Mental health and well-being of the LGBTQ+ population: Religious trauma, and parental acceptance and support

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Thesis Portfolio Abstract

Background: LGBTQ+ people face discrimination on many fronts. Acceptance of an individual's sexual orientation or gender identity is vital for psychological well-being. Equally, rejection is psychologically harmful. This portfolio aims to investigate two areas of acceptance and rejection of LGBTQ+ people, through an exploration of religious trauma, and parental acceptance and support.

Method: A systematic review synthesised the efficacy of interventions aimed at increasing parental acceptance and support for LGBTQ+ people. An empirical study investigated the psychological impact of religious trauma on LGBTQ+ people in the UK who grew up in an unaccepting Christian environment.

Results: The systematic review identified seven studies on seven different novel interventions. The review found preliminary evidence for the efficacy of the interventions for increasing parental acceptance and support. However, the small number of studies and lack of UK-based research limits generalisability and highlights the need for context-specific intervention development. The empirical study found that minority stress significantly predicted anxiety, depression and complex trauma in the study sample, but social safety did not. Anxiety and depression levels were significantly higher in the study sample than in a general UK population sample. Complex trauma levels were comparable to those in a UK trauma-exposed sample.

Conclusions: The findings highlight the critical role of parental acceptance and support, and the mental health impact associated with minority stress in unaccepting Christian environments, emphasising the need for targeted support and further research.

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به پدرم، ممنونم که همیشه به من ایمان داشتی

Chapter One – Introduction

Central to the practice of Clinical Psychology is the concept of ethical practice. In the UK, The British Psychological Society (BPS) outlines in its code of ethics, the expectations of ethical conduct and behaviour for Psychologists (BPS, 2021). This includes the ethical principle of respect for all people, with a statement of recognition of the inherent worth of all human beings regardless of any perceived or actual differences. There are known mental health disparities between LGBTQ+ people and their heterosexual cisgendered counterparts (Kassing, et al., 2021). As such, there is a clear ethical imperative for practitioner psychologists to understand the unique mental health needs of this community, and to work towards better and more effective care for this minoritized group.

There are multifaceted ways in which prejudice, discrimination, oppression and stigmatization can impact upon LGBTQ+ peoples' mental health, and this can happen in many different arenas of life (King et al., 2008; McCann & Sharek, 2016). Despite this, the unique mental health needs of this community are notably under-researched and not well understood (Rees et al., 2021), and often go unrecognised when individuals present to health services (Hollier et.al., 2022). More than this, many LGBTQ+ people report experiences of discrimination and stigma when accessing services (Parameshwaran, et al., 2017). This can result in a loss of trust in professionals, with experiences of discrimination leading to reduced adherence to treatment and avoidance of healthcare services (Guest & Weinstein, 2020; Casey, et al., 2019). In this way, the health of LGBTQ+ people is directly impacted by these factors.

Minority Stress Theory holds that discriminatory experiences can lead to a chronic stress response in minoritised individuals, which goes some way in explaining the observed mental health impact of discrimination (Meyer, 2003). Human beings have evolved to find safety in

groups, and as such minoritising events are experienced as threatening (Brewer & Caporael, 2013). When discriminatory, excluding and stigmatising experiences permeate everyday life, this experience of threat can lead to the chronic stress response identified in Minority Stress Theory (Mongelli et al., 2019). It is perhaps not surprising that group inclusion has been associated with positive mental health outcomes, and exclusion has been associated with negative mental health outcomes (Begen & Turner-Cobb, 2015; Martin et al., 2018; Drydakis, 2021). In a similar vein, it has been shown that family acceptance is protective for LGBTQ+ peoples mental health (Ryan, et al., 2009), and family rejection is associated with increased risk of mental health difficulties (Ryan et al., 2010).

An area of group rejection of LGBTQ+ people that is under-researched, is the psychological impact of experiences of being part of a religious group that is unaccepting of sexual and gender minorities (Hollier et al., 2022). The impact of social group rejection of a person's identity can have a lasting effect (London, et al., 2014). And when this identity rejection is framed in moral terms as a transgression against God, this can undermine an individual's sense of self (Lefevor, et al., 2021). In a similar vein to the undermining impact of invalidating developmental environments, this can have a traumatic impact on mental health (Cardona, et al., 2022). The psychological damage that can result from exposure to religious messages that undermine mental health is religious trauma (Stone, 2013).

The aim of this thesis is to explore the mental health and well-being of LGBTQ+ people through investigating two areas of the impact of acceptance and rejection: religious trauma, and parental acceptance and support. The systematic review explores interventions aimed at increasing parental acceptance and support for LGBTQ+ people. The empirical study investigates the psychological impact of religious trauma on LGBTQ+ in the UK who grew up in unaccepting Christian environments. This contributes to a broader aim of increasing

understanding of the mental health needs of LGBTQ+ people, and consider how a better understanding can lead to more effective approaches for support of this community.

Key Terms

LGBTQ+: The term 'LGBTQ+' is used throughout this thesis as an umbrella term to refer to anyone who identifies as a sexual orientation or gender identity minority individual. For the purpose of this thesis, the term is used to inclusively denote all orientations and identities that are not heteronormative cisgendered. The + is in recognition that not all orientations or identities are directly represented with the letters LGBTQ.

Sexual and gender minorities: The term 'sexual and gender minorities' is used throughout this thesis since this term denotes the minoritisation of individuals who are not heteronormative cisgendered.

Parent: The term "parent" is used throughout this thesis to denote a parent, caregiver, or parental figure.

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Chapter Two – Systematic Review

A systematic review of interventions that aim to increase parental acceptance and support of their LGBTQ+ children.

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Abstract

Parental acceptance and support are salient factors for the psychological well-being of LGBTQ+ people (Needham & Austin, 2010; Ryan et al., 2010). This review investigates interventions that aim to increase parental acceptance and support for LGBTQ+ people, and provides a synthesis of the efficacy of these interventions. Through systematic database searches and the application of systematized inclusion and exclusion criteria, the review identified seven studies reporting outcomes from seven different novel interventions. Five of the studies reported quantitative outcomes and two reported qualitative outcomes. The quantitative data was synthesized through comparison of effect sizes, and the qualitative data was synthesized through thematic synthesis. The review found preliminary evidence of the efficacy of the interventions for increasing parental acceptance and support of their LGBTQ+ children. However, the small number of studies identified, and the fact that none were conducted with UK populations, limits the applicability of the findings for UK practice. Future intervention development and research directions are considered on these grounds.

Key words

Intervention, LGBTQ+, parental acceptance, parental support, systematic review

Public significance statement

Parental rejection and lack of support can have a lasting negative impact on LGBTQ+ people. Interventions are needed that aim to increase parental acceptance and support for LGBTQ+ people. This review investigates what interventions have been developed, and how effective they are, with a consideration of applicability to UK mental health practice.

Introduction

LGBTQ+[1] individuals face many challenges as sexual orientation and/or gender identity minority (SGM) people, including both physical and mental health disparities in comparison to their non-LGBTQ+ counterparts (Kassing, et al., 2021). Minority status factors, such as experiences of prejudice, discrimination, exclusion and hate-crimes, have been shown to put LGBTQ+ people at higher risk of developing physical and mental health difficulties (King et al., 2008; McCann & Sharek, 2016). Minority stress theory holds that these experiences can lead to a chronic stress response, and that this may go some way to explain the health disparities observed in LGBTQ+ people (Meyer, 2003). Family rejection, in particular, is associated with negative health outcomes for LGBTQ+ people, indicating that this is a salient health risk factor in this population (Ryan, et al., 2009). Parental[2] rejection can be internalised and result in homonegativity, which impacts psychological well-being (Carastathis, et al., 2017). Equally, lack of parental support is associated with increased risk of mental health difficulties for LGBTQ+ young people (Ryan et al., 2010). Notably, a recent literature review of minority stress research specifically identified parental rejection and lack of support as factors within the minority stress that many LGBTQ+ people experience (Mongelli et al., 2019).

In contrast to this, parental acceptance and support have been shown to be protective factors for the health of LGBTQ+ people (Needham & Austin, 2010; Ryan et al., 2010). Mongelli et al. (2019) found that feeling loved and supported by parents facilitates the

[1] The term 'LGBTQ+' is used throughout this paper as an umbrella term to refer to anyone who identifies as a sexual orientation or gender identity minority individual. 'LGBTQ' stands for Lesbian, Gay, Bisexual, Transgender, Queer. The + is in recognition that not all orientations or identities are directly represented with the letters LGBTQ. For the purpose of this paper, the term is used to inclusively denote all orientations and identities that are not heterosexual cisgendered. Additionally, the term 'sexual and gender minorities' is used throughout the paper since this term denotes the minoritisation of individuals who are not heterosexual cisgendered.

[2] The term "parent" is used throughout this paper to denote a parent, caregiver, or parental figure.

development of confidence and relational security in LGBTQ+ people, both of which have been associated with improved health outcomes in this population (Romijnders, et al., 2017). Katz-Wise, et al. (2016) argue that a secure attachment to a parental figure, which is characterised by acceptance and support, is a protective factor for both the mental and physical health of LGBTQ+ young people, and relate this to ability to cope with experiences of minority stress. Additionally, current research shows that family acceptance specifically of LGBTQ+ peoples' sexual orientation and/or gender identity are protective factors for mental health (Mongelli, et al., 2019).

Given these factors, there is a clear need for interventions which aim to increase parental acceptance and support for LGBTQ+ people (Mills-Koonce et al., 2018). A recent systematic review explored the evidence-base for psychological interventions for LGBTQ+ young people (Hobaica, et al., 2018), and identified eight quantitative studies detailing effective interventions. However, the review focussed on interventions aimed at LGBTQ+ youth mental health outcomes. To date, there has not been a systematic review of interventions for parents of LGBTQ+ people, in particular interventions aimed at increasing parental acceptance and support. Additionally, there is currently no clinical guidance on the implementation of interventions in this area (Hobaica et al., 2018).

The aim of this review is to provide a comprehensive synthesis of the efficacy of interventions aimed at increasing parental acceptance and support for LGBTQ+ people. And, on the basis of this, to consider relevance to UK health service practice for working with unaccepting or unsupportive families of LGBTQ+ people. Therefore, the review seeks to answer the following question:

What are the interventions aimed at increasing parental acceptance or support of their LGBTQ+ children, and how effective are these interventions?

Method

The systematic review was pre-registered on PROSPERO (registration number: CRD42024542425, 02/08/2024). The PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-analyses) checklist was followed (Page et al., 2021).

Search strategy

Systematic searches of five electronic databases were conducted to identify studies relevant to the review topic: APA PsychInfo, CINAHL (Cumulated Index to Nursing and Allied Health Literature), Medline, Scopus and Web of Science. These databases were identified as covering the broad research area through an initial library electronic catalogue search. Only published studies were sought since the aim of the review is to understand what research is in the public domain and therefore what interventions are being utilized. Therefore, databases of unpublished studies were not searched, and grey literature was not sought.

The same search terms were used across all five databases (Table 2.1). Due to the number of search terms utilized, database taxonomy terms (such as MeSH terms) were not deemed necessary. To ensure indexing and categorization relevant to the review topic were not missed, the search terms used were checked against MeSH terms and equivalents. No additional taxonomy terms were identified.

Studies from January 2000 until October 2024 were included in the search. This was to ensure that the research evaluated related to current clinical practice. The final search was conducted on 27th October 2024.

Table 2.1. *Search terms used across all databases*

Term One	AND	**Term Two**	AND	**Term Three**	AND	**Term Four**
Title		All Fields		Title		All Fields
interventio* or therap* or treatment* or practice* or program*		parent* or caregiver* or mother* or father* or carer*		lgb or lgbt* or lesbian* or gay* or homosexual* or bisexual* or transgender* or queer* or sexual minority		child* or adolescen* or youth* or teen*

Inclusion and exclusion criteria

The SPIDER tool (Tawfik et.al., 2019; Table 2.2) was used to develop the inclusion and exclusion criteria for the review, which informed the development of the search terms (Table 2.1). The inclusion criteria for studies in the review was (1) primary empirical intervention studies of any kind that (2) include a reported quantitative or qualitative outcome, (3) are studies of interventions aimed at increasing parental acceptance or support of their LGBTQ+ child, (4) that describe a parental outcome of the intervention – acceptance, support or parental self-efficacy, and (5) are interventions aimed at parents whose child of any age has identified as LGBTQ+ or their parent believes this to be their identity. See Table 2.2 below for full inclusion and exclusion criteria details. Parental self-efficacy was included as an outcome because as a construct it is understood to be intrinsically linked to supportive parenting (Albanese et al., 2019).

Parental self-efficacy is parents' belief in their ability to positively influence their child's health and success (Albanese et al., 2019). It is directly linked to parental support because higher levels of parental self-efficacy are associated with supportive parenting

(Waid, et al., 2025). Supportive parenting is a parent's sensitivity and responsiveness to their child's needs. Parents with higher levels of parental self-efficacy tend to feel better able to help their children cope with challenges, thus tending to be better able to support their child (Waid, et al., 2025). Since parental self-efficacy is understood to facilitate parents' ability to support their child, it was included as an outcome within the review, under parental support (Murdock, 2013).

Table 2.2 *SPIDER Framework*

Study characteristic	Inclusion criteria	Exclusion criteria	Rationale
Sample	Parent/caregiver who has a child who identifies as LGBTQ+, or the parent believes their child to be LGBTQ+. Child can be any age, including adult. Parental age 18+.	Parent/caregiver whose child identifies as cisgendered heterosexual. Parental age under 18.	Acceptance and support are salient familial relational factors throughout the lifespan.
Phenomenon of Interest	Research that has explored the use of interventions aimed at increasing parental support or acceptance for their LGBTQ+ child. An outcome of the intervention must be described.	Research that describes an intervention but does not include an outcome of some sort (quantitative or qualitative). Interventions that are not aimed at increasing parental acceptance or support.	In order to ensure that the review examines the interventions in this area.
Design	Intervention studies with outcomes reported. Outcome of intervention given can be quantitative or qualitative.	No outcome measure or qualitative outcome of intervention given. No data collected or analysed.	In order to be able to answer the research questions.
Evaluation	Parental outcome of intervention - acceptance, support, parental self-efficacy. Child outcomes that pertain to parental support, acceptance or parental self-efficacy.	Parent outcomes not aimed at increasing parental acceptance or support. Child outcome only (when not related to parental support, acceptance or parental self-efficacy).	Aim of review is to understand the effectiveness of interventions aimed at increasing parental acceptance, support or parental self-efficacy.

Research Type	Peer reviewed intervention studies – primary research only e.g. case studies, pilot studies, pre/post intervention studies, RCTs.	Books, non-peer reviewed articles, review articles.	To ensure the quality of studies included in the review. To ensure the relevance to the research questions.
Timeframes	Reviews published in the last 24 years (since 2000).	Reviews published prior to 2000.	This is to ensure that the research that is being evaluated relates to current practice
Publication	Published studies	Unpublished studies	Purpose of review is to understand what is in the public domain, and what interventions are being utilised.
Language	English	Non-English (although translations will be sought if needed)	International research included, but English language only, which is standard in the field.

Only primary empirical intervention studies with reported outcomes were sought because the aim was to find out what interventions are being utilized and how effective they are. The use of outcome measures or qualitative outcomes allows for an understanding of the effectiveness or impact of the intervention from those for whom the intervention is designed, as opposed to simply the clinical impression of the therapist (APA, 2006).

Parental acceptance and support can have a significant impact on long-term health outcomes in LGBTQ+ people (Ryan et al., 2009), and remain salient relational factors throughout the lifespan (Rohner et al., 2012). Therefore, interventions aimed at parents whose LGBTQ+ child was any age were sought. Interventions aimed both at parents whose child had identified as LGBTQ+, and parents who believed their child's identity to be LGBTQ+ even without disclosure, were included. This is because parents' beliefs about their child's

identity can influence parenting approaches even without explicit disclosure on the part of their child (D'amico, et al., 2015).

Screening method

Following the final search, all identified records were imported into EndNote. Additionally, one study that did not come up in the search was identified from a registered intervention protocol that did come up in the search, and so was included in the identified records. Duplicates were removed, and the remaining titles and abstracts were screened by the lead researcher (JKM) against the inclusion and exclusion criteria. A random 10% were also screened independently by a peer who is research active and external to the research team (KLP). The full text of the eligible studies was then screened by the lead researcher (JKM), and a random 30% of these studies were independently screened by two research active peers external to the research team (KLP and PJK). KLP and PJK screened 15% each. Two peers were asked, rather than just one, due to the time involved in screening. Any studies that did not meet the inclusion criteria were excluded.

Data extraction

The study characteristics and results of included studies were extracted using two adapted data extraction tables from Boland et al. (2024). Since each study used different outcome measures, or qualitative outcomes, and different types of analysis, the tables were adapted to allow for a full extraction of all data relevant to the research question.

Only outcomes and findings pertinent to the research question were extracted. Since the review seeks to investigate interventions aimed at increasing parental acceptance or support, child outcomes were only included if they pertained to these constructs. Other child measures were not extracted. Parent measures that did not pertain to acceptance or support of

their child were not extracted. Data exploring intervention feasibility and acceptability were not extracted, since they did not pertain to the research question.

Quantitative data synthesis plan

The quantitative data was synthesized through a comparison of effect sizes of the different interventions. All the quantitative studies included in the review were pilot intervention studies, and not all reported *p* values. This is not unusual for pilot studies, where the focus is on developing an intervention (Leon, et al., 2011). All the studies reported effect sizes, although one reported in words only, but Cohen's *d* effect size was calculable from the data reported in the study. Reporting of effect sizes in pilot studies is usual practice since initial effect sizes at the early stage of intervention development are used to power more definitive studies at the next stage (Leon, et al., 2011). Comparison of the reported effect sizes of pilot studies allows for a consideration of the impact of the interventions at this stage of development.

The effect sizes for each measure included in the data extraction were categorized according to Cohen's rule of thumb as either no effect, small, medium or large effects (Cohen, 1988). Cohen's *d* effect sizes were reported in three of the five quantitative studies, and was calculable for the one study which did not report a value. One study reported partial η^2 effect sizes for repeated measures ANOVA values, which is the standard SPSS output for effect sizes for this test (Lakens, 2013). There is some debate about rule of thumb categories for partial η^2 since it does not account for the whole variance, unlike η^2 (Levine & Hullett, 2002). However, there is justification for the application of conservative estimates of effect size categories for partial η^2 (Cohen, 1992). Therefore, the following rule of thumb categories were used to categorize and compare the effect sizes from the included studies (Table 2.3):

Table 2.3. *Rule of thumb effect sizes*

Effect size	No effect	Small	Medium	Large
Cohen's *d*	<0.2	≥0.2	≥0.5	≥0.8
Partial η^2	<0.02	≥0.02	≥0.13	≥0.26

Qualitative data synthesis plan

The qualitative data was synthesized through thematic synthesis. Thematic synthesis is an adaptation of thematic analysis, used to methodically synthesize themes in secondary qualitative data (Ryan et al., 2018). This was the chosen method of synthesis for the qualitative data because it is an inductive approach which allows for the generation of higher-order themes from extracted data from multiple studies (Nicholson, et al., 2016). Rather than applying a pre-existing model to the data, the researcher sought to explore themes that may be revealed in the extracted data when considered as a whole. The researcher took an essentialist/realist approach, which takes the position that a reality is present in the data which can be analyzed and reported. The research took this approach because participants' experiences of the interventions were inferred from the extracted data, on the assumption that there was a direct relationship between the language participants used to describe their meaning and experiences, and the impact on them of the intervention (Braun & Clark, 2006).

The three stages of thematic synthesis were followed: coding of the data extracted from the studies; development of descriptive themes; generation of analytical themes (Thomas & Harden, 2008). Following the steps outlined by Thomas and Harden (2008), the researcher first read and re-read the extracted data to ensure familiarization. The data was then coded line by line according to meaning and content. This allowed for the translation of concepts from one study to the other (Thomas & Harden, 2008). Free coding was applied

since this was an inductive approach, with the aim of mitigating against pre-conceived notions in the mind of the researcher due to the research question. As each line was coded, it was either added to a code already found or a new code was created. Each line was given at least one code, and often more than one applied. For example, the codes "I feel proud of my child" and "I am impressed by my child's strengths" could both apply to one line of data.

Following this, the researcher looked for similarities and differences between all the codes, and started grouping them together. At this stage, the synthesis remained close to the original findings of the two studies. This process of coding and re-coding resulted in the development of higher-order codes. From these higher-order codes, descriptive themes were developed which remained close to the text and reflected the original themes identified by the study authors.

In order to then develop the analytical themes from the descriptive themes, the author compared the descriptive themes to the research question of how effective the interventions are at increasing parental acceptance and support (where "effective" in qualitative studies is understood to mean the subjective experience of the impact of the intervention for participants). This involved the researcher's subjective interpretation of how the descriptive themes could relate to the research aim, thus going beyond the findings of the original studies to generate higher-order themes to answer the research question. The descriptive themes were then gathered under the generated analytical themes they related to, and the coded data was recorded under the analytical themes (Appendix B).

Quality assessment

The National Institute for Health and Care Excellence (NICE) quality appraisal tool (NICE, 2012) was used to assess risk of bias. The quality appraisal checklist for quantitative intervention studies was used to assess both the quantitative studies and the mixed methods

studies, where only quantitative data was extracted to answer the research question. The quality appraisal checklist for qualitative studies was used to assess the qualitative intervention studies. Two research active peers external to the research team (KLP and PJK) independently assessed a number of the included studies (57%). These were randomly selected. These were the same two peers who assisted with screening. Two peers were asked, rather than just one, due to the time involved in quality assessment.

NICE offers clinical guidelines for standards of care in the NHS, and produces quality standards for that care (Rawlins, 2004). There is currently no NICE guidance on working with unaccepting or unsupportive families of LGBTQ+ people, so the NICE quality appraisal tool was utilised in order to aid consideration of relevance to UK health service practice within the quality assessment.

The NICE tool has three possible risk of bias category ratings (Table 2.4). The quantitative tool results in a rating for both internal validity (IV) and external validity (EV), whereas the qualitative tool results in one overall rating. Since the same risk of bias categories are used for both checklists, this allows for an overall comparison of the quality of the included studies.

