age, age of coming out to the parent, sexual orientation, sex assigned at birth, and gender identity.

Parental Response Indicators

Ten questions assessed parental responses to their child’s SGM identity and related factors. To incorporate indicators across the negative-to-positive continuum, five questions assessed more neg-

Table 1
Parent and Child Demographic Characteristics by Parent's Latent Class Membership

Variable	N = 205 n (%)	Negative parental response class (n = 31) n (%)	Mixed parental response class (n = 22) n (%)	Positive parental response class (n = 152) n (%)	F or χ^2
Parent age (n = 200) M, SD	46.9, 8.1	43.3, 7.3 _a	45.0, 9.7 _{ab}	47.9, 7.7 _b	5.3**
Parent gender					24.9***
Male	44 (21.5)	17 (54.8) _a	5 (22.7) _b	22 (14.5) _b	
Female	161 (78.5)	14 (45.2)	17 (77.3)	130 (85.5)	
Parent education level					11.5**
Lower than 4-year college degree	76 (37.1)	13 (41.9) _{ab}	15 (68.2) _a	48 (31.6) _b	
4-year college degree or higher	129 (62.9)	28 (58.1)	7 (31.8)	104 (68.4)	
Parent race/ethnicity					14.0***
White	172 (83.9)	22 (71.0) _a	14 (63.6) _a	136 (89.5) _b	
Person of color	33 (16.1)	9 (29.0)	8 (36.4)	16 (10.5)	
Coparent knows child is sexual or gender minority					10.9**
Yes	169 (82.4)	24 (77.4) _{ab}	13 (59.1) _a	132 (86.8) _b	
No, don't know, no co-parent	36 (17.6)	7 (22.6)	9 (40.9)	20 (13.2)	
Parent identifies with a religion					3.0
Yes	154 (75.1)	27 (87.1)	17 (77.3)	110 (72.3)	
No	51 (24.9)	4 (12.9)	5 (22.7)	42 (27.6)	
Religion accepting of sexual or gender minorities (n = 153)					7.1*
Less accepting	105 (68.6)	22 (81.5) _a	15 (88.2) _a	68 (62.4) _a	
More accepting	48 (31.4)	5 (18.5)	2 (11.8)	41 (37.6)	
Child age					3.7*
M, SD	19.4, 4.7	21.4, 3.2 _a	20.0, 4.0 _{ab}	18.9, 5.0 _b	
Age child came out to parent (n = 204)					5.1**
M, SD	16.1, 4.3	18.2, 3.5 _a	16.7, 3.0 _{ab}	15.5, 4.5 _b	
Years since child came out to parent (n = 204)					0.34
M, SD	3.5, 3.1	3.1, 2.5	3.2, 3.0	3.6, 3.2	
Child sexual orientation					20.3**
Gay or lesbian	119 (58.1)	28 (90.3) _a	13 (59.1) _{ab}	78 (51.3) _b	
Bisexual	44 (21.5)	3 (9.7)	7 (31.8)	34 (22.4)	
Queer	15 (7.3)	0 (0.0)	1 (4.6)	14 (9.2)	
Heterosexual or uncertain	27 (13.2)	0 (2.8)	1 (4.6)	26 (17.1)	
Child sex assigned at birth					19.4***
Male	92 (44.9)	25 (80.7) _a	10 (45.5) _b	57 (37.5) _b	
Female	113 (55.1)	6 (19.4)	12 (54.6)	95 (62.5)	
Child gender identity					17.0***
Transgender or gender diverse	84 (41.0)	5 (16.1) _a	4 (18.2) _a	75 (49.3) _b	
Cisgender	121 (59.0)	26 (83.9)	18 (81.8)	77 (50.7)	

Note. Proportions or means without a common subscript letter differ ($p < .05$) as analyzed by pairwise chi square tests with Holm-Bonferroni adjustment or analysis of variance and the Tukey's test.

