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Parental Acceptance of LGBTQ Individuals: Influences on Psychological Well-Being and Substance Abuse

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Abstract

LGBTQ individuals face negative social attitudes in numerous aspects of their lives, including their relationship with their parents. This study aimed to uncover how parental acceptance and negative health outcomes interact with LGBTQ identity, and the relationships between parental acceptance and negative health outcomes. Heterosexual participants were compared to LGBQ participants, and cisgender participants were compared with transgender participants. Results showed significant differences in parental acceptance and psychological well-being between heterosexual and LGBQ participants, as well as between cisgender and transgender participants, however neither comparison showed significant differences for substance abuse. These significant findings show the importance of considerations of identity when addressing certain negative health outcomes.

Keywords: LGBTQ, Parental Acceptance, Health Outcomes

1. Introduction

Parent-child relationships are important in numerous aspects of a child's life. A positive relationship between a child and their parent(s) can boost self-esteem during childhood[1]. It can also benefit psychosocial development. Specifically, researchers have found that higher perceived loving capabilities of parents, with greater involvement by parents in a child's life, can aid psychosocial development during adolescence. Too much parental control, on the other hand, can harm the emotional health of children and increase distress of a child[2]. Khaleque and Rohner found that the impact of parental acceptance or rejection was especially important in childhood compared to adulthood, which the researchers explained might be due to children being more influenced by others, including their parents. On the other hand, adults have a more remote relationship with their parents, and tend to seek support elsewhere with partners and friends[3]. A balanced relationship with parents in childhood gives one room to develop freely, while still able to seek support from one's parents.

People whose sexual orientations are in the minority, such as lesbian, gay, bisexual, or queer-identified, face challenges when it comes to parental acceptance. As found by multiple researchers, LGBQ people have lower parental support when compared to their heterosexual counterparts. In D'Augelli, Grossman, and Starks[4], participants' parents who were aware of the participant's sexual orientation were reported to use more verbally abusive behaviors than parents who were unaware. This could indicate that the knowledge of a minority sexual orientation could lead to differential treatment, whereas parents who assumed their children were heterosexual had no need to treat them differently. In addition, parental support can often outweigh the support of friends[5]. D'Augelli[5] determined that relationships with parents were more important than relationships with friends to lesbian, gay, and bisexual participants between the ages of 14 and 21. Additionally, the effects of family acceptance in adolescence and childhood persist later in life, including associations with higher psychological well-being[1, 2]. Research has demonstrated that lesbian, gay, and bisexual people have significantly more psychological symptoms compared to a norm comparison

group[6]. In D'Augelli[5], LGB participants had significantly more symptoms in six out of the nine scales that make up the Brief Symptoms Index. In a study conducted in Israel with LGBTQ participants utilizing the same measure, participants' average score on the Index was twice as high as that of the Israeli norms[7].

1.1. Parental Support as a Protective Factor

Parental support and acceptance can act as a protective factor against negative health outcomes, as investigated by multiple researchers. Espelage, Aragon, Birkett, and Koenig[8] found that, among a sample of students, higher perceived parental support was associated with less depressive symptoms, suicidal feelings, and substance use. Eisenberg and Resnick looked at family connectedness, which the researchers defined as how much the participant's family cared about them and respected them. Not surprisingly, higher family connectedness was associated with lower levels of suicidal ideation[9]. Perceived parental acceptance is correlated with psychological symptoms, in which less parental acceptance, or more parental rejection, leads to more psychological symptoms[3].

Several studies in Israel have demonstrated the importance of family acceptance as a protective factor against psychological distress and well-being. In one study, the researchers studied LGBT adolescents and found that family support did have an impact on psychological symptoms[10]. Samarova, Shilo, and Diamond[11] found that the current perceived acceptance was associated with the participants' psychological well-being. Bebes et al.[7] found that parental psychological control, which is associated with parental acceptance, was related to more psychological issues.

In addition to psychological issues, LGBTQ individuals face problems with substance use. Padilla, Crisp, and Rew[12] found that the drug use rate of gay, lesbian, and bisexual youth ages 12 to 17 was double the national rate of people the same age. Looking at the relationship between parental acceptance and alcohol/drug use, D'Amico and Julien[13] found that there was a positive relationship between rejection by parents and alcohol and drug use. Likewise, positive reactions of parents, particularly mothers, to their child coming out led to a child who was 39 percent less likely to use illegal substances compared to a child whose parents had negative reactions[12]. In Ryan et al. (2010), lower levels of family acceptance were related to more substance abuse[6].