Table 2.4. *NICE quality appraisal checklists overall study quality grading*

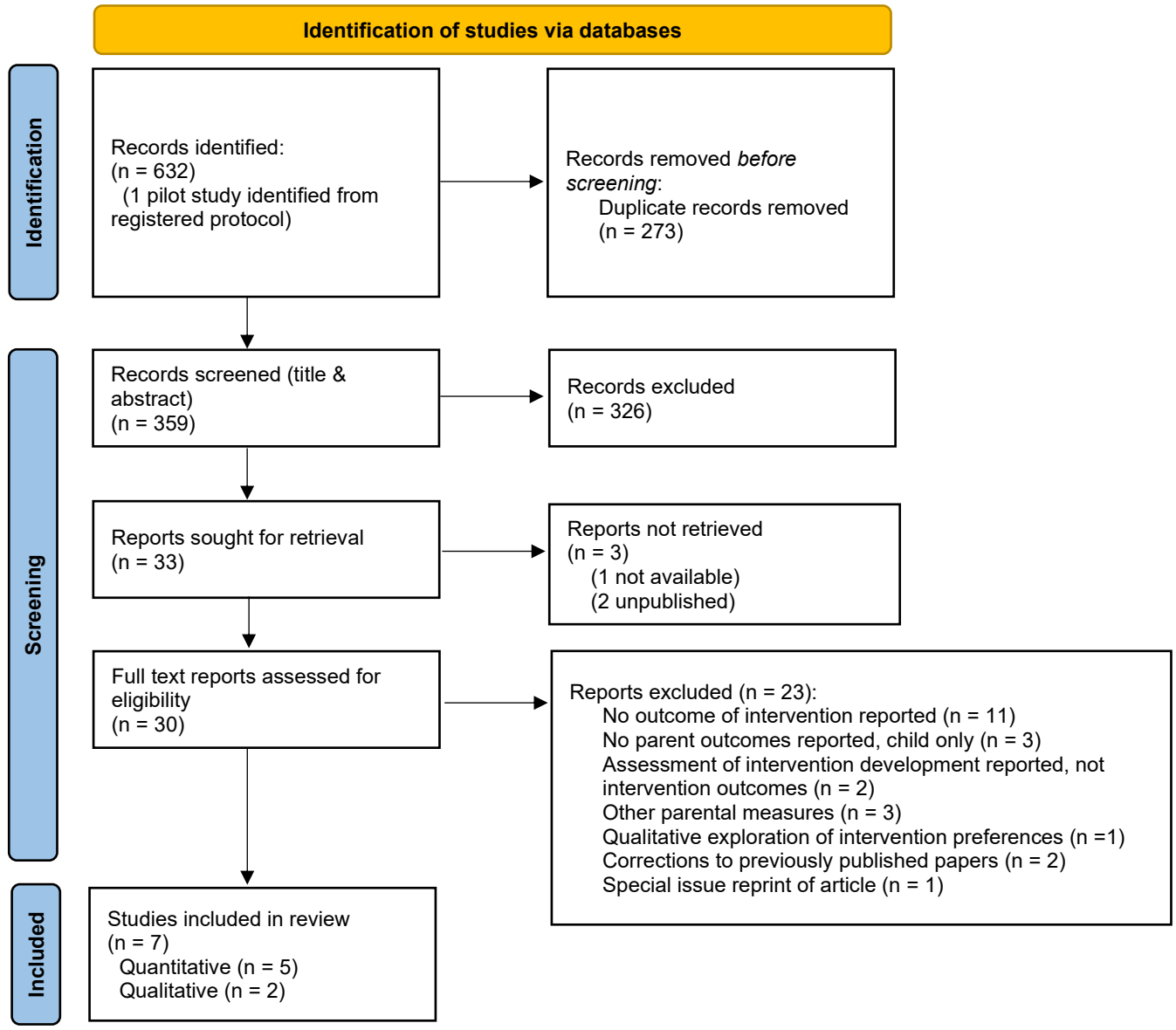
Rating	Description
++	All or most of the checklist criteria have been fulfilled, where they have not been fulfilled the conclusions are very unlikely to alter.
+	Some of the checklist criteria have been fulfilled, where they have not been fulfilled, or not adequately described, the conclusions are unlikely to alter.
–	Few or no checklist criteria have been fulfilled and the conclusions are likely or very likely to alter.

Results

Screening results

632 records were identified in the final search (Figure 2.1). One additional study was identified from a registered intervention protocol. After duplicates were removed, there were 359 records remaining. The titles and abstracts of these records were screened by the researcher, with 10% of records independently screened by a research active peer external to the research team (KLP), resulting in 97.22% agreement. The disagreement was resolved through discussion between JKM and KLP of the title and abstract of the study in question against the SPIDER criteria, consensus was reached, and the study in question was included. 30 studies were found to be eligible. The full texts of these studies were then screened by the lead researcher (JKM), 30% of which were also screened independently by two research active peers external to the research team (KLP and PJK, who screened 15% each). This resulted in 88.89% agreement, with disagreement between JKM and KLP over one study. The disagreement was discussed through JKM and KLP reviewing the full text together against the SPIDER criteria, and JKM discussing the study with one of the project supervisors (AB). Consensus was reached, and the study in question was included in the review. Following screening, seven studies were included in the review. The reasons for the excluded reports are detailed in Figure 2.1.

Figure 2.1. *PRISMA diagram detailing flow of record retrievals, exclusions and inclusions.*



Study characteristics

Of the seven studies that met the inclusion criteria, five were quantitative pilot intervention studies and two were initial qualitative studies of novel interventions (see table 2.5 for details). Two of the quantitative studies took a mixed methods approach, but the qualitative data comprised participant feedback on intervention acceptability, so was not extracted for the review. None of the studies were conducted in the UK; five were conducted in the USA, one in Peru and one in Israel. All but one of the studies were conducted in the

last five years. The earliest study was conducted in 2013. Each of the quantitative studies used different measures and different data analysis methods. There were 11 different measures represented across the studies, resulting in 19 separate outcomes for parental acceptance, support or self-efficacy: 10 for acceptance, six for support, three for self-efficacy. The two qualitative studies used different data collection methods, but both used the same analysis method. See table 2.5 for an overview of study characteristics.

Three of the interventions were aimed at parents of LGBTQ+ children, and four were aimed at parents of lesbian, gay or bisexual (LGB) children (Table 2.5). In these four studies, the authors explained that there were constraints on recruitment such that their participants were parents of LGB children only. Four of the interventions were aimed just at parents, and three were family interventions that included the SGM child – in one of these studies the children were adolescents, in one they were young adults, and in one they were both.

Interventions

Each study presented a different novel intervention, with a range of lengths of intervention and formats (Table 2.5 – intervention names bolded). Three were online interventions: one was an educational film based on motivational interviewing techniques; one was a self-led five-module interactive online intervention based on parent training; one was an online three-session strengths-based parenting workshop which was clinician led. Three were face-to-face interventions: one was a manualized 26-week family therapy intervention for parents and their LGBTQ+ young adult child; one was a seven-session manualized CBT-based group intervention for foster parents; one was a 14-session family-based intervention for parents and their adolescent LGB child. The last was an expressive writing intervention to which participants were either emailed or posted the intervention pack.

Table 2.5. *Included studies' characteristics*

Author/date	Country	Study design	Participant demographics	Intervention
Abreu et al. (2020)	USA	Qualitative intervention study – thematic analysis of open-ended question about the emotions participants experienced as a result of the intervention. (Thematic analysis of participant's intervention responses not included, as not relevant to the review question).	30 Latinx parental figures of LGBTQ+ individuals (17 mothers, 9 fathers, 4 aunts). 19 Cuban American, 11 Puerto Rican, resident in USA. Age 38-76 (*M*=52.6, *SD*=7.76) 24 completed the open-ended question following the intervention.	**Expressive writing intervention** – writing the story of coming to accept their child.
Austin et al. (2021)	USA	Quantitative pilot intervention study – intervention group only, no comparison or control. Pre, post and 3 month follow up measures of affirmative caregiving attitudes, behaviours, and self-efficacy. Intervention delivered at two different sites.	103 foster parents of LGBTQ+ individuals enrolled, 92 completed the programme, 40 completed the measures. Gender data was available for 87 – 59 female, 27 male, 1 agender. Kinship data was available for 88 – 9 were kinship foster parents, the rest were unrelated. Age range not given – just numbers falling within all age brackets.	**AFFIRM Caregiver** – a manualised, CBT-based, group intervention programme for foster parents (7 sessions).
Diamond et al. (2022)	Israel	Quantitative pilot intervention study – intervention group only, no comparison or control. Pre, 8 weeks, 16-week, post and 3-month follow up measures of parental rejection and acceptance.	30 families were recruited – 30 LGBTQ+ young adults and their parents. Both the mother and father participated in 24 cases, and just	**Attachment-based family therapy (ABFT)** – 26-week manualised family therapy intervention.

		(Child measures also taken, but not included for purposes of this review)	the mother in 6 cases. 1 family dropped out. 29 families completed between 11 to 31 sessions. No age data provided for the parents. Age range of young adults 20-36, average age 25.98.	
Estrada et al. (2024)	USA	Mixed methods pilot intervention study – intervention vs control, participants randomised to conditions. Pre/post measures of parent-adolescent communication, parental involvement and positive parenting. (These measures only were included in this review, since the other measures and the qualitative outcomes were not relevant to the research question.)	30 Latinx parent-adolescent dyads, where the young people were LGB (not TQ+). Mean age of parents 44.9 – no further breakdown of age data provided. No gender data given. Adolescents age range 13-17, average age 15.53. No gender data given.	**Familias con Orgullo (FcO)** – a 14 session multi-level family-based intervention, comprised of 7 parent-only group sessions, 3 adolescent-only group sessions, 4 family sessions. (Intervention aimed at the macro-system, micro-system, and individual-level)
Goodman & Israel (2020)	USA	Quantitative pilot intervention study – intervention vs control, participants randomised to conditions. Pre/post measures of parental self-efficacy and supportive parenting. (Intervention acceptability measures not included in this review, since not relevant to the research question.)	184 parents, legal guardians, or primary carers of LGB (not TQ+) young people aged 13-18. 134 identified as women. Average age was 42, age range 30-60, *SD* = 6.70.	**PRISMS** – brief, interactive online intervention to promote parental self-efficacy and behavioural intentions for supporting a sexual minority child (5 modules). Based on parent training literature.
Huebner et al. (2013)	USA	Mixed methods pilot intervention study – intervention group only, no comparison or	1,865 parents of LGB (not TQ+) children aged ≤ 25, viewed the film	**Lead with Love** – film intervention (educational entertainment) to improve parental responses to

		control. Pre/post measure of parental self-efficacy. (Qualitative exploration of intervention acceptability from parents and youth not included, since not relevant to the research question.)	– 991 female, 332 male. Average age was 48.6. 796 parents (43%) completed the post-film follow-up questions. 555 completed the self-efficacy question, since it was added part way through the study.	their lesbian, gay and bisexual children (single session). Motivational Interviewing based intervention.
Zavala & Waters, (2024)	Peru	Qualitative intervention study. Thematic analysis of pre and post intervention semi-structured interviews.	6 Latinx parents of LGB (not TQ+) individuals – 5 mothers, 1 father. Age range 38-54, average age 49.6. 5 LGB (not TQ+) children of the parents. Age range 12-29, average age 19.8.	**Strength-based parenting intervention** – 3 online workshops. The intervention was for the parents only, but both the parents and their LGB child were interviewed before and after the intervention.

Overview of studies' findings

The extracted study results are detailed in Table 2.6. In total, the number of participants represented in the data extracted from the seven studies was 954 (890 parental figures and 64 children – age range 12-36 years). Not all studies reported age ranges for the parental figures, but for the three that did, the age range was 30-76 years. Three of the five quantitative studies found significant increases in parental acceptance, support or self-efficacy following the intervention. For the PRISMS intervention, the increase in parental support and self-efficacy did not reach significance, but a small effect size of the intervention was found. For the FcO intervention, the authors reported intervention effect size only for increase in parental support (Estrada et al., 2024).

The two qualitative studies identified themes in the data indicating a positive impact of the interventions on parental acceptance and support. Both studies utilised thematic analysis to analyse their data. However, Abreu et al. (2020) asked one short open-ended question to understand the impact of their intervention, whereas Zavala et al. (2024) conducted pre and post intervention semi-structured interviews. As such, Zavala et al. (2024) gathered a greater richness and depth of data than Abreu et al. (2020). Abreu et al.'s (2020) use of a short open-ended question may not have yielded the richest of data about the impact of their intervention. Certainly, Zavala et al. (2024) offer longer quotes, with deeper exploration of how their data supports the themes they identified, than Abreu et al. (2020). Additionally, Zavala et al. (2024) identified two themes with three sub-themes each, whereas Abreu et al. (2020) identified three themes but did not detail any sub-themes (see Table 2.6 for the names of all themes and sub-themes). However, Abreu et al. (2020) gathered data from 24 participants, whereas Zavala et al. (2024) interviewed 11 participants. As such, Abreu et al. (2020) have greater breadth in their data, and thematic analysis is well established as a method for drawing out meaning from both larger data sets and data with less

depth (Joffe, 2011). This suggests that although Abreu et al.'s (2020) data did not have the richness or depth of Zavala et al.'s (2024) data, their methodology was nevertheless appropriate for gaining an understanding of participants' experiences of the intervention.

Both studies present evidence of the distinction and coherence of the themes they identified through the use of multiple quotes to illustrate the meaning of the themes, and choosing quotes that appear to well align with their descriptions of their themes. However, although Abreu et al. (2020) offer both short quotes and paragraph quotes, Zavala et al. (2024) offer a greater amount of quotation material than Abreu at el. (2020), and more narrative description of how the quotes demonstrate the meaning of their themes, thus offering greater evidence of the strength of their themes than Abreu et al. (2020). This illustrates a limitation of Abreu et al.'s (2020) use of one short open-ended question to gather data on the impact of their intervention, in comparison to Zavala et al.'s (2024) use of pre and post intervention interviews, which meant that Zavala et al. (2024) had richer and deeper data to work with.

However, both studies detail the processes the researchers engaged in which lend credibility to their data analysis. Abreu et al. (2020) detailed how they mitigated against bias through the first author keeping a reflexive journal throughout, and through continued discussion around positionality and bias between the three authors. Their use of a second-rater approach in the coding of their data adds to the credibility of their analysis, and therefore the strength of the themes they identified. Zavala et al. (2024) also utilised a reflexive approach in identification, exploration and intentional suspension of assumptions through their analytic process. They employed both second-rater checking of codes, and member-checking of the themes by the participants, thus also demonstrating the use of methodology that supports the strength of their identified themes. Given that Abreu et al.

(2020) did not take the additional step of member-checking their themes, it is possible that Zavala et al. (2024) had greater credibility and trustworthiness of themes.

Table 2.6. *Results of included studies*

Study	Sample size (number of participants included in analysis)	Study outcomes	Analysis	Findings
Abreu et al. (2020)	24 parents	Open-ended question – qualitative exploration of emotions participants experienced as a result of the intervention.	Thematic analysis	Three themes identified: a – Mixed Feelings b – Happiness, Pride and Peace c – Satisfaction and Relief Conclusion: The positive emotions the intervention facilitated in relation to the parents' journey of acceptance, may foster a stronger parent-child relationship and also facilitate insight and understanding.
Austin et al. (2021)	40 parents	5 quantitative measures which were created for this study Parental acceptance: *Affirmative caregiving attitudes (ACA)* – Attitudes Towards Diverse Orientations and Attitudes Towards Diverse Gender Identities and Expressions (Attitudes LGB and Attitudes T) Parental support: *Affirmative caregiving behaviours (ACB)* – Behaviors Related to Working with Lesbian, Gay and Bisexual Children/Youth and Behaviours Related to Caring for	Repeated measures ANOVA – pretest, posttest, 3-month follow-up. Gains analysis	Significant difference between pretest and posttest, and between pretest and 3-month follow up. All p's <0.0001. This indicates that the intervention increased affirmative caregiving attitudes, behaviours and self-efficacy. No significant difference between posttest and 3-month follow-up, indicating that posttest gains were maintained at 3-month follow-up. No significant pretest differences between sites. No significant differences at posttest between site other than the Behaviors T, which was higher at one site than the other. Partial eta squared effect sizes reported: Attitudes LGB – 0.228

		Transgender Children/Youth (Behavior LGB and Behavior T) Parental self-efficacy: *ACSI*: The Affirmative Caregiving Self-Efficacy Inventory		Attitudes T – 0.268 Behavior LGB – 0.204 Behavior T – 0.284 ACSI – 0.448 Gains analysis indicated that participants with low, medium and high pretest scores, all had posttest gains. Conclusion: AFFIRM Caregiver is an effective intervention for improving affirmative caregiving attitudes, behaviours and parental self-efficacy in foster parents of LGBTQ+ youth.
Diamond et al. (2022)	Parents: Pretest – 28 mothers, 23 fathers 8 weeks – 26 mothers, 20 fathers 16 weeks – 27 mothers, 20 fathers Posttest – 27 mothers, 22 fathers 3-month follow-up – 24 mothers, 20 fathers Children (20-36 y/o): Pretest – 25 8 weeks – 21 16 weeks – 22 Posttest – 21	Parental acceptance: *PARSOS* – Parental Acceptance and Rejection of Sexual Orientation Scale.	Multi-level growth model (multiple regression)	Mothers' acceptance – *d* = 0.63 Mothers' rejection – *d* = -0.68 Fathers' acceptance – *d* = 0.69 Fathers' rejection – *d* = -0.12 YPs perception of Mothers' acceptance – *d* = 1.01 YPs perception of Mothers' rejection – *d* = -0.72 YPs perception of Father's acceptance – *d* = 1.02 YPs perception of Father's rejection – *d* = -0.53 Conclusion: The authors argue that these results show that both the mothers' and the YPs independently reported increases in the mothers' acceptance and decreases in rejection. They state that the results show that the YPs reported an increase in their Fathers' acceptance and decrease in rejection, but the Fathers' did not report this. They argue that the gains continued when measured 3 months after treatment.

	3-month follow-up – 20(acceptance), 19 (rejection)			The authors conclude that this is evidence of the efficacy of this intervention.
Estrada et al. (2024)	30 parents 30 children (13-17 y/o)	Two quantitative measures Parental support: *Parenting Practices Questionnaire (PPQ)* – to measure parental involvement and positive parenting. *Parent-Adolescent Communication Scale (PACS)* – to measure communication	Effect sizes for the intervention outcome measures – Cohen's *d*	Parental involvement (*d*=0.34, 95% CI [-0.43, 1.13]) Positive parenting (*d*=0.02). No CI given. Parent-adolescent communication (*d*=0.46, 95% CI [-0.33, 1.22]) Conclusion: The authors conclude that these results indicate encouraging preliminary intervention effect sizes for parent-adolescent communication and parental involvement in this pilot study, and warrant a fully powered intervention efficacy study. They report large confidence intervals, but their conclusions are cautious.
Goodman & Israel (2020)	184 parents	Two quantitative measures: Parental self-efficacy: *LGB-CSI adapted* – therapist self-efficacy measure adapted to measure parental self-efficacy for parenting an LGB child. Parental support: *Behavioral Intentions (BI)*: Behavioral Intentions for supportive parenting – measure developed by the researchers	Two one-way ANCOVAs	Association between PRISMS and parental self-efficacy was not significant – $F(1, 180) = 3.54$, $p = 0.61$, $d = 0.31$. However, a small effect size was found. Association between PRISMS and behavioral intentions for sexual-minority supportive parenting was not significant – $F(1, 181) = 2.97$, $p = .086$, $d = 0.21$. However, a small effect size was found. Authors' hypothesize ceiling effects of the measure since pre-test self-efficacy and supportive parenting was relatively high. However, post hoc assessment of only participants who reported high distress about their child's sexual

				orientation revealed significant associations on both constructs: Parental self-efficacy – F(1, 16) = 6.28, *p* = .023 Behavioral intentions – F(1,17) = 6.80, *p* = .018 Conclusions: The authors suggest that the small effect sizes found with the whole group analysis are comparable with other online interventions. They suggest that their post-hoc analysis of parents who were highly distressed about their child's sexual orientation may suggest that the intervention is effective for this population.
Huebner et al. (2013)	555 parents	Parental self-efficacy assessed with the question "How confident are you that you can be a good parent to an LGB child?" 5-point Likert scale for response.	Paired-sample *t* test comparing pre and post intervention ratings	Pre film: *M* = 3.7, *SD* = 1.2 Post film: *M* = 4.1, *SD* = 1.0 *t*(554) = 10.36, *p* = <.0001 Effect size reported in words as "small effect". However, Cohen's *d* is calculable from the data provided – *d* = 0.36* Conclusion: The authors suggest that this offers preliminary evidence that the intervention is effective at increasing parental self-efficacy.
Zavala & Waters, (2024)	6 parents 5 children (12-29 y/o)	Pre and post intervention qualitative semi-structured interviews – with parents and with their children.	Thematic analysis	Themes identified: Theme – Parents' psychological growth Subthemes: Identity growth; emotional growth; cognitive growth. Theme – Strengthened parent-child relationship Subthemes: Changed perception of child's identity; relationship closeness; family functioning.

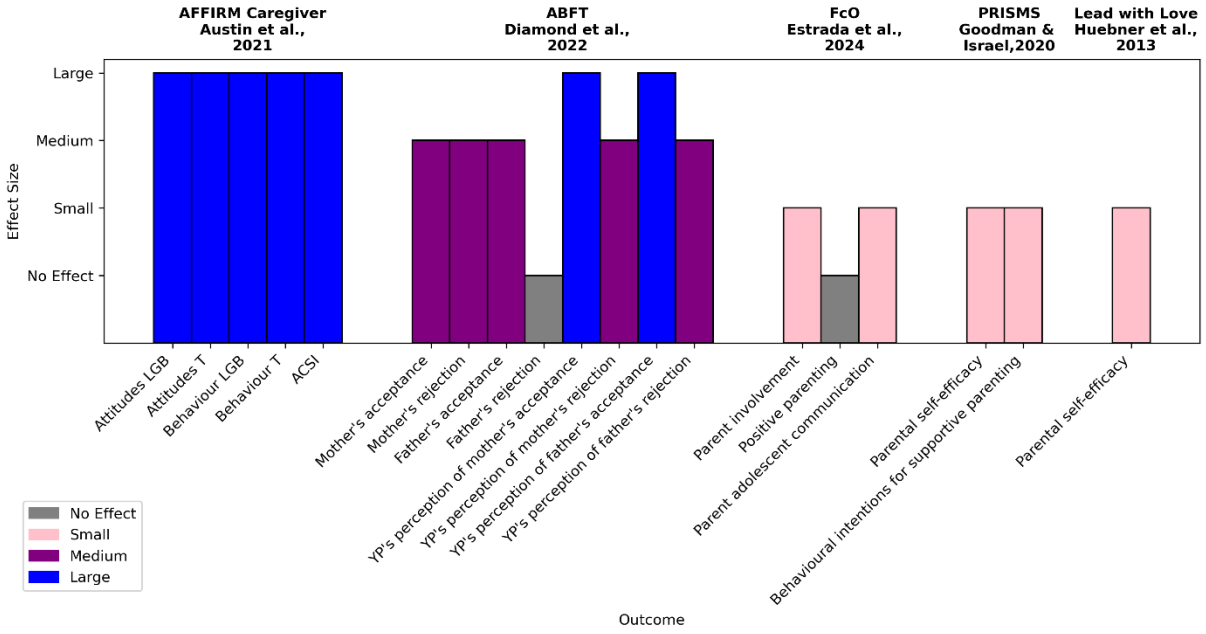
	Conclusion: The authors conclude that this strength-based parenting approach to intervention demonstrates that parents who are shown how to recognise and draw upon their own and their child's strengths experience psychological growth. And that this results in improvements in the parent-child relationship.

*Cohen's *d* effect size calculated by the review author from the data provided in the paper. Value not reported by the study authors in their paper.

Quantitative data synthesis

A comparison of the effect sizes reported across the 19 outcomes for parental acceptance, support or self-efficacy represented in the review, revealed that 17 outcomes showed an intervention effect (Figure 2.2). The direction of effect for all 17 favoured the interventions, suggesting preliminary evidence for the efficacy of these pilot interventions. Of the two outcomes that did not show an intervention effect, one was 'Father's rejection' (acceptance) from ABFT and one was 'positive parenting' (support) from FcO.

Figure 2.2. *Harvest plot of effect sizes reported in included studies*



See Table 2.7 for details of which outcomes measured parental acceptance, support and self-efficacy. Of the 10 outcomes for parental acceptance from two interventions (AFFIRM and ABFT), four showed a large intervention effect, five medium, and one no effect. The medium and large effect sizes reported suggest a genuine impact of the interventions on parental acceptance. Overall, this is encouraging preliminary evidence for the development of effective interventions aimed at increasing parental acceptance. AFFIRM was a seven-session group-based intervention, whereas ABFT was a 26-session family

intervention, which is therefore more resource intensive. However, ABFT was the only intervention aimed at persistently non-accepting parents where a more intensive intervention might be expected for change to occur.

Table 2.7. *Quantitative studies' interventions, measures and outcomes for each construct*

Construct	Intervention: Measure – Outcomes
Parental acceptance	**AFFIRM Caregiver**: ACA – Attitudes LGB, Attitudes T
	ABFT: PARSOS – Mother's acceptance, Mother's rejection, Father's acceptance, Father's rejection, YP perception Mother acceptance, YP perception Mother rejection, YP perception Father acceptance, YP perception Father rejection
Parental support	**AFFIRM Caregiver**: ACB – Behavior LGB, Behavior T
	FcO: PPQ – parental involvement, positive parenting; PACS – parent-adolescent communication.
	PRISMS: BI – behavioral intentions for supportive parenting
Parental self-efficacy	**AFFIRM Caregiver**: ACSI
	PRISMS: LGB-CSI adapted – parental self-efficacy
	Lead with Love: Parental self-efficacy question

Of the six outcomes for parental support from three interventions (AFFIRM, FcO and PRISMS), two showed a large intervention effect, three small, and one no effect. Of the three outcomes for parental self-efficacy from three interventions (AFFIRM, PRISMS and Lead with Love), one showed a large intervention effect, and two small. Parental self-efficacy is understood as a component of supportive parenting (Albanese et al., 2019). These reported effect sizes indicate a likely impact of the interventions on parental support, but given the range of effect sizes this should be interpreted cautiously. Overall, these results suggest that effective interventions aimed at increasing parental support can be developed. AFFIRM and

FcO are group-based interventions requiring a clinician, whereas PRISMS and Lead with Love are self-led online interventions, and so are comparatively less resource intensive.

