

ABSTRACT

Title of Thesis:

LGBTQ+ YOUTH THERAPEUTIC
ENGAGEMENT AND EXPERIENCES:
ASSOCIATIONS WITH LGBTQ+ FAMILY
ENVIRONMENT

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LGBTQ+ YOUTH THERAPEUTIC ENGAGEMENT AND EXPERIENCES: ASSOCIATIONS
WITH LGBTQ+ FAMILY ENVIRONMENT

by

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Thesis submitted to the Faculty of the Graduate School of the
University of Maryland, College Park, in partial fulfillment
of the requirements for the degree of
Master of Science
2024

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List of Abbreviation

CDC	Center for Disease Control and Prevention
LGB	Lesbian, gay, bisexual
LGBQ	Lesbian, gay, bisexual, queer, and/or questioning
LGBTQ+	Lesbian, gay, bisexual, transgender, queer and/or questioning
SOGICE	Sexual orientation and gender identity change efforts
TGD	Transgender and gender diverse
TGNC	Transgender and gender non-conforming
YRBS	Youth Risk Behavior Survey
RQ	Research Question
DAS	Depression and Anxiety Symptoms

Chapter 1: Introduction

LGBTQ+ youth are a vulnerable minority group in the U.S. population. According to the data from the Youth Risk Behavior Survey (YRBS), 9.5% of U.S. adolescents aged 13-17 identify as LGBTQ+ (Conron, 2020). LGBTQ+ youth often encounter unique developmental challenges and stressors that elevate their risk for negative health outcomes, such as substance use (Zaza et al., 2016), mood disorder (Scannapieco et al., 2018), and suicidal ideation and attempts (Marshal et al., 2011; Zaza et al., 2016), compared to their heterosexual, cisgender counterparts. For example, findings from the YRBS indicated that 60% of LGBQ¹ youth have felt sad or hopeless almost every day for the past year, compared to 26% of heterosexual youth (Kann et al., 2016). Similarly, a school-based sample from New Zealand indicated that 41% of transgender youth reported depressive symptoms, compared to 11.8% of cisgender students (Clark et al., 2014).

The minority stress theory (Brooks, 1981; Meyer, 2003) provides a foundational framework for understanding the increased mental health risks of LGBTQ+ youth. Minority stress theory posits that individuals with minoritized identities experience additional stressors related to the prejudice and stigma they face, which in turn increases their risk of mental health problems (Brooks, 1981; Meyer, 2003). Research on minority stress theory has linked stressors, such as victimization, stigmatization, and negative sense of self (i.e., internalized homophobia), to elevated rates of mental health symptoms among LGBTQ+ youth when compared to their heterosexual and cisgender peers (Goldbach & Gibbs, 2017; Meyer, 2003; Testa et al., 2015).

¹ The acronyms LGBTQ/LGB/LGBQ are used in this paper to denote the specific sexual and/or gender minority groups that were the focus of the cited research. Likewise, the acronym TGNC/TGD is used to indicate the particular subgroups of transgender, gender non-conforming, and/or gender-diverse individuals that were included in the studies. These acronyms are not meant to exclude or erase other identities within the LGBTQ+ umbrella but to reflect the terminology and scope of the existing literature.

In addition to these unique challenges, minority stress theory also highlights that social support can mitigate the negative effects of stressors on health and enhance individuals' resilience (Meyer, 2003). Goldbach and Gibbs (2017) emphasized the role of family environment, especially parental support, in helping LGBTQ+ youth cope with minority stress. For example, parental support, such as affirming youth's LGBTQ+ identity and advocating for LGBTQ+-related rights, is associated with better mental health outcomes and higher self-esteem for LGBTQ+ youth than for those who lack these parental supports (Bouris et al., 2010; Simons et al., 2013). On the contrary, behaviors indicating parental rejection of youth's LGBTQ+ identity negatively impact youth's mental health (D'Augelli, 2002; D'Augelli et al., 2006; Ryan et al., 2009). Non-affirming parental behaviors regarding youth's LGBTQ+ identity (e.g., homophobic/transphobic comments, disconnection between parent-child) can lead to lower self-esteem (Homma & Saewyc, 2007), greater rates of substance use (Goldbach et al., 2014; McGraw et al., 2023; Needham & Austin, 2010; Ryan et al., 2009), and higher suicidality (D'Augelli et al., 2005; Hatchel et al., 2019).

Parents serve as crucial facilitators for youth to access therapy (Radovic et al., 2015). Current research illustrates that when parents recognize the existence and severity of youth's mental health struggles, they are more likely to seek and access mental health services for their children (Radez et al., 2022; Reardon et al., 2017). Importantly, psychotherapy is a key intervention in addressing adolescents' mental health concerns (Pfeiffer & In-Albon, 2022). For LGBTQ+ youth, affirmative therapy (e.g., therapy that acknowledges, supports, and integrates youth's sexual orientation and/or gender identity throughout treatment) can help address and combat minority stress and increase resilience in the face of adversity (Lange, 2020; O'Shaughnessy & Speir, 2018; Puckett & Levitt, 2015). Meta-analyses of psychotherapy among

LGBTQ+ populations showed significant reductions in depressive symptoms and improvements in self-esteem and coping skills (Bochicchio et al., 2022; Hobaica et al., 2018). However, LGBTQ+ youth may face unique challenges in accessing therapy when compared to cisgender heterosexual youth (Zullo et al., 2021). A recent national survey on LGBTQ+ youth mental health finds that six out of ten youth who wanted therapy reported they did not receive it. Among youth who wanted but did not receive therapy, 41% reported that they were worried about getting parental consent for treatment (The Trevor Project, 2023).

One of the challenges that LGBTQ+ youth face in accessing mental health services is obtaining parental consent for services (Osborn, 2023), especially among those whose parents are unaware or unsupportive of their LGBTQ+ identity (Mehus et al., 2017; Toomey, 2021; Zullo et al., 2021). One study found that LGBTQ+ youth with unsupportive parents were less likely to disclose their suicidal ideation to their parents (Chang et al., 2022). Additionally, LGBTQ+ youth may have limited agency in choosing the type of therapy or therapist they engage with when parental consent is required (Zullo et al., 2021). For example, depending on their level of support for their child, parents may or may not seek out therapists who will provide affirmative therapeutic services. In addition, youth could be further harmed by unsupportive parents who initiate sexual orientation and gender change identity change efforts (SOGICE) – sometimes referred to as “conversion therapy” or “reparative therapy” – which has strong negative effects on individual mental health and wellbeing (Dehlin et al., 2015; Human Rights Campaign, 2023; Turban et al., 2020). Conversely, parents who support their children in their LGBTQ+ identity may seek out services that also affirm and can support LGBTQ+ youth in this identity. However, these parents often have trouble navigating the healthcare system and finding LGBTQ+-friendly resources (Shin et al., 2021; Zifkin et al., 2021). Together, studies highlight

the need to understand how parents facilitate LGBTQ+ youth's access to mental health services and the perceived quality of those services related to youth LGBTQ+ identity.

Although several qualitative studies suggest that parents supportive of their LGBTQ+ are proactive in connecting them to therapy and other resources (Katz-Wise, Godwin, et al., 2022; Riley et al., 2011), there are no quantitative studies that test the association between parents' support and/or rejection of LGBTQ+ youth's sexual and gender identity and their access to therapy and their perceptions of their therapist as being competent in LGBTQ+ issues. The purpose of this study was to explore these associations to contribute understandings that might inform strategies to support LGBTQ+ youth's access to (affirmative) therapy.

Chapter 2: Review of the Literature

LGBTQ+ youth are at a greater risk of poor mental health compared to cisgender heterosexual youth (Russell & Fish, 2016). Studies consistently show that LGBTQ+ youth are more likely to experience depressive symptoms and higher levels of suicidality than their cisgender and heterosexual peers (Marshall et al., 2011; Hatchel et al., 2021). Although literature highlights the association between parents' LGBTQ+-specific behaviors and LGBTQ youth's mental health and well-being, the role of parents as gatekeepers of mental health care access for LGBTQ+ youth is not often explored. To synthesize the relevant literature in this area, I start by discussing LGBTQ+ mental health disparities and the theoretical and empirical mechanisms of these disparities. I then examine how LGBTQ+ youth's family context is associated with their mental health. Lastly, I discuss the literature documenting LGBTQ+ youth's experience in therapy, followed by the research highlighting parent's role in youth mental health service engagement and experience. Together, this literature helps frame LGBTQ+ youth's need for mental health services and the potential LGBTQ+-specific family environment that may instigate LGBTQ+ youth's access to affirming mental health care.

LGBTQ+ Youth Mental Health Inequalities and Disparities

Adolescence is a critical developmental stage for developing self-concept and mental health symptomology onset. Research indicates that adult mental health problems often originate early in life, and the effects of early mental health concerns often last beyond childhood and adolescence (Alderman et al., 2019). According to a recent meta-analysis, 48.4% of the individuals sampled in 192 epidemiological studies worldwide reported that the onset of their mental health disorders was before the age of 18 (Solmi et al., 2022).

Compared with cisgender heterosexual adolescents, LGBTQ+ youth are more likely to experience unique stressors related to their minoritized gender and/or sexual identities, that often lead to adverse mental health outcomes (Russell & Fish, 2016; Fish, 2020). Among LGBTQ+ youth in the United States, roughly 57% reported experiencing symptoms of depression (The Trevor Project, 2023). In a meta-analysis of 24 studies, Marshal et al. (2011) found that LGB youth reported significantly higher rates of depressive symptoms than their heterosexual youth (Marshal et al., 2011). Another meta-analysis showed that LGB youth were approximately three times more likely to report depression and anxiety symptoms compared to heterosexual youth, with female sexual minority youth being more likely to report depressive symptoms compared to their male counterpart (Lucassen et al., 2017). LGBTQ+ youth are also at a higher risk for suicidal ideation and behavior when compared to cisgender heterosexual peers (CDC, 2023). According to the Youth Risk Behavior Survey (YRBS), a cross-sectional, school-based survey conducted biennially, LGB youth were three times more likely to attempt suicide in the last year than heterosexual youth (Ivey-Stephenson et al., 2020).

Although representative data on transgender and gender-diverse youth depression are relatively scarce (Connolly et al., 2016), Clark et al. (2014) found that students who identified as non-cisgender reported significantly higher depressive and anxiety symptoms compared to their cisgender counterparts in a nationally representative high school survey in New Zealand (Clark et al., 2014), suggesting a heightened prevalence of depression in transgender and gender-diverse youth than cisgender peers. In the 2017 YRBS survey, results showed that transgender students were four times more likely to report suicidal ideation than cisgender students. Transgender and gender-diverse adolescents also reported higher odds of engaging in suicidal behaviors that

required medical attention than their counterparts, predisposing them to additional suicidal risks (Thoma et al., 2019).

In general, the literature on mental health disparities between heterosexual, cisgender, and LGBTQ+ youth has largely examined the prevalence and severity of symptoms; however, recent work shows that these disparities emerge early in the life course, oftentimes as young as 10 years old (La Roi et al., 2016; Fish et al., 2021). Given this early onset, LGBTQ+ youth are at increased risk for more chronic and worsening mental health conditions across the life course, including mental health and substance use disorders in adulthood (Kessler et al., 2012; Fish, 2020). Therefore, it is crucial to investigate mutable factors that influence LGBTQ+ individuals' access to mental health services during adolescence (Fish, 2020).