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

ative responses and five questions assessed more positive responses. To standardize indicators across Likert-type scales, we transformed indicators by the proportion of maximum scaling method that transforms each scale from 0 (minimum possible response) to 1 (maximum possible response), with the maximum response denoting highest endorsement of each indicator (Little, 2013).

Negative indicators included the following:

1. Disagreements related to child's SGM identity—"My child and I get into disagreements related to my child's LGBTQ status" (1 = *never*, 3 = *sometimes*, 5 = *often*).
2. Sadness—"I feel sad that my child came out as LGBTQ" (1 = *strongly disagree*, 4 = *somewhat agree*, 6 = *strongly agree*).

3. Grief—"My child coming out as LGBTQ feels like the loss of the child I once had" (1 = *strongly disagree*, 4 = *somewhat agree*, 6 = *strongly agree*).

4. Worsened relationship—"My relationship with my child has gotten worse since my child came out as LGBTQ" (1 = *strongly disagree*, 4 = *somewhat agree*, 6 = *strongly agree*).

5. Shame—"I feel shame for my child being LGBTQ" (1 = *strongly disagree*, 4 = *somewhat agree*, 6 = *strongly agree*).

Positive indicators included the following:

1. Acceptance—"I feel accepting towards my LGBTQ child" (1 = *not at all*, 2 = *somewhat*, 3 = *very much*).

2. Social support—"I plan to ensure my child has social support to cope with some of the challenges with being LGBTQ" (1 = *very unlikely*, 3 = *neither unlikely or likely*, 5 = *very likely*).
3. Education—"I plan to support my child by educating myself to understand my child and the LGBTQ community better" (1 = *very unlikely*, 3 = *neither unlikely or likely*, 5 = *very likely*).
4. Involvement—"I plan to support my child by showing my support for the LGBTQ community (e.g., by getting involved in activism and LGBTQ rights campaigns, joining LGBTQ groups)" (1 = *very unlikely*, 3 = *neither unlikely or likely*, 5 = *very likely*).
5. Improved relationship—"My relationship with my child has improved since my child came out as LGBTQ" (1 = *strongly disagree*, 4 = *somewhat agree*, 6 = *strongly agree*).

Child's Mental Health and Related Social Difficulties

Parents reported their child's recent mental health problems and related social difficulties in response to the question, "How often has your child been experiencing any of the following problems in the last 6 months? (0 = *never/not at all*, 4 = *very often*)" for four outcomes, including (1) anxiety/worry, (2) depression, (3) substance use, and (4) experiencing bullying. A binary variable was created for each outcome to identify those parents who reported that their child experienced the problem often or very often in the last 6 months.

Statistical Analyses

Statistical analyses proceeded in three stages. First, latent profile analysis (LPA) was conducted to uncover classes of parents based on the five positive and five negative indicators of parental responses to their child's SGM identity. LPA is an analytic technique whereby a sample of individuals is categorized into classes based on the probability of responses to a selection of continuous indicator variables (Lanza & Rhoades, 2013; Muthén & Muthén, 2000). Everyone in the sample is assigned to the class to which they have the highest likelihood of belonging (Woo et al., 2018). We used LPA with maximum likelihood estimation to fit models containing between one and

five classes. Optimal class number was selected based on the following criteria: Akaike information criterion; Bayesian information criterion; entropy; the bootstrap likelihood ratio test; and class size, stability, and interpretability (Lanza & Rhoades, 2013; Nylund et al., 2007). Based on these fit criteria, each three-, four-, and five-class solution was supported as a candidate model, but a three-class solution was considered optimal because of the size and stability of emergent classes (Nylund-Gibson & Choi, 2018; see Table 2).

Second, to compare differences in demographic characteristics and mental health problems across the three uncovered classes, we conducted a series of bivariate analyses, including chi-square tests and post hoc tests with Holm-Bonferroni-adjusted *p* values for categorical variables and analyses of variance with post hoc Tukey's tests for continuous variables. Third, to determine whether a parent's class membership was associated with their child's mental health, we conducted a series of multivariable logistic regression models regressing the presence of a child's mental health problems onto their parent's latent class membership. Models were adjusted for potential confounders including child's age, sexual orientation, sex assigned at birth, gender identity, and years since coming out to their parent.