Qualitative thematic synthesis

Thematic synthesis was carried out on the extracted qualitative data by the researcher (see qualitative analysis plan section above). This resulted in the development of six descriptive themes, from which two analytical themes were generated (Table 2.8). See Appendix B for full extracted data grouped under the two analytical themes.

Table 2.8. *Thematic synthesis analytical themes with the associated descriptive themes from which they were derived.*

	Analytical themes	
	Improved parent-child relationship	**Insight, understanding and awareness**
Descriptive themes	Happiness, pride and closeness	Express emotions
	Satisfaction in relationship	Personal growth
	Improved understanding of child	Improved understanding of self

Improved parent-child relationship related to participants' accounts of improvements in their relationship following the intervention. In both studies, parent participants described a sense of happiness and pride in the relationship they had come to develop with their sexual/gender minority child across barriers they initial experienced, such as difficulty adjusting to a change in expectations for what their child's future may hold. Parent and child participants described an increased closeness in the relationship following the intervention, which seemed to lead to greater satisfaction in their relationship. Parents expressed that they felt better able to understand their children following the intervention, and as a result were more accepting of their child. Child participants noticed changes in their parents' understanding of them following the intervention, which helped them to feel more accepted

by their parents: “When I see my mom putting these changes into action, it’s like, my inner teenager feels relieved, like he’s saying, “I’m not in danger anymore.” She used to be so invasive, and now she’s much more curious and empathetic with me.” (Child, Zavala & Waters, 2024). Parents expressed making efforts to be more supportive of their child, and child participants noticed improvements in the support their parents were offering them. Overall, these findings illustrate the impact that the interventions had on the parent-child relationship, and how this led to improved acceptance and support. “I feel very happy [in] accepting him and that I was able to be by his side to support him.” (Parent, Abreu et al., 2020)

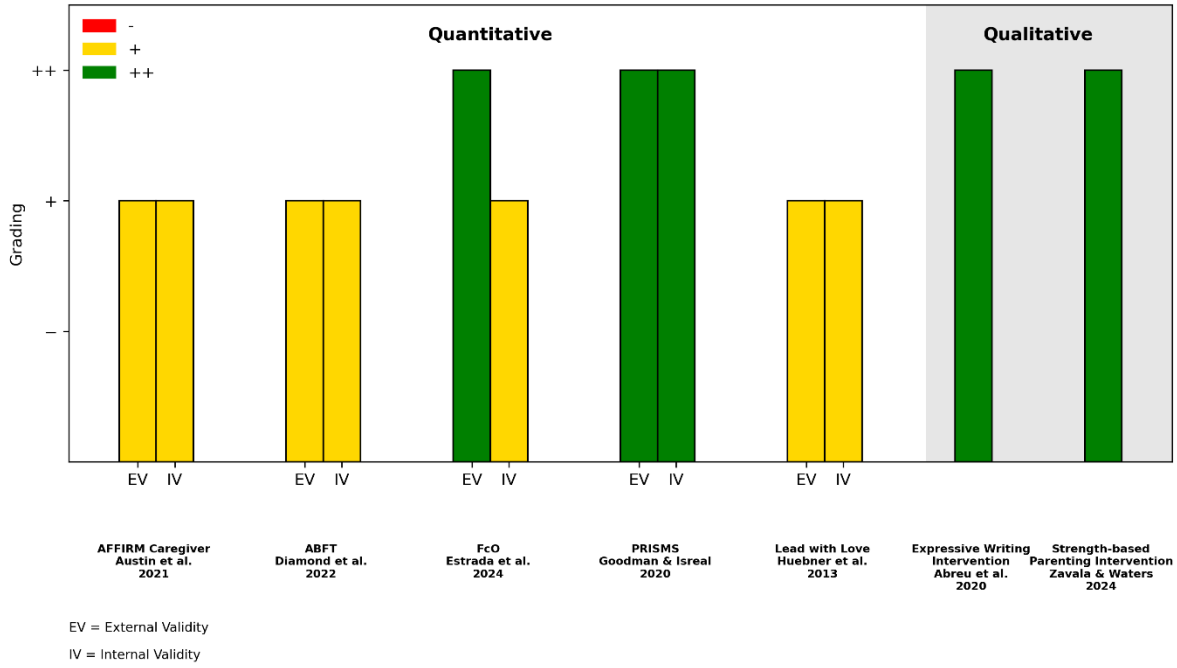
Insight, understanding and awareness related to participants’ accounts of both parents and children feeling safer to express emotions, due to parents having a greater awareness of these emotions, following the intervention. Participants expressed that the parents had gained an improved understanding of themselves, and had experienced personal growth in becoming better parents to their children. This increased insight and understanding of themselves enabled parents to recognize their own biases and prejudices against LGBTQ+ people. “It hurt me to recognize I may have biases, but owning up to that helps me keep them in check and question them. Now, I truly just care that she finds a loving partner – no matter what package they come in.” (Parent, Zavala & Waters, 2024). Through this increased awareness, parents recognized the impact their unacceptance was having on their child, and were able to become more accepting of who their children are. This also involved an awareness of their child’s need for support, and a desire to be the supportive parent their child needed. “My other daughter asked me what bothered me most about the situation and I told her: ‘I don’t want anybody to do anything bad to my youngest daughter.’ She responded: ‘Think about what you’re saying and reflect on all that’s happened.’ And then I understood: I was the one hurting my daughter because I wasn’t accepting her just as she is.” (Parent, Abreu et al.,

2020). Overall, these findings indicate that the impact of the interventions on the parents' insight, understanding and awareness positively influenced the parents' acceptance and support of their child.

Study quality

The independent reviewer quality assessment of 57% of the studies (4 of the 7) resulted in 85.71% agreement. KLP and PJK conducted the quality assessment of two studies each. Consensus on quality rating was then reached through discussion between the reviewers (JKM, KLP and PJK). Overall, the quality assessment revealed that risk of bias was low across the included studies. Although some studies met the majority of the criteria (++) and others only met some (+), in all cases the conclusions were unlikely to change, indicating that risk of bias was low. None of the studies fell into the (–) rating. (See figure 2.3 for an overview of study quality across each study).

Figure 2.3. *Harvest plot indicating quality assessment ratings for included studies.*



The quality assessment for quantitative studies results in a rating for both external validity (EV) and internal validity (IV). Three studies gained a (+) rating for EV, and two studies gained a (++) rating. This suggests that, overall, the results are likely to be generalizable beyond the study samples. A consideration of the assessment was that all of the studies were pilot intervention studies, and this was taken into account in the assessment by the researcher and the external reviewers. Although the pilot nature of these intervention studies does limit generalizability, within the parameters of pilot studies, risk of bias was minimized for external validity.

Four studies gained a (+) rating for internal validity, and one gained a (++) rating. This suggests that the studies were for the most part well-designed, and the outcomes reported are likely attributable to the intervention. Three of the five studies did not have a control group, although this is not unusual in a pilot intervention study (Leon et al., 2011). The two which did, randomized participants to groups.

The NICE quality assessment for quantitative intervention studies includes an assessment of relevance to UK practice, which was a pertinent consideration of this review since all of the studies were from outside the UK. All of the studies met the criteria in this regard.

The quality assessment for qualitative studies results in one overall rating, and both studies in the review received a rating of (++). This indicates that studies were well designed, that the results were trustworthy, the analysis was rigorous and reliable, and the findings were convincing. Both studies were well-designed and relevant, and added to the field under investigation. Both studies were explorations of novel interventions, the qualitative methodology allowed for rich exploration of the impact of the interventions for participants, and the conclusions were appropriate, thus warranting a (++) rating.

Overall, this suggests that the preliminary evidence of efficacy of the pilot interventions for increasing parental acceptance and support found in the quantitative data synthesis, and the positive impact of the novel interventions on parental acceptance and support found in the qualitative data synthesis, can be considered reliable. Since the quality assessment suggests that the results of the quantitative studies are likely to be generalizable beyond the study samples, this is good grounds for trialing the pilot interventions with other populations of parents of LGBTQ+ people. The quality assessment also suggests that the findings of the qualitative studies are likely to be transferable since the results were trustworthy, offering grounds for trialing these novel interventions with other groups of parents of LGBTQ+ people.

Discussion

This review investigated what interventions there are that aim to increase parental acceptance and support of their LGBTQ+ children, and synthesized findings on the effectiveness of these interventions. The review identified seven published studies reporting evidence of outcomes from seven different interventions, five with quantitative outcomes and two with qualitative outcomes. Overall, the synthesis found evidence for the efficacy of the interventions. The quantitative data synthesis of intervention effect sizes shows encouraging preliminary evidence for an impact on parental acceptance from two interventions, and preliminary evidence of a likely impact on parental support from four interventions. The qualitative data synthesis found a helpful influence on parental acceptance and support from two interventions, through participants' subjective experiences of improved parent-child relationships, and improved insight, understanding and awareness for parents. The quality assessment of the studies found that risk of bias was low across interventions, with consideration that these were all studies of novel interventions. This supports the finding of this review that the interventions are effective, and suggests there is grounds for trialing the

interventions with other populations of parents of LGBTQ+ children, beyond the populations represented in the studies.

A finding of this review is that the seven published studies with reported outcomes were all from outside the UK. The cultures represented by the studies are likely to differ from UK culture in multiple ways. Three of the studies were of interventions developed in the USA with racially heterogeneous participants, but they were all from within a US culture. Three of the interventions were developed specifically for Latinx culture; two for US Latinx families, and one for Peruvian Latinx families. The authors of these studies developed these interventions for these communities specifically because the intersectionality of Latinx culture and LGBTQ+ identity is known to increase the risk of mental health difficulties due to a tendency towards heteronormative family values (Estrada, et al., 2024). The final study was developed in Israel with predominantly Jewish families. Again, the authors highlight the intersection of a strong sense of family connection in this culture, but high levels of rejection of LGBTQ+ family members (Diamond, et al., 2022).

This limits the applicability of the findings of this review of the efficacy of the interventions for UK populations. There is variability within the UK of cultural attitudes towards LGBTQ+ identities (Collins et al., 2023). Although there has been a general trend towards more liberal attitudes in the UK, there are populations where more intolerant views can still be held, for example within some religious and ethnic minority groups (Collins, et al., 2023). For example, the intersectionality of Black British and LGBTQ+ identities has been identified as carrying an increased risk of discriminatory experiences within some groups, due to cultural values and expectations (Jones, 2025). A possible future direction could be to develop adaptations of the interventions for UK cultures. Since the Latinx and Israeli studies were designed specifically for cultures with heteronormative family values, a comparison of the values represented in these studies with UK cultures that place value on

heteronormative families could offer a beginning for adaptation. In their meta-analysis of cultural adaptations for psychological interventions, Hall et al. (2016) found that culturally adapted interventions are more effective than un-adapted versions of the same interventions, and processes for adaptation have been developed (for example, Perera et al., 2020; Hendricks, et al., 2019).

Additionally, the quality assessment indicated that the interventions described in the quantitative studies were relevant to UK practice, meaning that the settings the interventions were delivered within, and the professions delivering the interventions, were comparable to usual practice in the UK. This may offer a foundation for adaptation of these interventions for UK services.

This review found that all but one of the seven identified studies were published in the last five years, and they all presented novel interventions that had not previously been investigated. The 11 studies that were excluded because they did not report any intervention outcomes (Figure 2.1) were all published in the last 10 years. Taken together, this indicates that this is an under-researched but growing area of intervention development. Trends in the average age at which LGBTQ+ people disclose their sexual orientation or gender identity to their families have been decreasing over time (Dunlap, 2016). Additionally, measured trends in levels of acceptance for LGBTQ+ people worldwide were shown to increase from 1981 to 2017, illustrating the general trend towards more tolerant attitudes (Flores, 2019). This may go some way in explaining why intervention research in this area is growing – perhaps greater awareness and understanding of LGBTQ+ identities generally has led to issues of acceptance and support within families to come to the fore more readily.

However, it is also the case that due to historic bias, the mental health needs of LGBTQ+ people have been under-researched compared to those of heterosexual cisgendered

people (Rees et al., 2021). LGBTQ+ people commonly report negative experiences with healthcare services such as stigma, discrimination, ignorance and discomfort from healthcare professionals (Parameshwaran, et al., 2017). The latency and recency of intervention research in this area may be partly a reflection of these biases, and this may also go some way in explaining why all the studies are recent and there are so few.

It is notable that 4 of the 7 studies identified in this review were for parents whose children were lesbian, gay or bisexual only (LGB). These interventions either focused specifically on parents of sexual minority young people, or were unable to recruit parents of trans-gender or gender-expansive young people. In one study the authors noted that parents of transgender children who had originally expressed interest in participation, had withdrawn due to fear of being identified, despite the use of pseudonyms (Zavala & Waters, 2024). This may reflect the wider issue of increasing discrimination against gender minority individuals (Lewis, et al., 2024). It also highlights a potential issue with treating sexual and gender minorities as one group. Although there are likely to be many overlapping experiences of discrimination and prejudice, there are also likely to be experiences that are different Bayrakdar & King, 2023). For example, a recent meta-analysis found differences in prevalence of mental health difficulties between sexual minority and gender minority young people (O'Shea, et al., 2025). Since only three of the studies identified in this review included parents of gender minority children, this limits the applicability of the review findings of the efficacy of these interventions for this population. This also highlights the need for the development of interventions aimed at increasing acceptance and support specifically in parents of gender minority individuals.

Limitations

The small sample size of seven identified studies limits the review findings of the overall efficacy of interventions for increasing parental acceptance and support in general. Additionally, the variability of the interventions means that conclusions about overall efficacy of interventions in this area are tenuous. However, given that all seven studies present initial investigations of novel interventions, what the findings do show is that there is evidence for trialing the interventions with other populations of parents of LGBTQ+ children.

The seven interventions were all different. A different model was utilized as the basis of each one (CBT, ABFT, motivational interviewing, expressive writing, multi-level family intervention, parent training, strength-based parenting), and there was substantial variation in intervention lengths. This may suggest a lack of consensus for how best to support these families. However, one element that all seven studies had in common was a willingness on the part of the parents to take part in the intervention. Many studies have found willingness to engage in therapy to be a predictor of symptom change (Neimeyer et al., 2008). Perhaps this indicates that the parents' willingness to engage in an intervention was a more important factor for change in their acceptance and support than the model or length of the intervention? This is too small a sample to answer this with any certainty, but this may offer an avenue for future investigation.

All the studies used different outcome measures. Some of the studies used measures created specifically for their intervention development, given that appropriate measures were not available. The review focused on the reported impact of the interventions on the two constructs of parental acceptance and support, but the variation in outcome measurement limits the reliability of the findings. A future direction for research in this area could be to

develop reliable measures of parental acceptance and support that have been validated with this population.

Conclusions

Having unaccepting and unsupportive parents can negatively impact on the mental health of LGBTQ+ people (Ryan, et al., 2009; Carastathis, et al., 2017; Ryan et al., 2010; Mongelli et al., 2019). In contrast, parental acceptance and support have been shown to be protective factors for the mental health of LGBTQ+ individuals (Needham & Austin, 2010; Ryan et al., 2010; Romijnders, et al., 2017; Katz-Wise, et al., 2016; Mongelli et al., 2019). There is a clear need for interventions aimed at increasing parental acceptance and support for LGBTQ+ people (Mills-Koonce et al., 2018). Despite this, this review identified only seven interventions studies with reported outcomes, all of which were pilot studies or qualitative studies of novel interventions, and none of which were conducted with UK populations. The review found preliminary evidence of the efficacy of the interventions, but intervention adaptation and development would likely be needed in order for these interventions to be implemented in the UK.

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Chapter Three – Bridging Chapter

The previous chapter synthesised the efficacy of interventions aimed at increasing parental acceptance and support for LGBTQ+ people. Following on from this, the subsequent chapter will investigate the psychological impact of religious trauma on LGBTQ+ people in the UK who grew up in an unaccepting Christian environment.

Whilst these studies explore two different areas of impact upon LGBTQ+ peoples' mental health and well-being, their exploration collectively highlights the need for greater understanding of the mental health impact of prejudice and discrimination against LGBTQ+ people, and what can be done to better support and help this community. A central theme of this thesis portfolio is rejection and acceptance of sexual and gender minorities, and the impact of these. Inter-personal and social rejection of a person on the basis of their sexual orientation or gender identity can cause psychological harm (Drydakis, 2021). And on the other side of the coin, when individuals and groups accept a person for who they are, this is protective for psychological well-being (Begen & Turner-Cobb, 2015).

The systematic review of the previous chapter focussed on one aspect of what can be done to aid acceptance for this community, through a consideration of interventions for parents of LGBTQ+ people. Acceptance and love from a parent is, perhaps, one of the most universal of human needs (Katz-Wise, et al.,2016). The empirical study of the following chapter focusses on an area where LGBTQ+ people experience rejection, through looking at Christian environments where sexual and gender minority identities are not accepted, supported or embraced. Research into both of these areas is in its early stages (Mills-Koonce, et al., 2018; Jones, et al., 2022). By increasing our understanding of the impact of acceptance and rejection for LGBTQ+ people, we can work towards more effective approaches for supporting this community.

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Chapter Four – Empirical Study

Religious trauma in the LGBTQ+ population in the UK: are minority stress and social safety predictors of anxiety, depression and complex trauma?

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Abstract

This study explored the impact of religious trauma on LGBTQ+ people in the UK who grew up in a Christian environment that was unaccepting of sexual and gender minorities. The study investigated (1) whether levels of minority stress and social safety experienced in this environment would predict levels of anxiety, depression and complex trauma in this population, and (2) whether levels of anxiety, depression and complex trauma were higher in this population than the population in general. 78 UK-based LGBTQ+ people who grew up in an unaccepting Christian environment participated in the study. Participants completed measures of minority stress and social safety experienced in the unaccepting environment, and measures assessing current levels of anxiety, depression and complex trauma. The data was analysed through multiple linear regression and Z-tests. The results showed that minority stress predicted a proportion of anxiety, depression and trauma symptoms in the study sample, but social safety did not. The results showed that levels of anxiety and depression were significantly higher in the study sample than a general UK population sample, and that levels of complex trauma were not different in the study sample compared with a UK trauma-exposed sample. This suggests that minority stress can be understood as a mechanism by which LGBTQ+ people in the UK experience religious trauma in unaccepting Christian environments. The mental health impact of religious trauma may be understood in terms of anxiety, depression and complex trauma, but further research in this area is needed.

Key words

LGBTQ+, mental health, religious trauma, sexual and gender minorities.

Public significance statement

Religious trauma is psychological damage that can result from exposure to religious messages that undermine mental health. LGBTQ+ people in Christian environments that are unaccepting of sexual and gender minorities are vulnerable to religious trauma. This study suggests that minority stress is a mechanism by which LGBTQ+ experience religious trauma, and that anxiety, depression and complex trauma are higher in this population than the general population.

Introduction

LGBTQ+[3] people are at higher risk of developing mental health difficulties than the general population (Cochran et al., 2003; WHO, 2021) due to factors such as institutional and societal prejudice, social stress and exclusion, hate crimes and violence (King et al., 2008; McCann & Sharek, 2016). The mental health needs of LGBTQ+ people are under-researched compared to heterosexual cisgendered people due to historic bias (Rees et al., 2021), and discrimination-based trauma is often missed or not understood when individuals present to mental health services (Hollier et.al., 2022). Additionally, many LGBTQ+ people report experiences of discrimination, stigma and ignorance from healthcare professionals when they do access services (Parameshwaran, et al., 2017). This can have a direct impact on health, with discrimination experienced in UK services shown to be a significant negative predictor of both trust in professionals and adherence to treatment (Guest & Weinstein, 2020). Additionally, experiences of discrimination can lead to individuals avoiding accessing healthcare services, thus compounding health problems (Casey, et al., 2019). There is a clear need for both a better understanding of discrimination-based trauma in services, and for better education of healthcare professionals on the health needs of LGBTQ+ people and the health impact of discrimination. This could aid effective assessment, formulation and intervention in mental health services.

Although religiosity can be protective for mental health (Galek et al., 2015), religiosity in LGBTQ+ people exposed to unaccepting religious environments has been shown to be both protective and harmful (Longo, et al., 2013). For example, internalised

[3] The term 'LGBTQ+' is used throughout this paper as an umbrella term to refer to anyone who identifies as a sexual orientation or gender identity minority individual. For the purpose of this paper, the term is used to inclusively denote all orientations and identities that are not heteronormative cisgendered. The + is in recognition that not all orientations or identities are directly represented with the letters LGBTQ. Additionally, the term 'sexual and gender minorities' is used throughout this paper since this term denotes the minoritisation of individuals who are not heteronormative cisgendered.

homonegativity can be a consequence of exposure to such environments (Boppana & Gross, 2019). This is the process through which LGBTQ+ people can internalise a negative and prejudicial self-image through exposure to discriminatory societal messages, which has been associated with mental health difficulties (Berg et al., 2016)

There is growing research on abusive practices within religions, such as intimate partner religious coercive control (Mulvihill et al., 2022), spiritual abuse (Ellis, et al., 2022), and so-called 'conversion therapy' (Jones et al., 2023). 'Conversion therapy' refers to talking therapy, counselling and/or prayer that attempt to change a person's sexual orientation or gender identity, based on the belief that these aspects of a person can and should be changed (Lawford-Smith, 2024). This has been demonstrated to cause lasting psychological damage (Davison & Walden, 2024). In the UK, guidance from accrediting bodies such as the British Psychological Society (BPS) and the Heath and Care Professions Council (HCPC) consider 'conversion therapy' to be unethical, and support a legal ban on the practice (BPS, 2023; HCPC, 2022).

Over the last decade the broader concept of religious trauma has emerged in the literature, in recognition that there are multifaceted ways in which religious environments have the potential to negatively impact upon psychological well-being (Downie, 2022). Stone (2013, pp.324-5) defined religious trauma as "pervasive psychological damage resulting from religious messages, beliefs and experiences…Religious trauma generally accrues gradually through long-term exposure to messages that undermine mental health". Religious trauma can impact upon individuals who are subjected to these messages and environments, even without concrete acts of abuse, in a similar way to the traumatising effects of other chronically invalidating environments, such as the experience of emotional neglect within a family (Cardona, et al., 2022).

Although the terms ‘spiritual abuse’ and religious trauma’ were originally used more interchangeably, as research in this area has developed a distinction between the concepts has emerged (Ellis et al., 2022). Spiritual abuse can be understood as abusive acts perpetrated in a spiritual context, for example, leveraging religious authority to manipulate or coercively control another person (Mulvihill et al., 2022). Religious trauma can be understood as the impact on the individual of the traumatising religious environment (Stone, 2013). Individuals can experience religious trauma as a result of spiritual abuse, but they can also experience it as a result of exposure to religious messages that undermine mental health. This can happen without intent on the part of the leader or faith group to manipulate or harm congregants in any way (Stone, 2013).

Research on the impact of religious trauma on LGBTQ+ people is limited but growing. To date, most studies have either taken a qualitative approach or been case studies (Jones, et al., 2022). Minority stress theory (Meyer, 2003) has been utilised in these studies as a construct to understand LGBTQ+ peoples’ experiences in unaccepting Christian denominations (Lefevor et al, 2021). Minority stress theory suggests that groups that hold a minority status within a community, can experience chronic stress responses as a result of stigma, prejudice and discrimination experiences that can permeate everyday life (Mongelli et al., 2019).

Lefevor et al. (2021) describe how LGBTQ+ people can be subject to traumatic experiences within conservative Christian environments on three levels – institutional (e.g. discriminatory policies, institutionalized homophobia), interpersonal (e.g. stigma, closeting, rejection), and intrapersonal (e.g. internalized homo/trans negativity), and identified minority stress as a mechanism through which these are experienced. Hollier et al. (2022) found that LGBTQ+ people were subject to mischaracterisations, being viewed as a threat, erasure, and

relational distancing in conservative evangelical churches, and utilised minority stress theory to make sense of participants' experiences.