Minority Stress Theory

The minority stress theory provides a foundational framework for understanding the increased mental health risks of LGBTQ+ youth. Distinguished from general stress, minority stress theory describes how sexual (Brooks, 1981; Meyer, 2003) and gender (Testa et al., 2015) minority people experience excess stressors stemming from prejudice and stigma related to minoritized sexual orientation and gender identity. Meyer (2003) categorized stress into distal and proximal stress processes in LGB populations. Distal stressors refer to institutionalized discrimination and direct victimization from the heteronormative social structures, such as discriminatory laws and policies, victimization of violence, and microaggressions. Proximal stressors refer to the subjective, internalized beliefs of one's LGB identities from socialization with others. For example, developing expectations of rejection based on one's LGB identity, concealing LGB identities, and/or internalized homophobia are the manifestations of stressors based on individual experiences with stigma related to their LGB identities (Meyer, 2003). In

addition, Meyer pointed out that the prominence of individuals' LGB identities may impact the level to which they experience minority stressors (Meyer, 2003). For example, disclosing one's sexual minority status in a hostile environment may increase exposure to enacted stressors (e.g., discrimination and harassment), whereas affiliating with the LGB community may reduce the impact of these stressors on health and health behavior.

Although the minority stress theory was initially designed to explain sexual orientation-related health disparities, Testa et al. (2015) further expanded the theory to incorporate the unique stressors and experiences related to being transgender and gender non-conforming (TGNC). In this adapted model, the construct of gender non-affirmation is included to better capture gender minority stressors that are distinct from those experienced by cisgender sexual minorities. For example, TGNC may face specific distal stressors in updating legal documents that affirm their gender identities. They might also encounter unique proximal stressors when their gender presentations do not align with their internal sense of gender (Testa et al., 2015).

Given Meyer's original focus on adults, Goldbach and Gibbs (2017) addressed and incorporated developmental consideration for minority stress theory. They emphasized developmental processes and the importance of youth's social context (e.g., family environment, parental practices) in experiencing minority stress and its effects on health. For example, compared to adults, LGBTQ+ adolescents are often in the throgs of identity developmental processes, which include the process of exploring and understanding their sexual and/or gender identities. Moreover, LGBTQ+ youth have less control over their environment and more reliance on their family than LGBTQ+ adults, making them more vulnerable to poor mental health and victimization, particularly in the context of less affirming families and schools (Goldbach & Gibbs, 2017).

Overall, the minority stress theory is a well-established framework that explains the adverse mental health outcomes of LGBTQ+ youth (Russell & Fish, 2016). This theory has been validated by numerous studies that demonstrate the association between minority stress and various indicators of psychological and behavioral distress among LGBTQ+ youth. For instance, perceived discrimination based on sexual orientation is positively correlated with depression among LGBTQ+ youth (Baams et al., 2015). Similarly, family rejection based on sexual orientation or gender identity increases the risk of depression and suicide among sexual minority young adults (Ryan et al., 2009). A meta-analysis of 44 studies also found that minority stressors such as victimization, bullying, and negative family interactions are significantly related to suicidal ideation and or attempts among LGBTQ+ youth (De Lange et al., 2022). Another meta-analysis of 128 studies revealed that internalized homophobia is linked to more mental health problems, such as anxiety, depression, and alcohol use among LGB individuals (Newcomb & Mustanski, 2010). Among transgender and gender non-conforming youth, those who reported higher levels of internalized transphobia were significantly more likely to meet the diagnosis of major depressive disorder and generalized anxiety disorder (Chodzen et al., 2019). Moreover, in a recent online survey with a sample of 39,126 LGBTQ+ youth, the odds of attempting suicide were almost 12 times higher for those who experienced cumulative minority stress than for those who did not (Green et al., 2022). Thus, minority stress theory and related studies consistently demonstrate the deleterious impacts of stigma on LGBTQ+ youth's mental health.

LGBTQ+ Youth and Their Family Environment

A substantial body of research has explored the significance of parents in contributing to adolescents' well-being (Scully et al., 2020; Steinberg, 2001). The CDC (2021) identifies the family environment as a crucial systemic indicator for promoting adolescents' mental health. For

example, a positive family environment, often measured by parental support and warmth, is associated with youth's self-esteem (Plunkett et al., 2007), future optimism, and school satisfaction (Smokowski et al., 2015). Conversely, a negative family environment, measured by high parent-child conflicts and a lack of support, is related to the youth's tendency to internalize problems and externalize behavior (Yeh, 2011).

However, in comparison with heterosexual, cisgender adolescents, there is far less research on how LGBTQ+ youths' family environment shapes their development and health (Bouris et al., 2010; Fish & Ezra, 2023; Newcomb et al., 2019). The most common research focus in this area is how parents respond to a child's disclosure of their LGBTQ+ identity (Ryan et al., 2009, 2010) and how parent-child relationship quality influences youth's mental health outcomes (Bouris et al., 2010). Although some studies show that positive parental support can buffer the negative effects of minority stress to a degree (Stettler & Katz, 2017), parental rejection is overwhelmingly harmful to LGBTQ+ youth's mental health (Ryan et al., 2009). As such, family environment, specifically related to youth's LGBTQ+ identity, has a significant impact on LGBTQ+ youth's mental health (Bouris et al., 2010; Goldbach & Gibbs, 2017; Toomey, 2021).

LGBTQ+-parental support is linked to positive mental health outcomes among LGBTQ+ youth (Abreu et al., 2022; Ryan et al., 2010; Simons et al., 2013). Current literature commonly measures supportive LGBTQ+ family environment through parental acceptance regarding youth's LGBTQ+ identity, parental advocacy about LGBTQ+ communities, and general parental warmth (Abreu et al., 2022; Ryan et al., 2010; Seibel et al., 2018). For instance, in a quantitative study with 245 LGBT young adults, participants' perceived parental support of their LGBT identity was associated with greater self-esteem, less depressive symptoms, substance use, and

suicidal ideations (Ryan et al., 2010). Another study found that parental support during adolescence was the strongest association of positive outcomes compared to support from friends or the LGB community (Snapp et al., 2015). Similarly, among transgender and gender-diverse youth, parental support is associated with lower depressive symptoms (Olson et al., 2016; Simons et al., 2013), less identity disclosure stress (Grossman et al., 2021), higher self-esteem (Grossman et al., 2021; Seibel et al., 2018), and overall higher life satisfaction (Simons et al., 2013). Specifically, in a study with 6,837 LGBTQ+ youth, the association between parental support and depressive symptoms was stronger in transgender and gender-diverse youth compared to cisgender youth (Abreu et al., 2022).

Meanwhile, there is also evidence that parental support may not be enough to buffer LGBTQ+ youth's mental health (Stettler & Katz, 2017). For instance, Mustanski et al. (2011) found that parental support did not significantly dampen the negative effects of victimization among LGB youth and young adults (Mustanski et al., 2011). In another study with an LGBT Israeli sample, parental support was not associated with psychological symptoms, showing a lack of protective effect for LGBT youth (Bebes et al., 2015). Additionally, emerging research suggests nuanced differences in parental support for LGBTQ+ youth of color. For example, LGBTQ+ youth of color report significantly lower parental support compared to their white counterparts (Abreu et al., 2022). Whereas parental support was negatively associated with depressive symptoms, the association was weaker for Latinx youth than compared to non-Latinx youth (Abreu et al., 2022). Furthermore, Abreu et al., (2023) found that parental support was only protective of depressive symptoms when Latinx LGBTQ+ youth experienced low levels of intersectional microaggressions, but not when they experienced high levels of intersectional microaggressions (Abreu et al., 2023). These findings highlight the need for more inclusive and

nuanced research on LGBTQ+-parental support and its impact on LGBTQ+ youth's development and health.

Parental rejection broadly consists of non-affirming attitudes and behaviors related to youth's LGBTQ+ identity from parents, such as homophobic/transphobic comments, discriminatory action against the LGBTQ+ community, and avoidance of LGBTQ+-related topics (Pariseau et al., 2019; Ryan et al., 2009). A growing body of research on LGBTQ+ youth's family environment documents the harms of parental rejection on youth's development (Hall, 2018). The *2023 U.S National Survey on the Mental Health of LGBTQ Young People* revealed that more than 60% of LGBTQ+ youth report that their home was LGBTQ+ unfriendly (Trevor Project, 2023). Research suggests that parental rejection is associated with poorer mental health outcomes (D'Augelli, 2002; D'Augelli et al., 2006; Pariseau et al., 2019; Ryan et al., 2009), lower levels of self-esteem (Homma & Saewyc, 2007), increased risks for substance use (Goldbach et al., 2014; McGraw et al., 2023; Needham & Austin, 2010; Ryan et al., 2009), and greater suicidality (D'Augelli et al., 2005; Hatchel et al., 2019). In a systematic review of 13 studies that examined the impact of family factors on LGB's depressive symptoms, 60% showed that parental and family rejection was a risk factor for depression (Hall, 2018). Similarly, transgender youth and young adults who reported parental verbal/physical abuse regarding their gender identity were significantly more likely to report suicide attempts (Grossman & D'Augelli, 2007). In another study, researchers coded parents' reactions to transgender youth's gender identity through clinical interviews and found that past parental non-affirming behavior predicted the youth's current depressive symptoms (Pariseau et al., 2019). These studies indicate that unsupportive and rejecting parental attitudes are harmful to LGBTQ+ youth's mental health and development.

That said, LGBTQ+ family environments often encompass a complex mix of parental support and rejection, which are distinct constructs (Hidalgo et al., 2017; Ryan et al., 2010). LGBTQ+ youth often report a mix of supportive and rejecting behaviors from caregivers and family (Allen et al., 2022; Pollitt et al., 2023). For instance, a study with 293 LGB youth living with their parents reported co-occurrence of verbal victimization and family support from their parents (D’Augelli, Grossman, & Starks, 2005). Similarly, another study with 873 transgender adults showed that over half of the respondents reported receiving a mix of both positive and negative messages from their parents, which were negatively associated with mental and physical health (Allen et al., 2022). Moreover, studies on supportive parents of LGBTQ+ youth indicate that parental support often develops over time, evolving through psychoeducation, parent-support groups, and a grieving process for the child’s assumed lost identity (Hillier & Torg, 2019; Katz-Wise, Galman, et al., 2022; Pullen Sansfaçon et al., 2020; Zifkin et al., 2021), highlighting a dynamic family environment characterized by varying degrees of support and rejection. Although earlier research viewed parental support and rejection as a continuum (e.g. D’Augelli & Grossman, 2001), recent studies increasingly measure parental support and rejection as separate constructs, acknowledging their coexistence within the family environment of LGBTQ+ youth (Pollitt et al., 2023).

LGBTQ+ Youth and Therapy Access and Experiences

Psychotherapy, also known as counseling and mental health therapy services, is an important tool for improving adolescents’ mental health (Pfeiffer & In-Albon, 2022). In one meta-analysis, an analysis of over 50 years of papers showed that therapy is an effective strategy for enhancing youth mental health (Weisz et al., 2017). Although there is less research on the effectiveness of therapy outcomes for LGBTQ+ youth compared to heterosexual cisgender youth

(Hobaica et al., 2018), two systemic reviews on the mental health interventions adopted for LGBTQ+ youth indicated that they are associated with improved mood and self-esteem and decreased stress (Bochicchio et al., 2022; Hobaica et al., 2018). Seven of the 10 studies reviewed by Bochicchio et al. (2022) had adapted the therapy models to consider minority stress and developmentally informed topics, which suggest the importance of engaging in mental health services that directly address LGBTQ+ experiences among youth (Bochicchio et al., 2022).

Parents are arguably some of the most important facilitators in youth's access to therapy, in that youth rely on parents to find healthcare resources, navigate the healthcare system, and arrange logistics for youth to attend care (Radovic et al., 2015; Reardon et al., 2017). In a qualitative study on parents' experience in accessing mental health care for their adolescent child, parental recognition of youth's mental health issues (e.g. existence, severity, and impacts) significantly boosts parents' motivation to seek help for their children (Reardon et al., 2017). Similarly, youth report that parental awareness of their severe mental health problems, especially when these problems disrupt other life aspects like school performance, prompts a more proactive approach in parents initiating therapy and seeking referrals from schools or physicians (Radez et al., 2022).