Children's mental health problems might be more likely to be reported by parents whose children live at home versus those whose children do not live at home simply by virtue of being in closer proximity to their children and/or being more aware of their children's recent mental health problems. We therefore conducted post hoc sensitivity analyses to determine whether parents whose children were likely to be living at home (i.e., 18 years or younger) reported more recent mental health problems than parents whose children were less likely to be living at home (i.e., over age 18). To do so, we first created a binary variable identifying those parents whose children were 18 years or younger ($n = 89$; 43.6%) versus over 18 ($n = 115$; 56.4%). Second, we compared the proportions of children's recent mental health problems and related social difficulties by age category using chi-square tests. Last, we ran the multivariable logistic regression models described above with the binary age cohort variable included as a predictor of children's mental health problems. LPA was conducted in *R* using the *tidyLPA* package (Rosenberg et al., 2019) that provides an interface to Mplus Version 8.4 (Muthén & Muthén, 2019); all other analyses were conducted in SAS Version 9.4 (SAS Institute, 2017).

Table 2
Latent Profile Analysis Fit Criteria

Latent profile analysis fit index	One-class model	Two-class model	Three-class model	Four-class model	Five-class model
Log likelihood	-415.21	170.96	315.65	393.11	470.50
Bayesian information criterion (BIC)	936.88	-176.90	-407.74	-504.10	-600.32
Sample size adjusted BIC	873.51	-275.12	-540.81	-672.02	-803.09
Akaike information criteria	870.42	-279.91	-547.30	-680.22	-812.99
Entropy	1.000	0.986	0.985	0.983	0.986
Bootstrapped likelihood ratio test (BLRT)		1172.33***	289.39***	154.91***	154.77***
Minimum class, <i>n</i> (%)		47 (22.9)	22 (10.7)	14 (6.8)	16 (7.8)
Maximum class, <i>n</i> (%)	205 (100.0)	158 (77.1)	152 (74.1)	148 (72.2)	123 (60.0)

*** $p < .001$.

Results

LPA of Parental Responses to Their SGM Child

A three-class solution was considered optimal (Lanza & Rhoades, 2013; Nylund et al., 2007; Nylund-Gibson & Choi, 2018). Class 1, negative parental response ($n = 31$; 15.1%) was characterized by highest mean responses to each of the five negative parental response indicators and low-to-moderate mean responses to each of the five positive parental response indicators. Class 2, mixed parental response ($n = 22$; 10.7%), was characterized by low-to-moderate mean responses to all parental response indicators, including positive and negative elements. Class 3, positive parental response ($n = 137$; 66.8%), was characterized by highest mean responses to each of the five positive parental response indicators and lowest mean responses to each of the five negative parental response indicators. Figure 1 illustrates the specific indicator means for each emergent latent class.

Demographic Correlates of the Three Parental Response Classes

Each latent class was associated with distinct parent and child demographics (see Table 1). Overall, the negative response class had the highest proportion of parents who were male and identified with a religion, and of youth who were older, came out to their parent later, identified as gay or lesbian, and were cisgender males. The mixed response class had the highest proportion of parents with lower than a 4-year college degree, who identified with a less accepting religion, who identified as being a member of a racial/ethnic minority group, whose coparent did not know about their child's SGM identity, and of youth who identified as bisexual. The

positive response class was characterized by the highest proportion of parents who were older, female, had at least a 4-year college degree, whose coparent knew about their child's SGM identity, were not affiliated with a religion, and identified as white, and of youth who were younger, came out to their parent earlier, were assigned female sex at birth, identified as queer, and held a transgender or gender diverse (e.g., nonbinary) gender identity.