Parental acceptance can also act as a protective factor against failure in school[14]. For participants who reported they had attractions to the same sex, their grades and feeling of belonging at their school was lower and their amount of school troubles was higher than participants who reported attractions to the opposite sex. Parental support protected for higher GPAs, less school troubles, and a higher sense of school belonging[14].

1.2. LGB Compared to TQ

Most past research avoids researching the experiences of transgender and queer-identified people. This previous research on parental acceptance in relation to minority identifications just used lesbian, gay, and bisexual cisgender participants[4, 5, 8-15]. One set of researchers explained their exclusion of transgender and queer-identified people, stating that the identifications are "qualitatively different" from lesbian, gay, and bisexual cisgender identifications[11]. For most of the other studies mentioned above, there is no mention of a consideration of transgender or queer participants. In Willoughby, Doty, and Malik[15], one percent of participants identified as queer, but this categorization is glossed over, and the analyses only apply to lesbian, gay, and bisexual participants.

This pattern shows precisely why future research incorporating the experiences of transgender and queer-identified people is necessary. Researchers leave out transgender and queer-identified participants, but attempt to generalize results based on lesbian, gay, and bisexual cisgender participants towards the entire 'LGBTQ' acronym. The markedly different experiences of 'T' and 'Q' people call for research separately analyzing their associations with parental acceptance, psychological well-being, and substance use. Samarova et al.[11] found that the parents of bisexual participants exhibited less increase in acceptance of their child over time compared to the lesbian and gay participants. The researchers attributed this finding to the stigma around bisexuality. With binary transgender identifications and sexual orientations such as pansexuality, there are even more nuances when compared to bisexual identifications. Adding in non-binary gender identifications, the discussion becomes even more complicated. It could be possible that patterns found among lesbian, gay, and bisexual people, such as the drug use rate, could be even worse among transgender and queer-identified people[12]. As demonstrated in Ryan et al. (2010), which did use transgender and queer-identified participants, transgender youth had lower general health compared to the participants who were cisgender (and whose sexual orientations were lesbian, gay, bisexual, or queer). Participants who identified their sexuality as queer had more earlier suicide attempts reported than lesbian, gay, and bisexual participants[6]. Further analysis of these participants found that transgender participants also had lower LGBT self-esteem and were less satisfied with their life situation[16].

1.3. Parental Acceptance as Representing Multiple Variables

One set of researchers found that past measures of parental acceptance might measure multiple variables that are related to parental acceptance. Bebes et al.[7] examined parental acceptance with parental psychological control, another dimension of family support. However, the researchers actually found that parental acceptance, alone, had no association with psychological symptoms. Instead, the perception of higher parental psychological control was associated with higher levels of psychological symptoms[7]. The researchers were surprised by this finding as researchers have shown repeatedly that there are associations between parental acceptance and psychological well-being[2, 3, 5, 6, 8-11, 13].

The researchers concluded that it is possible that these results of associations are due to the separation of perceived parental acceptance from perceived parental psychological control, something that was only fully researched in Bebes et al[7]. Previous studies studied parental psychological control as a part of parental acceptance. The researchers explain that it could be possible that associations between parental acceptance and psychological well-being are truly associations between parental psychological control and psychological well-being. This points to clearly defining what parental acceptance is in future studies, and separating it completely from parental psychological control.

1.4. The Current Study

The current study looked at how parental acceptance differs between LGBTQ people and heterosexual and cisgender people, and the relationship between parental acceptance and health factors such as psychological well-being and substance abuse. This study stemmed from the necessity to use the experiences of transgender and queer-identified people in discussions surrounding minority identities. Additionally, comparing the experiences of LGBTQ people with those of heterosexual and cisgender participants can show differences between the groups and establish a specific LGBTQ norm.

1.4.1. hypotheses by sexuality

The first hypothesis was that participants who identify as heterosexual would have higher parental acceptance than participants who identify as lesbian, gay, bisexual, or queer (referred to as LGBQ for simplicity). A second hypothesis is that LGBQ participants would have less psychological well-being than heterosexual participants. The next hypothesis was that LGBQ participants would have greater substance abuse compared to heterosexual participants.

1.4.2. hypotheses by gender identity

For hypotheses by gender identity, the first was that participants with a cisgender identity would have higher parental acceptance than participants with a transgender identity. The next hypothesis was that transgender participants would have less psychological well-being than cisgender participants. The final hypothesis of this section is that transgender participants would have greater substance abuse compared to cisgender participants.