Moreover, research from the perspective of primary care providers (PCPs) indicates that the willingness of parents to engage in their adolescent's mental health care is a crucial factor in treatment accessibility. PCPs note that parental desire for mental health treatment makes it easier for them to facilitate treatment for depressed youth. Conversely, scenarios where parents are reluctant to seek treatment for their children pose considerable challenges for youth to enter services (Radovic et al., 2015). These insights collectively affirm the vital gatekeeping role of parents in initiating youths' access to therapy, especially when signs of depression and anxiety

are acknowledged. Lastly, parents are also instrumental in keeping youth engaged in therapy. A systematic review of 12 randomized control trials has identified that logistical challenges managed by parents, alongside parental resistance to therapy, have consistently led to the premature termination of therapy among children and adolescents, thereby diminishing therapy's effectiveness (Nock & Ferriter, 2005).

In addition to these general challenges of youth mental health service engagement, LGBTQ+ youth report high incidences of not being able to access wanted mental health care. The *2023 National Survey on LGBTQ+ Youth Mental Health* reported that 56% of LGBTQ+ youth in their sample desired therapy in the past 12 months but were unable to access it (The Trevor Project, 2023). Among those who had not engaged in wanted therapy in the past year, 41% had concerns about their parents' permission, 21% felt unsafe taking virtual therapy at home, and 20% reported that their parents denied them therapy access (The Trevor Project, 2023). These findings suggest that LGBTQ+ youth have unique barriers to accessing care despite a greater preponderance of poor mental health.

Multiple factors may contribute to the complicated barriers to accessing therapy through parents for LGBTQ+ youth compared to cisgender heterosexual youth. First, LGBTQ+ youth may show lower intention to ask for mental health services from rejecting parents. In a study with 592 LGBTQ+ youth, participants who experienced higher levels of family rejection reported lower intention to disclose their suicidal ideation to parents compared with youth who reported less family rejection (Chang et al., 2022). In a qualitative study with LGBTQ+ youth who have been in treatment for suicidal thoughts, participants mentioned that one of the primary barriers to accessing affirmative care is voicing the need for LGBTQ+-informed care to unsupportive parents (Zullo et al., 2021). From a structural lens, most states require consent from

both legal guardians for minors to access mental health care (Osborn, 2023), which could inhibit LGBTQ+ youth's access, especially among youth who have not come out one or both parents.

Second, even when LGBTQ+ youth voice their therapy needs, they broadly do not have autonomy in selecting what therapists they see (Zullo et al., 2021). As parents and caregivers are responsible for navigating insurance, agency waitlists, payment of the session, and commute logistics, (LGBTQ+) youth have limited say over what type of therapy they can access, and whether or not they would like to continue therapy services with non-affirming or ill-equipped therapists (Zifkin et al., 2021). This is particularly true for family therapy, where unsupportive parents of LGBTQ+ youth may show greater resistance to relational work (Blankenship et al., 2006).

Third, parents who are unsupportive of youth's LGBTQ+ identity may initiate sexual orientation or gender identity change efforts (SOGICE). Commonly known as "conversion" or "reparative" therapy, SOGICE negatively impacts individuals' mental health (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). Despite consensus from all major professional mental health organizations on the harmful effects of SOGICE, it is still practiced by mental health providers, clergy, and religious leaders that aim to "change" or suppress individuals' same-sex attraction and behavior and/or gender identity/expression (Forsythe et al., 2022). According to a study by the Williams Institute, an estimated 73,000 LGBTQ+ youth under 18 will be subjected to SOGICE (Mallory et al., 2019). Despite the scientific consensus that sexual orientation and gender identity cannot be altered, some parents may initiate SOGICE hoping to change or "fix" their children's sexual and/or gender identities (Ryan et al., 2020). Specifically, research suggested that religious parents, immigrant parents, and parents with lower education levels are more likely to subject their LGBTQ+ children to

SOGICE (Ryan et al., 2020). Packaged as “therapy”, these parent-initiated SOGICE are associated with more internalized discrimination, higher suicidal rates, and worse mental health outcomes for LGBTQ youth (Alempijevic et al., 2020; Green et al., 2020; Ryan et al., 2020).

Lastly, research on supportive parents of LGBTQ+ youth highlights the challenges they face in accessing affirmative mental health care for their children, such as limited availability, long waitlists, and arranging other logistics (Zifkin et al., 2021). Specifically, finding and affording affirmative care may demand more parental effort and resources. For example, in a heterosexism audit study, researchers found that potential clients calling would-be therapists who presented as gay were less likely to receive calls from mental health facilities, particularly in LGB-hostile states (Shin et al., 2021). Although not specific to youth, similar prejudices likely occur for parents seeking affirmative therapy for LGBTQ+ youth.

The Current Study

Although research has documented that LGBTQ+-specific family environment is associated with mental health among LGBTQ+ youth, less often studied is how these family factors may be related to LGBTQ+ youth’s access to therapy and experiences with LGBTQ+ competent providers. Therefore, I used a recent national sample of LGBTQ+ youth aged 13-17 to examine parental support and rejection of youth’s LGBTQ+ identity and its association with youth reports of past-year mental health service engagement. Among youth who reported therapy engagement, I also assessed how parental support and rejection of youth’s LGBTQ+ identity was associated with their perceptions of their therapist as LGBTQ+ informed. Among youth who did not attend therapy in the past year, I assessed the association between parental support and rejection of the youth’s LGBTQ+ identity and the youth’s desire for therapy. Specifically, I addressed 3 research questions:

Research Questions

1. What is the relationship between LGBTQ+-specific parental (a) support and (b) rejection and LGBTQ+ youth's therapy engagement in the previous 12 months?
2. Among LGBTQ+ youth who reported therapy engagement in the previous 12 months, how is LGBTQ+-specific parental (a) support and (b) rejection associated with youth's perceptions of their therapist as LGBTQ+ informed?
3. Among LGBTQ+ youth who did not attend therapy in the previous 12 months, what is the relationship between their parental support/rejection and their desire for therapy?

Hypotheses

- 1a. LGBTQ+ youth with higher levels of perceived LGBTQ+-specific parental support will be more likely to report attending therapy in the past 12 months than those reporting lower levels of support
- 1b. LGBTQ+ who report higher levels of parental rejection will be (a) less likely to report attending therapy in the previous 12 months
- 2a. Among LGBTQ+ youth who attended therapy in the previous 12 months, those with higher LGBTQ+-specific parental support will be (a) more likely to perceive their therapists as LGBTQ+ informed
- 2b. Among LGBTQ+ youth who attended therapy in the previous 12 months, those with higher levels of LGBTQ+-specific parental rejection will be less likely to perceive their therapist as LGBTQ+ informed

3a. Among LGBTQ+ youth who did not attend therapy in the past 12 months, those who reported higher parental support would be less likely to have reported needs for therapy

3b. Among LGBTQ+ youth who did not attend therapy in the past 12 months, those who reported higher parental rejection would be more likely to desire therapy

Chapter 3: Methods

Study Design and Participant Recruitment

This current study uses data from the *2022 LGBTQ National Teen Survey*, partnered with the Human Rights Campaign (HRC). The survey was collected between February and October 2022. Youth were eligible to participate if they were 13-18 years of age, identified as LGBTQ+, English speaking, and residing in the United States. Among all participants, 52% of participants were recruited from social media websites, such as Facebook, Instagram, and Discords; 38% of participants were from TikTok influencer's posts, and 10% of participants from school-based LGBTQ+ organizations such as Gay-straight-alliance, and LGBTQ+ Centers. Participants who completed the survey were offered \$5 Amazon or Starbucks gift cards. The original study was approved by the Institutional Review Board at the University of Connecticut.

Sample and Data Collection

Of the 37,221 participants who visited the survey, approximately 66% of participants met the inclusion criteria ($n = 24,570$). Among the eligible participants, 17% of participants did not complete the survey ($n = 6,200$), 2% of participants were removed due to probable mischievous ($n = 412$), and fraudulent email addresses ($n = 380$) were removed, yielding a final sample of 17,578. For the current study, I restricted the sample to participants who provided valid data to all study questions ($n = 9,528$), which is the sample I used to address the research question (RQ 1; see Figure 1). We then restricted the sample to those in therapy ($n = 4,694$) to assess RQ2. We again restricted the sample for RQ3 to those who did not access therapy in the past 12 months to assess their desire for therapy ($n = 3,954$).

Measures

LGBTQ+-Specific Parental Support. LGBTQ+-specific parental support was measured with a three-item scale evaluating parental support toward LGBTQ+ youth specific to their identity. These items were modified from previous research (Ryan et al., 2009), and were used in other studies (Abreu et al., 2023; Miller et al., 2020). The scale assessed three positive family behaviors, including “How often do your parents or caregivers say that they like you as you are regarding being an LGBTQ person?”, “How often do your parents or caregivers say that they were proud of you for being an LGBTQ person?”, and “How often do your parents or caregivers speak positively about your LGBTQ identity?” Responses included: “never” (0), “rarely” (1), “sometimes” (2), and “often” (3). Participants’ responses were averaged, with higher scores indicating greater parental support. This measure showed good internal reliability in our sample ($\alpha = .88$)

LGBTQ+-Specific Parental Rejection. Similarly, LGBTQ+-specific parental rejection was measured with a three-item scale evaluating parents’ rejecting behaviors toward LGBTQ+ youth’s sexual and/or gender identity (Abreu et al., 2023; Miller et al., 2020; Ryan et al., 2009). The scale assessed three negative family interactions specific to youth’s LGBTQ+ identity, including “How often do your parents or caregivers taunt or mock you because you are an LGBTQ person?”, “How often do your parents or caregivers say negative comments about you being an LGBTQ person?”, and “How often do your parents or caregivers make you feel like you are bad because you are an LGBTQ person?” Responses included “never” (0), “rarely” (1), “sometimes” (2), and “often” (3). Participants’ responses were averaged, where higher scores indicate greater parental rejection. This measure showed good internal reliability in our sample ($\alpha = .86$)

Therapeutic Engagement. Therapeutic engagement was assessed through participants' answers to the item "In the past 12 months, have you received therapy or counseling services?" Response options contained "Yes" (1), "No" (0), and "Don't know" (66). Participants who selected "Don't know" (66) were excluded from the analysis.

Perceived LGBTQ+ Competence of the Therapist. For participants who identified that they have received therapy in the past year, they responded to the following item "How informed is your therapist or counselor about LGBTQ issues?" with the following options: "Not at all informed" (0), "Not very informed" (1), "Somewhat informed" (2), and "Very informed" (3). The responses were recoded into a dichotomous variable reflecting those who responded, "Not at all /Not very informed" (0), and "Somewhat/Very informed" (1).

Desire for Therapy. Participants who had not received therapy in the past year, were asked "Do you wish you would have received therapy or counseling services in the past 12 months?" with the following response options: "Yes" (1), "No" (0), and "Don't know" (66). Participants who selected "Don't know" (66) were excluded from the analysis.

Covariates

Covariates were selected to help isolate the effects of parental acceptance and rejection with outcomes, independent of the desire for therapy (i.e., depression and anxiety symptoms), and other factors that might influence youth's mental health and access to therapy (i.e., race/ethnicity, sexual orientation, gender identity, parental education, and age).

Depression and Anxiety Symptoms (DAS). Participants responded to the four-item Patient Health Questionnaire-4 (PHQ-4), a well-validated measure for depression and anxiety symptoms from the past 2 weeks (Löwe et al., 2010; Mills et al., 2015). The PHQ-4 consists of four items that inquire about the frequency of experiencing anxiety, worry, depression, and loss

of interest. Responses range from “Not at all” (0) to “Nearly every day” (3). The mean score of the PHQ-4 was used as an indicator of depression and anxiety symptoms, with higher scores reflecting higher levels of distress.

Race and Ethnicity. To report their race/ethnicity, participants answered the question “Are you Hispanic or Latina/e/o/x?” with “yes” or “no”. Participants who selected yes were coded as “Hispanic/Latina”. Then, participants who selected “no” to the question were asked to indicate their Race in the “checkbox” manner where they could find all identities applicable to them. For race, the options included: “American Indian”, “Asian”, “Black or African American”, “Native Hawaiian or Pacific Islander”, “White”, and “Something else”. Participants were assigned to the race they selected, with those who identified with more than one race being recoded as “multiracial”. For the current analyses, American Indian/Alaska Native, Native Hawaiian/Pacific Island, and Something Else were combined as one group.