Diamond and Alley (2022) suggest that the construct of 'social safety' may explain the health impacts of minoritizing experiences for LGBTQ+ people that are not explained by minority stress theory alone. Social safety is reliable social connection, belongingness, inclusion, recognition and protection, which are essential human needs (Slavich, 2020). This protective social fabric is not always available to stigmatized individuals leading to chronic threat-vigilance, which can impact health even when levels of minority stress are low (Diamond & Alley, 2022). They argue that the health impact for LGBTQ+ people can be explained through both the presence of minority stress and the absence of social safety (Diamond & Alley, 2022). In this way, social safety could be a mechanism through which LGBTQ+ people experience religious trauma, as well as minority stress.

In the UK, 46.2% of the population identify as Christian (Office for National Statistics, 2021) and Christianity has shaped UK culture and values more than any other religion or belief system (Pike, 2019). There is currently no UK guidance for mental health professionals working with religious trauma. There are a number of third sector organisations in the UK offering support to survivors (for example, Faith to Faithless, UK; Replenished Life, UK), but these do not offer psychological therapy. There are many private therapists who offer therapy, although charities working in this area report that people working in public services, such as social work and the NHS, generally have little understanding of religious trauma (Faith to Faithless, 2025). Although it is not currently known how many LGBTQ+ people in the UK are survivors of religious trauma, around 3.3% of the UK population identify as LGBTQ+ (Office for National Statistics, 2022). Therefore, given all these factors, it seems pertinent to clinical psychology practice in the UK for there to be a greater understanding to inform treatment options.

Following on from the initial qualitative studies, there is a need for quantitative studies to understand the impact of unaccepting religious environments on LGBTQ+ people in the UK. While the previous qualitative research allowed for an exploration of experiences to begin the process of discovery in this area, quantitative research is now needed to collect empirical data upon which inferences about the impact on this population can be made (Clark-Carter, 2019). Therefore, this study took a quantitative approach. There is currently no validated and reliable measure for religious trauma (Ellis et al., 2022). Anxiety, depression and complex trauma are salient factors in the distress that has been reported by LGBTQ+ people who have experienced Christian environments that are unaccepting of sexual and gender minorities (Hollier, et al., 2022), and are also indicative of chronically invalidating environments that traumatise (Cardona et al., 2022). Since minority stress and social safety can be understood as mechanisms through which LGBTQ+ people may experience religious trauma, religious trauma was operationalised through measuring minority stress, social safety, anxiety, depression and trauma.

Research aims

In order to examine the impact of religious trauma on LGBTQ+ people in the UK who grew up in an unaccepting Christian environment, this study investigated the following two hypotheses:

1 – Levels of minority stress and social safety will predict levels of anxiety, depression and complex trauma in LGBTQ+ people in the UK who grew up in a Christian environment that was unaccepting of sexual and gender minorities.

2 – Levels of anxiety, depression and complex trauma will be significantly higher in this population than the general population.

Method

Design

Patient and public involvement (PPI) is considered central to research design that shapes NHS healthcare (NHS, 2023). Two UK-based LGBTQ+ people who had grown up in an unaccepting Christian environment were consulted in the development and implementation of this study. (See chapter 5 for further information). A quantitative cross-sectional within-groups design was utilised to investigate the research aims. The study was an online survey with a demographic questionnaire followed by five measures.

Participants were asked to bring to mind their experiences of growing up in a Christian environment for the minority stress and social safety measures, in order to elucidate the levels of both of these that they experienced in the environment. They were also asked to do this for just the first question on the trauma measure, since respondents are asked to identity the experience that troubles them most and answer the questions in relation to this experience. The aim was to elucidate the most traumatising experience from the participants' time in the Christian environment. The rest of the questions on the trauma questionnaire ask about present symptoms and functioning, in order to measure current levels of CPTSD symptomology. The depression and anxiety measures asked about current symptoms, in order to measure the participants current levels of anxiety and depression.

Participants

Participants were recruited who were adults (18+ years old), identified as LGBTQ+, grew up in a Christian environment that was unaccepting of sexual and gender minorities, and currently lived in the UK. "Grew up" was understood to mean spending a length of time the participant considered significant in a Christian environment at any point between birth

and 25 years of age. “Environment” was understood to mean settings such as family, church, school or other social settings. (See chapter 5 for inclusion criteria rationale).

Measures

Since there is no single measure of religious trauma, it was assessed through measuring minority stress, social safety, anxiety, depression and complex trauma.

Daily Heterosexist Experiences Questionnaire (DHEQ; Balsam, et al., 2013)

The DHEQ was validated to measure minority stress in LGBT[4] people. It has 50 items on 9 subscales: vigilance, harassment and discrimination, gender expression, parenting, victimisation, family of origin, vicarious trauma, isolation, HIV/AIDS. It has been demonstrated to have good validity and internal reliability ($\alpha = .92$) (Balsam et al., 2013). It generates both an occurrence score with each item scored as ‘did’ or ‘did not happen in the past 12 months, and a distress score as the mean score from a 5-point Likert scale for each item where the higher the score, the higher the overall minority stress level.

Social Safety Questionnaire (SSQ; Diamond & Alley, 2022)

The SSQ was developed to measure reliable social connection, belongingness, inclusion, recognition and protection in minoritised individuals. There are 8 items measuring social safety on a 5-point Likert scale across 7 settings, resulting in a mean social safety score where higher scores equate to higher levels of social safety. This is a recently developed measure which has preliminary validation in a population of marginalised women (Diamond, 2023).

[4] The authors use the term ‘LGBT’ without Q+, so this is represented here.

International Trauma Questionnaire (ITQ; Cloitre et al., 2018)

The ITQ measures PTSD and complex PTSD (CPTSD). There are three subscales for PTSD – re-experiencing, avoidance, sense of current threat – and three for DSO (Disturbances in Self Organisation) – affective dysregulation, negative self-concept, disturbances in relationships. There are 6 items each measuring PTSD and DSO, with an additional 3 items each for functional impairment under PTSD and DSO. The items are scored on a 5-point Likert scale. Diagnostic scoring gives a diagnosis of PTSD or CPTSD. The criteria for both PTSD and DSO must be met for a diagnosis of CPTSD. Dimensional scoring gives an overall score for PTSD and DSO. The ITQ has been shown to have good validity and satisfactory reliability (α's between 0.67 and 0.79; Cloitre et al., 2018).

The PTSD score relates to current PTSD symptoms of re-experiencing, avoidance and sense of current threat, whereas the DSO score relates to ongoing personality and relational difficulties: affective dysregulation, negative self-concept and disturbances in relationships (Stubley, et al., 2025).

Patient Health Questionnaire, depression module (PHQ-9; Kroenke et al., 2001)

The PHQ-9 is a widely used 9 item measure of symptoms of depression. Items are scored on a 4-point Likert scale, and results in an overall continuous score which falls into one of four possible categories for depressive symptoms. The higher the score, the greater the symptoms of depression. It has been shown to have good validity and reliability (Kocalevent et al., 2013).

Generalised Anxiety Disorder Questionnaire (GAD-7; Spitzer et al., 2006)

The GAD-7 is a widely used 7 item measure of symptoms of anxiety. Items are scored on a 4-point Likert scale. It results in an overall continuous score which falls into a one of four possible categories for anxious symptoms. The higher the score, the greater the

symptoms of anxiety. It has been shown to have good validity and reliability (Lowe et al., 2008).

Ethics

This study was reviewed by the Faculty of Medicine and Health Sciences Research Ethics Subcommittee at the University of East Anglia, and granted ethical and risk approval on 17th January 2024 (Appendix E). The study conformed to the British Psychological Society's Code of Human Research Ethics (Oates, et al., 2021). All participants provided informed consent. The data collected was anonymous, so no personally identifying information was taken, in line with GDPR (Data Protection Act, 2018). No payment or other incentives were offered for taking part in the study. (See chapter 5 for further details of the ethics for this study).

Procedure

The study was advertised through LGBTQ+ support organisations and charities, through Christian and ex-Christian organisations, and through social media platforms and groups. The study advert (Appendix F) included a link to the online survey. Study information (Appendix G) was given including support information in case of distress or risk, informed consent was gained (Appendix H), and then the participants were taken to the demographic questionnaire followed by the 5 measures (Appendix I), and then debrief information (Appendix J).

Analysis plan

A multiple regression study was utilised to examine whether levels of minority stress and social safety experienced in an unaccepting Christian environment would predict current levels of anxiety, depression and complex trauma in this population. A comparison study

using Z-tests was employed to examine whether levels of anxiety, depression and complex trauma were higher in this population than the general UK population.

Power analysis

An a priori power analysis was used to calculate an approximate sample size required to achieve a statistically significant result for both the multiple linear regression study and the comparison Z-test study. The regression analysis yielded a larger sample size than the Z-test analysis, so this sample size was used to guide study recruitment. The alpha level was set to the standard value of 0.05. The F^2 effect size was not known so a value of 0.15 was chosen, which corresponds to a medium effect size. This is in line with Cohen's guidance on effect sizes (Cohen, 1988). The power was set to 0.8. These settings were satisfied by a sample size of 68 participants.

Multiple linear regression

Multiple linear regression was performed on the data, with minority stress distress scores and social safety scores as predictor variables, and anxiety, depression, PTSD and DSO scores as outcome variables. A regression model was produced for each of the outcome variables. This analysis was utilised because it allows for an examination of the extent to which change in two continuous predictor variables can predict change in a continuous outcome variable. An adjusted R^2 value was calculated, as this is more likely to represent the population as a whole (Field, 2013). (See chapter 5 for further explanation of the analysis plan).

Z-tests

Z-tests were performed to compare participants scores with general UK population scores on anxiety, depression and complex trauma. General population scores were sourced through a search of the literature over the last 10 years, to ensure that the data was current. A

recent large population study was sourced for mean GAD-7 and PHQ-9 scores in the UK general population (Shevlin et al., 2022). ITQ scores for the general UK population were not found, despite an extensive literature search. However, a recent study on a UK trauma-exposed population reported percentage of complex trauma (CPTSD) diagnoses using the ITQ (Karatzias, et al., 2019), although mean PTSD and DSO scores were not reported. Therefore, a Z-test was performed to compare percentage of complex trauma diagnoses from ITQ scores of participants in this study, with the percentage reported in the UK trauma-exposed population.

Additionally, a search of the literature was performed to ascertain whether population norms for the UK LGBTQ+ population for the PHQ-9, GAD-7 and ITQ were available, in order that Z-tests could be performed to compare the study sample with the UK LGBTQ+ population in general. However, despite an extensive literature search, the research team were unable to find these norms.

Results

Participants

79 adults participated in this study. One participant was excluded because they stated they did not currently live in the UK, so the final sample size was 78. The sample was heterogeneous in terms of age, gender identity and sexual orientation. The age range was 18–71. 30% identified as non-cisgendered. Most of the participants identified as white. 86% of participants had accessed mental health services. (See Appendix C for full demographic details).

There was a wide range of Christian denominations represented within the sample. 76 participants stated that they attended church services when they were growing up. Of the two who didn't, one attended a church school and attended services through school, and the other

worshipped weekly as a family at home. For the large majority (94%) Christianity was part of their family life growing up. Just under two thirds attended a Christian school (63%). Just under a third (30%) still identified as Christian. (See Appendix D for full religious data).

Analysis assumptions

In order to ascertain whether multiple linear regression could be performed on the collected data, the assumptions of multiple linear regression analysis were first assessed. Once the assumptions had been checked, the regression analysis was run for anxiety, depression, PTSD and DSO. Equally, the assumptions required for the application of Z-tests were assessed before the Z-test analysis was run for anxiety, depression and trauma.

For the multiple linear regression analysis, an examination of the Pearson's *r* correlation values between the predictor and outcome variables, and visual inspection of scatterplots of the correlations, suggested that the relationship between the predictors and outcome variables could be represented via a linear relationship (Appendix K). Visual inspection of the scatterplots also suggested that there were no outliers. This was confirmed since Cook's distances indicated that there were no values that were greater than 1. Tests of normality of the residuals was met for anxiety, but not for depression, PTSD or DSO. However, the deviations from normality were minor and with a sample size of over 50 this, therefore, did not suggest that the use of a linear regression model was problematic. The variance inflation factor (VIF) to assess for multicollinearity of the predictor variables was 1.203 which suggests that the regression is unlikely to be biased since the value was less than 5. For all the outcome variables, visual inspection of plots of the residuals against the predicted values of each model confirmed homoscedasticity.

For the Z-tests comparison of means analysis, while Shapiro-Wilk tests were significant for both anxiety and depression, and therefore indicated a lack of normality,

skewness was low (between -1 and 1) indicating that distributions were symmetrical and therefore suitable for Z-tests. Additionally, Z-tests for sample sizes over 30 are robust to violations of normality. For the Z-test comparison of proportions analysis, the sample size of the study sample, and that the observations of the two groups were independent, indicated that a Z-test comparing proportion of CPTSD diagnosis in the study sample with the proportion in the UK trauma-exposed sample was suitable.

Power analysis

Post-hoc power analysis was run on the regression tests for the four outcome variables, and the three Z-tests. See table 6.1.

Table 5.1. *Power values calculated for each statistical test run*

Test	Power
Anxiety regression model	.99
Depression regression model	.97
PTSD regression model	.93
DSO regression model	.95
Anxiety Z-test	.93
Depression Z-test	.99
CPTSD Z-test	.63

Since a power value of greater than .95 is considered overpowered (Cohen, 1988), this suggests that the results for three tests should be interpreted with this in mind: anxiety regression model, depression regression model, depression Z-test.

Multiple linear regression analysis

Multiple linear regression analysis was run to predict each of the four outcome variables from minority stress and social safety. The regression models showed that levels of minority stress and social safety significantly predicted 25% of levels of anxiety [$F(2, 75) = 13.745$, $p < .001$, adjusted $R^2 = .249$], 17% of depression [$F(2, 75) = 8.668$, $p < .001$, adjusted $R^2 = .166$], 14% of PTSD [$F(2, 75) = 7.177$, $p = .001$, adjusted $R^2 = .138$], and 15% of DSO [$F(2, 75) = 7.839$, $p < .001$, adjusted $R^2 = .151$].

However, for all outcome variables, the predictive power of minority stress was significant for the proportion of change explained by the model, whereas it was not for social safety (all *p* values for minority stress ≤.01, and all *p* values for social safety >.05; Tables 4.1–4.4). The *β* values observed for minority stress were all between .30 and .44, indicating a medium effect size of minority stress in all four regression models (Cohen, 1988; Tables 4.1–4.4). The *b* values for minority stress were all positive, indicating that higher minority stress scores predicted higher anxiety, depression, PTSD and DSO scores (all *b* values between 3.16 and 4.49; Tables 4.1– 4.4).

Table 4.1. *Regression model for anxiety scores*.

	b	*SE B*	*β*	*p*
Constant	2.22 (-5.58, 10.03)	3.91		.572
Minority Stress	3.70 (1.20, 5.94)	0.99	.44	<.001
Social Safety	-1.26 (-3.01, 0.49)	0.88	-.16	.157

Adjusted R^2 = .249, *p* = <.001

Table 4.2. *Regression model for depression scores*.

	b	*SE B*	*β*	*p*
Constant	6.61 (-3.68, 16.90)	5.17		.205
Minority Stress	3.65 (1.06, 6.25)	1.31	.32	.006
Social Safety	-1.92 (-4.23, 0.39)	1.16	-.19	.102

Adjusted R^2 = .166, *p* = <.001

Table 4.3. *Regression model for PTSD scores*.

	b	*SE B*	*β*	*p*
Constant	-3.30 (-13.15, 6.60)	4.95		.507
Minority Stress	4.49 (2.00, 7.00)	1.25	.42	<.001
Social Safety	0.42 (-1.79, 2.62)	1.11	.04	.708

Adjusted R^2 = .138, *p* = .001

Table 4.4. *Regression model for DSO scores*.

	b	*SE B*	*β*	*p*
Constant	10.36 (0.85, 19.87)	4.77		.033
Minority Stress	3.16 (0.76, 5.56)	1.21	.30	.011
Social Safety	-1.75 (-3.88, 0.36)	1.07	-.19	.107

Adjusted R^2 = .151, p = <.001

All four regression models had a high power value (≥ .93), and depression and anxiety were >.95, so were considered over-powered . However, the medium effect sizes observed for minority stress suggests that a genuine effect was observed, and therefore this overall indicates that change in minority stress scores predicted change in anxiety, depression, PTSD and DSO scores, whereas change in social safety scores did not.

Z-test analysis

Z-tests were run to compare the sourced UK general population mean GAD-7 (anxiety) and PHQ-9 (depression) scores with the study sample mean scores (Table 4.5).

Table 4.5. *General population and study sample mean scores on the GAD-7 and PHQ-9*.

	General population mean (SD)	Study sample mean (SD)
Anxiety (GAD-7)	5.15 (5.68)	8.17 (5.33)
Depression (PHQ-9)	5.37 (6.21)	10.06 (6.67)

This showed that both anxiety [Z = 4.70, p <.001, d = 0.53] and depression [Z = 6.67, p <.001, d = 0.76] were significantly higher in the study sample than the general population sample. A medium effect size was found for anxiety, suggesting that there is likely to be a noticeable difference in levels of anxiety in the study population compared with the general UK population. A large effect size was found for depression, suggesting that there is likely to be a substantial difference in levels of depression in the study population compared with the general UK population. The power value for the depression Z-test was .99, indicating that the

test was overpowered, but the large effect size observed suggests that the difference is likely to be a genuine effect.

A Z-test was run to compare the sourced percentage of CPTSD diagnoses from the ITQ in the trauma-exposed UK population (12.9%), with the percentage of participants meeting the threshold for ITQ CPTSD diagnosis in the study sample (17.95%). This showed that there was not a significant difference: $Z = 1.33$, $p = .183$, $h = 0.14$.

Post-hoc exploratory analysis

A notable difference in the mean scores for PTSD ($M = 8.26$, $SD = 6.28$) and DSO ($M = 13.12$, $SD = 6.11$) on the ITQ was observed in the study sample. To investigate whether the difference in mean scores observed was significant, a paired sample *t*-test was conducted. This showed a significant difference between participants' PTSD and DSO scores, and a large effect size was detected: $t(77) = 7.55$, $p < .001$, $d = 0.86$.

Although LGBTQ+ specific UK population norms for the PHQ-9, GAD-7 and ITQ were not found, two studies of treatment-seeking LGBQ people were found, both of which used the GAD-7 and PHQ-9, although not the ITQ (Hambrook et al., 2022; Rimes et al., 2019). The study sample in both studies were sexual minority adults, and did not include gender minority individuals.

Hambrook et al. (2022) investigated the impact of a group intervention for sexual minority adults. 61 participants completed the intervention, with reported baseline scores for the GAD-7 ($M = 9.7$, $SD = 5.3$) and for the PHQ-9 ($M = 11.5$, $SD = 6.1$). Z-tests were run to compare the mean GAD-7 and PHQ-9 baseline scores from Hambrook et al.'s (2022) study with those from the present study's sample. This showed that both anxiety [$Z = 1.68$, $p = 0.092$, $d = 0.29$] and depression [$Z = 1.33$, $p = 0.185$, $d = 0.23$] were not significantly different in this study's sample than in Hambrook et al.'s (2022) sample.

Rimes, et al. (2019) investigated differences in treatment outcomes for depression and anxiety between sexual minority and heterosexual patients accessing Improving Access to Psychological Therapies (IAPT) services. They reported baseline GAD-7 and PHQ-9 scores for 4,472 sexual minority adults. These were reported for gay men, lesbian women, bisexual men and bisexual women as separate groups, but overall sample scores were not reported. The primary researcher calculated weighted means and standard deviations from this data (GAD-7: $M = 13.6$, $SD = 4.9$; PHQ-9: $M = 15.5$, $SD = 6.0$), in order to generate overall baseline scores to compare with this study's sample. They also reported post-treatment outcomes from which the primary researcher calculated weighted means and standard deviations for the GAD-7 ($M = 8.5$, $SD = 5.9$) and PHQ-9 ($M = 9.7$, $SD = 6.9$)

Z-tests were run to compare the mean GAD-7 and PHQ-9 baseline scores from Rimes, et al.'s (2019) study sample with those from this study's sample. This showed that both anxiety [$Z = 8.93$, $p < 0.001$, $d = 1.06$] and depression [$Z = 7.15$, $p < 0.001$, $d = 0.86$] were significantly higher in this study's sample. Z-tests were also run to compare the post-treatment mean GAD-7 and PHQ-9 scores from Rimes, et al.'s (2019) sample with this study's sample. This showed that both anxiety [$Z = 0.54$, $p = 0.588$, $d = 0.059$] and depression [$Z = 0.47$, $p = 0.637$, $d = 0.053$] were not significantly different between this study's sample and Rimes, et al.'s (2019) sample's post-treatment scores.

Discussion

This study explored the impact of religious trauma on LGBTQ+ people in the UK who grew up in an unaccepting Christian environment. A multiple regression study investigated whether levels of minority stress and social safety would predict levels of anxiety, depression and complex trauma in this population. A Z-test study investigated

whether levels of anxiety, depression and complex trauma were higher in this population than the general UK population.

The results from the regression analysis showed that change in levels of minority stress and social safety predicted a proportion of change in levels of anxiety (25%), depression (17%), PTSD (14%) and DSO (15%). Although not unusual for real-world regression models (Field, 2013), this showed that a relatively small proportion of anxiety, depression and trauma levels in the participants was predicted. This study attempted to isolate the minority stress and social safety that participants experienced growing up in unaccepting Christianity through asking participants to bring to mind their experiences in the environment, for the predictor variable measures. However, this relied on participants' memories of events that may have been years previously, which could have impacted the accuracy of the measurement (Shields et al., 2016). The study measured current levels of anxiety, depression and trauma symptoms. Other variables that could impact these were not controlled for in the design of the study. As LGBTQ+ people, the participants are likely to have had other discriminatory experiences, and these could have impacted their current mental health (King et al., 2008; McCann & Sharek, 2016). Additionally, the intersectionality of different characteristics can increase the likelihood of discriminatory experiences in the UK – for example, being female and transgender – which can impact mental health (Bayrakdar & King, 2023).

The regression models for all four outcome variables showed that the predictive power of minority stress was significant, whereas it was not for social safety. This indicates that the effect detected in the analysis was that minority stress was predicting the proportion of anxiety, depression and trauma levels in participants explained by the model, and social safety was not. This may indicate that levels of social safety experienced in an unaccepting Christian environment do not predict levels of anxiety, depression and trauma in this

population. This could mean that minority stress is a more important factor for this population than social safety. However, levels of social safety are likely to have a health impact on minoritised populations (Slavich, 2020; Diamond & Alley, 2022). The measure for social safety was recently developed, and was validated in a group of marginalised women (Diamond, 2023), so it is possible that the measure was not sensitive to the experiences of social safety in the study population.

Another consideration is differences between the two measures of minority stress and social safety. The DHEQ uses specific examples of minoritising experiences to quantify minority stress (Balsam, et al., 2013), whereas the SSQ measures general sense of safety and inclusion with different social groups (Diamond & Alley, 2022) which may be harder to capture and quantify. A possible future direction for further research is validation of the measure in different LGBTQ+ populations, and refining of the measure through this process.

Medium effect sizes were detected for minority stress, and the direction of effect indicated that higher levels of minority stress predicted higher levels of anxiety, depression and trauma (PTSD and DSO). These results suggest that when LGBTQ+ people in the UK grow up in unaccepting Christian environments, the higher the levels of minority stress they experience in this environment, the higher their levels of anxiety, depression and trauma are likely to be. The study posed minority stress and social safety as mechanisms through which LGBTQ+ people experience religious trauma. Overall, the results offer support for minority stress, but do not offer support for social safety, as a mechanism of religious trauma in this population. Given that only a proportion of change in the outcome variables was accounted for, it is likely that other mechanisms that were not tapped by the measures were at play. For example, the measures did not directly assess emotional invalidation. The traumatising impact of unaccepting religious environments has been likened to that of other invalidating environments, such as emotionally neglectful families (Cardona, et al., 2022). Measures such

as the Socialization of Emotions Scale (SES) have been developed to assess emotional invalidation in childhood (Krause et al., 2003). A possible avenue for future research could be to use or adapt measures of invalidation to investigate this as a possible mechanism of religious trauma.

