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Risk and Protective Factors for Disordered Eating in LGBTQ+ Youth: A Systematic Review

And

“He doesn’t understand but I know he'll always support me”: An Interpretative Phenomenological Analysis of Young People Coming Out to Their Parents

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Lay Summary

Lesbian, gay, bisexual, transgender and queer (LGBTQ+) young people face a lot of challenges in today’s society. They may be discriminated against or bullied because of their sexuality or gender and they might find it difficult to talk about their identity with their friends and family. Research suggests that dealing with these stressful experiences can negatively impact the physical and mental health of LGBTQ individuals. It is important, therefore, to study this population to better understand their experiences and to inform resources and care to improve their wellbeing. The current research project explored LGBTQ+ young peoples’ experiences of eating disorders and their experiences of coming out to their parents.

Firstly, a systematic review explored what factors increase the risk of developing an eating disorder for LGBTQ+ young people, and what factors are protective against LGBTQ+ young people developing an eating disorder. This involved searching through research databases to find the most relevant studies. Nineteen studies were selected and were judged to be of acceptable quality to include in the review. This research revealed that LGBTQ+ young people are generally more likely to develop disordered eating than heterosexual cisgender young people. Disordered eating involves unhealthy or irregular eating behaviours that do not reach criteria for a diagnosed eating disorder. It was found that being dissatisfied with your body, feeling pressured about your appearance, being bullied and experiencing emotional distress all increased the risk of developing disordered eating for LGBTQ+ young people. The studies also showed that bisexual individuals and people whose gender did not match their sex assigned at birth were at greater risk of disordered eating. Having a positive parent-child relationship and getting the right support for difficulties around gender was found to be protective against disordered eating. Further research is needed to explore these risk factors and protective factors in greater detail. In the meantime, this review highlights important factors for clinicians to be aware of when working with LGBTQ+ young people with concerns around eating, weight and shape.

The second part of this research is a study exploring how LGBTQ+ young people in the UK experience coming out to their parents or carers. Existing research suggests that the strength of family relationships is important and can impact how an LGBTQ+ young person is accepted. This project involved recruiting people from across the UK who identified as LGBTQ+ and were between 16 and 25 years-old. Eight people participated and were interviewed by the researcher over video call. The approach used was Interpretative Phenomenological Analysis (IPA), which aims to gain a deep understanding of how people experience life events. To do this, the researcher examined each participant interview in detail and interpreted what sense the participant made of coming out to their parent and how they felt about coming out in general. The study found that the nature of the parent-child relationship had a significant influence on how and if the LGBTQ+ young person chose to come out. The participant’s narratives also revealed that coming out to themselves was important for most
people. Some felt that they did not need to come out to their parent, because they were comfortable with their sexuality and gender identity and either felt that their parent would accept them or felt secure enough to manage if their parent rejected them. Finally, this project found that all participants to some extent selectively disclosed their LGBTQ+ identity, depending on the situation and their relationships with others. Religion, culture and safety were found to be important considerations for participants. Overall, although this study’s findings are very specific to the eight people who shared their experiences, they can still improve awareness and understanding for parents and clinicians. More research is needed to understand and support LGBTQ+ young people, to minimise stressors and improve their wellbeing.
Thesis Portfolio Abstract

Background: LGBTQ+ young people are at increased risk of negative health outcomes compared to heterosexual and cisgender peers. It is theorised that this relates to greater exposure to minority stress, as well as systemic barriers and negative experiences within healthcare. Further insight is needed into the experiences of sexual and gender minority individuals to inform resources and to develop clinical practice.

Aims: This thesis is split into two studies. The first aimed to conduct a systematic review of the literature to identify risk factors for and protective factors against disordered eating in LGBTQ+ youth. The second study aimed to gain a deeper understanding of LGBTQ+ young peoples’ experiences of coming out to their parents or carers.

Method: A systematic search of eight databases was conducted using key words and inclusion and exclusion criteria to identify relevant research for review. The quality of the final papers was assessed. The empirical project utilised Interpretative Phenomenological Analysis and semi-structured interviews to examine the experiences of eight LGBTQ+ young people.

Results: The systematic review produced nineteen relevant articles which were judged to be of acceptable quality. A narrative synthesis identified body dissatisfaction, appearance pressure, bisexuality, emotional distress, bullying and gender incongruence as risk factors for disordered eating. Positive parent-child relationships and access to gender-affirming care were identified as protective factors. Findings from the empirical study revealed the significance of the nature of the parent-child relationship, navigating identity and expression and selective disclosure within LGBTQ+ young peoples’ experiences of coming out to parents.

Conclusion: Though more research is urgently required, the systematic review highlighted possible risk and protective factors to be addressed at screening and within prevention and intervention strategies for disordered eating in LGBTQ+ young people. Clinicians and parents may also benefit from engaging with the coming out narratives of LGBTQ+ young people. Despite evidence of increasing acceptance of one’s own sexuality and gender, the study suggests that coming out remains a multi-faceted and challenging process for young people to navigate, particularly for those with complex family relationships and cultural considerations.

Key words: LGBTQ+, Disordered Eating, Coming Out; Young People
Risk and Protective Factors for Disordered Eating in LGBTQ+ Youth: A Systematic Review

Abstract
Background: Lesbian, gay, bisexual, transgender and queer (LGBTQ+) individuals are at greater risk than heterosexual and cisgender peers for developing an eating disorder. Evidence examining the mechanisms behind this increased prevalence is sparse. This review aims to investigate the risk and protective factors for disordered eating in LGBTQ+ youth.
Method: A systematic review of studies identified by an electronic database search (CINAHL, EMBASE, OVID Medline, Proquest, PsychINFO, Pubmed, ScienceDirect and Scopus) up to December 2021. Studies were quality assessed against the NICE Guidelines Quality Appraisal Checklist.
Results: Nineteen studies were identified, largely of acceptable quality and varying in study design. Most reported an increased prevalence of disordered eating among LGBTQ+ young people. Body dissatisfaction, appearance pressure, bisexuality, emotional distress, bullying and gender incongruence were identified as risk factors for disordered eating. Positive parent-child relationships and access to gender-affirming environments and care were identified as protective factors.
Conclusion: Findings suggest that the identified risk and protective factors should be considered at screening and incorporated into evidence-based prevention and intervention strategies for disordered eating in LGBTQ+ young people. Further exploration is required, as well as research validating standardised disordered eating measures with LGBTQ+ populations.

Key words: LGBTQ+, Disordered Eating, Youth, Adolescents
Introduction

Eating disorders are serious mental health conditions associated with significant functional impairment and have among the highest mortality of any psychiatric disorder (Arcelus, Mitchell, Wales & Nielsen, 2011; Herpertz-Dahlmann, 2009). The Diagnostic Statistical Manual of Mental Disorders (5th ed., DSM-V, American Psychiatric Association, 2013) details several conditions including Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED) and Avoidant/Restrictive Food Intake Disorder (ARFID). Clinical severity is typically measured by body mass index or frequency and severity of weight control behaviours. Moreover, eating disorders often present with additional physical and psychiatric comorbidities (NICE, 2017). The lifetime prevalence of eating disorders is estimated to be around 0.21% for AN, 0.81% for BN and 2.22% for BED (Qian et al., 2013). Historically, eating disorders are considered illnesses of white, western, middle class, heterosexual females, though such a perception increases the likelihood of eating disorders being overlooked and underdiagnosed in different populations (Wagner & Stevens, 2017). Over the last 10 to 15 years, research has revealed an increased incidence of eating pathology among sexual and gender minority individuals (Parker & Harriger, 2020).

An individual of a sexual minority (SM) is typically someone whose sexual orientation differs from the majority within their society, including lesbian, gay, bisexual and other non-heterosexual identities (Hunt, Vennent & Waters, 2018). An individual of a gender minority is typically someone whose gender identity does not align with the sex they were assigned at birth or whose gender identity does not align with the male/female gender binary (Warwick & Shumer, 2021), and differs from the majority within their society, including transgender, non-binary and other gender expansive identities. Collectively, these populations may be referred to as LGBTQ+, for lesbian, gay, bisexual, transgender, queer and more. Cisgender individuals have a gender identity that aligns with their sex assigned at birth (Hunt, Vennent & Waters, 2018). As noted by O’Flynn (2019), it can be challenging to accurately conceptualise and define sexual and gender minority identities, as they are fluid and encompass behaviours, preferences and expression.