Sexual Orientation. Participants selected one sexual orientation that best described their current gender identity, from a list of options: “gay or lesbian”, “bisexual”, “straight/heterosexual”, “queer”, “pansexual”, “asexual”, “questioning”, and “something not listed”. Participants who selected “questioning” or “something not listed” were recoded into “something else”. For the current analyses, participants who reported their sexual orientation as pansexual or queer were merged as one group; participants who reported their sexual orientation as straight/heterosexual or something not listed were combined as one group labeled “Others”.

Gender Identity. Participants selected one gender identity that best describes their current gender identity, from a list of options: “cisgender boy”, “cisgender girl”, “transgender girl,”

transgender boy”, “gender non-conforming”, “genderqueer”, “gender fluid”, “non-binary”, “questioning”, and “different identity not listed”. Participants who selected “questioning” or “different identity not listed” were recoded into “something else”. For the current analyses, participants who reported their gender identity as genderqueer, gender fluid and nonbinary were combined into one group labeled “nonbinary”; participants who reported their gender identity as gender nonconforming or something else were merged into one group labeled “Others”.

Parental Education. Participants identified their caregivers’ highest education level by responding to the question “Across all of your caregivers, please indicate the highest level of education that any of your caregivers completed (check one)” with options including “Less than high school or GED”, “High school or GED”, “Vocational/technical school (2 years)”, “Some college”, “College graduate”, “Postgraduate degree or higher”, “Do not know”, and “I do not have caregivers”. For current analyses, participants who reported their parents’ education level as “Less than high school or GED” or “High school or GED” were combined into one group labeled “High school/GED or less”; participants who reported “Vocational/technical school (2 years)” or “Some college” were recoded into “Vocational school or some college”.

Age. Participants reported their ages in years.

Analytical Plan

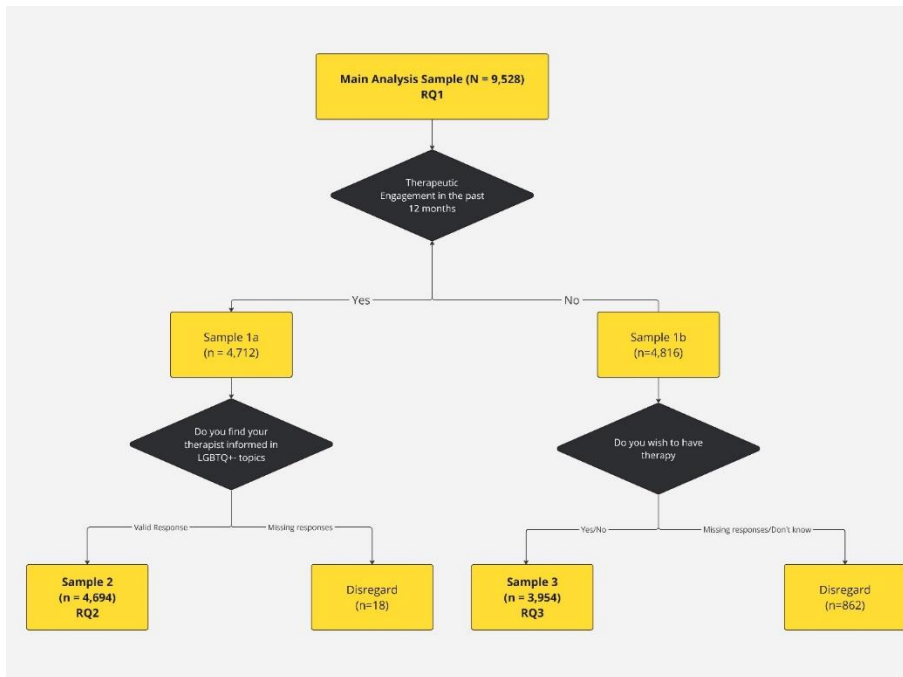
First, I calculated univariate descriptive statistics summarizing the sample demographic information and the variable characteristics, including the prevalence of LGBTQ+ who engaged in therapy in the past 12 months, the perceived LGBTQ+ competence of therapists (for those in therapy), and desire for therapy (for those not in therapy). We also ran Pearson correlations

among parental support, parental rejection, and DAS, and conducted *t*-test to assess differences in these three variables by each level of the outcomes.

Second, to address our research questions. We ran step-wise logistic regression to assess the relationship between youth's therapeutic engagement and 1) parental support; 2) parental rejection; 3) parental support and parental rejection; 4) parental support adjusting for DAS; 5) parental rejection adjusting for DAS; and 6) parental support, parental rejection, and DAS.

Among youth in therapy, I ran the same six-step model with their perceived therapist competence in LGBTQ+ issues. Similarly, among youth not in therapy, I ran the same regression with their desire for therapy. Models are adjusted for race, ethnicity, sexual orientation, gender identity, parental education, and age.

Figure 1. Sample Selection Process



Chapter 4: Results

Characteristics of the Study Sample

Sample sociodemographic characteristics are shown in Table 1. The majority of the participants in the study were white (73.5%), biracial/multiracial (10.1%) and Latinx (16.6%) were the next most common racial/ethnic groups. For sexual orientation, most participants identified as gay/lesbian (29.4%), followed by bisexual (27.5%), and pansexual (14%). For gender identity, most participants identified as gender nonbinary (28.4%), followed by transgender boy (19.4%), and cisgender boy (15.4%). Most participants reported their parent's highest education level as college (39%) or postgraduate (30%). In addition, the mean score of DAS in this sample is 6.52 ($M = 6.52, SD = 0.03$), which falls into the category of moderate depression.

Around 49% of participants reported receiving therapy in the past year. Among those who participated in therapy, 38.6% reported that they perceived their therapist as somewhat or very informed about LGBTQ+ issues, whereas 61.4% reported that their therapist was not at all or not very informed; 0.3% ($n = 18$) did not respond to this question. Among those not in therapy, 64.1% expressed wanting therapy or counseling services, 18% did not want therapy or counseling services and 18% did not respond to the question ($n = 862$).

Bivariate Descriptive Statistics of Study Variables

Table 2 reports *t*-tests examining mean differences of main study variables (LGBTQ+-parental support, LGBTQ+-parental rejection, and DAS) by therapy engagement, desire for therapy, and experiences in therapy. In the full analytic sample (RQ1 sample, $n = 9,526$), participants who engaged in therapy in the past year reported higher levels of parental support ($M = 2.11, p < .001$) and higher levels of DAS ($M = 1.72, p < .001$) than youth who did not

attend therapy last year ($M = 1.79$, $M = 1.55$, respectively). There were no significant differences in youth's reports of parental rejection across these groups. Among youth in therapy (RQ2 sample, $n = 4,694$), participants who perceived their therapists as somewhat/very informed of LGBTQ+ issues reported higher parental support ($M = 2.40$, $p < .001$) and lower parental rejection ($M = 1.67$, $p < .001$) than those who perceived their therapist as not at all/not very informed of LGBTQ+ issues ($M = 1.83$, $M = 1.80$, respectively). There were no significant differences in depressive and anxiety symptoms by perceptions of therapist LGBTQ+ competency. Among youth who did not receive therapy (RQ3 sample, $n = 3,954$), participants who desire therapy reported lower parental support ($M = 1.75$, $p < .001$), higher parental rejection ($M = 1.84$, $p < .001$), and higher DAS ($M = 1.71$, $p < .001$) than youth who did not want therapy ($M = 1.98$, $M = 1.51$, $M = 1.67$, respectively).

We then ran the correlations among parental support, parental rejection, and DAS for each of the three RQ samples. There was a weak negative correlation between DAS and parental support ($r = -0.08$ for the RQ1 sample, $r = -0.10$ for RQ2 sample, and $r = -0.10$ for RQ3 sample). There was a moderate positive correlation between DAS and parental rejection ($r = 0.26$ for RQ1 sample, $r = 0.23$ for RQ2 sample, and $r = 0.29$ for RQ3 sample). Lastly, there was a moderate negative association between parental support and parental rejection ($r = -0.27$ for RQ1 sample, $r = -0.33$ for RQ2 sample, and $r = -0.22$ for the RQ3 sample).

Research Question 1: Therapeutic Engagement

A 6-step logistic regression was run to explore the association between therapeutic engagement and parental support, parental rejection, and DAS in the full analytic sample ($n = 9,526$; see Table 3), adjusting for all sociodemographic covariates. In Model (M1), parental support was positively associated with therapy engagement; each unit change in support was

associated with 28-39% greater odds of therapy ($p < .001$). In M2, parental rejection was not significantly associated with youth's participation in therapy. When simultaneously modeling parental support and parental rejection (M3), parental support was positively and significantly related to therapeutic engagement ($OR = 1.36, p < .001$), whereas parental rejection remained non-significant. M4 modeled the relationship between parental support and past-year therapy engagement adjusting for depression and DAS and found that both were associated with greater odds of therapeutic engagement ($OR = 1.36, p < .001$ for parental support, and $OR = 1.27, p < .001$ for DAS). On the contrary, when modeling the association between parental rejection and past-year therapy engagement adjusting for DAS, I noted that the association between parental rejection and therapeutic engagement became significant, whereby higher parental rejection was related to lower odds of therapy engagement ($OR = 0.92, p = .002$); DAS was positively and significantly associated with therapeutic engagement ($OR = 1.24, p < .001$). This shift in direction and significance suggests both a suppression and mediating effect. Lastly, in M6, modeling parental support, parental rejection, and DAS (M6), I observed that parental support and DAS were positively related to the youth's therapeutic engagement ($OR = 1.37, p < .001$ and $OR = 1.26, p < .001$, respectively), whereas rejection was not significantly associated with therapeutic engagement.

Compared to gay/lesbian, youth who identified as pansexual/queer had higher odds of therapeutic engagement across all models. Compared to non-binary, youth who identified as a cisgender boy or cisgender girl showed lower odds of therapeutic engagement, whereas youth who identified as a transgender boy had higher odds of engagement across all models. Lastly, compared to youth whose parents had earned a college degree, youth with parents who earned less than a college degree had lower odds of therapeutic engagement, whereas youth whose

parents earned more than a college degree (i.e., a professional degree) showed higher odds of therapy engagement.

Research Question 2: Youth's Perceived Therapists' LGBTQ+ Competence

Among youth in therapy ($n = 4,694$), I ran the same 6-step logistic regression (see Table 4), controlling for demographic covariates. Parental support (M1) was associated with greater odds ($OR = 1.55, p < .001$) of therapists' LGBTQ+ competence, whereas parental rejection (M2) was associated with lower odds ($OR = 0.84, p < .001$) of therapists' LGBTQ+ competence. When parental support and rejection were modeled together (M3), parental support remained positively associated with therapists' LGBTQ+ competence ($OR = 1.55, p < .001$), whereas parental rejection was non-significant ($OR = 1.01, p = .972$). When adjusting for DAS, parental support (M4) remained positively associated with therapists' LGBTQ+ competence ($OR = 1.55, p < .001$), whereas parental rejection (M5) remained negatively associated with therapists' LGBTQ+ competence ($OR = 0.84, p < .001$). In both M4 and M5 models, DAS was not statistically associated with youths' perceptions of their therapists' LGBTQ+ competence. Lastly, when all variables were modeled together, parental support was associated with greater odds of therapists' LGBTQ+ competence ($OR = 1.55, p < .001$); associations between therapist's perceived LGBTQ+ competence with parental rejection and DAS were not significant ($OR = 1.01, p = .697$, and $OR = 0.97, p = .504$, respectively).

Most covariates were unrelated to therapist competence except for youth gender identity; transgender boys had greater odds of perceiving their therapists as LGBTQ+ competent compared to nonbinary youth across most models except for M3 and M4.