The results from the Z-tests comparing participant anxiety and depression scores with sourced UK general population scores, revealed that levels of anxiety and depression were significantly higher in the study sample than the general population sample. The effect sizes detected indicate that the results are likely to represent a genuine difference between the study population and the general UK population. This suggests that LGBTQ+ people who have grown up in an unaccepting Christian environment are more likely to experience symptoms of anxiety and depression than the general population in the UK.

The results from the Z-test comparing the proportion of participants meeting the threshold for CPTSD diagnosis in the study sample with the proportion in the sourced UK trauma-exposed population, revealed that the rates were not significantly different, even though they were higher in the study sample. This suggests that the complex trauma levels in this group are on a par with a UK population with known trauma-exposure.

Overall, these results offer support for the proposition that symptoms of anxiety, depression and complex trauma are an impact of religious trauma, given the levels found in the study population. Although this study did not test whether exposure to these environments caused anxiety, depression and trauma, what can be said from these results is that the participants were overall more anxious and depressed than the general UK population, and were as traumatised as a UK population with known exposure to trauma. Taken in conjunction with the results from the regression analysis, this overall gives a picture of

anxiety, depression and complex trauma as likely mental health difficulties found at the intersection of being LGBTQ+ and growing up in an unaccepting Christian environment.

This could inform psychological provision for LGBTQ+ people who present to services with these difficulties. Practitioners may consider asking LGBTQ+ service users if they have experienced an unaccepting Christian environment, which could help inform the formulation of their difficulties. For example, if they are experiencing depression, this could be linked to low self-esteem as a result of internalising beliefs about the unacceptability of their orientation (Boppana & Gross, 2019). There are many ways, such as this, in which an understanding of how experiencing this type of unaccepting environment may underly anxiety, depression or trauma symptoms could help inform formulations for clients. Given that 86% of the study sample had accessed mental health services at some point, this suggests that LGBTQ+ people who are survivors of religious trauma are accessing services, and incorporating an understanding of this particular form of trauma into formulation and treatment would serve this population well.

The findings that levels of anxiety and depression were higher in the study sample than the general population, and that levels of complex trauma were comparable to a trauma-exposed population, could inform adaptation of interventions for this population, because this suggests that these may well be presenting issues for this population when accessing services. For example, many approaches to the treatment of complex trauma involve relational-based therapies, often through an attachment framework (for example, Pearlman & Courtois, 2005; Courtois & Ford, 2012). The harm of religious trauma could be understood as akin to institutional emotional abuse, where a consideration of power-dynamics is key in therapeutic intervention (Goldenson & Bailey, 2024). These could offer a beginning for adapting traditional trauma therapy for experiences of religious trauma in this population.

The post-hoc exploratory analysis of the difference between PTSD scores and DSO scores in the study sample showed that symptoms of disturbances in self-organisation were significantly higher than classic symptoms of PTSD. Although DSO is not a diagnostic category, it is notable that pervasive symptoms of difficulties in relation to self and others were significantly higher than acute PTSD symptoms such as flashbacks, hypervigilance and avoidance (Stubley, et al., 2025). DSO symptoms are characteristic of prolonged trauma exposure which result in the individual having difficulties regulating their emotions such that they may either experience numbing or may be overly reactive, they tend to have both a persistent and consistently negative view of themselves, and have ongoing difficulties with interpersonal relationships (Maercker et al., 2022). Notably, the negative sense of self does not fluctuate the way one might expect in EUPD (Stubley et al., 2025).

It is possible that the measure of DSO symptoms in this study tapped an impact of religious trauma that was not fully captured by the measures. This could offer a further avenue of research for understanding the phenomenon of religious trauma, and could inform development of a measure. Perhaps interpersonal difficulties are the construct that lingers following religious trauma, more than acute symptoms of PTSD. Experiences of social threat, social exclusion and prolonged trauma are known to influence personality traits and social functioning (Rutkowski et al., 2016; DeWall et al., 2011). And an impact of complex trauma can be disruption in attachment, therefore leading to interpersonal difficulties (Pearlman & Courtois, 2005). As such, one might expect on-going exposure to unaccepting Christian environments to have an impact on how LGBTQ+ people may see themselves and how they relate to others, more than producing acute trauma symptoms such as re-experiencing that are characteristic of threat to life traumas (Holbrook et al., 2001).

The findings of the post-hoc exploratory analysis comparing anxiety and depression levels in this study's sample with two treatment-seeking LGBQ groups in the UK offer

further avenues for research in this area. Although there was no significant difference found between this study's sample and the scores reported in Hambrook et al.'s (2022) study, Hambrook et al. (2022) was a much smaller study than Rimes et al. (2019). The finding that the scores in this study's sample were significantly higher than the baseline scores for the IAPT treatment seeking group, may suggest that the levels of anxiety and depression identified in this study's sample could be explained by minority stress experienced as a sexual minority individual in UK society in general. However, given that the IAPT sample was treatment-seeking it is not possible to know what other factors may have impacted their levels of anxiety and depression. Additionally, this study's sample was not treatment seeking, and 86% of participants had previously accessed mental health support at some point. Given that the IAPT group's post-treatment scores were not significantly different from the scores for this study's sample, this may indicate that the levels of anxiety and depression in this study's sample are on a par with a treatment-seeking LGBQ group post-treatment, which might be explained by the fact that 86% had experienced some form of mental health input.

It is not possible to say with any certainty, but this illustrates that a useful next step in research in this area could be to compare anxiety and depression levels between LGBTQ+ people in the UK who have grown up in unaccepting Christian environments with those who have not, in order to gain further insight into the nature of religious trauma, and investigate the way minority stress may be experienced in these environments in comparison to the minority stress that LGBTQ+ people in the UK experience in society in general. We do not know what the pre-treatment scores would have been for this study's sample, since this was not part of the study aims, but this may be something to consider for future research in this area.

Overall, the findings of this study offer support for Lefevor et al.'s (2021) study asserting that minority stress is the mechanism through which LGBTQ+ people experience

religious trauma. The findings offer support for the findings of Hollier et al. (2022)'s qualitative study which conceptualised the experiences of religious trauma of LGBTQ+ through an understanding of minority stress theory. The use of quantitative measures in this study extends the previous research through measuring the minority stress this population experienced in unaccepting Christian environments, and examining the possible impact of this in terms of measuring anxiety, depression and trauma.

Hollier et al. (2022) identified anxiety, depression and complex trauma as salient factors in the distress reported by LGBTQ+ people as a result of experiences in unaccepting Christian environments. Cardona et al. (2022) argued that minority stress can lead to traumatic invalidation which results in anxiety, depression and complex trauma symptoms in LGBTQ+ people. The findings of this study of the levels of anxiety, depression and trauma in the study population, supports this previous research. Additionally, this study extends the findings of both these previous studies: by providing quantitative measures of anxiety, depression and complex trauma which extends the findings of Hollier et al. (2022), and by looking at unaccepting Christianity as an invalidating environment for LGBTQ+ people, which extends the research of Cardona et al. (2022) to this specific environment.

Limitations

This was a cross-sectional study, so it was not possible to determine causality between variables. Although the results suggest a predictive relationship between minority stress and anxiety, depression and trauma, it cannot be concluded from this study that minority stress experienced in an unaccepting Christian environment causes anxiety, depression and trauma. The study design means that there may be confounding variables that were not accounted for. Participants' current anxiety, depression and trauma symptoms were measured. Since the participants in this study were LGBTQ+, they could have experienced minority stress in other

environments that impacted their scores. Additionally, they may have had other experiences and factors which contributed to their anxiety, depression and trauma.

For the ITQ measure, participants were asked to bring to mind their most traumatising experience withing the unaccepting Christian environment they grew up in. Although the PTSD items relate specifically to the experience brought to mind, the DSO items are general, and so it is possible that participants may have experienced other traumas that impacted their score that could not be excluded from the measure.

Participants were recruited either through LGBTQ+ support organisations and charities, or through online study advertising. This may have introduced sampling bias since this would have captured only people who were active in online groups and on social media platforms, and those who were involved with support organisations and charities. Additionally, the sample size of 78 limits the generalisability of the findings, particularly in respect to the comparison between the study population and general population.

Conclusions

The results of this study indicate that LGBTQ+ people in the UK who grew up in an unaccepting Christian environment are more likely to experience symptoms of anxiety and depression than the general UK population, and that levels of complex trauma in this population are comparable to those in a UK trauma-exposed population. The study findings suggest that this may be due to the impact of religious trauma, and that minority stress is one possible mechanism through which LGBTQ+ people experience religious trauma in these environments. Religious trauma may be conceptualised as a combination of anxiety, depression and complex trauma symptoms. Avenues for future research in this latent area of investigation have been suggested, and implications for clinical psychology practice have been highlighted.

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Chapter Five – Additional Methodology for the Empirical Study

The chapter that follows details some elements of the methodology of the empirical study (chapter 4) in greater depth, where there was not the scope for inclusion in the empirical paper.

Patient and Public Involvement in Research (PPI)

In March 2023, the NHS signed up to the 'Shared commitment to further public participation in research' in recognition of the importance of patient and public involvement in research that shapes NHS healthcare (NHS, 2023). This is because members of the public who represent those whose care research is aimed at, can offer insights to make the research more relevant to the needs of that group (NIHR, 2023). Therefore, this study utilised a PPI group throughout the development of the project.

People who identified as LGBTQ+, grew up in a Christian denomination that was unaccepting of sexual and gender minorities, and understood this to have negatively impacted their mental health, were recruited for the PPI group via the LGBTQ+ organisations that agreed to share the study with their networks. Initially six individuals agreed to be part of the group. However, four dropped out so the group consisted of two people.

The group was consulted as the study was developed on the measures used; the demographic questions; the study materials - such as the participant information and debrief; and the recruitment strategy. The study materials and demographic questions were developed collaboratively with the group, with particular attention given to language usage. A number of questions were added into the demographics due to PPI feedback. The group offered feedback on the measures chosen, and how to prime the questionnaires to aim to capture the impact on participants of growing up in an unaccepting Christian environment.

The PPI members trialled the online format of the study before it went live, which resulted in some changes in format and language, and informed how long participants were told participation was likely to take.

Rationale for inclusion criteria for participants

The study sought adult participants (18+ years old), who identified as LGBTQ+, grew up in a Christian environment that was unaccepting of sexual and gender minorities, and currently live in the UK. Participants did not have to have grown up in the UK, but did have to live in the UK currently. This was because a consideration of this study is how the findings can inform mental health service provision in the NHS. "Grew up" was defined as spending a length of time the participant considered significant in an unaccepting Christian environment at any time between birth and 25 years of age, since the evidence suggests that this is the period of formative development (Arain et al., 2013). It was left to participants to decide what they considered a significant length of time in order to allow for participants with a wide range of experiences to take part, since religious trauma is an under-researched construct.

Ethics

Participants were provided with detailed information about the study, and the primary researcher's contact details for any questions they may have about participation, in order that they could give informed consent if they chose to participate. Participants were not able to access the survey until they had given consent, through electronic confirmation on the survey platform. It was explained that participants had the right to withdraw at any point before completing the questionnaires and that participation was completely voluntary, but that once the questionnaires were completed it would not be possible to withdraw their data, because their data is anonymous and collated with other participant data, so by answering the questionnaires they were giving consent.

The data was stored on a password protected computer, and only the researcher and research supervisors had access to the data. The University of East Anglia policy is that anonymised data is kept for at least ten years in the University's research storage and archive facility. This was explained to participants before consent was asked for. It was explained that although the study was not expected to cause harm to participants, it was possible that answering the questions may bring up distressing feelings and memories. Information for support organisations, and support information for any risk of self-harm or suicide, was given.

Multiple linear regression analysis plan

This section details further considerations of the multiple linear regression analysis plan that were not included in chapter 4.

For the minority stress variable, the mean distress score was used rather than the occurrence score, because the research aim was to elucidate levels of minority stress the participant was exposed to in the unaccepting Christian environment, rather than the number of minority stressors experienced. Additionally, the distress score accounts for the impact of the stressor on the individual – i.e. the same type of event may result in different amounts of distress for different people. For the trauma variable, the dimensional scores for PTSD and DSO from the ITQ were used, since these are continuous variables, rather than the categorical diagnostic scoring of the measure. This allowed for the same test to be performed on all of the outcome measures for meaningful comparison between outcome variables in answering the research question.

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Chapter Six – Discussion and Critical Review

Thesis overall aims and findings

The overall aim of this thesis was to explore the mental health and well-being of LGBTQ+ people through an exploration of religious trauma, and parental acceptance and support. The systematic review synthesised the efficacy of interventions aimed at increasing parental acceptance and support for LGBTQ+ people. The empirical study investigated the psychological impact of religious trauma on LGBTQ+ people in the UK who grew up in an unaccepting Christian environment. The exploration of interventions aimed at increasing LGBTQ+ peoples' well-being in one area, and the investigation of the negative impact on LGBTQ+ peoples' mental health in another area, contribute to a broader aim of increasing understanding of the unique mental health needs of this community, an historically under-recognised, under-valued and under-researched area (Rees, et al., 2021). Discrimination, prejudice, oppression and stigmatisation are known to negatively impact mental health (King et al., 2008; McCann & Sharek, 2016). In the current global political climate, where we are seeing funding taken away from research into LGBTQ+ peoples' health (The Independent, 2025), this is all the more prescient. The recent Church of England ruling against allowing non-heterosexual marriages in churches (BBC, 2023), and the recent announcement of changes to the Gender Recognition Act (For Women Scotland Ltd v. The Scottish Ministers, 2025), are examples of societal forces of discrimination currently at play in the UK.

The systematic review identified seven studies that reported outcomes from seven different novel interventions. The review found preliminary evidence of the efficacy of the interventions for increasing parental acceptance and support of their LGBTQ+ children. However, the finding that there were only seven identified studies and that none were conducted with UK populations, limits the applicability of the efficacy findings for UK

practice. The empirical study found that minority stress predicted a proportion of anxiety, depression and trauma in a sample of LGBTQ+ people in the UK who had grown up in an unaccepting Christian environment, but that social safety did not significantly predict these factors in the study sample. The study found that levels of anxiety and depression were higher in the study sample than a general UK population sample, and that levels of complex trauma were comparable to a general UK trauma-exposed sample. These findings overall suggest that this population are more likely to experience symptoms of anxiety and depression than the general UK population, and that levels of complex trauma in this population are on a par with a population with known trauma exposure. Religious trauma may be understood in terms of these three factors, and minority stress is a possible mechanism for this.

Both studies highlight an impact of heteronormative cisgendered values, and the potential harm that rejecting people because of their sexual orientation or gender identity can have. There is a need for interventions aimed at increasing parental acceptance and support of their LGBTQ+ children precisely because of this (Mills-Koonce et al., 2018). Family acceptance specifically of LGBTQ+ young peoples' orientation or identity is known to be a protective factor for long-term mental health (Mongelli et al., 2019), and family rejection is known to increase the risk of mental health difficulties (Ryan et al., 2009). There is no known need for interventions aimed at increasing parental acceptance and support for heterosexual cisgendered young peoples' sexual orientation or gender identity! Despite a general trend worldwide towards more liberal and accepting attitudes (Flores, 2019), LGBTQ+ people are still minoritised, and heteronormative cisgendered identity is often assumed as the default position.

Similarly, all the participants in the empirical study had grown up in environments that did not accept their sexual orientation or gender identity, on the basis of religious beliefs. At a minimum, the beliefs of these unaccepting Christian denominations hold that

heterosexual marriage between a cisgendered man and woman is the only morally acceptable partnership, and at the most extreme deny the existence of anything other than heterosexual cisgendered identity (Lomash et al., 2019; Jones et al., 2022). Group social rejection such as this is known to put LGBTQ+ people at risk of negative physical and mental health outcomes (Drydakis, 2021).

As a result of this, the population the empirical study investigated find themselves at the intersection of conflicting identities – growing up Christian and LGBTQ+ (Kashubeck-West et al., 2017). Social belonging is a powerful behavioural driver in human beings, because in our evolutionary past inclusion in the group equated to a greater chance of survival, so we are driven to seek social inclusion and acceptance (Brewer & Caporael, 2013). As such, it is not surprising that social belonging is linked to health outcomes, with inclusion in the group associated with positive physical and mental health indicators (Begen & Turner-Cobb, 2015) and exclusion associated with immediate negative health indicators that have long-lasting effects (Martin et al., 2018). As a result of this, the conflict between growing up within a culture that holds heteronormative cisgendered values, and knowing ones' identity to be LGBTQ+, can cause great distress (Boyer & Lorenz, 2020). Anecdotally, a number of participants contacted the lead researcher to express how difficult it was for them to accept their LGBTQ+ identity due to their Christian upbringing, and how long it took them to leave the unaccepting Christianity they were a part of, explaining that they felt this difficulty was not captured by the measures.

94% of the participants in the empirical study said that Christianity was part of their family life growing up. As highlighted by the systematic review, family rejection is potentially particularly harmful (Carastathis, et al., 2017). The population the empirical study represents are likely to be facing potential rejection from their family and from the wider social context of the faith group their family is a part of (Lefevor et al., 2021). This

intersection of rejection risk may make them particularly vulnerable to the negative health impact of exclusion. Of the seven studies identified by the systematic review, four were of interventions designed specifically for cultures where heteronormative cisgendered values are prevalent. The children of the parents in these studies were therefore likely at this risk intersection. Despite this, these studies reported that the interventions were effective at increasing parental acceptance and support. The empirical study represents a population at the sharp end of rejection, but the intervention studies identified in the systematic review indicate that it is possible for parents to become more accepting even within social groups with heteronormative cisgendered values. Although this is only a small number of studies, it is at least a beginning.

A number of participants from the empirical study contacted the primary researcher to say that they were concerned that the measures were not capturing the impact of religious trauma for them. Many explained that they had had therapy to help them process their experiences, and as such that their current levels of anxiety, depression and trauma symptoms were much less than they had been when they were within the unaccepting Christian environment, or when they had just recently left. This may indicate possible bias that the study selected for participants who had received support and so felt emotionally able to participate. People at an earlier stage of processing their experience might have found the idea of participation emotionally overwhelming and chosen not to participate. Further analysis of the data collected for this study in terms of length of time since participants had left Christianity, length of time spent in the environment, and current age, may offer a beginning for research in this area.

Others who contacted the primary researcher said that they felt that the measures were asking questions that were not relevant to their experience within unaccepting Christianity, and were not asking questions they hoped to be asked that they felt were relevant. Many

asked if the study involved interviews, as they felt strongly that they wanted to share their unique experiences with the researchers. An avenue for future research is qualitative exploration of participants experiences in unaccepting Christianity and the impact this had on their lives and identity. On the basis of such a qualitative exploration, future research could then involve developing a measure of religious trauma validated for LGBTQ+ people, which could accurately measure the mental health impact of unaccepting Christianity in this population.

Clinical Implications

A lack of research was found for the topics of both the systematic review and the empirical study. Psychology has a long history of homogeneity in research, drawing conclusions about humankind as a whole from studies where participants were mostly male, white, heterosexual, and from western societies (Henrich et al., 2010). The majority of neuropsychological measures have been developed on white, middle-class, educated, western samples, and yet are still used to assess people who fall outside of that demographic group (Pedraza & Mungas, 2008). Psychological research has a history of focussing on majorities, so it is perhaps not surprising that research into the mental health needs of minoritised groups such as LGBTQ+ people is lacking (Rees et al., 2021). However, this poses a problem for clinical practice when treatment models and interventions are based on research on a narrow demographic in this way. LGBTQ+ people in the UK often report that health professionals lack an understanding of diverse sexual orientations and gender identity, leading to assumptions about needs and care (Parameshwaran, et al., 2017).

Anecdotally, survivors of religious trauma report a lack of understanding when they access mental health services (Faith to Faithless, 2025). Therefore, when LGBTQ+ survivors of religious trauma seek mental health support, they may well encounter a lack of

understanding of their LGBTQ+ identity, their religious trauma, and the impact of these two factors on each other. There is increased recognition of the importance of intersectional approaches in Clinical Psychology, both in terms of research and practice, through calling attention to systems of oppression and privilege and how these can impact mental health (Rosenthal, 2016). For example, the ADDRESSING framework aids intersectional therapeutic work with clients through increasing therapist understanding of the impact of systems of oppression, and the recognition of the strengths that can emerge in clients through their intersectional identities (Hays, 2024). The participants in the empirical study represent a group where individuals may well have experienced simultaneous oppressed (LGBTQ+) and oppressor (unaccepting Christian) identities in their formative years. A consideration for clinical practice could be the active modelling of discussing social graces with LGBTQ+ clients seeking support for religious trauma (Birdsey & Kustner, 2021). In this way, therapists can communicate to their clients non-judgmental acceptance, and an openness to exploring conflicting identities. When LGBTQ+ clients perceive that their therapist is affirming of their identity, this is associated with a stronger therapeutic relationship and higher levels of client psychological well-being (Alessi et al., 2019).

The systematic review found that despite all seven studies presenting different interventions, in all cases parent willingness to engage in the interventions was noted. Willingness to engage in therapy is a known factor for change (Neimeyer et al., 2008). Although the sample size of the systematic review was too small to answer this definitively for interventions in this area, it does highlight a consideration for clinical practice. When working with families with LGBTQ+ children (young people or adults), a pertinent question might be parental willingness to engage in therapeutic interventions. Systemic therapy approaches generally hold the view that families are doing their best, and the aim of therapy is to find different ways of solving problems as a family system (Dallos & Vetere, 2018).

However, this can be difficult when family members hold different values and beliefs. Parents may truly believe that they are doing the best for their child by not accepting their sexual orientation or gender identity. The thematic synthesis in the systematic review highlighted how parents were able to adjust their views through a desire to have a better relationship with their child and understand them better. Acceptance strategies for parents have been shown to be more effective with adolescent-parent conflict than change-oriented strategies alone in therapy (Greco & Eifert, 2004). Perhaps willingness to engage in therapy is the first step towards acceptance, and this may be key for clinicians working with families of LGBTQ+ people.

Theoretical Implications

Minority Stress Theory is a major current theory for understanding health disparities in LGBTQ+ people (Meyer, 2003). Experiences of rejection, including parental rejection and lack of support, have been identified as factors that contribute to the chronic stress impact of the discrimination, prejudice, exclusion, and oppression that LGBTQ+ people can be subjected to (Mongelli et al., 2019). In contrast to this, experiencing acceptance and support from a parent can help LGBTQ+ cope with other experiences of minority stress throughout life (Katz-Wise, et al., 2016). The systematic review contributes to an understanding of the evidence-base for what can be done to counter the impacts of minority stress, through looking at the efficacy of interventions aimed at increasing parental acceptance and support. In this way, the review highlights the importance of intervention development for factors that mitigate the impact of minority stress, through identifying the latency and recency of intervention research on parental acceptance and support.

Minority Stress Theory argues that the reason that there are higher levels of mental health difficulties in the LGBTQ+ population than are found in their heterosexual

cisgendered counterparts, is because of the chronic stress impact of discriminatory experiences (Meyer, 2003). The empirical study found that there were higher levels of anxiety and depression in the study sample than a general UK population sample, and comparable levels of complex trauma than a trauma-exposed general UK population sample. However, the study also found that levels of minority stress in the study sample only explained a proportion of their levels of anxiety, depression and complex trauma. This may mean that minority stress does not explain the whole of the disparity identified in this group. The study hypothesised social safety as a possible explanation for the health disparities not explained by minority stress, but found that it did not predict levels of anxiety, depression and complex trauma in the study sample.

Experiences of emotional invalidation are not included within the construct of minority stress, and can lead to anxiety, depression and complex trauma symptoms (Cardona, et al., 2022). The empirical study highlights that invalidating religious environments have been likened to other invalidating environments (Cardona, et al., 2022). Perhaps emotional invalidation is a key construct in the discrimination LGBTQ+ people can face in unaccepting social groups? And perhaps this represents one of the minoritising effects of groups that do not accept sexual and gender minority identities? A next step in research in this area could be to investigate emotional invalidation as a mechanism of religious trauma. It may be that experiences of emotional invalidation are a component of the minority stress that LGBTQ+ are subjected to in unaccepting Christian environments. This could add to the theory of minority stress more widely, by exploring group social rejection and its impact.

Strengths and limitations

Particular strengths and limitations of each study were detailed in the previous chapters. Below is a consideration of wider strengths and limitations of the portfolio.