The evidence base is beginning to indicate that sexual minority and gender minority (GM) individuals are at greater risk for subclinical disordered eating and clinically diagnosed eating disorders (Matthews-Ewald, Zullig & Ward, 2014; Parker & Harriger, 2020). A nationally representative US sample found that SM adults were at two to four times greater risk of receiving a DSM-V diagnosis of AN, BN or BED compared to heterosexual cisgender peers (Kamody, Yonkers, Pluhar & Olezeski, 2020). Nagata, Ganson and Austin (2020) also reported a notable increase in lifetime prevalence estimates for eating disorders for LGBTQ+ individuals, particularly for transmen and transwomen. Increased incidence of disordered eating for SM males is largely consistent across studies (Austin et al., 2013; Diemer et al., 2015; Feldmen & Meyer, 2007; Russell & Keel, 2002; Shearer et al., 2015). Conclusions are less clear, however, for SM females. Some report findings mirroring those of SM males, with lesbian adults...
demonstrating increased rates of subclinical disordered eating (Von Schell, Ohrt, Bruening & Perez, 2018), clinically diagnosed eating disorders (Bell, Rieger & Hirsch, 2019) and maladaptive weight control behaviours (Meneguzzo et al., 2018). Others found no significant difference in disordered eating between lesbian and heterosexual women (Feldman & Meyer, 2007; Matthews-Ewald, Zullig & Ward, 2014; Shearer et al., 2015), with some going so far as to conclude that a SM identity is a protective factor against eating pathology in women (Huxley, Halliwell, & Clarke, 2015; Lakakis, Ricciardelli, & Williams, 1999). The smaller number of studies examining SM females relative to SM males, and heterogeneity in disordered eating measures, may go some way to explain this contrasting picture. Research into disordered eating in GM populations is even more limited, though findings suggest that trans individuals show significantly greater disordered eating compared to cisgender controls (Sequeira et al., 2017) and are four times more likely than heterosexual female peers to self-report a clinical eating disorder diagnosis in the past year (Diemer et al., 2015). Despite inconsistencies around SM females, a general increased incidence of disordered eating and eating disorders for SM and GM populations is apparent in the literature.

In examining how eating pathology presents for LGBTQ+ individuals, research notes some gender disparities. SM men and boys demonstrate increased binge eating, purging, restrictive dieting and anabolic steroid use compared to heterosexual peers (Blashill, Calzo, Griffiths & Murray, 2017; Calzo et al., 2013; Calzo et al., 2017; Matthews-Ewald, Zullig & Ward, 2014). The use of steroids is a more recently studied phenomenon, thought to relate to ‘muscle dysmorphia’ or the distressing drive to increase muscle mass (Harvey & Robinson, 2003). Brennen, Craig and Thompson (2012) noted that eating disorder symptomology in males often correlates with motivation for muscularity rather than thinness, in accordance with western sociocultural pressures. Pressure to achieve muscularity has been found to be evident for SM males as early as 14 years of age (Eik-Nes, Austin, Blashill, Murray & Calzo, 2018). Correspondingly, behavioural symptoms in women are often driven towards achieving a slim physique with little body fat (Rohde, Stice & Marti, 2015). SM women and girls have been found to engage in more excessive weight-control behaviours compared to heterosexual peers, including bingeing, purging and use of diet pills and laxatives (Austin et al., 2013; Parker & Harringer, 2020). Bisexual women appear to be particularly at risk, with 12% of a large college-age sample reporting clinical levels of bingeing and 17.5% reporting clinical and subclinical levels of excessive exercise over the past month (Von Schell, Ohrt, Bruening & Perez, 2018). GM individuals reported greater use of fasting, laxative and diet pill and steroid use, dietary restraint, binging and purging compared to cisgender peers, with transgender youth demonstrating the highest prevalence (Parker & Harriger, 2020). Notably, in Meneguzzo et al.’s (2018) systematic review of 45 papers, they highlighted that over two thirds of studies examining disordered eating in SM women were undertaken in Northern America, and are therefore biased by western perspectives of eating disorders and non-heterosexual orientations. This is particularly relevant when considering mental health and the impact of sociocultural factors, and consequently limits the ability to generalise conclusions to non-western SM populations. From the
existing evidence base, however, it appears that SM individuals largely engage in more maladaptive weight-control behaviours than heterosexual peers.

A number of theories have been proposed to explain the increased risk for and incidence of disordered eating and eating disorders in SM and GM populations, the most prominent of which are Objectification Theory and Minority Stress Theory. Objectification Theory (Fredrickson & Roberts, 1997) emphasises the role of sociocultural factors in contributing to eating pathology and was originally developed in reference to the increased prevalence of body dissatisfaction and eating disorders in heterosexual women. The theory posits that women experience greater sociocultural pressure to achieve thinness, as this is deemed attractive to men in many western cultures. Women then internalise unrealistic cultural beauty standards and objectification from men, leading to body dissatisfaction and disordered eating. According to Objectification Theory, as SM males are motivated to appear attractive to males to establish romantic relationships, they experience similar internalisation and objectification as heterosexual women and are therefore at greater risk of body dissatisfaction and eating disorders (Beren, Hayden, Wilfley & Grilo, 1996; Brewster et al., 2014; Wiseman & Moradi 2010). Indeed, Feldmen and Meyer (2007) note that gay cultural norms emphasise the importance of physical appearance and muscularity. This theory is supported by greater self-objectification and body dissatisfaction being reported by SM men compared to heterosexual peers (Martins, Tiggemann & Kirkbridge, 2007), and femininity in cisgender and transgender women being associated with more abnormal eating attitudes and behaviours (Cella, Iannaccone & Cotrufo, 2013). It may be assumed that because lesbian cultural norms are more accepting of overweight bodies and non-traditional physical attractiveness (Alvy, 2013), that Objectification Theory offers an explanation for lower rates of disordered eating in this population. However, even SM women who do not seek relationships with men may experience objectification and its effects on eating behaviour due to the media’s exploitation of female same-sex sexuality to entice male viewers (Brewster & Moradi, 2010).

The impact of the media and internalisation of sociocultural factors is expanded upon by the Tripartite Influence Model (Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999). This model proposes that pressure to conform to sociocultural appearance ideals from family, friends and the media leads to body dissatisfaction and disordered eating via mediating factors of internalisation of thin ideals and appearance comparisons (Lovering, Rodgers, George & Franko, 2018). This has been supported in heterosexual women (Lovering, Rodgers, George & Franko, 2018). Conclusions for SM women are once again mixed, with evidence supporting these pathways for bisexual women (Hazzard et al., 2019) but fewer significant associations for lesbian women (Huxley, Halliwell & Clarke, 2015). Moreover, thin ideals may also lead to a drive for weight loss in transwomen, potentially resulting in disordered eating (Diemer et al., 2018). Despite the more tenuous explanation for SM women, both Objectification Theory and the Tripartite Influence Model emphasise and evidence the role of internalising sociocultural factors in contributing to eating pathology in SM populations. How these models fit for a GM population appears to be largely unexplored in the literature.
Minority Stress Theory provides an alternative explanation of mechanisms behind the prevalence of eating pathology in both SM and GM individuals. Minority stress is defined as psychological distress resulting from one’s exposure to social stressors (Meyer, 1995). The theory proposes that individuals with minority characteristics are at greater risk of experiencing chronic stress due to stigma, harassment and isolation in their social environment (Meyer, 1995). Health disparities emerge as a result of this chronic stress, including poor physical and mental health outcomes (Fredriksen-Goldsen et al., 2013; Meyer, 2003). In 2003, Meyer distinguished between distal and proximal stressors, distal involving external events such as discrimination, violence and harassment, and proximal involving subjective stressful experiences such as rejection, internalised homophobia and stress from concealing one’s identity. LGBTQ+ populations, with their minority sexual orientation and/or gender identity, are at increased risk of experiencing minority stress (Kelleher, 2009; Meyer, 2003).