Children's Mental Health Correlates of the Three Parental Response Classes

Table 3 presents unadjusted associations between parents' latent class memberships and their children's mental health problems and related social difficulties in the last 6 months. Overall, youth whose parents were in the negative response class experienced the highest proportion of recent anxiety/worry (51.6%) and substance use (19.4%). Youth whose parents were in the mixed response class experienced the lowest proportion of anxiety/worry (18.2%), but the highest proportion of bullying (19.1%) and slightly higher proportion of depression (27.3%).

Multivariable logistic regression models, adjusted for the child's sex assigned at birth, gender identity, sexual orientation, age, and years since coming out, documented that youth with parents in the negative response class demonstrated elevated odds of recent anxiety/worry (adjusted odds ratio [AOR] = 3.91, 95% CI [1.52, 10.00], $p < .10$), substance use (AOR = 12.79, 95% CI [2.51, 65.27], $p < .01$), and bullying (AOR = 6.85, 95% CI [1.55, 30.21], $p < .05$) compared with youth with parents in the positive response class (see Table 4). There was also a trend such that youth with parents in the negative response class experienced disproportionately higher odds of depression (AOR = 2.73, 95% CI [0.93,

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Figure 1
Latent Profiles of Parents' Responses to Their Sexual and/or Gender Minority Children

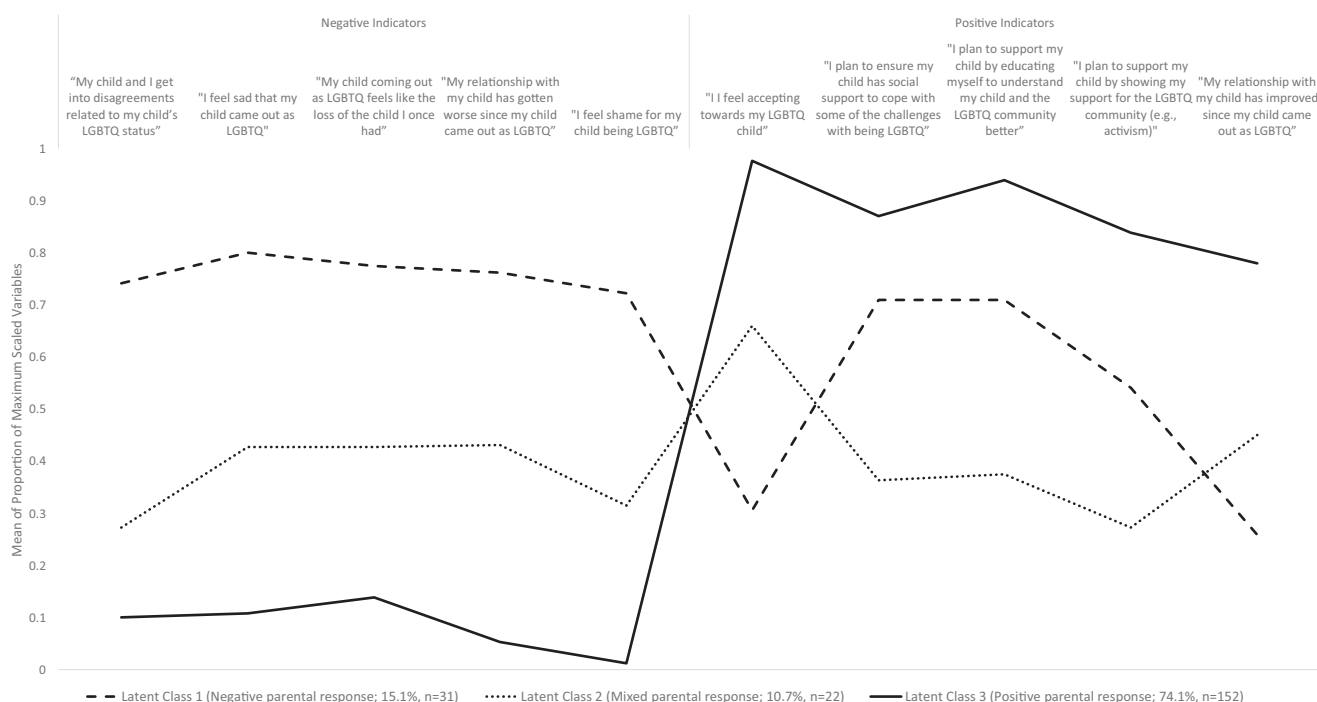


Table 3
Bivariate Associations Between Child Mental Health and Parents Latent Class Membership