To the author's knowledge, the systematic review is the first to look at the evidence base for interventions aimed at increasing parental acceptance and support of LGBTQ+ people. And to the author's knowledge, the empirical study is the first quantitative research study on religious trauma in a UK LGBTQ+ population. There is currently no NICE (National Institute of Health and Care Excellence) guidance on interventions for working with unaccepting or rejecting families of LGBTQ+ people, or for working with religious trauma. Although offering some guidance around language usage when talking to people about sexual orientation or gender identity (NICE, 2024), for the most part NICE offers guidance for working with conditions only rather than populations. And guidelines are only offered on the basis of substantial evidence. The systematic review and the empirical study represent a beginning of evidence in these areas, but a great deal more is needed for an evidence-base.

A recent systematic review found that, in general, mental health practitioners have affirming attitudes towards LGBTQ+ people, but there was a significant gap in knowledge and skills for addressing the specific needs of LGBTQ+ people (Cruciani, et al., 2024). It is perhaps, therefore, not surprising that many LGBTQ+ people report experiences of lack of understanding from healthcare professionals when they access services (Parameshwaran, et al., 2017). The BPS (British Psychological Society) guidance on working with Gender, Sexuality and Relationship Diversity (GSRD) are general guidelines for working with adults only, and there is currently no guidance for working with parents, families, young people, or guidance on interventions for mental health support for LGBTQ+ people (BPS, 2024).

This highlights a wider difficulty within UK health services of a lack of awareness, understanding and training in this area. For example, there is a known lack of knowledge regarding the particular physiological health needs of transgender people in primary care practitioners, which leads to a lack of good quality care for many patients (Mikulak, 2021).

By offering such limited guidance, organisations such as NICE and the BPS model to practitioners that it is acceptable to continue to practice without a better understanding and awareness. However, given that these organisations are careful not to offer guidance in the absence of research, the lack of guidance may be a reflection of a lack of research. It is notable that the systematic review only identified seven studies. In recruiting for the empirical study, the researcher encountered a number of barriers, including an unwillingness on the part of organisations and charities to advertise a study on religious trauma. Perhaps both of these instances reflect a wider cultural sense of vulnerability in championing LGBTQ+ research? It is difficult to know with any certainty, but what is known is that evidence-based practice is the basis of NICE guidelines, and so this must be navigated if progress is to be made. Additionally, while lack of evidence does tend to lead to caution in the NHS, it does not necessarily lead to an increase in research. The recent NHS temporary ban on puberty blockers for transgender young people is an example of this type of wider systemic issue (The King's Fund, 2025). Barriers to care due to lack of research is perhaps a core obstacle that must be overcome for progress to be made in healthcare provision for the LGBTQ+ community. In this way, a strength of this thesis portfolio is that both the systematic review and the empirical paper add to under-researched areas of LGBTQ+ mental health. But at the same time, a limitation is the small number of studies in the systematic review, and the number of participants in the empirical study, which limits the generalisability of the findings in both cases.

It was not possible within the design of the empirical study to investigate a causal relationship between unaccepting Christian environments and mental health outcomes for LGBTQ+ people. This means that, although the findings of this study point to the potential psychological harm of these environments, it cannot be concluded that the environment caused anxiety, depression and complex trauma. A longitudinal study of the mental health of

LGBTQ+ people remaining within unaccepting Christianity would be one possible avenue to address this. However, given the nature of rejection of any orientations or identities that are not heteronormative cisgendered within these environments, it may well be difficult to recruit participants. This highlights a barrier to research in this area generally. In one of the studies identified in the systematic review, the authors noted that parents of transgender young people withdrew due to fear of being identified, despite the use of pseudonyms (Zavala & Waters, 2024). Many potential participants in LGBTQ+ research may be concerned about identification and the possible consequences of this. Although this is always an ethical consideration in all research with human participants (Oates, et al., 2021; Data Protection Act, 2018), this perhaps indicates a heightened need for explicit reassurances and policies outlining procedures for anonymising data and protecting peoples' identities in research with this population.

Increasing levels of discrimination against gender minority individuals in particular may mean that recruiting non-cisgendered participants for research is especially difficult (Lewis, et al., 2024). A strength of the empirical study is that 30% of participants were non-cisgendered. Perhaps the fact that the study was anonymous helped individuals feel safe to take part?

Since the empirical study was, to the author's knowledge, the first quantitative research study on religious trauma in a UK LGBTQ+ population, the scope was kept broad because there was no previous quantitative research to build on. Next steps that are indicated by this study are to investigate differences in religious trauma in different Christian denominations. The participants in this study came from a wide range of denominations, and it is likely that the form unacceptance took within the culture of each denomination is variable, and therefore the impact may be different. This would allow for a comparison between experiences within different denominations, which would build a more nuanced

understanding of the effect that growing up in these environments has on LGBTQ+ people. Additionally, this study was limited to Christianity. Comparison with LGBTQ+ peoples' experiences in other unaccepting religions may prove fruitful for increasing understanding of religious trauma in LGBTQ+ people more widely, and for developing psychological interventions aimed at recovery.

Overall conclusions

Experiences of rejection of an individual's sexual orientation or gender identity can be detrimental to both their physical and mental health, whereas acceptance is associated with both greater self-esteem and better health (Hunt et al., 2018). LGBTQ+ people are subjected to rejection on multiple fronts. The mental health impact of this needs to be addressed. This thesis has explored interventions to increase parental acceptance and support, and has empirically investigated the impact of religious trauma in unaccepting Christian environments. In this way, this thesis has contributed to an understanding of the mental health impact of rejection on LGBTQ+ people, and what can be done to help. The systematic review found preliminary evidence of the efficacy of seven interventions for increasing parental acceptance and support of their LGBTQ+ children, but the small number and non-UK populations they were developed in, limits the applicability of the efficacy findings for UK practice. Intervention adaptation and development would likely be needed in order for these interventions to be implemented in the UK. The empirical study found that minority stress experienced within unaccepting Christianity predicted a proportion of anxiety, depression and complex trauma in a sample of UK-based LGBTQ+ people. The study presented evidence to suggest that this population are more likely to experience symptoms of anxiety and depression than the general UK population, and that levels of complex trauma in this population are on a par with a UK population with known trauma exposure. In this way, this thesis added to an understanding of the need for interventions in this area, and to the impact

of religious trauma on LGBTQ+ people, thus contributing to the broader aim of deepening understanding of the mental health needs of LGBTQ+ people. In turn, this has implications for clinical practice through informing assessment, formulation and intervention for this population when accessing mental health services, through offering an insight into how these unique areas of difficulty could be impacting individuals' mental health, and through consideration of what can be done to support recovery.

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Appendices

Appendix A – Journal guidelines for Psychology of Sexual Orientation and Gender Diversity

Journal scope statement

Psychology of Sexual Orientation and Gender Diversity®, the official publication of APA Division 44 (Society for the Psychology of Sexual Orientation and Gender Diversity), is a scholarly journal dedicated to the dissemination of information in the field of sexual orientation and gender diversity. It is a primary outlet for research particularly as it impacts practice, education, public policy, and social action.

The journal is intended to be a forum for scholarly dialogue that explores the multifaceted aspects of sexual orientation and gender diversity. Its focus is on empirical research (both quantitative and qualitative), theoretical and conceptual articles, in-depth reviews of the research and literature, clinical case studies, book reviews, and letters to the editor.

Many issues include a major article or set of articles on a specific theme of importance to theory, research, and/or practice in the psychology of sexual orientation and gender diversity. In addition, articles address professional issues, methodological and theoretical issues, and comments on previous publications in the journal as well as such topics that advance the psychological knowledge of lesbian, gay, bisexual, and transgender individuals and their families, couples and marriage, health and health care, aging, work, and careers.

The journal includes all areas of psychological research, especially developmental, social, clinical, community, counseling, family, gender roles and gender nonconformity, lifespan and aging, cultural diversity including race and ethnicity, and international issues.

Subscribe to the RSS feed for *Psychology of Sexual Orientation and Gender Diversity*

Equity, diversity, and inclusion

Psychology of Sexual Orientation and Gender Diversity supports equity, diversity, and inclusion (EDI) in its practices. More information on these initiatives is available under EDI Efforts.

Editor's Choice

Each issue of the *Psychology of Sexual Orientation and Gender Diversity* will honor one accepted manuscript per issue by selecting it as an "Editor's Choice" paper. Selection is based on the discretion of the editor if the paper offers an unusually large potential impact to the field and/or elevates an important future direction for science.

Author and editor spotlights

Explore journal highlights: free article summaries, editor interviews and editorials, journal awards, mentorship opportunities, and more.

Submission Guidelines

Prior to submission, please carefully read and follow the submission guidelines detailed below. Manuscripts that do not conform to the submission guidelines may be returned without review.

Submission

To submit to the editorial office of M. Paz Galupo, PhD, please submit manuscripts electronically through the Manuscript Submission Portal in Microsoft Word (.docx) or LaTex (.tex) as a zip file with an accompanied Portable Document Format (.pdf) of the manuscript file.

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* using the 7th edition. Manuscripts may be copyedited for bias-free language (see Chapter 5 of the *Publication Manual*). APA Style and Grammar Guidelines for the 7th edition are available.

Submit Manuscript

M. Paz Galupo
Washington University at St. Louis
Missouri

Manuscript types

Psychology of Sexual Orientation and Gender Diversity® (*PSOGD*) accepts a variety of article types consistent with the journal's mission, including:

Standard articles containing a maximum of 7,500 words of text (excluding tables and references). These will be the most typical articles.

Longer, monograph-style articles containing a maximum of 12,000 words of text. These longer contributions will not be typical and to be considered, must provide a particularly enhanced coverage of the topic addressed.

This can take the form of:

- especially extensive literature review with a methodological critique and/or public policy implications explicated
- description of an interlocked series of research projects
- synthesis of material on sexual orientation and gender diversity with material from other aspects of psychology and/or other disciplines
- similarly extensive contributions

Authors MUST OBTAIN APPROVAL OF THE EDITOR PRIOR TO SUBMITTING THIS ARTICLE TYPE.

Brief reports are research-oriented and contain a maximum of 4,000 words of text.

Letters to the editor should be limited to 500 words. In unusual circumstances, the editor may allow a longer limit with the author.

Commentaries may address developments in the behavioral sciences and related fields, the legal system, national or world events, as these pertain to the content areas of *PSOGD*. These should be a maximum of 1000 words, unless a longer length is allowed by the founding editor.

As a rule of thumb one double-spaced page of standard font and size text contains about 300 words. If submissions contain an unusually larger number of references for the article type and/or unusually large tables/charts/graphs, authors may be required to reduce these. "Words" refers to words and other symbols or characters.

Qualitative research

PSOGD welcomes a variety of methodologies in its submissions, including quantitative, qualitative, and mixed quantitative/qualitative methodologies.

All submissions are expected to maintain word limits specific to the type of manuscript (see manuscript types); offer replicable methodology; involve an *N* commensurate with the purpose of the research and which allows reasonable inference; and be written in a concise and focused manner.

In particular, extensive quotations from research participants are ill-advised, and should be limited to a few which are especially evocative of key themes. The theme descriptions should be the predominant vehicle for conveying participants' responses in qualitative research.

Manuscript preparation

Review APA's Journal Manuscript Preparation Guidelines before submitting your article.

Since *PSOGD* first began publishing in 2014, a number of recurring questions and situations have arisen.

This material attempts to respond to these proactively, in the hope that potential authors have a clearer sense of *PSOGD's* expectations and procedures.

Please feel free to contact the editor with any inquiries about these topics below or others.

Masked submission

Nothing in your manuscript should indicate authors' identities, institutional affiliation, or other identifying features. Common examples include: naming the institution that granted institutional review board approval; citing by name previous publications on which the current submission explicitly builds; naming specific organizations that cooperated in data collection, etc.

The words "MASKED FOR REVIEW" should be substituted.

When masking earlier work on which the current submission is based, remember to remove the identifying citation both from the text and the references. Insufficiently masked submissions will be returned to authors for masking before being sent for review, which slows the review process.

If the article is accepted for publication, the identifying information can be added subsequently.

Please ensure that the final version for production includes a byline and full author note for typesetting.

Language guidelines

Authors should be cognizant that language and terminologies used to describe sexual orientation and gender diversity have been used in pejorative ways, have undergone transitions, may likely undergo more transitions, and should be used in ways that convey respect yet maintain precision.

When APA offers language guidelines or policy statements that address terminology, authors are generally expected to use these guidelines and statements. There are exceptions to this, such as accurately quoting or describing older literature which might use outdated or problematic terminology.

Revisions

Revisions must be accompanied by a description of changes made, including previously rejected and rewritten papers incorporating feedback.

As the decision letters state, when submitting a revision, authors must include a letter or memo describing the changes made in response to reviewer and editor feedback. This letter should address all the points raised by the editor and reviewers. It is acceptable to disagree with feedback and reject or modify a requested change; this should be clearly stated, and a rationale provided for the disagreement.

Resubmission of a previously rejected manuscript is generally not recommended without consultation with the editor. If resubmission of a previously rejected manuscript is made, authors should note the manuscript number of the earlier rejected submission, and include the same full description of changes made as described in the above paragraph.

Revisions/resubmissions without a description of changes made will not be read and will be returned to authors with instructions to provide this description.

Abstract and keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page.

After the abstract, please supply up to five keywords or brief phrases.

PSOGD encourages submissions from all countries and aspires to disseminate knowledge about sexual orientation and gender diversity internationally.

To this end, authors should submit abstracts and keywords in English and, if they wish, in addition provide abstracts in any other language(s) relevant to the submission in question.

Specifically, authors may submit abstracts and keywords in languages in addition to English in the following circumstances:

- When the research subjects or content matter involve non-English speaking populations
- When the authors are based in a non-English speaking country or comprise a multi-national team with some members from non-English speaking countries.
- There may be other circumstances where authors wish abstracts in other languages to be included. These should be reviewed and approved by the editor.

Note that all submissions must include an abstract and keywords in English.

Non-English language abstracts

PSOGD is committed to encouraging and disseminating scholarship on sexual orientation and gender diversity world-wide as much as is feasible. To facilitate this goal, authors working in a non-English speaking country, or whose sample is from a non-English speaking country, should submit another abstract in their other language, or that of the sample. This will appear below the English abstract if the article is published.

If authors or samples are from multiple non-English speaking countries, abstracts in all the relevant languages should be included. These additional abstracts need not be provided until the final accepted revision.

PSOGD does not have the resources to provide a final copyediting of non-English abstracts, so authors should carefully check the non-English abstracts.

PSOGD can publish the main article text only in English.

Public significance statement

Authors submitting manuscripts to PSOGD are required to provide a short statement of one to two sentences to summarize the article's findings and significance to the educated public (e.g., understanding human thought, feeling, and behavior and/or assisting with solutions to psychological or societal problems). This description should be included within the manuscript on the abstract/keywords page.

- View Guidance for Translational Abstracts and Public Significance Statements

Equity, Diversity, and Inclusion in *Psychology of Sexual Orientation and Gender Diversity*

Psychology of Sexual Orientation and Gender Diversity is committed to improving equity, diversity, and inclusion (EDI) in scientific research, in line with the APA Publishing EDI framework and APA's trio of 2021 resolutions to address systemic racism in psychology.

To promote a more equitable research and publication process, *Psychology of Sexual Orientation and Gender Diversity* has adopted the following standards for inclusive research reporting.

Author contribution statements using CRediT

The *APA Publication Manual (7th ed.)* stipulates that "authorship encompasses…not only persons who do the writing but also those who have made substantial scientific contributions to a study." In the spirit of transparency and openness, *Psychology of Sexual Orientation and Gender Diversity* has adopted the Contributor Roles Taxonomy (CRediT) to describe each author's individual contributions to the work. CRediT offers authors the opportunity to share an accurate and detailed description of their diverse contributions to a manuscript.

Submitting authors will be asked to identify the contributions of all authors at initial submission according to the CRediT taxonomy. If the manuscript is accepted for publication, the CRediT designations will be published as an author contributions statement in the author note of the final article. All authors should have reviewed and agreed to their individual contribution(s) before submission.

CRediT includes 14 contributor roles, as described below:

- **Conceptualization**: Ideas; formulation or evolution of overarching research goals and aims.
- **Data curation**: Management activities to annotate (produce metadata), scrub data and maintain research data (including software code, where it is necessary for interpreting the data itself) for initial use and later re-use.
- **Formal analysis**: Application of statistical, mathematical, computational, or other formal techniques to analyze or synthesize study data.
- **Funding acquisition**: Acquisition of the financial support for the project leading to this publication.
- **Investigation**: Conducting a research and investigation process, specifically performing the experiments, or data/evidence collection.

- **Methodology**: Development or design of methodology; creation of models.
- **Project administration**: Management and coordination responsibility for the research activity planning and execution.
- **Resources**: Provision of study materials, reagents, materials, patients, laboratory samples, animals, instrumentation, computing resources, or other analysis tools.
- **Software**: Programming, software development; designing computer programs; implementation of the computer code and supporting algorithms; testing of existing code components.
- **Supervision**: Oversight and leadership responsibility for the research activity planning and execution, including mentorship external to the core team.
- **Validation**: Verification, whether as a part of the activity or separate, of the overall replication/reproducibility of results/experiments and other research outputs.
- **Visualization**: Preparation, creation and/or presentation of the published work, specifically visualization/data presentation.
- **Writing—original draft**: Preparation, creation and/or presentation of the published work, specifically writing the initial draft (including substantive translation).
- **Writing—review & editing**: Preparation, creation and/or presentation of the published work by those from the original research group, specifically critical review, commentary or revision—including pre- or post-publication stages.

Authors can claim credit for more than one contributor role, and the same role can be attributed to more than one author. Not all roles will be applicable to a particular scholarly work.

Participant description, sample justification, and informed consent

Authors are encouraged to include a detailed description of the study participants in the Method section of each empirical report, including (but not limited to) the following:

- Age
- Sexual orientation
- Gender
- Racial identity
- Ethnicity
- Nativity or immigration history
- Socioeconomic status
- Clinical diagnoses and comorbidities (as appropriate)
- Any other relevant demographics (e.g., disability status; sexual orientation)

In both the abstract and in the discussion section of the manuscript, authors are encouraged to discuss the diversity of their study samples and the generalizability of their findings (see also the constraints on generality section below).

Authors are also encouraged to **justify their sample demographics** in the Discussion section. If Western, educated, industrialized, rich, and democratic (WEIRD) or all-White samples are used, authors should justify their samples and describe their sample inclusion efforts (see Roberts, et al., 2020 for more information on justifying sample demographics).

The Method section also must include a statement describing how informed consent was obtained from the participants (or their parents/guardians), including for secondary use of data if applicable, and indicate that the study was conducted in compliance with an appropriate Internal Review Board.

Reporting year(s) of data collection

Authors are encouraged to disclose the year(s) of data collection in both the Abstract and in the Method section in order to appropriately contextualize the study.

Positionality statements

Authors are encouraged to include a positionality statement in the author note. Positionality statements are intended to address potential author bias by transparently reporting how the identities of the authors relate to the research/article topic and to the identity of the participants, as well as the extent to which those identities are represented in the scientific record. The statement should be included in the author note and expanded upon in the Discussion section. See this example from Jovanova, et al. (2022):

- Sample positionality statement: "Mindful that our identities can influence our approach to science (Roberts, et al. 2020), the authors wish to provide the reader with information about our backgrounds. With respect to gender, when the manuscript was drafted, four authors self-identified as women and four authors as men. With respect to race, six authors self-identified as white, one as South Asian and one as East Asian."

For more guidance on writing positionality statements, see Roberts, et al. (2020) and Hamby (2018).

Inclusive reference lists

Research has shown that there is often a racial/ethnic and gender imbalance in article reference lists, and that Black women's work is disproportionately not credited or cited as often as White authors' work (Kwon, 2022). Authors are encouraged to ensure their citations are fully representative by both gender and racial identity before submitting and during the manuscript revision process. Authors are encouraged to evaluate the race and gender of the authors in their reference lists (see this open-source code by Zhou, et al., 2020, that authors can use to predict the gender and race of the authors in their reference lists) and to report the results in a **citation diversity statement** in the author note or Discussion section of the manuscript.

See Dworkin, et al. (2020)'s sample citation diversity statement:

"*Citation Diversity Statement*. Recent work in neuroscience and other fields has identified a bias in citation practices such that papers from women and other minorities are under-cited relative to the number of such papers in the field (Caplar et al., 2017, Chakravartty et al., 2018, Dion et al., 2018, Dworkin et al., 2020, Maliniak et al., 2013, Thiem et al., 2018). Here, we sought to proactively consider choosing references that reflect the diversity of the field in thought, gender, race, geography, seniority, and other factors. We used automatic classification of gender based on the first names of the first and last authors (Dworkin et al., 2020, Zhou et al., 2020), with possible combinations including man/man, man/woman, woman/man, and woman/woman. Code for this classification is open source and available online (Zhou et al., 2020). We regret that our current

methodology is limited to consideration of gender as a binary variable. Excluding self-citations to the first and last authors of our current paper, the references contain 12.5% man/man, 25% man/woman, 25% woman/man, 37.5% woman/woman, and 0% unknown categorization. We look forward to future work that could help us to better understand how to support equitable practices in science."

Data, materials, and code

Authors must state whether data and study materials are available and, if so, where to access them. Recommended repositories include APA's repository on the Open Science Framework (OSF), or authors can access a full list of other recommended repositories.

In both the author note and at the end of the method section, specify whether and where the data and material will be available or note the legal or ethical reasons for not doing so. For submissions with quantitative or simulation analytic methods, state whether the study analysis code is available, and, if so, where to access it (or the legal or ethical reason why it is not available).

For example:

- All data have been made publicly available at the [repository name] and can be accessed at [persistent URL or DOI].
- Materials and analysis code for this study are not available.
- The code behind this analysis/simulation has been made publicly available at the [repository name] and can be accessed at [persistent URL or DOI].

Public significance statement

Authors submitting manuscripts to PSOGD are required to provide a short statement of one to two sentences to summarize the article's findings and significance to the educated public (e.g., understanding human thought, feeling, and behavior and/or assisting with solutions to psychological or societal problems). This description should be included within the manuscript on the abstract/keywords page.

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Clinicians' Digest

PSOGD includes a Clinicians' Digest section providing practitioners with clinically useful, yet scientifically robust ideas from articles published in the journal.

The Digest, consisting of one- or two-paragraph synopses of clinically relevant concepts from articles in that issue, presented together as one piece, is written by a rotating team coordinated by Kim Skerven, PhD.

Authors of the source articles from which the Digest synopses are drawn have the prerogative to decline their articles' participation in the Digest. They are, however, strongly encouraged to allow their articles to be included in order to facilitate their findings being maximally useful to practitioners.

Digest authors will work with source articles' authors to maintain fidelity with the source article.

The synopses in the Clinicians' Digest are intended to be used with the source article and its abstract, but offer original clinically relevant ideas based on the source article.

Formatting

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the APA Style website.

Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

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- Go to the Text section of the Insert tab and select Object.
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Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Computer code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

In online supplemental material

We request that runnable source code be included as supplemental material to the article. For more information, visit Supplementing Your Article With Online Material.

In the text of the article

If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

Tables

Use Word's insert table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

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References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the references section.

Examples of basic reference formats:

Journal article

McCauley, S. M., & Christiansen, M. H. (2019). Language learning as language use: A cross-linguistic model of child language development. *Psychological Review*, *126*(1), 1–51. https://doi.org/10.1037/rev0000126

Authored book

Brown, L. S. (2018). *Feminist therapy* (2nd ed.). American Psychological Association. https://doi.org/10.1037/0000092-000

Chapter in an edited book

Balsam, K. F., Martell, C. R., Jones. K. P., & Safren, S. A. (2019). Affirmative cognitive behavior therapy with sexual and gender minority people. In G. Y. Iwamasa & P. A. Hays (Eds.), *Culturally responsive cognitive behavior therapy: Practice and supervision* (2nd ed., pp. 287–314). American Psychological Association. https://doi.org/10.1037/0000119-012

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Preferred formats for graphics files are TIFF and JPG, and preferred format for vector-based files is EPS. Graphics downloaded or saved from web pages are not acceptable for publication. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file. When possible, please place symbol legends below the figure instead of to the side.