Minority Stress Theory posits that SM individuals experience unique distal and proximal stressors which increase the likelihood of mental and physical ill-health, including eating pathology (Meyer, 2015). Discrimination, victimisation, internalised homophobia and transphobia and concealment of identity, for example, have been associated with negative behavioural health outcomes in SM and GM individuals (Goldbach & Gibbs, 2017; Uniacke et al., 2021). Moreover, Katz-Wise et al. (2015) identified significant positive associations between SM stressors and unhealthy eating behaviours, partially explained by internalising symptoms, across youth into early adulthood. They concluded that this model best represented the experiences of bisexual females. It was notable that their sample was majority female, thereby reducing statistical power to detect significant effects for males. Whilst minority stress factors appear to relate to eating pathology across the LGBTQ+ population, the effect is not uniform across all subgroups (Parker & Harriger, 2020). The Minority Stress Theory has been adapted to produce a conceptual framework outlining the processes behind disordered eating for GM individuals (Hendricks & Testa, 2012). Hendricks and Testa (2012) highlight the pivotal role of gender dysphoria and its impact on mental health difficulties and body dysmorphia, in addition to the impact of other proximal and distal stressors. These factors then lead to disordered eating thoughts and behaviours. Stressors unique to GM individuals might include sex assigned at birth, gender expression, discrimination, systemic oppression and reduced access to healthcare. Further research is required into the application of this adapted Minority Stress model with GM populations. Of note, there is a tendency even in large-scale studies to group transmasculine individuals, transfeminine individuals, non-binary and gender expansive individuals into one GM population, likely due to small sample sizes (Kamody, Yonkers, Pluhar & Olezeski, 2020). There is a concern that, by conflating a potentially heterogenous group, significant variation in eating disorder presentations may be overlooked, particularly as transmen and transwomen face contrasting and unique societal stressors (Murray, 2017; Weber et al., 2019). Ideally, mixed method approaches with distinct samples, followed by longitudinal research, would be utilised to validate theories proposed for eating pathology in SM and GM populations (Kamody, Yonkers, Pluhar & Olezeski, 2020).
Within Minority Stress Theory, it is important to recognise the impact on negative health outcomes of multiple intersectional distal and proximal stressors within one individual. The majority of participants in LGBTQ+ eating disorder research are White, meaning the additional role of ethnic minority status largely goes unexplored. Ethnically minoritised individuals may regularly suffer stress related to racism and counter-culture pressures, both at an individual and systemic level (O’Flynn, 2019). For example, a person may experience a clash between body standards from their culture of origin verses their resident culture (Viladrich, Yeh, Bruning & Weiss, 2009). Research into eating pathology with ethnically minoritised populations is further hampered by study eligibility criteria potentially discriminating against differences in how symptoms present, for example ethnic minority women demonstrating less purging or laxative use for weight control (Cachelin, Rebeck, Veisel & Striegel-Moore, 2001) and therefore not meeting diagnostic or research criteria (O’Flynn, 2019). Moreover, ethnically minoritised individuals are more likely to experience structural barriers to accessing healthcare (Betancourt, Green, Carrillo & Ananeh-Firempong, 2003), and are therefore not only less likely to be included and recognised in research, but also prevented from receiving proper diagnoses and treatment. Becker, Franko, Speck and Herzog (2003) found that Latinx and Native American individuals presenting with disordered eating were significantly less likely than White peers to be referred for specialised care for eating disorders. Not only is this indicative of potential additional minority stress for ethnically minoritised SM and GM individuals which would increase their risk of eating pathology (Parker & Harriger, 2020), this also represents significant flaws in the evidence base. It is likely that the lack of ethnically diverse research biases conclusions drawn, which in turn impacts clinical practice and consequently individual’s access to and experience of treatment and support. The need for more ethnically diverse research and consideration of the intersections of minority stress factors is paramount for future research.

Objectification and Minority Stress theories highlight a selection of the possible risk factors for increased disordered eating and eating disorders in LGBTQ+ individuals. The impact of stigma, discrimination and victimisation due to non-heterosexuality has been examined in adolescents. A large-scale school survey found that LGBTQ+ adolescents feel unsafe at school (Kosciw, Clark, Truong & Zongrone, 2020). This may not be surprising when, compared to heterosexual peers, SM teenagers are twice as likely to experience bullying at school (Kahle, 2020), with rates even higher for transgender students (Myers, Turanovic, Lloyd & Pratt, 2020). A sample of 923 transgender youth in Canada revealed that enacted stigma increased risks of bingeing, fasting and vomiting to lose weight (Watson, Veale & Saewyc, 2017). Over half of this sample engaged in unhealthy weight-control behaviours, and those with highest enacted stigma and fewest protective factors were at greatest risk. Even perceived, rather than enacted, stigma was associated with greater eating disorder symptomology for SM and GM individuals (Bell, Rieger & Hirsch, 2019). Katz-Wise et al. (2015) described how those who identified as SM at a younger age were at greater risk of discrimination and were consequently at greater risk of negative outcomes including maladaptive eating behaviours. They proposed that young SM adolescents...
are less developmentally equipped to cope with stressors and are therefore more likely to engage in unhelpful coping mechanisms than those who reach SM milestones later in life. It is also worthy of note that discrimination occurs within SM and GM groups and negatively impacts physical and mental health. Bisexual individuals, for example, report experiencing ‘horizontal discrimination’ or biphobia (Bewster & Moradi, 2010). This additional level of stressor may go some way to explaining increased incidence of disordered eating among bisexual individuals (Mulick & Wright, 2002; Parker & Harriger, 2020; Shearer et al. 2015). It appears that minority-based stigma and victimisation, particularly from a young age and within the LGBTQ+ community, could be a significant risk factor for disordered eating for SM and GM populations.

Body dissatisfaction has also emerged as a prominent risk factor for eating pathology for these groups. SM boys demonstrated greater body image concerns and weight-control behaviours than their heterosexual peers, which was mirrored in adult samples (Miller & Luk, 2019). Males appeared to express a particular drive for leanness (Calzo et al., 2015). These boys were also more likely to perceive themselves as overweight whilst being in a healthy weight category. Exploration of the role of social media revealed that the strongest associations with muscularity dissatisfaction and eating disorder symptoms were from image-centric platforms, such as Instagram, for a large sample of SM men (Murray & McLean, 2018). Body image concerns have also been linked to dysregulated eating for SM women (Panza, Olsen, Selby & Wing, 2021), with increased social anxiety being associated with body dissatisfaction and, in turn, binge eating (Mason & Lewis, 2016). By contrast, Miller and Luk’s (2019) systematic review of 32 articles found that SM women were more likely to report a positive body image than their heterosexual peers, though this varied over development. This is supported by SM women demonstrating lower perceived pressure to be thin (Meneguzzo et al., 2018). Despite this, Miller and Luk’s (2019) conceptual developmental model of risk pathways from SM status to disordered eating emphasised body image as a key mechanism.

Body image has been found to be particularly relevant for GM populations (Jones et al., 2018). Gender-related body dissatisfaction is often cited as being at the core of disordered eating for transmasculine and transfeminine individuals (Testa, Rider, Haug & Balsam, 2017). Living in a body incongruent with your gender has been associated with many negative mental health outcomes (Dhejne, Van Vlerken, Heylens & Arcelus, 2016). Trans individuals demonstrate greater disordered eating than cisgender controls and are more likely to be diagnosed with an eating disorder (Coelho et al., 2019). Transmen have been found to have significantly higher body dissatisfaction than both transgender and cisgender women (Sequeira et al., 2017). GM individuals may seek to make changes to their bodies via maladaptive weight-control behaviours in support of their true gender expression (Jones et al., 2018). For example, individuals may utilise food restriction to delay puberty onset or progression and to suppress secondary sexual characteristics (Avila, Golden & Aye, 2019; Coelho et al., 2019; Pham, 2020). Greater congruence between one’s body and one’s gender identity reportedly lowers the risks of disordered eating (Uniacke et al., 2021). However, Gordon et al.’s (2016) interviews with ethnically
diverse transwomen highlighted the negative impact on body image of the medical transition process; “'Being on hormones, your weight is such a struggle as a woman… It’s a lot harder to take weight off. You maintain more fat. Through the hormones, it makes you eat more… I put on 65 pounds. As a woman, it makes me feel gross and disgusting’ (age 31 years, ID 11)”, (p. 146). This suggests that, even during a form of transition, GM individuals may experience body dissatisfaction, which in turn increases their risks of disordered eating. Risk factors unique to the GM population and subpopulations highlight the need for research to distinguish minority groups in the investigation of eating pathology (Parker & Harriger, 2020).

Parker and Harriger’s (2020) literature review appears to be the most comprehensive summary of relevant risk factors to date. They note the existence of risk factors beyond those captured by the Minority Stress Model. They identified and classified risk factors for eating disorders and disordered eating in the LGBTQ+ population by gender and age, including adult and adolescent lesbians, gay males, bisexuals, transgender and gender-nonconforming individuals. In addition to stigma and body dissatisfaction, many risk factors for clinical eating disorders in SM adults were detailed, including but not limited to low self-esteem, social media use, sexual objectification experiences, Latinx/Hispanic or Black ethnicity and mental ill-health. SM populations are at greater risk for internalised symptoms, including depression and anxiety (Katz-Wise et al., 2015) and both have been identified as associated factors or predictors of disordered eating in SM women (Bell, Rieger & Hirsch, 2019; Katz-Wise et al., 2015). Notably, two seemingly opposing factors, low social support and greater LGBTQ+ community involvement, were identified as risk factors for SM adults (Parker & Harriger, 2020). This contradictory picture indicates that while some LGBTQ+ individuals find comfort and support in queer spaces, some find it can perpetuate unhealthy ideals and weight-control behaviours and be associated with greater disordered eating (Convertino et al., 2021; Feldman & Meyer, 2007; Huxley, Clarke & Halliwell, 2014).