1.4.3. relational hypotheses

The first relational hypothesis was that there would be a positive relationship between parental acceptance and psychological well-being. Next, parental acceptance was hypothesized to have a negative relationship with substance abuse. Finally, psychological well-being was hypothesized to have a negative relationship with substance abuse.

2. Method

2.1. Participants

97 total participants were gathered through three separate methods. Initially, participants were collected through a convenience sample who attended two data collection days at Guilford College in North Carolina. These participants were incentivized to participate by the promise of extra credit in certain courses for their participation. After these data collection days, several participants (also college students) were snowball-sampled. Additionally, the link to the survey was posted online in several areas, including once on Tumblr and in multiple LGBTQ Facebook groups. These online participants were not affiliated with Guilford College, and were not incentivized to take the survey. Participants ranged in age from 16 to 71, with a median age of 20. The sample was skewed by one participant aged 71. White/Caucasian participants made up 66% of the sample, 14.4% were Black/African-American, 6.2% were Hispanic/Latinx, 6.2% were Asian, 4.1% were multiracial, and 1% was Native-American. Two people did not disclose their ethnicity.

There were 47 heterosexual participants and 45 LGBQ participants. Five participants either misunderstood the question or neglected to provide their sexual orientation. Of the 45 LGBQ participants, 31.1% were queer, 24.4% were bisexual, 15.6% were lesbian, 11.1% were homosexual, 11.1% were pansexual, and 6.7% were asexual. Cisgender participants made up 75.3% of the sample, and transgender participants were 24.7% of the participants. One participant neglected to respond to 17 out of the 18 items on the Brief Symptoms Inventory, and due to the inability to compute an accurate total score for them on the BSI, their data were excluded from all analyses. Likewise, the participants who did not provide their sexual orientation were also excluded from all analyses. This resulted in a final sample of 91 participants. Forty-six participants of this final sample were heterosexual and 45 were LGBQ. Sixty-seven participants were cisgender and 24 were transgender.

2.2. Materials

2.2.1. demographic information

Participants were asked about demographic information such as their ethnicity, age, and sexual orientation. They were also asked to circle their student status and indicate if their gender identity was cisgender or transgender. The term ‘cisgender’ was defined as gender identity that is the same as that assigned at birth, and ‘transgender’ was defined as gender identity is different from that assigned at birth.

2.2.2. parental acceptance

Parental acceptance was measured using two adapted scales. An adapted Index of Family Relations from Hudson[17] was used. Only items 5, 6, 8, 12, and 23 were used from the original scale. Items 5, 8, and 23 from the original scale (items 1, 3, and 5 in the new scale) were recoded, with a higher score on the original scale indicating worse family relationships. The second scale for parental acceptance that was used was the Family Emotional Involvement and Criticism Scale, specifically several items from the Perceived Criticism scale[18]. Only items 2, 12, and 14 from the original scale were used. Item 2 (item 6 in the new scale) from the original scale is meant to be recoded, with a higher score indicating more perceived criticism.

For the adapted scale, the language in each item was changed to refer to parents, rather than family, as well as different response options were used. In order for higher scores to indicate higher parental acceptance, the adapted scale was recoded differently from the original. In both original scales, a higher score was more negative. In this adapted scale, items 2, 4, 7, and 8 are recoded. Participants rated, using a Likert-type scale, how often they think their parents do the actions described in the statement. Participants responded between *1 = Almost never* to *5 = Almost always.* Example items are “My parents are always trying to get me to change” and “My parents are a real source of comfort to me.” The scores one could get on this adapted scale ranged from 8 to 40, with higher scores indicating higher perceived parental acceptance.

2.2.3. psychological well-being

To examine the psychological well-being of the sample, an adaptation of the 18-item Brief Symptoms Inventory (BSI-18) from Derogatis[19] was used. The BSI-18 consists of three scales, each with six items, for measuring somatization, depression, and anxiety. Participants rated how much they had been bothered by each symptom over the past seven days using a Likert-type scale ranging from *1 = Almost never/never* to *5 = Almost always*, rather than the original response options of *0 = not at all* to *4 = extremely*. For each scale, participants’ scores could range from 6 to 30, and

18 to 90 for all scales together. In order for a higher score to represent greater psychological well-being, all items on this inventory were recoded for the total score. However, the total scale scores for somatization, depression, and anxiety did not use recoded items, as higher scores on the somatization scale should correspond to higher somatization, and so on. Example items on this inventory included "Feeling hopeless about the future" and "Pains in heart or chest."