Child mental health problem	<i>N</i> = 204 <i>n</i> (%)	Negative parental response class (<i>n</i> = 31) <i>n</i> (%)	Mixed parental response class (<i>n</i> = 22) <i>n</i> (%)	Positive parental response class (<i>n</i> = 152) <i>n</i> (%)	χ^2
Anxiety/worry	78 (38.2)	16 (51.6) _a	4 (18.2) _b	58 (38.4) _{ab}	6.1*
Depression (<i>n</i> = 202)	52 (25.7)	8 (25.8)	6 (27.3)	38 (25.5)	0.03
Substance use	12 (5.9)	6 (19.4) _a	1 (4.6) _{ab}	5 (3.3) _b	12.0**
Bullying (<i>n</i> = 202)	17 (8.4)	5 (16.1) _a	4 (19.1) _a	8 (5.3) _b	7.3*

Note. Parent reported child experienced mental health problem “often” or “very often” in the last 6 months. Proportions or means without a common subscript letter differ ($p < .10$) as analyzed by pairwise chi square tests with Holm-Bonferroni adjustment.

* $p < .05$. ** $p < .01$.

8.00], $p < .10$) than those in the positive response class. Youth with parents in the mixed response class experienced greater odds of recent bullying (AOR = 6.74, 95% CI [1.60, 28.38], $p < .01$) compared with youth with parents in the positive response class.

Sensitivity Analyses

Post hoc sensitivity analyses showed that parents whose children were likely to live at home (i.e., those 18 years and younger) were not more likely to report child mental health problems than parents whose children were less likely to live at home (i.e., those over 18). Chi-square tests comparing proportions of mental health problems by parents whose children were over 18 (56.6%) versus 18 years or younger (43.4%) showed no significant differences in proportion of anxiety/worry (over 18: 35.6%; 18 or younger: 41.6%, $p = .39$), depression (over 18: 24.6%; 18 or younger: 27.3%, $p = .66$), or experiencing bullying (over 18: 7.1%; 18 or younger: 10.1%, $p = .44$). Parents whose children were less likely to live at home reported marginally more child substance use than parents whose children were more likely to live at home (over 18: 8.7%; 18 or younger: 2.3%, $p = .052$). Multivariable logistic regression models adjusted for potential confounders showed no significant associations between parent-reported child mental health outcomes and children’s age group (i.e., over 18 vs. 18 or younger; all 95% confidence intervals crossed the null). These results suggest that children’s likelihood of living in the same household as a parent, and therefore being more observed by a parent, did not seem to affect parents’ likelihood of reporting children’s recent mental health problems.

Discussion

With the goal of advancing understanding of parental responses to their child’s sexual or gender minority (SGM) identity to identify at-risk families, we quantitatively derived a typology of parental responses and linked this typology to children’s mental health. By drawing on information from parents themselves and assessing indicators of parental responses along the negative-to-positive continuum, these findings, to our knowledge, represent the most nuanced quantitative depiction of parental responses to SGM youth to date. Such information can inform clinicians’ capacity to identify families that might require additional support and guidance as they navigate the significant process of coming to terms with, and accepting, their child’s SGM identity (D’Amico & Julien, 2012; Dowshen & Ford, 2019; Ryan et al., 2010).