Indeed, Gordon’s (2019) LGBTQ+ undergraduate focus groups reported; “'queer spaces have the ability to be some of the most accepting places in terms of body image and appearance… but they also have the potential to be very… constricting’ (poster)”. For GM individuals, Park and Harriger (2020) identified anxiety, low self-esteem, non-affirmation and not being on hormone-replacement therapy to be among key risk factors for eating disorders in adults. Overall, fewer risk factors were found for adolescent populations, and the authors noted that research investigating these was sparse. This is concerning, given the importance of preventative measures in health care. Gordon (2019) found that 61% of the LGBT adolescent sample reported engaging in at least one disordered eating behaviour over the last year, and rates are known to be higher for GM youth (Guss et al., 2017). One common risk factor across SM and GM subgroups appeared to be mental ill-health (Parker & Harriger, 2020). The authors recommended a systematic review be conducted to more thoroughly capture risk factors present for eating disorders and disordered eating across each subgroup, particularly adolescents, as well as the examination of protective factors.
Protective factors have received relatively little research focus. To varying degrees, masculinity, stable relationships, self-compassion and SM status for women have been identified as potential protective factors against eating pathology for LGBTQ+ individuals (Parker & Harriger, 2020). For SM and GM youth, school safety has also been associated with lower risks of negative weight-control behaviours and disordered eating (Lessard, Wang & Watson, 2021; Watson, Veale & Saewyc, 2017). This may be especially pertinent for transgender adolescents, who report restricting food and fluid intake to avoid public and school bathroom use (Schlupp, Dowshen, Hawkins & Stallings, 2020). Parker and Harriger (2020) emphasise the importance of educating school staff on identifying risk factors within LGBTQ+ school populations, and on creating an accepting and diverse education environment, as part of a wider preventative approach. This training and environment should be expanded to medical and mental health care. Receiving gender-affirming intervention is cited as a potentially pivotal protective factor against disordered eating and eating disorders for GM individuals (Jones et al., 2018). Trans youth who accessed interventions such as pubertal suppression or hormone therapy were found to show improved body satisfaction, psychological wellbeing and decreased disordered eating (Coelho, Suen & Clark, 2019; Sequeira et al., 2017). Moreover, Testa et al.’s (2017) mediation models revealed that gender confirming medical interventions reduced experiences of non-affirmation, which in turn increased body satisfaction and thus decreased eating disorder symptomology for both transmen and transwomen. From the limited research, it appears that gender-affirming care, as well as safe and accepting environments, can be protective factors against eating pathology for SM and GM populations.

In summary, SM and GM populations are more likely than cisgender heterosexual peers to develop disordered eating and or eating disorders. Informed by the Objectification and Minority Stress theories, several risk factors have been identified to explain this increased incidence in adults, such as stigma, body dissatisfaction and sense of safety or social support. Despite this, studies outline the need for greater understanding of the mechanisms underpinning SM and GM disparities in eating pathology (Miller & Luk, 2019). There appear to be gaps in the literature around risk factors for adolescents, as well as potential protective factors. The prevalence of eating disorders for SM youth is 8.8% compared to 5.3% in the general population (McClain et al., 2013) and they have been found to underutilise specialist eating disorder mental health services (Parmer et al., 2021). Longitudinal research indicates that adolescents who engage in disordered eating are at increased risk of disordered eating behaviours 10 years later (Neumark-Sztainer, Wall, Story & Standish, 2012). Investigating these topics is fundamental to informing early preventative approaches and interventions, thereby reducing this health disparity and improving wellbeing. Whilst large-scale longitudinal research with diverse samples is required, the knowledge base would benefit from a systematic examination of the literature addressing disordered eating pathology in SM and GM adolescents, to establish where research focus would be best directed.

The aim of this systematic review is therefore to synthesise the available literature on risk and protective factors for disordered eating and eating disorders in LGBTQ+ youth.
Method

A systematic review was conducted in accordance with PRISMA guidelines (Moher et al., 2015). See Appendix A for full protocol.

Eligibility criteria
Articles were eligible for inclusion if: (a) they offered quantitative and/or qualitative data addressing eating disorders or disordered eating in LGBTQ+ youth, (b) participants were reported to have a diagnosed eating disorder according to the DSM-IV, DSM-5 or ICD-10, or disordered eating behaviours operationalised using a standardised questionnaire measure or screening tool, (c) participants were aged between 10 and 24 years-old, which constitutes ‘youth’ as defined by the World Health Organisation (2011), (d) they were published in an English-language peer-reviewed journal, and (e) they were published after 2010. Research conducted prior to 2010 was excluded to reflect more recent attitudes towards SM and GM populations to maximise generalisability and applicability of review findings in the present. Since 2010, trends of acceptance of LGBTQ+ people have improved worldwide, same-sex marriage equality has been openly debated and legally passed in several countries, and other policies and laws favouring LGBT rights have been secured (Flores, 2021; Languilaire & Carey, 2017). A similar approach was taken by Wilson and Cariola (2020) in their qualitative systematic review exploring mental health in LGBTQ+ youth. Articles were excluded if: (a) participants had co-morbid medical conditions or somatic disorders which may confound eating behaviour measures, such as Diabetes Mellitus or Prada-Willi Syndrome, (b) the article is a case study, case series, letter, commentary, poster, book or book chapter to minimise bias, and (c) the full text was unavailable, as an abstract was unlikely to provide sufficient detail.

Search strategy
Several research databases were selected to identify relevant literature, including CINAHL, EMBASE, OVIDMedline, Proquest, PsychINFO, Pubmed, ScienceDirect and Scopus. These databases were selected based on LGBTQ+ populations and eating disorders as key topics, thereby necessitating the exploration of literature from psychology, social psychology, nursing and allied health fields. The choice of databases was also informed by the search strategy of a comparable systematic review (Wilson & Cariola, 2020). As stated by Dehkordi et al. (2021), increasing the number of searched databases may enhance the comprehensiveness and accuracy of findings. The literature search was conducted in December 2021. The search comprised three sets of key concepts (Eating disorders, Youth, LGBTQ) combined with the AND operator. See Appendix B for exact search terms.

Screening
The initial search of databases yielded 4252 records. See Figure one. Following removal of duplicate articles, 3233 records were title and abstract screened using Covidence. This left 136 articles for full
text review. Nineteen articles were identified as meeting the full inclusion criteria (see Fig. 1). All articles were screened by the lead researcher. A second researcher (S.H; Trainee Clinical Psychologist, University of Glasgow) reviewed 25% of records through the screening process. Percentage agreement at screening of full text eligibility was found to be 88.2%, with a Cohen’s kappa score measuring inter-rater reliability of \( k = 0.53 \), which was indicative of moderate agreement (McHugh, 2012). Conflict over eligibility was subsequently resolved through consultation. No unresolved decisions needed to be taken to the academic supervisor.

**Figure 1.**

*PRISMA Flow Chart*

```
Identification
4252 references imported for screening 1019 duplicates removed

Screening
3233 records screened against title and abstract 3097 records excluded

Eligibility
136 articles assessed for full-text eligibility 117 articles excluded

Inclusion
19 articles included
```

**Data extraction and synthesis**

Data extracted included year of publication, location, study design, research aims, population, sample size, inclusion criteria, exclusion criteria, recruitment method, measures, comparisons, analysis, results, conclusions, limitations and source of funding. In text, the reference, location, population, sampling method, measures, main findings and overall quality assessment were reported. Though 17 of 19 study design were cross-sectional, heterogeneity in sample size and measures of disordered eating prohibited the use of meta-analysis (Dehkordi et al., 2021). A narrative synthesis was conducted.

**Quality Assessment**

Methodological quality was assessed against the Appendix G Quality Appraisal Checklist for Quantitative Studies reporting correlations and associations and Appendix H Quality Appraisal Checklist for Qualitative Studies from Methods for the Development of NICE Public Health Guidance (third edition; NICE, 2012). The quantitative checklist contained 19 items and the qualitative checklist contained 14 items. There were five possible response options for each item: ++ indicated that aspect
was designed or conducted in such a way as to minimise the risk of bias, + indicated that either that aspect was unclear from the way the study was reported, or that the study did not address all potential sources of bias for that aspect of study design, - indicated that that aspect of study design was likely to be subject to significant bias, NR indicated that details were not reported and NA indicated not applicable. Each article was given an overall study quality grading for internal validity (IV) and external validity (EV): ++ if all or most of the checklist criteria were fulfilled or where those unfulfilled were very unlikely to alter the conclusions, + if some of the checklist criteria were fulfilled or where those unfulfilled or not adequately described were unlikely to alter the conclusions, and – if few or no checklist criteria were fulfilled and the conclusions would likely or very likely be altered. As with the screening process, the second reviewer (S.H) quality assessed 25% of the final articles. Percentage agreement between researchers was found to be 91.2%, with a Cohen’s kappa score measuring inter-rater reliability of $k = 0.86$, which was indicative of near perfect agreement (McHugh, 2012).