2.2.4. substance abuse

The scale used to measure substance abuse problems was the Drug Abuse Screening Test[20]. This scale looks at drug use behaviors (excluding alcohol) from the last 12 months. Participants responded to each item using a Likert-type scale with responses of *1 = Almost never/never* to *5 = Almost* always, rather than the original responses of *Yes* or *No*. Example items from this scale included "Do you ever feel bad or guilty about your drug use?" and "Have you engaged in illegal activities in order to obtain drugs?" Items 4, 5, and 7 were recoded, and participants could score between 20 to 100, with a higher score indicating higher substance abuse.

2.3. Procedures

On the data collection day, participants were given the informed consent form to read and sign if they elected to participate. Those that signed the form were then led to a computer monitor, where the survey measures were displayed via SurveyMonkey. Participants were instructed to answer the questions in the survey after agreeing once again to the informed consent (this time presented electronically). Each page of the SurveyMonkey was associated with one scale, and the page presentation was randomized for the survey measures. All participants began with the informed consent page, and ended with the debriefing page. For participants who were a part of the snowball sampling or online recruitment, the link to the SurveyMonkey was provided to them, and they completed the electronic version of the informed consent before proceeding to the survey measures.

3. Results

3.1. Reliability Analysis

Cronbach's alpha for the parental acceptance scale was calculated using the eight items on this scale, and results showed good internal consistency (α = .90). Reliability analysis tests were conducted for the overall Brief Symptoms Inventory as well as the individual scales. The results for the inventory showed good internal consistency (α = .93). The analysis for the somatization, depression, and anxiety scales respectively showed a Cronbach's alpha of .78, .92, and .87. A reliability analysis for the substance abuse scale revealed a Cronbach's alpha of .71.

3.2. Heterosexual Compared to LGBQ

An independent-samples *t* test was conducted to compare scores on the parental acceptance scale between heterosexual (M = 31.15, SD = 6.32) and LGBQ participants (M = 25.22, SD = 7.23). Results were statistically significant and strong, $t(89) = 4.17$, $p < .001$, $d = 0.87$. an independent-samples *t* test to compare scores for psychological well-being between heterosexual (M = 74.64, SD = 10.96) and LGBQ participants (M = 59.69, SD = 13.91). Results showed that LGBQ participants had lower psychological well-being compared to heterosexual participants, and this difference was statistically significant and very strong, $t(83.55) = 5.69$, $p < .001$, $d = 1.19$. The results did violate the assumption of equal variance.

Further investigations into the scales on the BSI-18 were conducted. An independent-samples *t* test was conducted looking at the differences between heterosexual (M = 10.20, SD = 3.86) and LGBQ participants (M = 13.33, SD = 4.42) for scores on the somatization scale of the BSI. Results were strong and statistically significant, $t(89) = -3.61$, $p = .001$, $d = 0.76$. An independent-samples *t* test comparing scores on the depression scale of the BSI for heterosexual (M = 12.11, SD = 5.72) and LGBQ participants (M = 17.69, SD = 6.02) was also conducted. The results were statistically significant and strong, $t(89) = -4.54$, $p < .001$, $d = 0.95$. Additionally, an independent-samples *t* test comparing scores on the anxiety scale of the BSI between heterosexual (M = 11.02, SD = 4.19) and LGBQ participants (M = 17.20, SD = 5.58) showed very strong and statistically significant results, $t(81.68) = -5.96$, $p < .001$, $d = 1.25$. These results violated the assumption of equal variance. An independent-samples *t* test comparing scores for substance

abuse between heterosexual (M = 27.00, SD = 5.29) and LGBQ participants (M = 27.96, SD = 5.14) was also conducted, however results were not statistically significant, $t(89) = -0.87$, $p = .38$, $d = 0.18$.

3.3. Cisgender Compared to Transgender

An independent-samples t test was conducted to compare scores on the parental acceptance scale between cisgender (M = 29.94, SD = 6.96) and transgender participants (M = 23.42, SD = 6.41), and found strong and statistically significant results, $t(89) = 0.55$, $p < .001$, $d = 0.98$. An independent-samples t test was conducted to compare psychological well-being between cisgender (M = 71.44, SD = 12.42) and transgender participants (M = 55.54, SD = 13.77). Results were statistically significant, and there was a very strong effect, $t(89) = 5.23$, $p < .001$, $d = 1.21$.