Research Question 3: Youth's Desire for Therapy

Among youth who reported no engagement with therapy in the past 12 months ($n = 3,954$), I ran the same 6-step logistic regression to assess youth's desire for therapy as a function of parental support and rejection (see Table 5). Higher parental support (M1) was associated with lower odds of youth's desire for therapy ($OR = 0.79, p < .001$). Greater parental rejection (M2) was associated with higher odds of youth's desire for therapy ($OR = 1.49, p < .001$). When modeled together (M3), these associations remained significant for both parental support ($OR = 0.84, p < .001$) and rejection ($OR = 1.43, p < .001$) and, after adjusting for DAS (M4: $OR = 0.84, p < .001$ for parental support; M5: $OR = 1.24, p < .001$ for parental rejection). In these same models (M4, M5), greater DAS were associated with higher odds of youth's desire for therapy ($OR = 2.33, p < .001$ and $OR = 2.26, p < .001$ for M4 and M5, respectively). When all variables were modeled together, parental support was associated with lower odds ($OR = 0.87, p < .001$), and parental rejection ($OR = 1.20, p < .001$), and DAS ($OR = 2.24, p < .001$) with greater odds, of desiring therapy.

Across all six models, Black/African American youth reported lower odds of desiring therapy compared to their white counterparts across all models. Compared to their nonbinary counterparts, youth who identified as a cisgender boy or cisgender girl had lower odds of wanting therapy across all models.

Chapter 5: Discussion

In this thesis, I sought to understand whether and to what extent parental support and rejection of their adolescent child's LGBTQ+ identity was associated with youth's access to therapy, experience in therapy (if engaged in therapy), and their desire for therapy (if not engaged in therapy). The results reveal that parental support was consistently positively related to youth's access to therapy and the degree to which youth perceived their therapist as knowledgeable on LGBTQ+ issues. Conversely, parental rejection was inversely related to therapy access, once accounting for youth's depression and anxiety symptoms, and was unrelated to whether those in therapy perceived their therapist as knowledgeable of LGBTQ+ issues. Parental rejection was also associated with increased odds of wanting therapy among youth not engaged in mental health care. I address these major findings and consider their contribution to extending the literature below.

Family Environment and Youth's Therapy Engagement

My first research question examined the association between family environment and therapy engagement among LGBTQ+ youth. Consistent with our hypothesis (1a), greater parental support predicted higher odds of youth's therapeutic engagement, even after accounting for youth's depression and anxiety symptoms. This suggests that LGBTQ+ youth in more supportive family environments are more likely to access therapy. Perceived parental support for a youth's LGBTQ+ identity may be indicative of stronger parent-child relationships and a greater willingness on the part of the youth to seek external help compared to parents who may be engaging in behaviors that devalue youth's LGBTQ+ identity (Roe, 2017). In a qualitative study on LGBTQ+ youth's experience in the family context, adolescents expressed feeling more open

to discussing what they need when they perceive their parents as supportive of their LGBTQ+ identity (Mehus et al., 2017). Furthermore, parental support for the youth's LGBTQ+ identity may reflect the parents' openness to learning about sexual orientation and gender identity (Rosenkrantz et al., 2020). Existing literature on parental experiences with LGBTQ+ youth often describes a progression wherein parents may not immediately accept and support their children's LGBTQ+ identity (Huebner et al., 2019). As such, they may undergo stages of learning and processing before fully acknowledging and beginning to understand and accept their child's identity (Katz-Wise, Godwin, et al., 2022; Pullen Sansfaçon et al., 2020; Roe, 2017). Hence, parents who have demonstrated support and acceptance towards their LGBTQ+ youth likely possess a deeper understanding of their children's experiences and may be more likely to connect them with therapeutic resources. Future research should seek to explore the mechanisms through which family support creates access to therapy for LGBTQ+ youth.

At first, it appeared that our hypothesis (1b) was unsupported; when modeled independent of parental support and depression and anxiety symptoms, parental rejection was not significantly related to therapy access. However, when the model was adjusted for depression and anxiety symptoms, parental rejection was associated with lower odds of therapy engagement.

These results across models emphasize that the driving force between parental rejection and therapy access is youth's depression and anxiety symptoms. In other words, consistent with previous research (Hall, 2018; Hatchel et al., 2019; Marshal et al., 2011; Pariseau et al., 2019), greater parental rejection related to youth's LGBTQ+ identity is associated with greater depression and anxiety, which is then the rationale for youths' greater odds of therapy engagement. The fact that parental rejection was related to lower odds of therapy engagement after accounting for depression and anxiety symptoms, suggests that parents who are struggling

to support their adolescent child's sexual orientation and/or gender identity may be less likely to support their access to therapy, absent their concerns of their child's mental health.

Several factors may contribute to this finding. First, parental rejection is linked to poor family functioning (Baiocco et al., 2016), characterized by low levels of family cohesion and adaptability. This suggests that LGBTQ+ youth experiencing parental rejection may have fewer positive views of their parent-child relationships, making them less likely to discuss therapy needs with their parents. For example, Chang et al. (2022) found that LGBTQ+ youth with unsupportive parents were less likely to disclose suicidal ideation to their family compared to those with supportive parents (Chang et al., 2022). Similarly, Burke et al. (2021) reported LGBTQ+ youth experiencing increased worries about disclosing self-harm thoughts and behaviors to their parents (Burke et al., 2021) compared to their cisgender and heterosexual counterparts. Second, in line with minority stress theory, youth who perceive their parents as rejecting are likely to experience stigmatization from their family context. One of the most common coping strategies is to hide their LGBTQ+ identity from their parents, along with their struggles (Mehus et al., 2017). Therefore, although parents may recognize symptoms of depression or anxiety, they are less aware of their children's experiences regarding sexual and gender identity, and less likely to connect them with related resources. Moreover, parental rejection of LGBTQ+ identity is also related to more traditional beliefs and values (Baiocco et al., 2016), which may result in reduced willingness to initiate mental health services for their children due to stigma (Williams & Polaha, 2014), especially in the absence of youth's depression and anxiety.

Furthermore, when parental support, rejection, and youth mental health symptomology were modeled together, only parent support and youth mental health were related to greater odds

of therapy engagement. Thus, in sum, parental support and depression and anxiety symptoms were most consistently and strongly related to LGBTQ+ youth accessing therapy. Consistent with existing literature, depression and anxiety are common drivers of youth engagement in therapy in general (Kim et al., 2012). Symptoms of depression and anxiety can significantly impact various aspects of youth's lives, from family dynamics to academic performance. Consequently, parents may notice signs of depression and anxiety irrespective of youth's LGBTQ+ identity. Moreover, parental support was identified as a more influential factor in facilitating therapy engagement than parental rejection from our findings. This highlights how supportive parents, through their deepening understanding of their child's experiences, play a key role in connecting LGBTQ+ youth with the mental health support they need.

Family Environment and Perceived Therapist LGBTQ+ Competence

My second research question was restricted to youth who reported receiving mental health services in the previous year and tested the association between parental support and rejection and youth's perceptions of their therapists' LGBTQ+-related competence. Consistent with our hypotheses (2a, 2b), parental support was consistently related to higher odds of perceived LGBTQ+ competence among therapists, whereas parental rejection was associated with lower odds of therapists' LGBTQ+ competence. When support and rejection were modeled together, parental support was the only significant predictor of therapist LGBTQ+ competency, suggesting that this was the most important factor in increasing youths' access to mental health care providers that they perceived as aware of LGBTQ+ issues.

These findings support our supposition that supportive parents may be more proactive in seeking LGBTQ+ affirmative therapy for their children or, at the very least, a therapist who is more prepared to work with LGBTQ+ youth. This could be due to a variety of factors. First,

supportive parents are more aware of their children's need to explore their identity, which may inform their decision to seek out an LGBTQ+-affirming therapist (Pullen Sansfaçon et al., 2020). Second, beyond better communication between the supportive parents and their children, supportive parents often display greater resolve in seeking out LGBTQ+ informed therapists, a task that can be challenging due to the limited availability of therapists, and lengthy waitlists (Shin et al., 2021; Zifkin et al., 2021). Furthermore, in attempts to support and understand their youth's LGBTQ+ identity, supportive parents often leverage resources such as parent support groups, personal therapists, or local LGBTQ+ communities that may facilitate resources and referrals for mental health services that are LGBTQ+ affirmative (Hillier & Torg, 2019; Katz-Wise, Galman, et al., 2022; Pullen Sansfaçon et al., 2020; Zifkin et al., 2021).

Conversely, LGBTQ+ youth with more rejecting parents may find themselves linked to therapists less knowledgeable about LGBTQ+-related issues for three potential reasons. First, due to their negative beliefs regarding LGBTQ+ identity, rejecting parents may not actively seek out therapists who advertise themselves as LGBTQ+ affirmative. For instance, in a study exploring barriers to treatment engagement in family-focused settings, parents cited fear of criticism and judgment as hindrances to continuing therapy (Baker-Ericzén et al., 2013). Consequently, parents exhibiting rejecting behavior toward their youth's LGBTQ+ identity may be less willing to seek LGBTQ+-affirmative services for fear of this judgment. Second, rejecting parents may not even recognize their children's need for an affirmative therapist, as LGBTQ+ youth may conceal this identity if they perceive coming out as risky and detrimental to family dynamics with rejecting parents (Baiocco et al., 2016; Mehus et al., 2017; Roe, 2017). Lastly, parents who are more rejecting of LGBTQ+ youth's identity may purposefully connect therapists who are unaffirming of their child's LGBTQ+ identity in hopes of suppressing or "changing"

their children's LGBTQ+ identity. This could include parents consenting their child to sexual orientation and gender identity change efforts, a practice shown to be detrimental to youth's mental health (Fish & Russell, 2020; Ryan et al., 2020). In summary, LGBTQ+ youth with rejecting parents may be inadvertently connected to therapists less informed about LGBTQ+ issues due to parents' reluctance to seek out LGBTQ+ affirmative services, lack of awareness about their children's needs, and potentially harmful intentions to alter their children's LGBTQ+ identity. Again, future research in this area should explore how parents' attitudes towards their child's LGBTQ+ identity might influence their process of seeking out (or not) mental health care providers that are LGBTQ+ affirmative.

Family Environment and LGBTQ+ Youth's Desire for Therapy

My third research question examined youth who reported not receiving mental health services in the previous year and tested the association between parental support and rejection and their desire for therapy. Consistent with our hypotheses (3a, 3b), parental support predicted lower odds of youth wanting therapy, whereas parental rejection consistently predicted higher odds of wanting therapy. These results aligned with previous literature highlighting the protective role of a positive family environment on LGBTQ+ youth's mental health. On the one hand, LGBTQ+ youth with more supportive parents report higher self-esteem and life satisfaction (Grossman et al., 2021; Seibel et al., 2018, Simons et al., 2013), making them less likely to need therapy. They may also feel more comfortable raising their (lack of) needs for therapy when they perceive their parents as supportive (Mehus et al., 2017). On the other hand, LGBTQ+ youth with rejecting parents are more likely to report poor mental health outcomes and greater substance use (Marshall et al., 2011; Ryan et al., 2009; Scannapieco et al., 2018; Zaza et al., 2016) and thus may recognize their own need for therapy. Alongside narratives of concealing

their LGBTQ+ identity from rejecting parents (Baiocco et al., 2016; Mehus et al., 2017), LGBTQ+ youth may be hesitant to discuss their therapy needs with their parents, even in instances of self-harm and suicidality (Burke et al., 2021; Chang et al., 2022; Shin et al., 2021). This is supported by the 2023 National Survey on LGBTQ+ Youth Mental Health, which identified concerns about parental permission as the primary reason for youth not accessing therapy despite desiring mental health care (The Trevor Project, 2023). It could also be that LGBTQ+ youth may have requested mental health services but were denied access by their parents. For instance, in a study that explored barriers to accessing mental health treatment for their youth, parents indicated that their motivation for sending youth to therapy often dropped when they didn't recognize the significance of their youth's problems (Reardon et al., 2017). Given that parents exhibiting more LGBTQ+-related rejecting behaviors are less likely to engage their children in therapy services (RQ1), particularly in the absence of depression and/or anxiety symptoms, they may also be more likely to reject the youth's request to enter therapy. Ultimately, more research is needed to understand LGBTQ+ youth's barriers to accessing needed mental health care and the potential strategies to support this access, particularly in light of the increased mental health burden.