Results

The characteristics of the included studies are reported in Table 1. Seventy-nine percent of studies were conducted in the USA, with the remaining four conducted in the UK, Italy, Brazil and South Korea. The majority of studies, 89.5%, were cross-sectional in nature and one study was qualitative. The quality assessment indicated that, for the quantitative studies, 89.5% demonstrated internal validity rated ‘+’ and 19.5% demonstrated internal validity rated ‘++’. External validity was rated ‘+’ for 36.8% of studies and ‘++’ for the remaining 63.2%. These ratings suggested that while aspects of the studies were subject to potential bias, the overall quality of the research warranted their inclusion in the review. For the single qualitative study, the overall quality was rated ‘+’, indicating that the research was relevant and of acceptable quality to also warrant being included in the review.

Measures of disordered eating

None of the included studies recruited clinical samples with diagnosed eating disorders, and only one compared self-reported disordered eating behaviours, weight and height against clinical criteria from the DSM-V to produce a binary variable for ‘probable’ eating disorder diagnosis (Grammar et al., 2021). As such, review findings will relate to disordered eating behaviours only, rather than clinically diagnosed eating disorders. The included studies utilised a variety of standardised questionnaire measures to assess disordered eating, including the Eating Disorder Inventory (EDI; English, Italian, second and third editions), Eating Disorder Examination Questionnaire (EDEQ-4), Stanford-Washington University Eating Disorder Screen (SWED), Weight Concerns Scale (WCS), Eating Attitudes Test (EAT-26), Eating Pathology Symptoms Inventory (EPSI) and two items within the Youth Risk Behavior Surveillance System (YRBSS).
Disordered eating symptoms

The majority of studies with an exclusively heterosexual or cisgender control group found a higher prevalence of disordered eating behaviours for SM and GM youth (Austin et al., 2013; Calzo et al., 2019; Grammar et al., 2021; Hadland et al., 2014; Jones et al., 2019; Santos et al., 2021; Smith et al., 2011; Watson et al., 2017). Two studies somewhat contradicted this. Yu et al. (2018) found no significant difference in disordered eating behaviours between individuals reporting opposite sex-only partners and same sex-only partners, though individuals with partners of both sexes were found to be at greater risk. Zullig et al. (2019) found that only male sexual minority individuals were at greater risk of disordered eating. In GM youth, no differences by gender were found for disordered eating (Peterson et al., 2020). Several disordered eating symptoms were measured, including dietary restraint, bingeing, purging, fasting, diet pill, steroid and laxative use, compulsive exercise, cognitive restraint, drive for thinness, weight and shape concerns, body dissatisfaction and external and emotional eating.