Once again, the scales on the BSI-18 were analyzed using independent-samples t tests. Transgender participants (M = 14.71, SD = 4.49) had statistically significantly higher levels of somatization than cisgender participants (M = 10.69, SD = 3.90), $t(89) = -4.16$, $p < .001$, $d = 0.96$. Transgender participants (M = 19.25, SD = 6.10) also had significantly higher levels of depression than cisgender participants (M = 13.30, SD = 5.89), $t(89) = -4.21$, $p < .001$, $d = 0.99$. Likewise, transgender participants (M = 18.50, SD = 5.88) had significantly higher levels of anxiety compared to cisgender participants (M = 12.49, SD = 4.92), $t(89) = -4.87$, $p < .001$, $d = 1.11$. For all of the scales that make up the BSI-18, results showed strong to very strong effects. An independent-samples t test was also conducted comparing substance abuse between cisgender (M = 27.10, SD = 4.81) and transgender participants (M = 28.54, SD = 6.18). Results were not statistically significant, $t(89) = -1.18$, $p = .24$, $d = 0.26$.

3.4. Correlation Coefficients

A Pearson's r correlation coefficient revealed a medium effect and a statistically significant positive relationship between parental acceptance and psychological well-being, $r = .48$, $p < .001$. A Pearson's r correlation coefficient was calculated to examine the relationship between parental acceptance and substance abuse. This showed a moderate negative relationship that was statistically significant, in that higher parental acceptance predicted lower substance abuse, $r = -.34$, $p = .001$. In addition, a Pearson's r correlation coefficient was calculated to find the relationship between psychological well-being and substance abuse. Results showed a small, statistically significant, and negative relationship, $r = -.21$, $p = .04$.

4. Discussion

It was hypothesized that there would be higher parental acceptance for heterosexual participants than LGBQ participants, and the results supported this hypothesis. It was also expected that cisgender participants would have higher parental acceptance than transgender participants, and results also supported this hypothesis. Both of these findings demonstrate a likelihood that deviations from what is considered a normal sexual orientation or gender identity are associated with lower parental acceptance. These findings are related to those of D'Augelli et al.[4], where parental awareness of a 'non-normal' sexual orientation was associated with more verbally abusive behaviors of participants' parents. Furthermore, the strong effect sizes demonstrated by the results indicates that the identity of the participants was very influential on the acceptance of their parents. These findings show that LGBTQ people might face lower parental acceptance simply as a factor of their sexual orientation identity.

It was also hypothesized that parental acceptance would be positively associated with psychological well-being, and the results supported this expectation. The results also supported my hypothesis that parental acceptance would be negatively associated with substance abuse. These findings suggest that parental acceptance could function as a protective factor. Numerous researchers have found similar patterns establishing the effectiveness of parental acceptance for protecting against negative health outcomes, including for psychological well-being and substance abuse[6, 8, 10, 12, 14]. The results showing that psychological well-being was negatively associated with substance abuse. are not surprising. These results could demonstrate that individuals might not just have issues with psychological well-being or substance abuse separately, they could be dealing with both concurrently. These findings are also related to those found in Padilla et al.[12], where suicidal ideation and drug use were significantly related to each other, as well as research from D'Amico and Julien (2012)[13].

It was expected LGBQ participants would have lower psychological well-being than heterosexual participants, and the results confirmed this hypothesis. The results revealed that LGBQ participants had higher levels of somatization,

depression, and anxiety. The results also supported the hypothesis that transgender participants would have lower psychological well-being compared to cisgender participants. As with LGBQ participants compared to heterosexual participants, the same patterns for somatization, depression, and anxiety were also found for transgender participants when compared to cisgender participants.

These findings have been consistently found in previous research, such as Padilla et al.[12] and Ryan et al. (2010)[6], and point to the importance of protective factors for LGBQ individuals. Both sets of results also show the importance of targeted support for LGBTQ people when it comes to mental health assistance. Being knowledgeable of the risks around someone's identity, such as low psychological well-being, can influence the way one seeks support. In addition to experiencing much of the same discriminations and lack of support LGBQ people face, transgender people also deal with gender identity-related stress, such as victimization for being transgender[21]. The findings of this study could explain why transgender people tend to have lower health, including less positive life adjustment[6, 16].