We identified three unique classes of parental responses to their SGM children, including negative, mixed, and positive responses. This finding is aligned with recent qualitative evidence from the perspective of transgender adolescents that uncovered a similar three-factor structure of parental responses (Johnson et al., 2020). That more than one-in-ten parents were identified to be a member of the mixed response class supports existing qualitative evidence documenting that parental responses to a child’s SGM identity are sometimes neither wholly accepting nor rejecting, and reflect layered states of guilt, acknowledgment, denial, concern for the child’s well-being, acceptance, and gratitude (Ben-Ari, 1995; Goodrich, 2009; Phillips & Ancis, 2008; Savin-Williams & Dubé, 1998). Parents’ sociodemographic characteristics differed across

Table 4
Partial Results From Multiple Logistic Regression Models Regressing Child Mental Health Problems Onto Parent Latent Profile Membership

Parent latent profile membership	Child’s mental health problem ^a			
	Anxiety/worry AOR [95% CI]	Depression AOR [95% CI]	Substance use AOR [95% CI]	Bullying AOR [95% CI]
Negative parental response class	3.91 [1.52–10.00]**	2.73 [0.93–8.00]†	12.79 [2.51–65.27]**	6.85 [1.55–30.21]*
Mixed parental response class	0.41 [0.12–1.33]	1.52 [0.51–4.55]	1.42 [0.15–13.81]	6.74 [1.60–28.38]**
Positive parental response class	1 (reference)	1 (reference)	1 (reference)	1 (reference)

Note. $N = 202$. Parent reported that child experienced mental health problem “often” or “very often” in the last 6 months; models adjusted for child’s sex assigned at birth, gender identity, sexual orientation, age, and years since coming out. AOR = adjusted odds ratio.

† $p < .10$. * $p < .05$. ** $p < .01$.

the three classes, with the more negative and mixed response classes having a greater proportion of fathers, racial/ethnic minorities, and parents who reported a religious affiliation, especially one that is less accepting of sexual and gender minorities. These findings hew closely to prior evidence documenting that SGM youth's relationships with their fathers are often more fraught than with their mothers, and that gay and bisexual boys and transgender girls, in particular, report feeling less connected to their fathers than their mothers, in part due to masculinity threat (Horn & Wong, 2014; Pachankis et al., 2018; Savin-Williams, 2001; Savin-Williams & Dubé, 1998; Wren, 2002). Additionally, prior research has shown that racial/ethnic minority and more traditionally religious families often experience conflict between acceptance of their SGM child and conservative cultural values (Craig et al., 2017; Pastrana, 2015; Potoczniak et al., 2009). In line with recent clinical practice recommendations (Adelson, 2012), our results, therefore, suggest that mental health clinicians who serve communities with a higher proportion of religious and/or racial/ethnic minority clients might be in a position to help parents accept their SGM child. Such support can include identifying paths of acceptance that do not demand foregoing culturally specific systems of meaning, identity, and community support. Clinician support can include the provision of evidence-based counterstereotypic information (e.g., regarding SGM resilience and community thriving; Adelson, 2012) and referral to well-established organizations with experience facilitating parental acceptance within distinct cultural/religious traditions (e.g., PFLAG, faith-based resources specific to the families' religion; Human Rights Campaign, 2019).

In terms of associations with mental health, parents classified into the negative response class, compared with the positive response class, reported that their children experienced more difficulties in the last 6 months with anxiety/worry, depression, substance use, and bullying even after adjusting for potential demographic confounds. SGM youth who experience rejection at home and at school represent a priority population for intervention given that the cumulative toll of low social support at home and at school exacerbates poor mental health and associated maladaptive coping behaviors, including substance use (Huebner et al., 2015; La Roi et al., 2016; Reisner et al., 2015; Ryan et al., 2009). We posit that the substantially elevated propensity for frequent substance use engagement among SGM youth with parents who respond more negatively to their SGM identity might be a consequence of the stigma-related stress generated by the compounding influence of rejection from both peers and parents. Overall, more than one in four parents were classified into the negative or mixed response classes, with SGM youth in these classes experiencing similarly elevated levels of bullying.