Gay males reported significantly greater prevalence of fasting, purging and use of diet pills compared to heterosexual peers (Austin et al., 2013; Zullig, Matthews-Ewald & Valois, 2019). They were also found to show greater body dissatisfaction (Dakanalis et al., 2012; Smith et al., 2011), drive for thinness (Carper et al., 2010) and shape and weight concerns (Grammer et al., 2021) than controls. Similar to bisexual females, they were not at increased risk of engaging in excessive exercise to lose weight (Zullig et al, 2019). Of the five studies comparing bisexual to heterosexual participants, four demonstrated greater disordered eating cognitions and behaviours specifically for bisexual youth (Grammar et al., 2021; Hadland et al., 2014; Hazzard et al., 2019; Yu et al., 2018). Male and female bisexual students were found to have the highest weight and shape concerns of an SM and control sample, approaching and exceeding clinical thresholds (Grammer et al., 2021). In addition, Hazzard et al. (2019) found the strongest thin-ideal internalisation, over-evaluation of weight and shape and body dissatisfaction for bisexual females. However, once the model was adjusted for covariates including age, race, cigarette use, binge drinking, depression and school participation, bisexual females were not found to be more likely to engage in fasting, vomiting, or taking pills to lose weight than their heterosexual peers (Zullig et al., 2019). Examination of SM females revealed increased odds of bingeing, purging, dietary restraint and external and emotional eating compared to controls (Austin et al., 2013; Calzo et al., 2015). Whilst SM females have been found to demonstrate greater weight and shape concerns and body dissatisfaction (Grammar et al., 2021), Calzo et al. (2015) identified lower levels of body dissatisfaction for lesbian females. Indeed, SM females in one study were found to be more likely to misperceive their weight and shape as being underweight or healthy, when in fact they were overweight (Hadland et al., 2014). For GM youth, calorie restriction, muscle building, steroid use and weight and shape concerns were significantly greater than for cisgender peers (Grammer et al., 2021; Guss et al., 2017; Roberts et al., 2021). Their use of fasting, diet pills and laxatives for weight control was found to be as high as for heterosexual females (Guss et al., 2017). Moreover, Roberts et al. (2021) found that trans male and trans female participants demonstrated greater disordered eating than non-binary participants.
Table 1.
*
Key information extracted from reviewed studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Location</th>
<th>Population</th>
<th>Sampling</th>
<th>Measures</th>
<th>Main Findings</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austin et al., 2013</td>
<td>USA</td>
<td>N = 24,591; SM girls = 8%, SM boys = 5%; mean age 15.9 years (SD = 1.3; range = 13-18)</td>
<td>9th-12th grade high school students across four cities and five states; data pooled from 2005 and 2007</td>
<td>YRBSS</td>
<td>SM girls had two to four times the odds of purging and diet pill use compared to heterosexual peers. SM boys had three to seven times the odds of purging and diet pill use compared to heterosexual peers. Ethnicity did not moderate the association between SM status and eating behaviour outcomes.</td>
<td>Internal validity = + External validity = ++</td>
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<tr>
<td>Calzo, Austin &amp; Micali, 2018</td>
<td>UK</td>
<td>N = 5,048; 2,367 boys and 2,681 girls; 91.3% of boys self-identified as completely heterosexual, 6.2% as mostly heterosexual, 1.3% as bisexual, and 1.3% as gay; 86.3% of girls self-identified as completely heterosexual, 11% as mostly heterosexual, 2.1% as bisexual, and 0.6% as lesbian; 14-16 years-old</td>
<td>The Avon Longitudinal Study of Parents and Children (ALSPAC) cohort study</td>
<td>YRBSS; modified DEBQ; BDS; IBSS-R; modified PSPS; rated four novel statements</td>
<td>SM boys had higher odds of bingeing, dieting to lose weight and overeating compared to heterosexual peers, as well as higher mean emotional eating, external eating and perceived pressure to increase muscularity. SM girls had higher odds of bingeing, overeating, purging and dieting to lose weight compared to heterosexual peers, as well as higher restrained eating, emotional eating, and external eating. Gay and bisexual boys and mostly heterosexual girls reported greater body dissatisfaction than same-gender heterosexual peers.</td>
<td>Internal validity = + External validity = ++</td>
</tr>
<tr>
<td>Carper, Negy &amp; Tantleff-Dunn, 2010</td>
<td>USA</td>
<td>N = 78; 39 gay males and 39 heterosexual males; mean age 19.31 years (SD = 0.89)</td>
<td>Male undergraduate students from Psychology classes and LGBT society</td>
<td>EDI-3 Drive for Thinness subscale; SATAS-3; PAQ; PASTAS; Kinsey Rating Scale; three novel questions</td>
<td>Gay males scored significantly higher than heterosexual peers on drive for thinness, appearance-related anxiety and perceived media influence. No significant differences between gay and heterosexual males for importance of physical attractiveness. Though gay and heterosexual men valued physical attractiveness similarly, gay men felt more pressure from the media to achieve attractiveness, resulting in greater drive for thinness and anxiety about their appearance and body.</td>
<td>Internal validity = + External validity = +</td>
</tr>
<tr>
<td>Authors/Year</td>
<td>Country</td>
<td>Sample Size</td>
<td>Sample Characteristics</td>
<td>Measure/Tool</td>
<td>Findings</td>
<td>Internal Validity</td>
</tr>
<tr>
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<tr>
<td>Dakanalis et al., 2012</td>
<td>Italy</td>
<td>N = 255; 125 gay males and 130 heterosexual males; aged 20.89 ± 1.01 and 20.70 ± 1.30 respectively</td>
<td>Male university students</td>
<td>Italian OBCS; Italian BDI-II; Italian EDI-2; novel measure of sexual objectification from media</td>
<td>Gay males showed significantly higher sexually objectifying media exposure, body surveillance, body shame, depression, and disordered eating compared to heterosexual peers. For gay males, sexually objectifying media led to body surveillance, which in turn led to body shame, which then predicted disordered eating and depression. The same model held for heterosexual males. The model explained 56% of variance in disordered eating for gay males and 41% of variance for heterosexual males.</td>
<td>Internal validity = +</td>
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<tr>
<td>Fussner &amp; Smith, 2015</td>
<td>USA</td>
<td>N = 201; gay males = 73 (36.3% of sample); mean age = 20.46 (SD=3.22)</td>
<td>Male college students</td>
<td>Kinsey Rating Scale; BIG-O; EDEQ-4</td>
<td>For gay males, current body type vs ideal body type differed significantly, and current body type vs. ought body type (body type one believes he should have to attract a dating partner) differed significantly. Current body type vs ideal body type did not differ significantly differ by sexual orientation, but current body type vs. ought body type was significantly greater for gay males. Discrepancy significantly related to disordered eating in gay and heterosexual males. The current body type vs ought body type discrepancy by sexual orientation interaction term only significantly predicted dietary restraint.</td>
<td>Internal validity = +</td>
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<tr>
<td>Grammar et al., 2021</td>
<td>USA</td>
<td>N = 8,531; SM = 2,048 (24%); GM = 234 students (2.7%); mean age = 19.20 (SD=2.94)</td>
<td>Undergraduate college students</td>
<td>SWED; WCS; single novel item for ED chronicity; PHQ-9; SDFQ; GADQ-IV; PDSR</td>
<td>Compared to heterosexual peers, SM individuals, particularly bisexuals, had higher weight and shape concerns and greater odds of a probable eating disorder diagnosis and mental health condition. Bisexual and queer students showed higher clinical weight and shape concerns, more disordered eating over five years and greater depression and anxiety compared to heterosexual and other SM peers. Compared to cisgender males, cisgender females and GM students had greater odds of chronic eating disorder symptoms, a probable eating disorder diagnosis or mental health condition and significantly higher weight and shape concerns.</td>
<td>Internal validity = +</td>
</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>N</td>
<td>Gender Composition</td>
<td>Setting</td>
<td>Survey/Methodology</td>
<td>Findings</td>
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</table>
| Guss et al., 2017          | USA     | N = 2473   | Cisgender males = 1,117, cisgender females = 1,289, transgender students = 67; age 14-18 years | 9th-12th grade high school students from 57 high schools in 2013 | Massachusetts Youth Health Survey (MYHS) | Cisgender females showed highest prevalence of fasting and purging. Transgender students showed highest prevalence of diet pill use and laxative use. Compared to cisgender males, transgender adolescents had higher odds of fasting over 24 hours and using diet pills, laxatives and steroids. No significant differences were found between transgender students and cisgender females for fasting, diet pills, and laxative use, though they showed higher odds of perceiving themselves as a healthy or under-weight when they were overweight. | Internal validity = +  
  External validity = ++ |
| Hadland, Austin, Goodenow & Calzo, 2014 | USA     | N = 12,984 | Males = 6,387, females = 6,567; median age 15 years | 9th-12th grade high school students; data pooled from 2003, 2005, 2007 and 2009 | YRBSS | SM males and females are more likely than heterosexual peers to misperceive their weight and to engage in unhealthy weight control behaviours. Unhealthy weight control behaviours were more than four times greater among SM males and two times greater among SM females relative to heterosexual matched-gender peers. Bisexual females were more likely than heterosexual females to want to lose weight. Weight misperception was associated with unhealthy weight control behaviours for all and did not differ by sexual orientation. | Internal validity = +  
  External validity = ++ |
| Hazzard et al., 2019       | USA     | N = 1895   | Heterosexual = 1,528, bisexual = 89, lesbian = 278; mean age 19.35 years | Female undergraduate students | SATAQ-4; EDE-Q; one item assessing sexual orientation | Dietary restraint, shape/weight over-evaluation, body dissatisfaction, muscular-ideal internalisation and family and media appearance pressures were similar for SM and heterosexual women. Family appearance pressures, media appearance pressures, and muscular-ideal internalisation were associated with thin-ideal internalisation and eating pathology for all. Bisexual women demonstrated significantly stronger shape/weight over-evaluation, body dissatisfaction and thin idealisation than heterosexual and lesbian women. Heterosexual and bisexual women reported significantly higher peer appearance pressures than lesbians. | Internal validity = +  
  External validity = + |
<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>N</th>
<th>Sample Description</th>
<th>Measures</th>
<th>Results</th>
<th>Validity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jones et al., 2019</td>
<td>USA</td>
<td>965; SM = 197; aged 18 years</td>
<td>Pittsburgh Girls Study; data from 2010 to 2013; Majority (55%) black female sample</td>
<td>EAT-26; Body Image Measure; BMI; one item assessing sexual orientation</td>
<td>SM women had significantly higher BMIs, body dissatisfaction and eating pathology than heterosexual women. Body image mediated the association between BMI and eating pathology for all groups. White SM women had higher eating pathology across all groups. Black women reported significantly less eating pathology compared to white women, though body dissatisfaction was comparable across groups.</td>
<td>Internal validity = + External validity = +</td>
</tr>
<tr>
<td>Peterson, Mara, Conard &amp; Grossoehme, 2020</td>
<td>USA</td>
<td>86</td>
<td>Patients from Transgender Clinic in the Division of Adolescent and Transition Medicine</td>
<td>EDE-Q, UPPS, two items on NSSI and suicidality</td>
<td>Twenty-two percent of participants reported clinically significant eating pathology, with 25% having binged at least once in the previous month. Global eating pathology scores did not differ significantly by gender and were significantly related to negative urgency (the tendency to act impulsively when distressed), but no other UPPS subscale. Binge eating was significantly associated with negative urgency.</td>
<td>Internal validity = + External validity = +</td>
</tr>
<tr>
<td>Rezepa et al., 2021</td>
<td>USA</td>
<td>528</td>
<td>LGBTQ+ adolescents from larger national online study</td>
<td>Three EPSI subscales; BESAA; four items on SM victimization; four items from National Longitudinal Study of Adolescent to Adult Health</td>
<td>Gay/lesbian adolescents reported highest SM-based victimization. Experiences of sexual orientation-based victimization were associated with higher levels of restrictive disordered eating among SM girls, regardless of body esteem. Higher quality parent–adolescent relationship was associated with higher body esteem, and in turn, less disordered eating. Higher quality parent–adolescent relationship was also associated with greater appearance attribution, which in turn was associated with greater bingeing and purging behaviours.</td>
<td>Internal validity = ++ External validity = ++</td>
</tr>
</tbody>
</table>
Roberts et al., USA 2021 | National online survey | Greater gender identity congruence correlated with significantly lower bingeing, cognitive restraint, purging, caloric restriction and muscle building. Transfem adolescents reporting greater caloric restriction but less muscles building than cisgender and nonbinary AMAB peers. Transmas adolescents engaged in greater muscle building, purging and caloric restriction than cisgender and nonbinary AFAB adolescents. Cisgender adolescents reported more excessive exercise than trans peers. Nonbinary AFAB adolescents reported greater caloric restriction than cisgender females, suggesting calorie restriction can relieve gender-related stress. | Internal validity = + External validity = ++ |

Romito et al., USA 2021 | Transgender youth recruited from previous research and community groups around Pittsburgh | Three key themes emerged: (1) disordered eating aims to align the body with gender identity; (2) disordered eating relates to broader mental health concerns; (3) impact of developmental and social context. All participants engaged in at least one weight-control behaviour. Gender incongruence triggered body dissatisfaction. Weight control behaviours were driven by needing to alter or delay secondary sex characteristics, or by mental health concerns indirectly related to GM identity (depression/anxiety). Concerns about parents forbidding gender-affirming therapy and peers and partners perceiving their bodies. Gender transition steps largely improved body dissatisfaction and disordered eating. | Overall validity = + |