Clinical Implications

Our findings emphasize the critical role of parents as gatekeepers to (affirmative) mental health services for LGBTQ+ youth. Specifically, our study sheds light on the heightened vulnerability experienced by LGBTQ+ youth with parents who may be struggling to accept or outright reject their child's LGBTQ+ identity. Importantly, youth who report parental rejection are at greater risk for poorer mental health outcomes (Hall, 2018; Marshal et al., 2011; Ryan et al., 2009; Scannapieco et al., 2018; Zaza et al., 2016), which makes these barriers to accessing

therapy, and LGBTQ+ affirmative therapy in particular, all the more important to understand and address. These distinctions in access to (affirmative) mental health services for LGBTQ+ youth as a function of the youth's family environment underscore the urgent need for targeted interventions and support mechanisms tailored to LGBTQ+ youth, particularly those with parents exhibiting more rejecting behaviors. To address these disparities effectively, it is imperative to adopt a systemic approach that extends beyond the family system, encompassing LGBTQ+ youth's interpersonal, social, and legal contexts, as well as clinical settings.

First, a focus on non-familial settings may identify more diverse service and referral strategies that can enhance LGBTQ+ youth's access to affirming support, even in the context of unsupportive parents. Goldbach and Gibbs (2017) emphasize the beneficial role of support systems such as schools, peers, religious groups, ethnic communities, and LGBTQ+ communities in managing minority stress (Goldbach & Gibbs, 2017). By strategically leveraging these networks, LGBTQ+ youth can connect with affirmative care in various forms, thereby reaching LGBTQ+ youth who may face barriers to therapy access via parents. For instance, research suggests that engagement in online LGBTQ+ communities provides youth with greater flexibility and autonomy to navigate support in spaces where they feel safe (McInroy et al., 2019). In addition, getting personal links and referrals from trusted friends and adults outside of the family setting can help youth establish denser networks of support (Wolowic et al., 2018), which may facilitate more direct pathways to mental health support tailored to LGBTQ+ youths' unique needs. Such networks not only bridge the gap created by familial disapproval but also offer a wider array of mental health resources that are specifically designed to be inclusive and understanding of LGBTQ+ experiences.

Second, non-familial spaces are vital in guiding parents toward understanding and embracing the importance of therapy and LGBTQ+-affirming care for their adolescent children. For example, institutions such as schools and faith communities can serve as pivotal educational platforms, offering psychoeducation on sexual orientation and gender identity. They can introduce the concept of affirmative care and cultivate a comprehensive understanding among parents about the support of LGBTQ+ youth through appropriate resources (Hermann-Wilmarth & Ryan, 2019). Moreover, therapists should actively engage in fostering parental support for their adolescents' identities. This could involve educating parents about LGBTQ+-affirming parenting practices, helping parents navigate their biases against the LGBTQ+ community, and addressing their emotions related to their child's LGBTQ+ identity. By utilizing non-familial spaces for parent outreach, the aim is to equip parents with the tools to affirmatively support their adolescents, whether by linking them to appropriate resources or by fostering a supportive atmosphere within the family itself.

Third, policymakers need to confront the distinct obstacles faced by LGBTQ+ youth when seeking affirmative care by prioritizing youth's help-seeking autonomy and safeguarding the confidentiality of youth's health records. Recognizing that LGBTQ+ youth may encounter stigmatization within their own families, policymakers should establish pathways for LGBTQ+ youth to access affirmative health services with fewer restrictions on parental consent. For example, Washington State recently passed Senate Bill 5599 that allows transgender youth to access gender-affirming, ranging from talk therapy to surgery, with exemptions of parental contact when transgender youth are relocated to youth shelters (Washington State Legislature, 2023). This bill protects transgender youth from unsupportive family environments and protects their access to gender-affirming services. Similarly, it is imperative to safeguard the rights of

LGBTQ+ youth to decline SOGIGE and to maintain autonomy in terminating therapy if they wish. Moreover, policymakers must prioritize measures to protect the confidentiality of LGBTQ+ youth regarding their sexual orientation and gender identity from a legal standpoint.

Lastly, enhancing access to LGBTQ+ affirmative care necessitates the need for training LGBTQ+-informed therapists in the mental health profession. For example, a significant step in advancing LGBTQ+ informed care is to ban the sexual orientation and gender identity change treatments across different mental health professions across states (Fish & Russell, 2020; Ryan et al., 2020), which could reduce harmful practices and signify a broader acceptance of LGBTQ+ identities within the mental health profession. In addition, mandating Continuing Education Units (CEUs) focused on LGBTQ+ issues for licensing boards and professional organizations could ensure that therapists are better equipped to meet the needs of LGBTQ+ youth and adolescents. Such initiatives, aimed at promoting informed practices and elevating LGBTQ+ competency among therapists, are essential for catalyzing systemic change within mental health care.

Limitations

Although this study is among the first to explore the association between family environment and youth's access to affirmative therapy, it has limitations. First, this study relied on cross-sectional data, which prevents us from making causal inferences about the relationship between family environment and youth's access to mental health services. Second, data include reports of whether youth had received therapy in the past year, which may not reflect their overall engagement with mental health or social support services (e.g., school counseling, peer support groups). Additionally, although I assessed youth's perceptions of their therapists' competence in LGBTQ+ issues, these perceptions may be painted on youths' overall relationship

with their therapist and may not actually reflect therapists' training and skills in working with LGBTQ+ youth. Given the existing data, I also assumed that youth are willingly engaged in therapy, which may not be the case when their therapists may not be LGBTQ+ informed. Third, although I measured family environment through the lens of parental support and rejection, this provides only a snapshot in time. Furthermore, I am not able to assess the myriad mechanisms through which parents' support or rejection of LGBTQ+ youth's identity is related to therapeutic engagement and access to affirmative mental health care providers. Finally, I did not delve into the nuanced differences between various races and sexual/gender identities in relation to three research questions due to the scope of this thesis study. There may be important differences in youths' reports of mental health, family support, and access to therapeutic services that should be explored in future work. Overall, there needs to be more research to explore LGBTQ+ youth's entry into (wanted) therapeutic services the degree to which parents facilitate or hinder these approaches, and in what ways.

Conclusion

LGBTQ+ youth experience unique stressors that increase the risk of poor mental health (Russell & Fish, 2016). While current literature illustrates the association between LGBTQ+ family environment and youth's mental health outcome (D'augelli, 2002; D'Augelli et al., 2006; Ryan et al., 2009), this study further examines how the family environment is linked to youth's access to (affirmative) therapy services. Findings suggest parents who are more supportive of their adolescent's LGBTQ+ identity are more likely to facilitate access to therapy for their children and more likely to find LGBTQ+-informed therapists. Conversely, parents who show more rejecting behaviors of their children's LGBTQ+ identity are less likely to facilitate access

to therapy when concerns for youth's depression and anxiety symptoms are absent, and they are less likely to find affirming therapists for their children. In addition, among youth who did not get therapy last year, those with higher parental support expressed less need for therapy, whereas those with higher parental rejection reported increased odds of desiring therapy. Although the youth's depression and anxiety symptoms are an important factor associated with higher odds of therapy engagement and higher desire for therapy when youth did not get it, they do not relate to youth's perceived therapist LGBTQ+-competence. These findings highlight the necessity for multi-faceted referral strategies that extend beyond the family context, emphasizing the need for parental education on affirmative care and enhanced legal support for youths seeking such care. Future research should explore the pathways through which LGBTQ+ youths access desired therapeutic services and the extent to which parental beliefs of LGBTQ+ identity facilitate or impede this access.

Appendices

Table 1. Demographics Characteristics

	RQ1 (N = 9,526)				RQ2(n = 4,694)				RQ3 (N = 3,954)			
	In therapy		Not in therapy		Therapist is LGBTQ+ competent		Therapist is not LGBTQ+ competent		Want therapy		Don't want therapy	
	n	%	n	%	n	%	n	%	n	%	n	%
Race												
White	3,632	77.08	3,370	69.98	1,444	79.69	2,177	75.54	2,139	69.29	598	68.97
Black/African American	167	3.54	331	6.87	56	3.09	109	3.78	191	6.19	86	9.92
Asian	138	2.93	258	5.36	46	2.54	91	3.16	167	5.41	46	5.31
Multiracial	501	10.63	460	9.55	178	9.82	319	11.07	327	10.59	70	8.07
Others	274	5.81	397	8.24	88	4.86	186	6.45	263	8.52	67	7.73
Total	4,712	100.00	4,816	100.00	1,812	100.00	2,882	100.00	3,087	100	867	100.00
Latinx												
Yes	680	14.43	898	18.65	252	13.91	426	14.78	590	19.11	144	16.61
No	4,032	85.57	3,918	81.35	1,560	86.09	2,456	85.22	2,497	80.89	723	83.39
Total	4,712	100.00	4,816	100.00	1,812	100.00	2,882	100.00	3,087	100	867	100.00
Sexual Orientation												
Gay or lesbian	1,310	27.8	1,487	30.88	533	29.42	770	26.72	919	29.77	306	35.29
Bisexual	1,253	26.59	1,370	28.45	455	25.11	795	27.59	877	28.41	250	28.84
Pansexual/Queer	1,261	26.76	1,073	22.28	491	27.10	764	26.51	716	23.19	167	19.26
Asexual	444	9.42	452	9.39	152	8.39	291	10.10	304	9.85	61	7.04
Questioning	164	3.48	141	2.93	69	3.81	94	3.26	89	2.88	25	2.88
Others	280	5.94	293	6.08	112	6.18	168	5.83	182	5.9	58	6.69
Total	4,712	100.00	4,816	100.00	1,812	100.00	2,882	100.00	3,087	100	867	100.00
Gender Identity												
Cisgender boy	505	10.72	961	19.95	180	9.93	322	11.17	472	15.29	296	34.14
Cisgender girl	656	13.92	784	16.28	218	12.03	434	15.06	476	15.42	151	17.42

Transgender girl	424	9.00	329	6.83	184	10.15	237	8.22	220	7.13	50	5.77
Transgender boy	1,156	24.53	688	14.29	538	29.69	617	21.41	500	16.2	95	10.96
Nonbinary	1,378	29.24	1,329	27.6	505	27.87	867	30.08	937	30.35	167	19.26
Questioning	274	5.81	317	6.58	79	4.36	195	6.77	213	6.9	39	4.50
Others	319	6.77	408	8.47	108	5.96	210	7.29	269	8.71	69	7.96
Total	4,712	100.00	4,816	100	1,812	100.00	2,882	100.00	3,087	100	867	100.00
Parental education level												
High school/GED or less	530	11.25	893	18.54	179	9.88	348	12.07	574	18.59	163	18.8
Vocational college or some college	704	14.94	832	17.28	247	13.63	456	15.82	557	18.04	130	14.99
Bachelor's degree	1,887	40.05	1,826	37.92	733	40.45	1,146	39.76	1,160	37.58	335	38.64
Postgraduate degree	1,591	33.76	1,265	26.27	653	36.04	932	32.34	796	25.79	239	27.57
Total	4,712	100.00	4,816	100	1,812	100.00	2,882	100.00	3,087	100	867	100.00

Note. Mean age by research question: RQ1: M = 15.92 SD = 0.15, RQ2: M = 15.91 SD = 0.21, RQ3: M = 15.86 SD = 0.24