Resolution

- All color line art and halftones: 300 DPI
- Black and white line tone and gray halftone images: 600 DPI

Line weights

- Adobe Photoshop images

a. Color (RGB, CMYK) images: 2 pixels

b. Grayscale images: 4 pixels

- Adobe Illustrator Images

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The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., “the red (dark gray) bars represent”) as needed.

For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

- $900 for one figure
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Since *PSOGD* allows for longer submissions, up to 12,000 words, there should be few circumstances where publishing several pieces from the same data set is warranted. Data sets that have both quantitative and qualitative components should generally be published as a whole.

PSOGD recognizes, however, that some large data sets, for example as are common in epidemiological research, appropriately lend themselves to multiple publications. Authors are expected to contact the Editor before submitting a piece which may have fragmented data, provide a rationale for this, and obtain the Editor's consultation on the appropriateness.

Authors who undermine these guidelines by covertly splitting data sets and creating separate publications will be denied future consideration for *PSOGD* publication.

Submissions contingent on another article under development or review

If the submission is contingent on data under development or being published elsewhere, authors should wait until the underlying data is at least accepted for publication before submitting a secondary submission to *PSOGD*. For example, if authors rely on a measure whose reliability and validity data have not been published or are under review, authors should delay submission to *PSOGD* until acceptance for publication and final form of those underlying data are confirmed.

Submissions that rely on unpublished underlying data will be rejected without review.

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Ethical Principles

Previously published data

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

Availability of raw data

APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.

On a case by case basis, *PSOGD*'s editor may request that authors provide all or some of the raw data on which research reported in a submission is based. This might typically occur at the request of a reviewer, or when the editor believes there is something unusual, atypical or unclear about the reported results.

Authors are expected to provide the raw data requested in a timely manner. Authors' unwillingness to do so will result in the submission's rejection. Data may not be considered proprietary.

Ethical principles certification

Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

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The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on its website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

General expectations of submissions

Given the wide variety of manuscript types that *PSOGD* accepts, all of these recommendations may not be suitable for all submissions, but are most true for standard and longer research articles.

- **Clear description/intro.** Make certain readers are quickly oriented to the purpose and focus of your manuscript. Make sure that the words used to describe your purpose and focus are the same throughout the manuscript.
- **Literature review to set context.** The literature review should situate your work both in the literature on sexual orientation and gender diversity, and in the behavioral sciences more generally. It should include enough to make a compelling argument for why your study was needed, and should lead directly to your purpose and hypotheses/research questions. Too little, too much, or tangential literature review are common errors. Ensure that your sources present credible scientific findings.
- **Clear methodology.** Could others replicate it? Are the chosen methodologies adequately justified? Provide citations to support your rationale for selecting your given methodology and analytical strategy. Are your data appropriate for the study questions and analyses (e.g., adequate sample size)?
- **Information about measures.** Basic reliability/validity of measures should be summarized and, when possible, these data should be obtained from samples consistent with your study sample. Provide reasons for choosing the specific measures. In addition, report the number of items, scoring procedures, the directionality of scores (e.g., higher scores on this measure indicate higher...), and how scores are computed. If measures were modified in your study, describe the rationale for the modification, the specific modification, and whether this modification was guided by any theory or previous study's methods, and how the measure "behaved" in your study (e.g., reliabilities, factor scores).
- **Sample.** Describe clearly sampling and recruitment procedures. Describe demographics and other characteristics. Have you used up-to-date terminology?
- **Statistics.** Are your statistical results presented in a clear and accessible manner? Does your statistical plan map to your hypotheses? When programs other than SPSS or SAS are utilized to conduct the analyses, report the program (e.g., MPlus). Only identify quantitative results as significant when they meet the generally accepted minimum criterion of $p < .05$ (i.e., do not suggest that scores "trended toward significance" unless you did a trend analysis).

Discuss missing data (i.e., amount and whether data were missing at random) and how missing data were addressed. Were the tables/charts/graphs etc. checked for accuracy?

- **APA Style.** Headings, references, citations, and tables/charts are frequently done incorrectly. Please check these carefully.
- **Copyediting.** Your submission should be free of spacing, formatting, grammatical, spelling, and other copyediting errors. Manuscripts judged to contain an unreasonable number of errors will be rejected without review.
- **Conclusions.** Are the conclusions that are drawn clearly supported by the data and congruent with the limitations of your methodology? It is a common mistake to reach beyond your data, especially when discussing implications for practice, advocacy, education, etc. However, not discussing the full implications of one's findings can be problematic as well. Strive for balance, but err on the side of caution. Attempt to relate the findings to conclusions reached in previous research but watch speculating beyond the data.
- **Limitations.** Do not minimize or avoid. Describe limitations directly, and when possible use your limitations as a springboard for recommendations for future research.

Note compliance with institutional review board and ethical requirements, without sacrificing masking of the manuscript.

Concise writing

Be concise and avoid expansive writing.

Journal space is at a premium. Please review your submissions to keep the writing as concise and focused as possible. The goal is to write just enough to fully communicate the integrity of your work.

Manuscripts with an unnecessarily verbose writing style will be returned to authors, unreviewed, for a more focused and shorter revision. This is also true of references, which should be sufficient to fully justify and contextualize the submission-but no more.

Tables, charts, figures etc. should similarly summarize and clarify, and contribute to the understanding of the research being presented beyond the information reported in the text. If they do not do so, they serve no useful function and authors will be asked to condense or delete them.

Stylistic differences

Be aware of the stylistic differences between student and institutional papers versus journal publications. Papers that are initially prepared as student assignments, reports of research grant activities, internal institution documents, etc., are typically in formats and styles inconsistent with journal publication.

For example, faculty often expect student papers to demonstrate wide-ranging literature reviews and elaborate justifications of methodology and instrumentation; grant and institution-focused papers often address goals and issues uniquely relevant to those entities.

Such papers usually require considerable revision before they are appropriate journal submissions. This is almost always in the direction of sharper focus, more concise writing style, and significant shortening.

Faculty and funding sources usually expect such student and institutional paper authors to demonstrate skill sets and goals that go beyond concise presentation of the material. Journal publications seek only concise presentation of the material.

Please edit your work accordingly before submitting it.

Other information

See APA's Publishing Policies page for more information on publication policies, including information on author contributorship and responsibilities of authors, author name changes after publication, the use of generative artificial intelligence, funder information and conflict-of-interest disclosures, duplicate publication, data publication and reuse, and preprints.

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Appendix B – Extracted qualitative data grouped under the two analytic themes generated through the thematic synthesis

	Analytical themes	
	Improved parent-child relationship	**Insight, understanding and awareness**
Abreu et al. (2020)	"I feel very proud because I know that I have a good son…I know he is happy and being successful, and that is all a mother could ask for." (Parent) "[I feel] relief and content on how much I have learned, changed and accepted my son." (Parent) "His greatest fear [was that] he had disappointed me, that I would stop loving him because of who he was. My God, I wouldn't change him for any other person in this world! As I reassured him that I would never stop loving him and I would always be there for him…I wanted him to love and feel love and to me it didn't matter if it was a man or a woman." (Parent) "The information [PFLAG] provided us with was key in achieving the acceptance and love we all deserve from our family members regardless of our sexual orientation or identity" (Parent) "My daughter is [a lesbian], but she is a good daughter that hasn't given me any problems. She's a professional and…I feel very proud of my daughter and I feel very happy having been at her wedding." (Parent) "I like to communicate as much as possible with him, I like to talk to him about sexual experiences, about using protection. I also tell him that I want to be a part of his life experiences, that when he decides to have a partner I want to be introduced to his partner." (Parent)	"The feelings I have experienced during this process were of great peace, tranquility, and happiness, and I had the opportunity to…express the love toward my son and my support. [I was able to] express to other parents how was my experience and to let them know to love their children and to support them. Our children need us to demonstrate to them that we will always love them, regardless of what they decide to do with their life." (Parent) "My heart did not accept having another gay child. I only thought that I had done something wrong in order for them both to be gay. Clearly I was saying that I was not prejudiced but apparently my heart, my subconscious still would not accept it…If some other parent reads my letter and is going through a similar situation, support your children…it is a question of loving, of supporting, of looking after, or protecting." (Parent) "He was facing a world [where] people reject LGBTQ, people refusing to see one another as people and nothing else…" (Parent) "I had many friends, some were gay and never did I feel or see them any different from myself, they were my friends, period." (Parent) "My experience in coming to terms with my own heterosexism [are the result] of the messages I received from my parents and the Catholic church. These experiences formed the

	"I have a stubborn husband who after all these years continues to struggle with the fact that our son is gay. He has made some improvements though. Our son is able to come over to our house with his boyfriend…he tries to be more open-minded. I still have hopes that he'll open up even more, even if it takes another 20 years." (Parent). "And the most important thing to a mother is to have her children healthy, safe, and happy…As I, who gave her life, I am going to ask her to follow her happiness. In the end we the parents go first so I choose to see my daughter happy at my side and see her every chance I can and support her in her decisions." (Parent) "It was useful to recreate my process for coming to terms with my son, how it was influenced by my family and how I grew up. I was still saddened that some in my family could not accept him and fearful that it is still a homophobic world. I am happy that we do have an open relationship." (Parent) "I feel very happy [in] accepting him and that I was able to be by his side to support him." (Parent)	foundation for my reaction to discovering that my son is gay." (Parent) "I learned [the] hard way that happiness is in the power to smile sincerely, to be happy in one's heart, and to do good without worrying who's watching. That woman [who] told me her painful truth is my daughter." (Parent) "My other daughter asked me what bothered me most about the situation and I told her: 'I don't want anybody to do anything bad to my youngest daughter.' She responded: 'Think about what you're saying and reflect on all that's happened.' And then I understood: I was the one hurting my daughter because I wasn't accepting her just as she is." (Parent) "Writing this letter brought a lot of sad feelings and I experience a little bit of anxiety. But I liked thinking [of] the process that my daughter, now a son is going through and think[ing] regarding what I have gone through as a mother. In this moment I feel relaxed and ready to continue to support my [son]." (Parent) "I felt a bit of anxiety having to experience the whole journey again, but at the same time affirmation of my feelings of love and acceptance towards my son." (Parent) "relief and content on how much I have learned, changed, and accepted my son." (Parent)
Zavala & Waters, (2024)	"Believe it or not, one of the most important things I've learnt during these workshops is that I want to be a mother who is closer to her daughter in general, not just in regards to understanding her experiences as a bisexual woman. I still have a hard time	"I can express myself much more freely now. I have long hair, I paint my nails, we can talk freely about anything. I know that both my parents now have the disposition to learn and communicate about topics like gender, sexuality and how I'm feeling. And I also try to

	talking to her and expressing feeling about day-to-day stuff. I know it's something that stems from my childhood and something I need to work on changing, and now I'm committed to do it. I've even started trying to share more of my life and my emotions with her, and making more time for us to spend together." (Parent) "The other day, when we were talking about my potential future partner, she said the words 'boyfriend or girlfriend'. She'd never said them together before, she would usually opt for only one or the other, even though she knows I'm bisexual. So that was exciting, and I felt validated. She even asked me about non-binary and trans identities, which is definitely something new for her. I am so curious now about her internal process, and I would really like to continue talking about these issues now that the door has been opened." (Child) "When I see my mom putting these changes into action, it's like, my inner teenager feels relieved, like he's saying, "I'm not in danger anymore." She used to be so invasive, and now she's much more curious and empathetic with me. But for some reason I'm hesitant. I realize my hesitation stems from the past, not the present, and I will get to the point where I am fully not guarded, but it takes time." (Child) "Now I am aware of how some of the things I used to judge, like painting his nails, actually have strengths embedded in them. I'm able to empathize and see things from his point of view. I realize how brave my son has to be to face the cashier that could possibly judge him when she sees	be more understanding. I know they grew up very, very conservative and they're trying. So, I'm more willing to reach compromise and go at their pace, too." (Child) "It's crazy to me to think that, when I first learned of my daughter's sexual orientation, the first thing I thought about was her having sex with someone of her same gender. And now I think, 'What the heck?' That's not something I would think if anyone else was talking about their sexual orientation. So why am I doing it with her? I try to remember that it's not just about that, and that any preconceived notions I have are not necessarily true. It hurt me to recognize I may have biases, but owning up to that helps me keep them in check and question them. Now, I truly just care that she finds a loving partner – no matter what package they come in." (Parent) "I've discovered that you can't put parameters on life. You can't put parameters on human beings' desires, not as a parent nor as a child. It's just impossible. I've learned that human beings are expansive, they constantly transcend limitations. This new experience is, for me, like when you have a child all over again and you fully experience each step they take, when they learn to talk, to eat…it's like living a birth all over again, and I'm constantly analyzing and reflecting on that." (Parent) "It's horrible to admit, it hurts me and I'm ashamed, but I can no longer hold on to the idea I had of myself as someone with no prejudices. Before this, I really thought [my daughter being gay] wouldn't have mattered to me. I truly didn't think I had prejudiced beliefs, but I did, I still do – I'm

	him buying the nail polish, to face everyone in the world that can give him dirty looks for it. Instead of belittling it as unnecessary exposure, I think, 'Wow, he is brave, and this must really matter to him'." (Parent) "I'm grabbing hold of the strength of taking charge, one I had not seen in myself before. I used to be very passive in general and in my role as a mother, and I don't think that was helping me to be secure in myself, or to transmit security to my child, as we go through this experience. I'm learning to be tougher and take charge when I need to, so I can have the strength to face society with less shame, and to give my child what he needs to feel supported." (Parent) "I used to look at every move my son made. How he walked, how he moved, how he talked. And I would think, oh no, there he goes again with that mannerism or that tone of voice. Now, I only see my son, my caring, mature, smart son, I see him as a totality, and that's that. He's a whole being and I love him." (Parent) "She'll still have the impulse to tell me to hide, that it's better if people don't know. That makes no sense and it's not helpful to me, I don't want to hide. Now, I am able to tell her that I'm going to do a lot of things she may not be expecting, like trying things with my gender expression or sharing my identity with people, and if I tell her that it's because I want her to be in my life. And she doesn't respond and stays reflecting on that. I know she's listening now." (Child) "Before, I used to feel pity towards LGBTQ+ people. I saw them as fragile and weak, marginalized by the world, like a	working on it. It's like, me, someone with many queer friends, who preached equality and advocates for it…and now I'm not totally okay with my daughter being gay? That didn't align with the kind of person, the kind of mother, I thought I was. I was like, this is bull****." (Parent) "Now, for example, I've learned that I don't need to feel shame about my daughter's sexual orientation. When I was at work the other day, I don't know why the topic came up, but I said 'My daughter is part of the LGBTQ+ community', and I felt good. It's like, if there's no reason to bring it up, I won't, but if the topic comes up, I say it. I truly felt relieved that I was no longer ashamed of my daughter." (Parent)

	crystal glass. So, when I tried to talk with my son about these topics, I was afraid I was somehow invading his space or making him feel bad just by bringing it up. Now, I just see LGBTQ+ people as people, and I know it's not bad to talk about these topics because it's not offensive. I can talk to him directly now, it's like that crystal glass is broken, and now I can reach him." (Parent) "Before, what I would've typically done when I felt afraid that my son would be discriminated against is act like everything is fine, and left feeling heavy with everything I didn't say. But then when I do talk to him, all that comes out is exasperation and judgement, which actually hurts the relationship more in the long run…That's not what I want to do. So now I choose my strength of honest. It takes bi-directional understanding, empathy, and trust…and remembering the immense love we have for each other. So when he asks what I feel, I search, with patience, for the right words so I can express my fear in a way that I don't hurt him. It also helps me to treat his choices with more respect even if I don't like them, which is not easy, but I'm in the process." (Parent)	

Appendix C – Participant demographic information

Characteristic	N
Number of participants	78
Age range	18-71
Mean age (SD)	35.92 (11.62)
Gender identity	
Cisgender woman	38
Cisgender man	17
Transgender woman	4
Transgender man	6
Non-binary	8
Gender queer	4
Other gender identity	1
Sexual orientation	
Asexual	1
Bisexual	18
Demisexual	1
Gay	15
Lesbian	23
Pansexual	5
Queer	11
Other sexual orientation	4
Racial identity	
Asian/Asian British	5
Black/ Black British/ Caribbean/ African	3
Mixed or Multi-ethnic	2
White	67
Other racial identity	1
Country participant grew up in	
UK	61
Australia	1
France	1
Germany	2
Hong Kong	1
Ireland	2
Ireland & UK	1
Jamaica	1
Malaysia	1
Malaysia & Singapore	1
Portugal	1
Singapore	1
South Africa	1
USA	3
Accessed mental health services	67

Appendix D – Sample religious data

Table 2. Religious demographic data

Religious characteristic	N
Denomination participant grew up in	
Anglican	13
Anglican Reform	1
Anglican/Methodist	1
Anglican/Non-Denominational	1
Anglican and Quaker	1
Anglican and Presbyterian	1
Anglican and Baptist	2
Anglican and Catholic	2
Baptist	4
Baptist/Evangelical	2
Brethren	1
Catholic	21
Charismatic	1
Church of Wales	1
Dutch Reformed and Pentecostal	1
Evangelical	4
Evangelical Non-Denominational	5
Evangelical/Pentecostal	1
Jehovah's Witnesses	1
Lutheran	1
Methodist	3
Morman	2
New Frontiers (Evangelical Charismatic)	2
Non-Denominational	1
Pentecostal	1
Protestant	2
Seventh Day Adventist	1
Not stated	1
Attended church services growing up	76
Attended a Christian school	49
Christianity part of family life	73
Mean number of years spent in a Christian environment	22.49
Still in the Christian environment	12
Mean number of years since leaving for those who left	14.6
Currently identify as Christian	
Yes	24
Unsure	3
No	49
Other	2

Appendix E – Ethical approval

University of East Anglia

University of East Anglia
Norwich Research Park
Norwich. NR4 7TJ

Email: ethicsmonitor@uea.ac.uk
Web: www.uea.ac.uk

Study title: Religious trauma in the LGBTQ+ population: the relationship between minority stress, instances of microaggression experience, complex trauma, anxiety and depression.

Application ID: ETH2324-0132

Dear Jude,

Your application was considered on 17th January 2024 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

If your study involves NHS staff and facilities, you will require Health Research Authority (HRA) governance approval before you can start this project (even though you did not require NHS-REC ethics approval). Please consult the HRA webpage about the application required, which is submitted through the IRAS system.

This approval will expire on **30th May 2025**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

I would like to wish you every success with your project.

On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

Yours sincerely,

Dr Paul Linsley

Appendix F – Study advert

Religious trauma in LGBTQ+ people

Are you an LGBTQ+ adult who grew up in a Christian environment that was unaccepting of your LGBTQ+ identity?

You may be able to help us understand the impact of this on psychological well-being.

There is not enough research into religious trauma in LGBTQ+ people.

We're looking for LGBTQ+ adults, 18 years or over, who live in the UK currently, and grew up in a Christian environment that was unaccepting of sexual and gender minorities, to complete an anonymous online survey on your sexual and gender identity, your religious background, and aspects of your psychological well-being .

This survey will take around 30-40 minutes to complete. (You may want to allow a few minutes afterwards for a cup of tea and a break). This research study has ethical approval from the University of East Anglia.

For more information and to take part, please follow this link:
https://forms.office.com/e/m9PVKPYnJH

Or scan this QR code:

Religious trauma in the LGBTQ+ population

Any questions: Please contact Jude Kiley-Morgan at j.kiley-morgan@uea.ac.uk Trainee Clinical Psychologist

UEA
University of East Anglia

Appendix G – Participant information

Participant Information Sheet

Religious trauma in the LGBTQ+ population: minority stress and social safety as predictors of anxiety, depression and complex trauma.

You are invited to participate in a research study which aims to look at the impact on LGBTQ+ people of growing up in a Christian environment that was unaccepting of sexual and gender minorities. Please take time to read through the information below in order to understand why we are doing this research and what participation would involve, before you decide whether or not you would like to take part.

Why are we doing this research?

The aim of this study is to understand the psychological impact on people who identify as LGBTQ+ of growing up in Christian environments that were unaccepting of sexual and gender minorities. The aim is to better understand the mental health impact of exposure to invalidating religious messages on LGBTQ+ people, with the hope of improving mental health service provision.

Can I take part?

If you identify as LGBTQ+, are 18 or over, currently live in the UK, and grew up in a Christian denomination that was unaccepting of sexual and gender minorities, you are eligible to take part in this study (where "grew up" is understood to mean spending a length of time you consider significant in a Christian environment at any point between birth and 25 years of age. And "environment" is understood to mean settings such as family, school, church or other social settings.). You do not need to have grown up in the UK, but you do need to live in the UK now.

What will taking part involve?

- You will be asked to complete a series of questionnaires through an online survey platform.

- You will first be asked some questions about yourself, and some questions about your Christian background. These questions do not include any identifiable details.
- You will then be asked to complete five questionnaires that look at different aspects of your psychological well-being. This should take around 30 minutes.
- Your answers will be completely anonymous, no identifying information will be asked for, and your responses will be kept strictly confidential.
- You will not be given the results of your completed questionnaires because the purpose of completing them is to help with our research, and is not intended to be diagnostic.

What will happen to my data?

No identifying information will be taken. Your answers will be anonymous, and will be kept confidentially on a password protected computer. Only the researcher and the two research supervisors will have access to the data during the research study. The anonymous data from the study will be kept for at least ten years in the University of East Anglia's research storage and archive facility. This is University policy. The results of this study may be published or reported, but since your identifying details will not be taken, your name and details will not be associated in any way with published results.

What happens if I change my mind about participating?

Participation in this study is entirely voluntary. You can change your mind about participating at any time before completing the survey. However, once you have completed the survey, your answers will be automatically collated with other participants' answers, and since your answers will be completely anonymous and not attached to any personally identifying information, it will not be possible to identify and remove your responses once you have submitted them. By answering the questionnaires, you consent to your answers being used in this study.

What are the possible benefits of taking part?

Your participation will help give us an understanding of what you may have experienced growing up in a Christian environment that was unaccepting of your LGBTQ+ identity, and how this may have impacted you. Your participation is greatly appreciated because this research may have implications for understanding the psychological impact of

exposure to invalidating religious messages on LGBTQ+ people, which could help aid understanding of how best to psychologically support people who have had these types of experiences growing up.

What are the possible disadvantages and risks of taking part?

This study is not expected to cause any harm to participants. However, it is possible that answering the questions may bring up distressing memories or feelings. If you experience any distress, please do contact one of the following organisations who offer mental health support for LGBTQ+ people:

- Switchboard LGBT+ helpline: https://switchboard.lgbt/
- Pink Therapy: https://pinktherapy.com/en-gb/findatherapist.aspx
- Mind: https://www.mind.org.uk/information-support/tips-for-everyday-living/lgbtqia-mental-health/about-lgbtqia-mental-health/#.WVzoNUUrKM8

If you have any thoughts of harming yourself or ending your life:

- Please contact **111 option 2**.
- You can also contact your GP if you are in crisis or need help. All GP surgeries have an out of hours service that you can call in an emergency.
- You can also call the Samaritans on 116 123 (free call).
- If you do not feel that these services can support you, please go to your nearest A+E or call 999 in an emergency.

What if I have questions before participating?

If you have any questions about participation in this study, please contact the primary researcher Jude Kiley-Morgan, Trainee Clinical Psychologist on j.kiley-morgan@uea.ac.uk

If you have any concerns about the way this study is being conducted you can contact the primary research supervisor Dr Aaron Burgess on aaron.burgess@uea.ac.uk

Alternatively, you can contact the Deputy Programme Director for the UEA Clinical Psychology Doctorate programme (ClinPsyD), Dr Peter Beazley, on p.beazley@uea.ac.uk

Appendix H – Participant consent

Participant Consent Form

1. I confirm that I have read through the Participant Information Sheet and have had the opportunity to consider the information given about the study. I confirm that I understand the information given.
2. I confirm that I have been given the opportunity to ask any questions I may have about this study before agreeing to participate.
3. I understand that my participation in this study is voluntary, and I can withdraw at any time prior to completion of the questionnaires.
4. I understand that the data I provide will be kept anonymously, confidentially and securely, and will be used for the purpose of this research study.
5. I understand that the data I provide may be used anonymously in published research and reported at research conferences.

This study has received ethical approval from the University of East Anglia Faculty of Medicine and Health Sciences.