Santos et al., Brazil 2021 | Regional school survey; 27 schools | Greater unhealthy weight control behaviours were found among SM youth. Lower prevalence of SMs in school was significantly associated with unhealthy weight-control behaviours regardless of sexuality, and greater prevalence was protective. Heterosexual adolescents experienced pressure to comply with gender norms. SM adolescents experienced minority stress and victimisation. | Internal validity = + External validity = ++ |
<table>
<thead>
<tr>
<th>Study</th>
<th>Location</th>
<th>Sample Size</th>
<th>Sample Description</th>
<th>Measures</th>
<th>Findings</th>
<th>Internal Validity</th>
<th>External Validity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith, Hawkeswood, Bodell &amp; Joiner, 2011</td>
<td>USA</td>
<td>N = 204; heterosexual = 129, gay = 75; age 20 years (SD = 3)</td>
<td>Male undergraduate college students</td>
<td>EDEQ-4; MBAS; BIG-O; Kinsey Rating Scale</td>
<td>Gay males reported higher disordered eating and significantly more body fat dissatisfaction than heterosexual men. Body fat dissatisfaction and low body fat predicted dietary restraint and concerns about weight, shape, and eating in gay and heterosexual males. Muscular dissatisfaction did not differ by sexual orientation and did not predict disordered eating for either group. Gay males thought a potential partner preferred a leaner figure than they ideally desired for themselves.</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Watson et al., 2017</td>
<td>USA</td>
<td>N = 26,002; gay/lesbian = 1.6% in 2013, bisexual = 4.4% in 2013; mean age = 16.04 years</td>
<td>Grades 9-12 high school adolescents; eight data sets between 1999 and 2013 combined into four waves</td>
<td>MYRBS</td>
<td>Between 1999/2001 – 2011/2013, purging, use of diet pills and fasting declined or remained consistent for all genders and sexual orientations, except lesbian adolescents. There was an increased prevalence of fasting, diet pill use and purging among lesbians. With odds ratios adjusted for age and ethnicity, all but one of 48 comparisons demonstrated increased risk of disordered eating for SM youth compared to heterosexual peers, and most were statistically significant.</td>
<td>+</td>
<td>++</td>
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<tr>
<td>Yu et al., 2018</td>
<td>South Korea</td>
<td>N = 67,266; female = 32,511, male = 34,755; age = 12-18 years; 97.5% females and 93.4% males reported no sexual partners, 2.1% females and 5.6% males reported other-sex partners only, 0.3% females and 0.6% males reported same-sex partners only, and 0.2% females and 0.5% males reported partners of both sexes.</td>
<td>High school students from 800 schools</td>
<td>Korean YRBSS</td>
<td>Adolescents reporting partners of both sexes showed twice the odds of disordered weight-control behaviours compared to opposite-sex partner only peers. Adolescents who reported no sexual partners had half the odds of disordered weight-control behaviours. No significant differences in disordered weight-control behaviours were found between adolescents reporting same-sex partners only, compared to opposite-sex partners only.</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Zullig, Matthews-Ewald &amp; Valois, 2019</td>
<td>USA</td>
<td>N = 2,242; among females, heterosexual = 85.3%, lesbian = 1.5%, bisexual = 8.8% and unsure = 4.4%; among males, heterosexual = 91.5%, gay = 2.7%, bisexual = 2.9% and 2.9% = unsure; age = 12-18 years</td>
<td>9th-12th grade Connecticut high school students from 46 schools</td>
<td>YRBSS</td>
<td>Gay males were 5.67 times more likely to report fasting, vomiting, or using diet pills to lose weight compared to heterosexual peers. Bisexual females were significantly less likely to report exercising or eating less to lose weight compared to heterosexual peers. Bisexual females were not at increased odds of fasting, vomiting or using diet pills to lose weight compared to heterosexual peers, when the model was adjusted for demographic characteristics and covariates. Gay males were at increased risk for disordered eating and SM females are not at increased risk, when adjusting for covariates.</td>
<td>Internal validity = +</td>
<td>External validity = ++</td>
</tr>
</tbody>
</table>
Watson et al. (2017) reported that purging, use of diet pills and fasting had declined or remained constant between 1999 and 2013 for all genders and sexual orientations, except for lesbian adolescents who reported an increase in fasting and purging behaviours.

**Risk factors**

None of the reviewed research established an aim of exploring risk factors for disordered eating in LGBTQ+ youth. Nevertheless, many revealed individual-level factors which appeared to increase risk for eating pathology among SM and GM populations. The majority of studies identified an increased incidence of disordered eating for LGBTQ+ adolescents, thereby indicating that SM and GM status itself can be considered an established risk factor. Indeed, several studies revealed bisexual male and females as being at increased risk for disordered eating behaviours compared to heterosexual peers and peers of other SM orientations (Grammar et al., 2021; Hadland et al., 2014; Hazzard et al., 2019; Yu et al., 2018). Victimisation as a result of SM or GM status was associated with greater disordered eating (Rezeppa et al., 2021; Santos et al., 2021).

Body dissatisfaction, whilst also being a symptom of disordered eating and eating disorders, emerged as a potential risk factor. Lower body-related self-esteem was found to correlate with greater disordered eating (Jones et al., 2019; Rezeppa et al., 2021; Smith et al., 2011) and body image mediated the relationship between BMI and disordered eating in SM females (Jones et al., 2019). Smith et al. (2011) identified body fat dissatisfaction and low body fat as predictors of dietary restraint and concerns about weight, shape and eating in gay males. Notably, a similar model fit for heterosexual peers. Body dissatisfaction was positively correlated with exposure to sexually objectifying media and was identified as a mediator between body surveillance and disordered eating for gay males (Dakanalis et al., 2012). This is supported by gay males reporting greater pressure to emulate physical appearance ideals promoted by media compared to heterosexual peers (Carper et al., 2010). Whilst body dissatisfaction and media exposure were higher for gay males, Dakanalis et al’s (2012) model also fit for heterosexual males, suggesting that these factors are not entirely responsible for the increased prevalence of disordered eating in SM populations. Appearance pressures from peers were correlated with disordered eating in bisexual female participants (Hazzard et al., 2019), and high appearance attributions from quality parent-adolescent relationships was also found to predict greater restriction and purging behaviours (Rezeppa et al., 2021). Lack of LGB prevalence in school increases the odds of disordered eating for adolescents of all genders and sexual orientations (Santos et al., 2021). Furthermore, Fussner et al. (2015) found that discrepancy between the individual’s current body image and their ideal body image, as well as their current body image compared to their perception of their partner’s ideal body image, significantly related to disordered eating for gay men and heterosexual peers. From the reviewed research, body dissatisfaction, the impact of media, LGB prevalence in school and body image discrepancies emerge as potential risk factors for disordered eating, though not
exclusively for SM populations. These factors largely correlated with disordered eating for heterosexual controls too.

For GM participants, particularly trans male and trans female youth, gender-related body dissatisfaction emerged as a potential risk factor for disordered eating (Guess et al., 2017; Roberts et al., 2021; Romito et al., 2021). Guss et al. (2017) found that trans participants were at greater risk of fasting, diet pill and laxative use compared to cisgender males. Moreover, youth who were currently questioning their gender or who identified as non-binary were found to be at increased risk for binge eating (Robert et al., 2021). This study also found that greater gender congruence was associated with lower levels of disordered eating. For GM individuals, suppression of secondary sex characteristics appeared to be an implicit or explicit function of disordered eating (Romito et al., 2021). For example, GM participants described how restricting food intake helped to maintain a low weight, which better enabled trans males to ‘pass’ and for a trans female participant to use a tight corset to create an hourglass figure; “‘Sometimes I think about my feminine features, some of them on my face, some of them on my body… Some of them I can change through hormones and surgeries, but some of them I can’t really. I can’t really change my hips… I don’t think my body will ever completely look like a cis man’s body’ (Max, age 16, trans male, non-binary)” (pg.56). Other participants raised how concerns about body image and restricting food intake complied with their sense of femininity, suggesting they partly adopted these thoughts and behaviours to comply with gender norms (Romito et al., 2021). Finally, others mentioned disordered eating behaviours in response to emotional distress, which was partially or unrelated to their GM status. This appears to be supported by Peterson et al. (2020), who found that disordered eating, particularly binge eating, was associated with the trait of negative urgency in transgender individuals, which involves acting impulsively with maladaptive coping mechanisms when experiencing distress. See Figure two for a pictorial summary of identified risk factors.
Figure 2.

Identified Risk Factors

Protective factors
As with risk factors, none of the reviewed research explicitly aimed to identify protective factors against disordered eating in LGBTQ+ youth. However, four studies highlighted potential protective factors. Austin et al. (2013) found that Asian American and African American ethnicity was associated with fewer disordered eating behaviours for female adolescents. This was in part supported by Jones et al.’s (2019) finding that white females were at greater risk than black females. Identifying as a lesbian was associated with reduced impact of peer appearance pressures and disordered eating compared to bisexual and heterosexual female peers (Hazzard et al., 2019). Moreover, Rezeppa et al. (2021) noted that quality of parent-adolescent relationship positively correlated with body esteem, which in turn had an indirect effect by reducing disordered eating. Perhaps most revealing, however, was Romito et al.’s
(2021) qualitative study with transgender adolescents. Several of their participants described the positive impact of gender-affirming healthcare such as hormone therapies on their disordered eating behaviours. This was supported by the impression that progress with transitioning or increasing concordance between physical appearance and gender identity was protective for many. The authors note, for example, that for a trans feminine participant, “she stated that what mattered was the validation she felt when she saw a girl reflected in the mirror. Her body finally aligned with her internal self-concept; she felt “at home”. “ (pg. 54). Other positive aspects are worthy of note, despite not relating explicitly to disordered eating in the narratives. Having parents and a school who were supportive of their self-identification and transition appeared protective, as well as not experiencing bullying, independently purchasing gender-affirming clothing and chest binders and observing the positive experiences of a transgender peer within an accepting religious organisation. Overall, though not addressed directly, this review highlights particular demographics, parent-child relationships and gender-affirming environments and interventions as potential protective factors against disordered eating. See figure 3 for a pictorial summary of identified protective factors.