Table 2. T-test

	Parental Support				Parental Rejection				Depression and Anxiety Symptoms			
	<i>M</i>	<i>95% CI</i>	<i>t</i>	<i>p</i>	<i>M</i>	<i>95% CI</i>	<i>t</i>	<i>p</i>	<i>M</i>	<i>95% CI</i>	<i>t</i>	<i>p</i>
RQ1 Therapeutic engagement			-15.54	<.001			-1.02	.303			-10.28	<.001
No	1.79	1.76-1.82			1.73	1.70-1.75			1.55	1.52-1.57		
Yes	2.11	2.08-2.13			1.75	1.72-1.77			1.72	1.70-1.74		
RQ2 LGBTQ+ Competence of therapist			-15.70	<.001			4.09	<.001			1.89	.059
Not Competent	1.83	1.90-1.96			1.80	1.76-1.83			1.74	1.71-1.77		
Competent	2.40	2.35-2.45			1.67	1.65-1.73			1.70	1.66-1.73		
RQ3 Desire for therapy			6.29	<.001			-9.72	<.001			-20.00	<.001
No	1.98	1.91-2.05			1.51	1.46-1.56			1.67	1.01-1.23		
Yes	1.75	1.71-1.78			1.84	1.81-1.88			1.71	1.68-1.74		

Table 3. Logistic Regression for RQ1

	Model 1			Model 2			Model 3			Model 4			Model 5			Model 6		
	Support			Rejection			Support + Rejection			Support + DAS			Rejection + DAS			Support + Rejection + DAS		
	OR	95% CI	p	OR	95% CI	p	OR	95% CI	p	OR	95% CI	p	OR	95% CI	p	OR	95% CI	p
Parental support	1.33	1.28-1.39	<.001	--	--	--	1.36	1.30-1.42	<.001	1.36	1.31-1.42	<.001	--	--	--	1.37	1.31-1.43	<.001
Parental rejection	--	--	--	0.97	0.93-1.02	.230	1.07	1.02-1.13	.007	--	--	--	0.92	0.88-0.97	.002	1.02	0.97-1.07	.467
Depressive and anxiety symptoms (DAS)	--	--	--	--	--	--	--	--	--	1.27	1.21-1.34	<.001	1.24	1.18-1.31	<.001	1.26	1.20-1.33	<.001
Race																		
Black/African American	0.55	0.45 - 0.67	<.001	0.52	0.43-0.64	<.001	0.54	0.45-0.66	<.001	0.56	0.46-0.69	<.001	0.54	0.44-0.65	<.001	0.56	0.46-0.68	<.001
Asian	0.60	0.48-0.75	<.001	0.51	0.41-0.64	<.001	0.60	0.49-0.75	<.001	0.61	0.49-0.76	<.001	0.51	0.41-0.64	<.001	0.61	0.49-0.68	<.001
Multiracial	1.07	0.93-1.23	.378	1.04	0.90-1.19	.588	1.06	0.92-1.22	.425	1.06	0.92-1.22	.416	1.04	0.90-1.19	.597	1.06	0.92-1.68	.429
Others	0.94	0.77-1.13	.499	0.88	0.73-1.07	.189	0.93	0.77-1.13	.481	0.93	0.77-1.13	.484	0.88	0.72-1.06	.183	0.93	0.77-0.68	.479
Latinx																		
Yes	0.88	0.77-1.00	.052	0.87	0.76-0.99	.039	0.88	0.77-1.00	.058	0.89	0.78-1.02	.091	0.88	0.77-1.01	.061	0.89	0.78-0.68	.093
Sexual Orientation																		
Bisexual	1.04	0.93-1.17	.451	0.99	0.89-1.11	.854	1.05	0.94-1.18	.385	1.05	0.94-1.18	.371	0.99	0.89-1.11	.876	1.05	0.94-1.68	.356
Pansexual/Queer	1.21	1.08-1.36	<.001	1.16	1.03-1.30	.012	1.22	1.08-1.37	<.001	1.22	1.08-1.37	.001	1.16	1.03-1.30	.013	1.22	1.08-1.68	.001
Asexual	1.00	0.86-1.18	.969	0.93	0.79-1.09	.350	1.01	0.87-1.19	.857	1.01	0.86-1.18	.939	0.92	0.79-1.08	.311	1.01	0.86-1.68	.909
Questioning	1.24	0.97-1.59	.087	1.14	0.89-1.46	.294	1.26	0.98-1.62	.067	1.24	0.96-1.59	.097	1.12	0.88-1.43	.364	1.24	0.97-1.68	.091
Others	0.97	0.80-1.18	.781	0.94	0.78-1.13	.489	0.98	0.81-1.18	.833	0.98	0.81-1.18	.814	0.94	0.77-1.13	.485	0.98	0.81-0.68	.827
Gender Identity																		
Cisgender boy	0.53	0.46-0.61	<.001	0.53	0.46-0.61	<.001	0.54	0.47-0.62	<.001	0.58	0.50-0.67	<.001	0.57	0.49-0.65	<.001	0.59	0.51-0.68	<.001
Cisgender girl	0.53	0.67-0.88	<.001	0.77	0.68-0.88	<.001	0.78	0.68-0.89	<.001	0.80	0.70-0.92	.001	0.79	0.69-0.91	.001	0.80	0.70-0.68	.002
Transgender girl	1.19	1.00-1.40	.046	1.18	1.00-1.39	.053	1.20	0.04-1.42	.036	1.21	1.02-1.43	.029	1.19	1.01-1.40	.042	1.21	1.02-1.68	.027
Transgender boy	1.64	1.45-1.86	<.001	1.70	1.50-1.93	<.001	1.61	0.42-1.83	<.001	1.60	1.41-1.81	<.001	1.69	1.49-1.91	<.001	1.59	1.40-1.68	<.001
Questioning	0.88	0.73-1.05	.161	0.85	0.71-1.02	.081	0.89	0.21-1.07	.210	0.88	0.73-1.05	.159	0.84	0.70-1.01	.062	0.88	0.73-0.68	.172
Others	0.77	0.65-0.91	<.001	0.78	0.66-0.92	.004	0.77	0.03-0.91	<.001	0.78	0.66-0.92	.004	0.79	0.67-0.93	.006	0.78	0.66-0.68	.004
Parental education level																		
High school/GED or less	0.62	0.54-0.71	<.001	0.60	0.53-0.68	<.001	0.61	0.54-0.70	<.001	0.60	0.53-0.69	<.001	0.59	0.52-0.67	<.001	0.60	0.53-0.68	<.001
Vocational college or some college	0.81	0.72-0.92	<.001	0.82	0.72-0.92	.001	0.81	0.71-0.91	<.001	0.80	0.71-0.91	<.001	0.81	0.72-0.92	.001	0.80	0.71-0.68	<.001
Postgraduate degree	1.25	1.13-1.39	<.001	1.27	1.15-1.41	<.001	1.26	1.14-1.39	<.001	1.26	1.14-1.39	<.001	1.27	1.15-1.41	<.001	1.26	1.14-1.68	<.001

Ageyear	1.09	1.05-1.12	<.001	1.08	1.05-1.11	p<0.001	1.08	1.05-1.12	<.001	1.09	1.06-1.13	<.001	1.09	1.06-1.12	<.001	1.09	1.06-1.13	<.001
Intercept	0.17	0.10-0.28	<.001	0.34	0.20-0.55	p<0.001	0.15	0.09-0.24	<.001	0.09	0.06-1.58	<.001	0.22	0.14-0.37	<.001	0.09	0.05-0.15	<.001

Table 4. Logistic Regression for RQ2

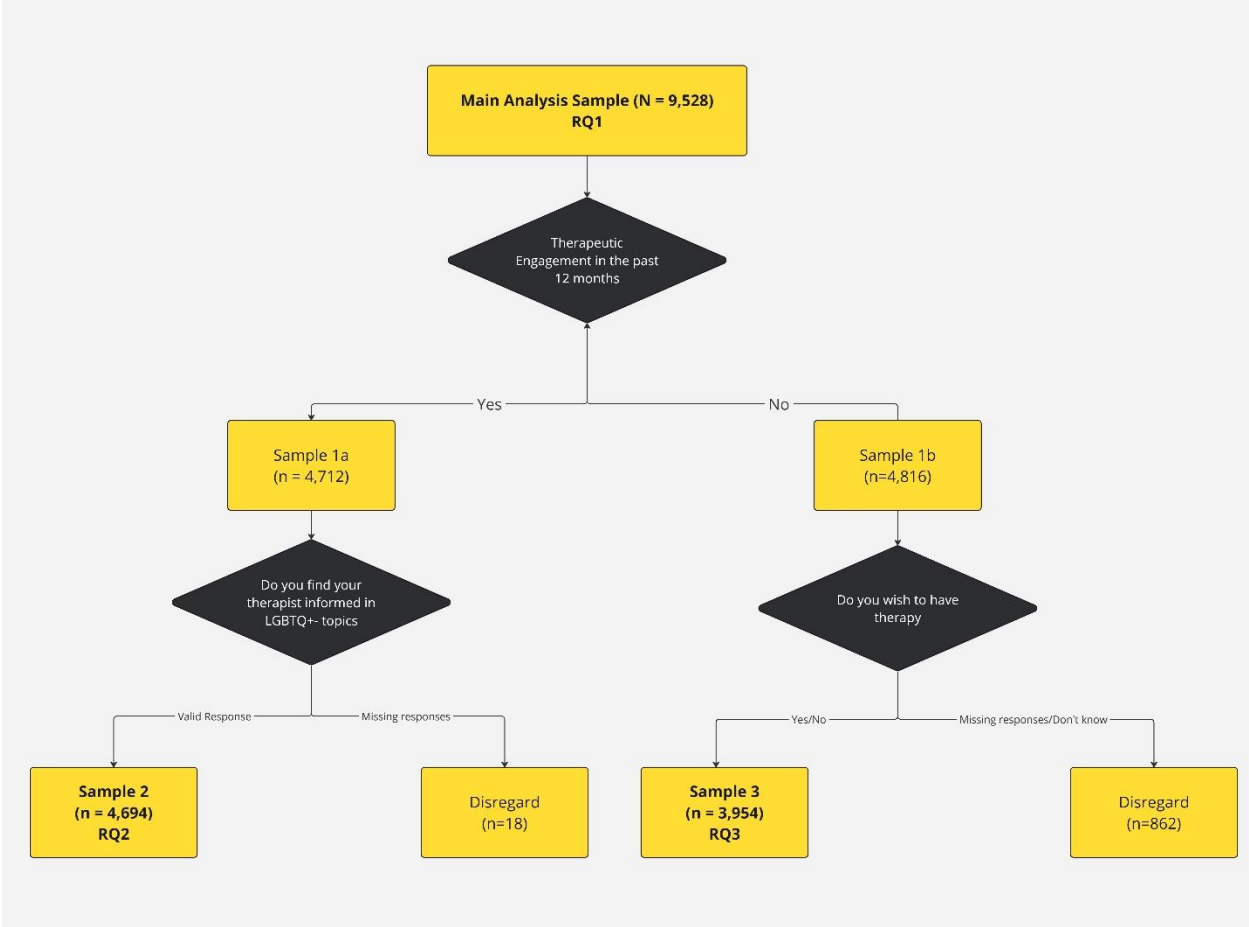
	<i>n</i> = 4,694			Model 1			Model 2			Model 3			Model 4			Model 5			Model 6		
	Support			Rejection			Support + Rejection			Support + DAS			Rejection + DAS			Support + Rejection + DAS					
	<i>OR</i>	<i>95% CI</i>	<i>p</i>	<i>OR</i>	<i>95% CI</i>	<i>p</i>	<i>OR</i>	<i>95% CI</i>	<i>p</i>	<i>OR</i>	<i>95% CI</i>	<i>p</i>	<i>OR</i>	<i>95% CI</i>	<i>p</i>	<i>OR</i>	<i>95% CI</i>	<i>p</i>			
Parental support	1.55	1.46-1.64	<.001	--	--	--	1.55	1.46-1.66	<.001	1.55	1.45-1.64	<.001	--	--	--	1.55	1.45-1.66	<.001			
Parental rejection	--	--	--	0.84	0.78-0.90	<.001	1.01	0.94-1.09	.792	--	--	--	0.84	0.79-0.91	<.001	1.01	0.94-1.10	.697			
Depressive and anxiety symptoms (DAS)	--	--	--	--	--	--	--	--	--	0.98	0.91-1.05	.546	0.96	0.89-1.04	.307	0.97	0.90-1.05	.504			
Race																					
Black/African American	0.91	0.65-1.29	.610	0.84	0.60-1.17	.298	0.91	0.65-1.29	.606	0.91	0.65-1.29	.607	0.84	0.60-1.17	.293	0.91	0.65-1.28	.602			
Asian	1.01	0.70-1.47	.949	0.80	0.55-1.15	.230	1.01	0.70-1.47	.949	1.01	0.70-1.47	.947	0.80	0.56-1.15	.233	1.01	0.70-1.47	.946			
Multiracial	0.89	0.72-1.09	.252	0.87	0.71-1.06	.168	0.89	0.72-1.09	.249	0.89	0.73-1.09	.258	0.87	0.71-1.06	.173	0.89	0.72-1.09	.254			
Others	0.86	0.63-1.16	.320	0.76	0.56-1.03	.080	0.86	0.63-1.16	.319	0.86	0.63-1.17	.323	0.77	0.57-1.03	.082	0.86	0.63-1.16	.322			
Latinx																					
Yes	1.05	0.86-1.28	.648	1.05	0.86-1.27	.638	1.05	0.86-1.28	.646	1.05	0.86-1.28	.653	1.05	0.86-1.27	.645	1.05	0.86-1.28	.650			
Sexual Orientation																					
Bisexual	0.88	0.74-1.04	.131	0.82	0.70-0.97	.019	0.88	0.75-1.04	.133	0.88	0.74-1.04	.127	0.82	0.70-0.97	.018	0.88	0.74-1.04	.129			
Pansexual/Queer	0.98	0.83-1.16	.787	0.91	0.77-1.07	.259	0.98	0.83-1.16	.793	0.98	0.82-1.16	.779	0.91	0.77-1.07	.255	0.98	0.83-1.16	.787			
Asexual	0.79	0.63-1.01	.056	0.72	0.57-0.90	.005	0.80	0.63-1.01	.058	0.79	0.63-1.01	.055	0.72	0.57-0.90	.005	0.80	0.63-1.01	.058			
Questioning	1.10	0.78-1.55	.607	0.97	0.69-1.36	.864	1.10	0.78-1.55	.599	1.10	0.78-1.55	.601	0.97	0.70-1.37	.882	1.10	0.78-1.56	.589			
Others	0.97	0.73-1.27	.806	0.91	0.69-1.19	.479	0.97	0.73-1.27	.807	0.97	0.73-1.27	.804	0.91	0.69-1.19	.478	0.97	0.73-1.27	.806			
Gender Identity																					
Cisgender boy	0.94	0.75-1.18	.573	0.88	0.71-1.10	.273	0.94	0.75-1.18	.594	0.93	0.74-1.17	.528	0.87	0.70-1.09	.234	0.93	0.74-1.17	.551			
Cisgender girl	0.85	0.69-1.04	.109	0.79	0.65-0.97	.023	0.85	0.69-1.04	.117	0.84	0.69-1.04	.106	0.79	0.65-0.97	.023	0.85	0.69-1.04	.115			
Transgender girl	1.32	1.05-1.66	.019	1.27	1.02-1.60	.035	1.32	1.05-1.66	.019	1.32	1.04-1.66	.020	1.27	1.01-1.59	.037	1.32	1.05-1.66	.019			
Transgender boy	1.46	1.24-1.73	<.001	1.54	1.31-1.82	<.001	1.46	1.24-1.73	<.001	1.47	1.24-1.73	<.001	1.54	1.31-1.82	<.001	1.46	1.24-1.73	<.001			
Questioning	0.73	0.55-0.98	.036	0.67	0.50-0.89	.007	0.73	0.55-0.98	.038	0.73	0.55-0.98	.037	0.67	0.51-0.90	.007	0.74	0.55-0.98	.039			
Others	0.88	0.68-1.15	.354	0.89	0.69-1.15	.374	0.88	0.68-1.15	.353	0.88	0.68-1.15	.355	0.89	0.69-1.15	.375	0.88	0.68-1.15	.354			
Parental education level																					
High school/GED or less	0.88	0.71-1.09	.243	0.85	0.69-1.05	.116	0.88	0.71-1.09	.240	0.88	0.71-1.09	.250	0.85	0.69-1.05	.122	0.88	0.71-1.09	.246			