Interventions focused specifically on mitigating parents' negative responses to their SGM child might involve coping interventions that educate and support parents to avoid rejecting behaviors, improve parent-child communication, and work with parents to process and cope with negative emotions related to their child's SGM identity. Diamond and Shpigel (2014) propose a model for adapting attachment-based family therapy (ABFT) for SGM young adults and their persistently nonaccepting parents, including several treatment tasks involving therapist alliance-building with both parents and children and processing parents' negative emotions including disappointment, anger, fear, and shame (Diamond & Shpigel, 2014). A pilot open trial of this adapted therapy with 10

suicidal lesbian, gay and bisexual adolescents demonstrated preliminary feasibility (i.e., successful recruitment and retention) and significant decreases in suicidal ideation, depressive symptoms, and maternal attachment-related anxiety and avoidance (Diamond et al., 2012). Although only a larger randomized-controlled trial can further demonstrate the efficacy of such an adapted ABFT for SGM youth and their parents, these findings suggest promise in family-based interventions that work with parents to reduce negative responses to their SGM child. Another family-based treatment that can help to support parents and SGM children is the multidimensional family approach (MDFA) for transgender and gender-nonconforming (TGNC) children and their families (Malpas, 2011). The MDFA employs the therapeutic goals of supporting parents in accepting their child's gender identity and expression, mitigating their anxiety, and ultimately advocating for their child beyond the family system in social environments (e.g., school, faith communities). The MDFA model involves several components to support parents and children including parent engagement and psychoeducation, child assessment and therapy, parental coaching, family therapy, and parent support group (Malpas, 2011). Although ABFT and MDFA both represent promising interventions for increasing acceptance among parents of SGM children, the most rejecting parents might also be the least likely to seek treatment; thus, any efforts to develop and test family based interventions for SGM youth and their nonaccepting parents should concurrently seek to develop effective avenues to identify and engage the most high-risk families.

Despite the current study's methodological strengths (i.e., direct reports from parents themselves, comprehensive typology, link to youths' mental health), results should be interpreted considering three limitations. First, our study only included parents of SGM youth, and parents might be less reliable reporters of youth's mental health and related social difficulties than youth themselves, especially in the case of internalizing mental health problems (De Los Reyes & Kazdin, 2005). Future research might therefore seek to link parental responses as reported by parents with their children's reports of their own mental health and identities particularly given recent qualitative evidence suggesting that SGM children's identity development is often a transactional process between child and parent (Katz-Wise et al., 2017). At the same time, our study extends prior research that has mostly relied on children's reports of their parent's responses and their own mental health, which also introduces several threats to validity as mentioned earlier. Second, the cross-sectional nature of this study precludes causal inference while it lays the groundwork for future prospective designs across the coming out process. Third, our recruitment approach likely yielded a higher proportion of accepting parents than exists in the general population, and thus, these findings may not be generalizable to all parents of SGM youth. At the same time, that our approach still identified a high proportion of parents characterized as holding negative responses, our results speak to the importance of continuing to identify and reach such parents in the general population.

Conclusion

Drawing on a novel analytic approach and information from parents themselves, we find that parents of SGM youth fall into three classes along the negative-to-positive continuum, including

negative, mixed, and positive responses to their SGM child. SGM children of parents classified as having negative responses were more likely to experience last-6-month anxiety, depression, substance use, and bullying than their SGM peers with parents who responded more positively to their SGM child. SGM children of parents with more mixed responses also experienced a high proportion of recent bullying relative to the other groups. These findings buttress prior evidence demonstrating that parental support of an SGM child is a critical element of SGM youth's mental health. We echo recent clinical recommendations suggesting that mental health professionals can play a critical role in helping parents understand the importance of acceptance for their SGM child (Adelson, 2012; Dowshen & Ford, 2019). These results suggest that interventions, such as provision of counterstereotypic information, family based therapeutic coping interventions, and referral to support resources might play an important role in reducing the mental health problems that disproportionately affect this vulnerable population.

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