I consent to participate in this study.

Appendix I – Study questionnaires

Demographic Questionnaire

In the questionnaires that follow, "grow/growing/grew up" is understood to mean spending a length of time you consider significant at any point between birth and 25 years of age. And "environment" is understood to mean settings such as family, school, church or other social settings.

Age:

Gender identity:

Woman

Man

Transgender woman

Transgender man

Gender queer

Non-binary

If the options above do not accurately describe how you identify, please specify here:

Sexual orientation:

Gay

Lesbian

Bisexual

Straight

Pansexual

Asexual

Queer

Demisexual

If the options above do not accurately describe how you identify, please specify here:

Racial identity/ethnicity:

Asian/ Asian British

Black/ Black British/ Caribbean/ African

Mixed or multi-ethnic

White

If the options above do not accurately describe how you identify, please specify here:

Did you grow up in the UK? (If not, where did you grow up?)

Do you currently live in the UK?

What Christian denomination did you grow up in?

How regularly did you attend church when you were growing up?

Did you attend a Christian school?

Was Christianity part of your family life growing up?

How many years did you spend in a Christian environment, and at what ages?

Do you currently identify as Christian?

How would you describe your current spiritual/religious identity?

How would you describe your current relationship status?

Have you accessed any mental health support services? If so, what services and for how long?

Daily Heterosexist Experiences Questionnaire (DHEQ)

Trigger Warning: you will see the use of slurs as examples in this questionnaire.

Please bring to mind your experiences in the past of growing up in a Christian environment when you answer these questions:

Daily Heterosexist Experiences Questionnaire (DHEQ)

The following is a list of experiences that LGBT people sometimes have. Please read each one carefully, and then respond to the following question:

How much has this problem distressed or bothered you ***during the past 12 months?***

0 = Did not happen/not applicable to me
1 = It happened, and it bothered me NOT AT ALL
2 = It happened, and it bothered me A LITTLE BIT
3 = It happened, and it bothered me MODERATELY
4 = It happened, and it bothered me QUITE A BIT
5 = It happened, and it bothered me EXTREMELY

1. Difficulty finding a partner because you are LGBT
2. Difficulty finding LGBT friends
3. Having very few people you can talk to about being LGBT
4. Watching what you say and do around heterosexual people
5. Hearing about LGBT people you know being treated unfairly
6. Hearing about LGBT people you don't know being treated unfairly
7. Hearing about hate crimes (e.g., vandalism, physical or sexual assault) that happened to LGBT people you don't know
8. Being called names such as "fag" or "dyke"
9. Hearing other people being called names such as "fag" or "dyke"
10. Hearing someone make jokes about LGBT people
11. Family members not accepting your partner as a part of the family
12. Your family avoiding talking about your LGBT identity
13. Your children being rejected by other children because you are LGBT
14. Your children being verbally harassed because you are LGBT
15. Feeling like you don't fit in with other LGBT people
16. Pretending that you have an opposite-sex partner
17. Pretending that you are heterosexual
18. Hiding your relationship from other people
19. People staring at you when you are out in public because you are LGBT
20. Worry about getting HIV/AIDS
21. Constantly having to think about "safe sex"
22. Feeling invisible in the LGBT community because of your gender expression
23. Being harassed in public because of your gender expression
24. Being harassed in bathrooms because of your gender expression
25. Being rejected by your mother for being LGBT
26. Being rejected by your father for being LGBT
27. Being rejected by a sibling or siblings because you are LGBT
28. Being rejected by other relatives because you are LGBT
29. Being verbally harassed by strangers because you are LGBT
30. Being verbally harassed by people you know because you are LGBT
31. Being treated unfairly in stores or restaurants because you are LGBT

32. People laughing at you or making jokes at your expense because you are LGBT
33. Hearing politicians say negative things about LGBT people
34. Avoiding talking about your current or past relationships when you are at work
35. Hiding part of your life from other people
36. Feeling like you don't fit into the LGBT community because of your gender expression
37. Difficulty finding clothes that you are comfortable wearing because of your gender expression
38. Being misunderstood by people because of your gender expression
39. Being treated unfairly by teachers or administrators at your children's school because you are LGBT
40. People assuming you are heterosexual because you have children
41. Being treated unfairly by parents of other children because you are LGBT
42. Difficulty finding other LGBT families for you and your children to socialize with
43. Being punched, hit, kicked, or beaten because you are LGBT
44. Being assaulted with a weapon because you are LGBT
45. Being raped or sexually assaulted because you are LGBT
46. Having objects thrown at you because you are LGBT
47. Worrying about infecting others with HIV
48. Other people assuming that you are HIV positive because you are LGBT
49. Discussing HIV status with potential partners
50. Worrying about your friends who have HIV

Scoring: The measure can be scored two ways:

1. Occurrence: Responses are recoded 0 = 0 (did not occur) and 1 through 5 = 1 (did occur). Items are then summed for a total score indicating how many of these experiences participants have had.

2. Distress: Responses are recoded so that 0 and 1 = 1 (did not bother) and the rest of the responses remain the same. A mean is then computed for responses to all items, indicating the mean level of distress participant feels related to these experiences.

9 Subscales:

Vigilance: Items 4, 16, 17, 18, 34, 35
Harassment and discrimination: Items 8, 19, 29, 30, 31, 32
Gender expression: Items 22, 23, 24, 36, 37, 38
Parenting: Items 13, 14, 39, 40, 41, 42
Victimization: Items 43, 44, 45, 46
Family of origin: Items 11, 12, 25, 26, 27, 28
Vicarious trauma: Items 5, 6, 7, 9, 10, 33
Isolation: 1, 2, 3, 15
HIV/AIDS: 20, 21, 47, 48, 49, 50

Social Safety Questionnaire

Please bring to mind your experiences in the past of growing up in a Christian environment when you answer these questions:

Social Safety – Diamond

(based on Diamond, L. M., & Alley, J. (2022). Rethinking minority stress: A social safety perspective on the health effects of stigma in sexually-diverse and gender-diverse population. *Neuroscience & Biobehavioral Reviews*, 104720. https://doi.org/https://doi.org/10.1016/j.neubiorev.2022.104720

Pdf of article: https://www.dropbox.com/s/kms9y96a4ohc258/Rethinking%20minority%20stress-A%20social%20safety%20perspective%20on%20the%20health%20effects%20of%20stigma.pdf?dl=0

1. Below, please select all the community groups with whom you feel a sense of belonging.

- ☐ People with a similar ethnic or racial identity.
- ☐ People with a similar socioeconomic status.
- ☐ People with a similar sexual identity.
- ☐ People with a similar gender identity.
- ☐ People with similar spiritual beliefs.
- ☐ People with similar political beliefs.
- ☐ People with similar physical, cognitive, or health challenges.
- ☐ Other: _____

2. Which group do you identify with most strongly?

- ☐ People with a similar ethnic or racial identity.
- ☐ People with a similar socioeconomic status.
- ☐ People with a similar sexual identity.
- ☐ People with a similar gender identity.
- ☐ People with similar spiritual beliefs.
- ☐ People with similar political beliefs.
- ☐ People with similar physical, cognitive, or health challenges.
- ☐ Other: _____

3. Please indicate (with the rating scale below) how much time do you spend interacting one-on-one with people in each of these groups?

___Household members
___Family members NOT in your household
___Close friends (including “chosen” family)
___People at work or school
___People in public spaces (gyms, coffeeshops, stores, health clinics)
___Your identity group (the group you identified earlier)
___People in the religious tradition you were raised in

Never	Less than once a month	A few times per month	About once a week	More than once a week	About every day

0	1	2	3	4	5

All the remaining questions using the following scale, and participants provide ratings for EACH separate social domain (household, family, etc…)

Never	Occasionally	Sometimes	Frequently	Always	Not Applicable
1	2	3	4	5	6

4. How often do these people notice and care if you're absent, sick, upset, uncomfortable, or hurt?

___Household members
___Family members NOT in your household
___Close friends (including "chosen" family)
___People at work or school
___People in public spaces (gyms, coffeeshops, stores, health clinics)
___Your identity group (the group you identified earlier)
___Members of the religious tradition you were raised in

5. When you're with these people, or interacting with them, how often do you see or hear something that makes YOU feel affirmed and included (this could be something that someone says or does, something that you see or hear about, even something that you just overhear)?

___Household members
___Family members NOT in your household
___Close friends (including "chosen" family)
___People at work or school
___People in public spaces (gyms, coffeeshops, stores, health clinics)
___Your identity group (the group you identified earlier)
___People in the religious tradition you were raised in

6. How often do you feel like you matter to these people?

___Household members
___Family members NOT in your household
___Close friends (including "chosen" family)
___People at work or school
___People in public spaces (gyms, coffeeshops, stores, health clinics)
___Your identity group (the group you identified earlier)
___Members of the religious tradition you were raised in

7. How often do you feel so secure with these people that you don't devote any thought or energy to how they perceive or treat you?

___Household members
___Family members NOT in your household
___Close friends (including "chosen" family)
___People at work or school

___People in public spaces (gyms, coffeeshops, stores, health clinics)
___Your identity group (the group you identified earlier)
___Members of the religious tradition you were raised in

8. How often do these people treat you, talk to you, or refer to you the way that you want them to?

___Household members
___Family members NOT in your household
___Close friends (including “chosen” family)
___People at work or school
___People in public spaces (gyms, coffeeshops, stores, health clinics)
___Your identity group (the group you identified earlier)
___Members of the religious tradition you were raised in

9. How often does someone in this setting make you laugh or feel really good?

___Household members
___Family members NOT in your household
___Close friends (including “chosen” family)
___People at work or school
___People in public spaces (gyms, coffeeshops, stores, health clinics)
___Your identity group (the group you identified earlier)
___Members of the religious tradition you were raised in

10. How often do you feel like your real self with these people?

___Household members
___Family members NOT in your household
___Close friends (including “chosen” family)
___People at work or school
___People in public spaces (gyms, coffeeshops, stores, health clinics)
___Your identity group (the group you identified earlier)
___Members of the religious tradition you were raised in

11. How often do you experience joy and pleasure with these people?

___Household members
___Family members NOT in your household
___Close friends (including “chosen” family)
___People at work or school
___People in public spaces (gyms, coffeeshops, stores, health clinics)
___Your identity group (the group you identified earlier)
___Members of the religious tradition you were raised in

SCORING: items 1 and 2 are simply designed to allow you to identify the specific “identity group” that folks will be reporting about for the rest of the measure. Item 3 is used to figure

out how much time people spend in different settings (so that you can determine relatively how much time they spend in safe versus unsafe settings).

For social safety, first recode each item to exclude settings that not applicable. For all other items, the scoring should range between 1 and 5, with higher scores indicating greater safety. Take the MEAN of safety within each setting (i.e., household, family, etc), and then you can create a composite safety score which is the average of each of these setting-specific means

International Trauma Questionnaire (ITQ)

Please bring to mind your experiences in the past of growing up in a Christian environment.

International Trauma Questionnaire

Instructions: Please identify the experience that troubles you most and answer the questions in relation to this experience.

Brief description of the experience _____

When did the experience occur? (circle one)

a. less than 6 months ago
b. 6 to 12 months ago
c. 1 to 5 years ago
d. 5 to 10 years ago
e. 10 to 20 years ago
f. more than 20 years ago

Below are a number of problems that people sometimes report in response to traumatic or stressful life events. Please read each item carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	Not at all	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
P1. Having upsetting dreams that replay part of the experience or are clearly related to the experience?	0	1	2	3	4
P2. Having powerful images or memories that sometimes come into your mind in which you feel the experience is happening again in the here and now?	0	1	2	3	4
P3. Avoiding internal reminders of the experience (for example, thoughts, feelings, or physical sensations)?	0	1	2	3	4
P4. Avoiding external reminders of the experience (for example, people, places, conversations, objects, activities, or situations)?	0	1	2	3	4
P5. Being "super-alert", watchful, or on guard?	0	1	2	3	4
P6. Feeling jumpy or easily startled?	0	1	2	3	4

In the past month have the above problems:

P7. Affected your relationships or social life?	0	1	2	3	4
P8. Affected your work or ability to work?	0	1	2	3	4
P9. Affected any other important part of your life such as parenting, or school or college work, or other important activities?	0	1	2	3	4

Cloitre et al. (2018) *Acta Psychiatrica Scandinavica*. DOI: 10.1111/acps.12956

Below are problems that people who have had stressful or traumatic events sometimes experience. The questions refer to ways you typically feel, ways you typically think about yourself and ways you typically relate to others. Answer the following thinking about how true each statement is of you.

How true is this of you?	***Not at all***	***A little bit***	***Moderately***	***Quit a bit***	***Extremely***
C1. When I am upset, it takes me a long time to calm down.	0	1	2	3	4
C2. I feel numb or emotionally shut down.	0	1	2	3	4
C3. I feel like a failure.	0	1	2	3	4
C4. I feel worthless.	0	1	2	3	4
C5. I feel distant or cut off from people.	0	1	2	3	4
C6. I find it hard to stay emotionally close to people.	0	1	2	3	4
In the past month, have the above problems in emotions, in beliefs about yourself and in relationships:					
C7. Created concern or distress about your relationships or social life?	0	1	2	3	4
C8. Affected your work or ability to work?	0	1	2	3	4
C9. Affected any other important parts of your life such as parenting, or school or college work, or other important activities?	0	1	2	3	4

Cloitre et al. (2018) *Acta Psychiatrica Scandinavica*. DOI: 10.1111/acps.12956

1. Diagnostic scoring for PTSD and CPTSD

PTSD
If P1 or P2 $\geq$ 2 criteria for Re-experiencing in the here and now (Re_dx) met
If P3 or P4 $\geq$ 2 criteria for Avoidance (Av_dx) met
If P5 or P6 $\geq$ 2 criteria for Sense of current threat (Th_dx) met
AND
At least one of P7, P8, or P9 $\geq$ 2 meets criteria for PTSD functional impairment (PTSDFI)
If criteria for 'Re_dx' AND 'Av_dx' AND 'Th_dx' AND 'PTSDFI' are met, the criteria for PTSD are met.

CPTSD
If C1 or C2 $\geq$ 2 criteria for Affective dysregulation (AD_dx) met
If C3 or C4 $\geq$ 2 criteria for Negative self-concept (NSC_dx) met
If C5 or C6 $\geq$ 2 criteria for Disturbances in relationships (DR_dx) met
AND
At least one of C7, C8, or C9 $\geq$ 2 meets criteria for DSO functional impairment (DSOFI)
If criteria for 'AD_dx' AND 'NSC_dx' AND 'DR_dx', and 'DSOFI' are met, the criteria for DSO are met.

PTSD is diagnosed if the criteria for PTSD are met but NOT for DSO.
CPTSD is diagnosed if the criteria for PTSD are met AND criteria for DSO are met.
Not meeting the criteria for PTSD or meeting only the criteria for DSO results in no diagnosis.

2. Dimensional scoring for PTSD and CPTSD.

Scores can be calculated for each PTSD and DSO symptom cluster and summed to produce PTSD and DSO scores.

PTSD
Sum of Likert scores for P1 and P2 = Re-experiencing in the here and now score (Re)
Sum of Likert scores for P3 and P4 = Avoidance score (Av)
Sum of Likert scores for P5 and P6 = Sense of current threat (Th)
PTSD score = Sum of Re, Av, and Th

DSO
Sum of Likert scores for C1 and C2 = Affective dysregulation (AD)
Sum of Likert scores for C3 and C4 = Negative self-concept (NSC)
Sum of Likert scores for C5 and C6 = Disturbances in relationships (DR)
DSO score = Sum of AD, NSC, and DR

PHQ-9

PHQ-9 Depression

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.....	0	1	2	3
2. Feeling down, depressed, or hopeless.....	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.....	0	1	2	3
4. Feeling tired or having little energy.....	0	1	2	3
5. Poor appetite or overeating.....	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.....	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.....	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving .around a lot more than usual.....	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.....	0	1	2	3
Column totals	___	+ ___	+ ___	+ ___

= *Total Score* _____

GAD-7

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Appendix J – Study debrief

Debriefing for Religious trauma in the LGBTQ+ population: minority stress and social safety as predictors of anxiety, depression and complex trauma.

Thank you for taking part in this study. As explained in the information you were given before you completed the survey, the aim of this research is to develop a better understanding of the impact of growing up LGBTQ+ in a Christian environment that was unaccepting of sexual and gender minorities. The hope is to better understand the mental health impact of exposure to invalidating religious messages on LGBTQ+ people, and that a better understanding will aid improvement of mental health service provision. To date there has been limited research in this area. Research is important both in order to generate an evidence base, and to improve the support that is offered. The hope is that the more evidence we can gather of the impact of exposure to invalidating religious messages on LGBTQ+ people, the more grounds there will be for improvement in availability and accessibility of much needed support for survivors. Additionally, the hope is that understanding the impact of growing up LGBTQ+ in an unaccepting Christian environment, may lead to recognition of the harm exposure to invalidating religious messages may cause.

Because this is a new area of research, there is not currently a measure of religious trauma. You were asked to complete five questionnaires which measured minority stress, social safety, trauma, anxiety and depression. This is because, from other research that has been done, it is thought that these five factors are likely to represent the mental health impact of religious trauma. It is expected that higher levels of minority stress and lower levels of social safety experienced within a Christian environment that was unaccepting of sexual and gender minorities will predict higher levels of anxiety, depression and trauma symptoms in people who are LGBTQ+. It is also expected that levels of anxiety, depression and trauma

symptoms will be higher in LGBTQ+ people who were exposed to invalidating religious messages growing up than the general population.

You will not be given the results of your completed questionnaires because the purpose of completing them is to help with our research, and is not intended to be diagnostic. Your participation in this study is greatly appreciated. It would not be possible to do this research without your willingness to take part. If you have any questions related to this study, please do not hesitate to contact the primary researcher.

This study is not expected to cause any harm to participants. However, it is possible that answering the questions may bring up distressing memories or feelings. If you experience any distress, please do contact one of the following organisations who offer mental health support for LGBTQ+ people:

- Switchboard LGBT+ helpline: https://switchboard.lgbt/
- Pink Therapy: https://pinktherapy.com/en-gb/findatherapist.aspx
- Mind: https://www.mind.org.uk/information-support/tips-for-everyday-living/lgbtqia-mental-health/about-lgbtqia-mental-health/#.WVzoNUUrKM8

If you have any thoughts of harming yourself or ending your life:

- Please contact **111 option 2**.
- You can also contact your GP if you are in crisis or need help. All GP surgeries have an out of hours service that you can call in an emergency.
- You can also call the Samaritans on 116 123 (free call).
- If you do not feel that these services can support you, please go to your nearest A+E or call 999 in an emergency.

The study will be completed by 30th September 2025. If you would like to find out more about the results of the study, you can request a copy by emailing the primary researcher. However, please be aware that although completion of the survey is anonymous, by emailing the researcher they will have your email address, which is identifiable personal information.

If you have any concerns about the project or the way it was conducted, please contact the primary project supervisor, or alternatively you can contact the Deputy Programme Director for the University of East Anglia Clinical Psychology Doctorate programme (ClinPsyD). Contact details below.

Thank you again for taking part in this study.

Contact details of primary researcher: Jude Kiley-Morgan, Trainee Clinical Psychologist – j.kiley-morgan@uea.ac.uk

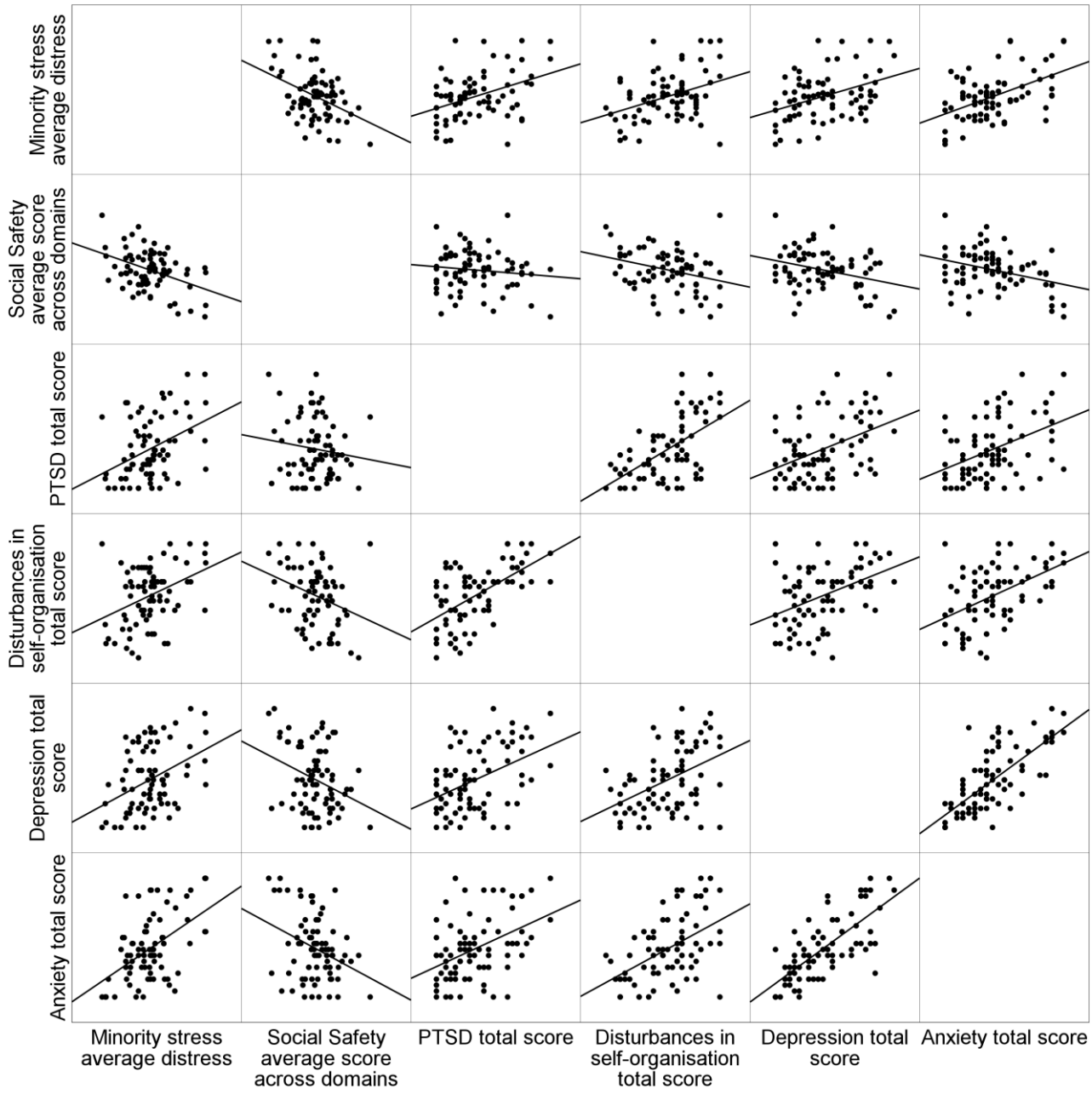
Contact details of primary supervisor: Dr. Aaron Burgess, Clinical Psychologist and Clinical Tutor – aaron.burgess@uea.ac.uk

Contact details of Deputy Programme Director for the University of East Anglia Clinical Psychology Doctorate programme (ClinPsyD): Dr. Peter Beazley, Clinical Psychologist and Clinical Associate Professor – p.beazley@uea.ac.uk

Appendix K – Correlation table and scatterplots of the variables.

Correlation table – Pearson's *r* values

	Minority Stress	Social Safety	PTSD	DSO	Depression	Anxiety
Minority Stress	1	-0.41	0.40	0.38	0.40	0.50
Social Safety	-0.41	1	-0.13	-0.31	-0.32	-0.33
PTSD	0.40	-0.13	1	0.58	0.43	0.44
DSO	0.38	-0.31	0.58	1	0.44	0.50
Depression	0.40	-0.32	0.43	0.44	1	0.73
Anxiety	0.50	-0.33	0.44	0.50	0.73	1


Minority stress average distress
Social Safety average score across domains
PTSD total score
Disturbances in self-organisation total score
Depression total score
Anxiety total score
Minority stress average distress
Social Safety average score across domains
PTSD total score
Disturbances in self-organisation total score
Depression total score
Anxiety total score