Vocational college or some college	0.87	0.72-1.04	.129	0.87	0.72-1.04	.131	0.86	0.72-1.04	.126	0.87	0.72-1.04	.133	0.87	0.72-1.04	.134	0.86	0.72-1.04	.129
Postgraduate degree	1.12	0.97-1.29	.115	1.13	0.98-1.30	.087	1.12	0.97-1.29	.114	1.12	0.97-1.29	.115	1.13	0.98-1.30	.086	1.12	0.97-1.29	.114
Ageyear	1.01	0.91-1.06	.536	1.01	0.97-1.06	.559	1.01	0.97-1.06	.543	1.01	0.97-1.06	.551	1.01	0.97-1.06	.591	1.01	0.97-1.06	.564
Intercept	0.20	0.09-0.42	<.001	0.76	0.37-1.56	.455	0.19	0.09-0.41	<.001	0.21	0.08-0.45	<.001	0.82	0.39-1.69	.586	0.20	0.09-0.44	<.001

Table 5. Logistic Regression for RQ3

	<i>n</i> = 3,954																	
	Model 1			Model 2			Model 3			Model 4			Model 5			Model 6		
	Support			Rejection			Support + Rejection			Support + DAS			Rejection + DAS			Support + Rejection + DAS		
	<i>OR</i>	<i>95% CI</i>	<i>p</i>	<i>OR</i>	<i>95% CI</i>	<i>p</i>	<i>OR</i>	<i>95% CI</i>	<i>p</i>	<i>OR</i>	<i>95% CI</i>	<i>p</i>	<i>OR</i>	<i>95% CI</i>	<i>p</i>	<i>OR</i>	<i>95% CI</i>	<i>p</i>
Parental support	0.79	0.73-0.86	<.001	--	--	--	0.84	0.78-0.91	<.001	0.84	0.78-0.91	<.001	--	--	--	0.87	0.80-0.94	<.001
Parental rejection	--	--	--	1.49	1.35-1.65	<.001	1.43	1.29-1.59	<.001	--	--	--	1.24	1.12-1.38	<.001	1.20	1.07-1.40	<.001
Depressive and anxiety symptoms (DAS)	--	--	--	--	--	--	--	--	--	2.33	2.10-2.57	<.001	2.26	2.03-2.51	<.001	2.24	2.01-2.49	<.001
Race																		
Black/African American	0.62	0.47-0.82	.001	0.61	0.46-0.81	.001	0.60	0.45-0.80	<.001	0.66	0.49-0.88	.005	0.66	0.49-0.88	.005	0.65	0.48-0.87	.004
Asian	1.05	0.74-1.49	.799	1.19	0.84-1.69	.334	1.08	0.76-1.54	.679	1.16	0.80-1.68	.422	1.27	0.88-1.84	.200	1.17	0.81-1.70	.404
Multiracial	1.20	0.90-1.59	.216	1.18	0.89-1.57	.245	1.16	0.88-1.55	.296	1.18	0.88-1.58	.269	1.19	0.88-1.60	.241	1.17	0.87-1.57	.292
Others	0.91	0.65-1.29	.609	0.92	0.65-1.29	.614	0.90	0.63-1.27	.535	0.94	0.66-1.34	.721	0.94	0.65-1.34	.730	0.93	0.65-1.32	.673
Latinx																		
Yes	1.28	1.00-1.63	.052	1.32	1.03-1.69	.029	1.31	1.02-1.68	.034	1.37	1.06-1.76	.015	1.39	1.07-1.79	.011	1.38	1.07-1.77	.014
Sexual Orientation																		
Bisexual	1.01	0.82-1.23	.958	1.10	0.90-1.34	.362	1.05	0.86-1.29	.612	1.00	0.81-1.23	.985	1.06	0.86-1.31	.559	1.03	0.83-1.27	.797
Pansexual/Queer	0.97	0.78-1.22	.820	1.03	0.82-1.29	.818	1.01	0.80-1.26	.964	1.00	0.79-1.26	.971	1.02	0.80-1.30	.849	1.01	0.79-1.28	.945
Asexual	1.09	0.79-1.50	.613	1.21	0.88-1.67	.238	1.15	0.83-1.59	.395	1.04	0.75-1.45	.810	1.12	0.80-1.56	.489	1.07	0.77-1.49	.683
Questioning	0.85	0.53-1.37	.498	0.99	0.62-1.61	.981	0.92	0.57-1.49	.746	0.83	0.50-1.36	.462	0.90	0.54-1.48	.681	0.86	0.52-1.42	.553
Others	0.71	0.51-1.00	.051	0.77	0.55-1.09	.139	0.75	0.53-1.05	.096	0.72	0.50-1.03	.070	0.76	0.52-1.08	.127	0.74	0.51-1.05	.093
Gender Identity																		
Cisgender boy	0.28	0.22-0.36	<.001	0.32	0.25-0.40	<.001	0.31	0.25-0.40	<.001	0.37	0.29-0.47	<.001	0.39	0.30-0.50	<.001	0.39	0.30-0.50	<.001
Cisgender girl	0.59	0.46-0.76	<.001	0.63	0.48-0.81	<.001	0.63	0.49-0.82	<.001	0.71	0.54-0.92	.010	0.72	0.55-0.94	.016	0.73	0.56-0.95	.020
Transgender girl	0.80	0.56-1.13	.205	0.84	0.59-1.19	.329	0.84	0.59-1.19	.323	0.83	0.58-1.20	.323	0.85	0.58-1.22	.379	0.85	0.59-1.23	.384
Transgender boy	0.98	0.74-1.30	.889	0.86	0.65-1.14	.306	0.90	0.68-1.19	.466	0.84	0.63-1.12	.239	0.78	0.58-1.04	.095	0.81	0.60-1.08	.154
Questioning	1.00	0.68-1.46	.993	1.06	0.72-1.56	.752	1.05	0.72-1.55	.792	1.02	0.69-1.52	.915	1.07	0.71-1.59	.749	1.05	0.71-1.57	.799
Others	0.73	0.54-1.01	.057	0.73	0.53-1.00	.048	0.74	0.54-1.02	.065	0.79	0.57-1.10	.163	0.78	0.56-1.09	.149	0.80	0.57-1.11	.173
Parental education level																		
High school/GED or less	0.97	0.78-1.22	.815	0.95	0.76-1.19	.650	0.94	0.75-1.18	.585	0.89	0.71-1.13	.345	0.89	0.70-1.12	.316	0.88	0.70-1.11	.290
Vocational college or some college	1.24	0.98-1.56	.077	1.19	0.94-1.51	.140	1.21	0.95-1.53	.116	1.17	0.92-1.49	.206	1.15	0.90-1.47	.253	1.16	0.91-1.48	.225
Postgraduate degree	0.96	0.79-1.17	.681	0.98	0.80-1.19	.833	0.98	0.81-1.20	.867	1.00	0.82-1.23	.984	1.01	0.81-1.23	.956	1.01	0.82-1.24	.911
Ageyear	1.02	0.96-1.07	.578	1.01	0.95-1.06	.829	1.01	0.95-1.06	.822	1.05	0.95-1.11	.076	1.05	0.99-1.11	.114	1.05	0.99-1.11	.117
Intercept	6.56	2.66-16.15	<.001	2.33	0.95-5.71	.064	3.52	1.40-8.82	.007	0.94	0.36-2.45	.899	0.52	0.20-1.33	.173	0.74	0.28-1.96	.550

Figure 1: Sample Selection Process



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