It is also important to note that risks such as higher anxiety and depression stem from social perceptions of LGBTQ people, rather than simply an internal aspect of the individual's identity. LGBTQ people are often told that their identity is the cause of their low psychological well-being, but instead these risks come from the perceptions and stigmas others put upon LGBTQ people. In D'Augelli[5], less psychological symptoms were associated with a better relationship between the participants and their parents. While also supporting the associations found in this study between parental acceptance and psychological well-being, these findings also demonstrate that when social stigma in a significant area of an individual's life is absent, the individual is more psychologically healthy.

The impact of social stigmas on parents can be influential in the perceptions that parents impose upon their LGBTQ children[22]. Participants who had had more contact with gay and lesbian people tended to say they would be less upset if their child was gay or lesbian[22]. In other words, people who had the chance to interact with gay and lesbian people were able to put aside social stigmas. This is perhaps a hopeful finding; as the number of openly LGBTQ people increase, non-LGBTQ people have more contact with LGBTQ people, and more opportunities to prevent social stigmatization of LGBTQ people. In turn, less social stigmatization of LGBTQ people could lead to an overall increase in psychological well-being, as well as parental acceptance, of LGBTQ people.

Interestingly, the hypothesis that substance abuse would be greater for LGBQ participants compared to heterosexual participants was not supported in this study. Additionally, the hypothesis that substance abuse would also be greater for transgender participants compared to cisgender participants was not supported. These results are surprising, as previous research has supported these hypotheses[8, 12]. However, there are several possible reasons to explain these results. The scale used to measure substance abuse was adapted, and this might have affected results. The original scale used simply *Yes*/*No* responses, which did not allow for the variability of the new response types. Secondly, across all participants, there was a low level of substance abuse, which could indicate that there wasn't a lot of opportunity for variance between groups. Additionally, with the comparison between cisgender and transgender participants, the cisgender participants outnumbered the transgender participants at about a three to one ratio. A larger sub-sample of transgender participants could possibly reveal significant results. However, it is interesting that the comparison between heterosexual and LGBQ participants wasn't significant despite nearly equal sub-samples (46 to 45 participants), which could indicate that the low substance abuse across all groups prevented any sort of significant results.

4.1. Limitations

There were some limitations in this study. One was the small sample of transgender participants. Transgender people do not make up a large part of the population, therefore obtaining a substantial sample to compare to cisgender people was hard in the time period of this study. Another limitation is that parental acceptance was based on what the participant perceived as their parents' acceptance, rather than actual parental acceptance. Without studying the participants' parents, there is no way to know how accurate that perceived parental acceptance is to reality. However, perceived parental acceptance is still an important construct, especially because of how influential perceived opinions can be on an individual. Participants' perceptions of their parents' acceptance are a very real factor in their lives and are still important to consider. However, self-reports such as perceived parental acceptance can be based on situational factors, such as a participant's state at the time of the reporting. Likewise, it could be possible that the scores on the BSI-18 might not truly represent the participants' typical psychological well-being. The measure asked about symptoms over the previous week, which could be influenced by a number of factors. For example, participants' psychological well-being could have already been compromised due to the complications that come with being a student and busy with schoolwork.

The substance abuse hypotheses could be an area where more research is needed, possibly utilizing more of a general population, rather than just primarily college students. The final limitation is that many participants were college students and other teenagers, and may have been keenly aware of others' views and acceptance of them[3]. For people who are older, it could be possible that their social identity is less contingent upon the acceptance of their parent(s), as they might be more socially established with more peer and friend support. Due to the typical age in this sample, participants may be more likely to let perceived opinions of their parents influence their well-being. A sample that has a broader age range could reveal that parental acceptance is not related to psychological well-being or substance abuse.

4.2. Research Directions

Future research examining changing parental acceptance across generations could provide interesting results, especially with the higher percentages of LGBTQ people in younger generations. Additionally, research using a broader and larger sample of transgender people, such as comparing binary transgender people with non-binary transgender people, could also show some interesting patterns, especially because of the relative nuance of non-binary identities compared to binary trans identities. It might be interesting to see if non-binary trans people face comparable levels of parental acceptance as binary trans people, as well as how the patterns hold up for psychological well-being. Finally, future research could examine how LGBTQ people find acceptance elsewhere if they cannot rely on parental acceptance, and if these other factors can protect against negative health outcomes. Previous research has found that supplementary protective factors can include involvement in one's community and social support from peers[10, 12]. Clearly defining the effectiveness of these alternative protective factors and finding more protective factors can help LGBTQ people combat the negative outcomes associated with their identity.

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