Figure 3.
Identified Protective Factors

Discussion

The aim of this systematic review was to examine the available literature for risk and protective factors for disordered eating and eating disorders in LGBTQ+ youth. The 19 included papers revealed a picture of eating pathology prevalence largely mirroring existing findings for adults and provided an initial insight into potential risk and protective factors for this at-risk group. In support of the wider literature, the majority of reviewed studies demonstrated a higher prevalence of disordered eating among SM and GM youth compared to heterosexual and cisgender peers (Austin et al., 2013; Calzo et al., 2019; Carper et al., 2010; Dakanalis et al., 2012; Grammar et al., 2021; Hadland et al., 2014; Jones et al., 2019; Santos et al., 2021; Smith et al., 2011; Watson et al., 2017; Zullig et al., 2019). Male SM participants were found to consistently show greater disordered eating than heterosexual peers, in line
with adult findings (Austin et al., 2013; Calzo et al., 2019; Carper et al., 2010; Dakanalis et al., 2012; Grammar et al., 2021; Hadland et al., 2014; Santos et al., 2021; Smith et al., 2011; Watson et al., 2017; Zullig et al., 2019). Similarly mirroring the knowledge base were mixed findings for SM females. Some studies highlighted greater prevalence of disordered eating for bisexual females (Grammar et al., 2021; Hadland et al., 2014; Hazzard et al., 2019; Yu et al., 2018) and increasing use of maladaptive weight control behaviours among young lesbians (Watson et al., 2017), while others revealed lower levels of disordered eating for lesbian females (Hazzard et al., 2019). Finally, studies examining GM youth demonstrated significantly greater disordered eating for this group when compared to cisgender peers (Grammar et al., 2021; Roberts et al., 2021), though Guss et al. (2017) only found a significant difference between transgender youth and male cisgender peers, but not female cisgender peers.

Potential risk factors for disordered eating in LGBTQ+ youth were identified despite the examination of risk factors not being an explicit aim of the reviewed studies. SM and GM status were found to be an established risk factor. This corroborates the assumptions of Objectification and Minority Stress Theories, where greater psychological distress and maladaptive coping mechanisms result from internalisation of unhealthy body ideals and the cumulative effect of unique proximal and distal stressors for at-risk populations, respectively. Bisexual individuals emerged as being particularly vulnerable to disordered eating. Bisexual males and females were identified as being at increased risk for disordered eating behaviours compared to heterosexual peers and peers of other SM orientations (Grammar et al., 2021; Hadland et al., 2014; Hazzard et al., 2019; Yu et al., 2018), though Zullig et al.’s (2019) findings did not support this. Bisexual orientation as a risk factor may be best explained by the Minority Stress Theory, as bisexual individuals are more likely than gay or lesbian peers to experience discrimination within and outside the LGBTQ+ community (Alarie & Gaudet, 2013). This additional stressor may contribute to their experience of minority stress and therefore to maladaptive coping mechanisms and negative health outcomes. This is supported by bisexual individuals experiencing higher rates of substance use (Feinstein, Dyar & Pachankis, 2017), mental health difficulties (Taylor, 2018) and suicidality (Haas et., 2010) than their gay, lesbian or heterosexual counterparts. Recognising bisexuality as a possible risk factor should be considered in the assessment, formulation and treatment of disordered eating in LGBTQ+ young people.

Experience of victimisation and bullying was identified as a potential risk factor for SM and GM individuals (Rezeppa et al., 2021; Santos et al., 2021). Bullying has been associated with poor mental health outcomes including disordered eating in child and adult populations (Benedict, Vivier & Gjelsvik, 2015; Day, Bussey, Trompeter & Mitchison, 2021; Verkuil, Atasayi & Molendijk, 2014). LGBTQ+ adolescents are at increased risk of bullying and cyber-bullying, and that bullying is more likely to be aggressive and associated with more negative mental health outcomes than for heterosexual peers (Garaigordobil, Larain, Garaigordobil & Larain, 2020). Such bullying likely constitutes another minority stressor that could contribute to increased risk of disordered eating for GM and SM youth. This relationship appears to be under studied in the literature but may provide a possible avenue for
preventative strategies against disordered eating. Indeed, lower LGB prevalence in schools was found by one reviewed study to be a potential risk factor for eating pathology for SM students (Santos et al., 2021). Developing a safe LGBTQ+ inclusive school environment and targeting bullying may reduce disordered eating for SM and GM young people.

Body dissatisfaction or body image concerns emerged as an important potential risk factor for eating pathology in SM youth (Jones et al., 2019; Rezeppa et al., 2021; Smith et al., 2011). The role of body dissatisfaction on disordered eating has been supported in SM adult populations (Brennen et al., 2011; Davids & Green, 2011; Panza, Olsen, Selby & Wing, 2021). In line with the Tripartite Model’s (Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999) assumption that the pressure to comply with sociocultural pressure for thinness increases an individual’s vulnerability to body dissatisfaction and disordered eating, appearance pressures from peers and parents and exposure to media were found to be relevant to body dissatisfaction (Carper et al., 2010; Dakanalis et al., 2012; Hazzard et al., 2019; Rezeppa et al., 2021). Participants expressed a drive for thinness and a need to emulate leanness and appearance ideals observed in the media. This has been observed more in male SM populations in relation to body dissatisfaction concerning muscularity, for example drive for muscularity predicting body dissatisfaction in bisexual males (Davids & Green, 2011). The picture is more ambiguous for SM women. A recent synthesis of 30 years of research concluded that SM females do not differ significantly from heterosexual females on measures of body dissatisfaction (He, Sun, Lin & Fan, 2020). Only three studies in the current review provided insight into body dissatisfaction with SM females, with one revealing no difference by SM status (Hazzard et al., 2019) and two revealing greater body dissatisfaction and eating pathology for SM girls compared to heterosexual peers (Grammar et al., 2021; Jones et al., 2019). This contrast may be attributed to less drive for thinness in lesbian cultural norms (Alvy, 2013). Nevertheless, conclusions for LGB females remain mixed. Discrepancy between current body image and ideal body image, and between current body image and perceived partner’s ideal body image were also found to relate to disordered eating (Fussner et al. 2015). It is notable, however, that the relationship between body dissatisfaction and disordered eating, and the roles of media and discrepancy in body image, were also evident for heterosexual adolescents (Dakanalis et al., 2012; Smith et al., 2011). This aligns with Objectification Theory (Brewster et al., 2014). Body dissatisfaction is prevalent among male and female adolescents (Lawler & Nixon, 2011) and adolescence is understood as a period of increased vulnerability for developing eating disorders as teens focus more on body image (Rawana, Morgan, Nguyen & Craig, 2010). This indicates that, while body dissatisfaction is a relevant risk factor for disordered eating in LGBTQ+ populations, it cannot fully explain the disparity in eating pathology between SM and heterosexual youth.

For GM individuals, body dissatisfaction and drive to suppress secondary sex characteristics associated with gender incongruence were identified as potential risk factors for disordered eating. Participants described engaging in unhealthy weight control behaviours to ‘pass’ as their true gender and outlined concerns around conforming with masculine or feminine expectations. In line with Objectification
theory and the Femininity Hypothesis, gender roles have been associated with disordered eating and eating disorders in cisgender females and gay males (Lakkis, Ricciardelli & Williams, 1999; Murnen & Smolak, 1997). It appeared from this review that part of the function of disordered eating for GM individuals may relate to aligning their body with their own, other’s and society’s expectations of their gender. The relationship between body dissatisfaction and disordered eating, and disordered eating to align one’s body with their gender, is mirrored in adult transgender samples (Ålgars, Alanko, Santtila & Sandnabba, 2012; Hepp & Milos, 2002; Jones et al., 2018), though much of the detailed insight in this area still stems from case studies (Couturier, Pindiprolu, Findlay & Johnson, 2014; Murray, Boon & Touyz, 2013; Strandjord, Ng & Rome, 2015). Avila, Golden and Aye (2019) found that 63% of their transgender sample disclosed weight manipulation for gender-affirming purposes, with no significant differences due to gender or hormonal therapy status. Perhaps surprisingly, they also found that there was no concordance between elevated EDE-Q global scores and weight manipulation for gender-affirming and menstrual suppression. Standardised measures potentially failing to detect aspects of disordered eating for transgender youth is a significant concern and further increases the risk of them developing eating disorders. It is vital to note that conclusions around risk factors for GM individuals from this review largely stemmed from a single study, Romito et al. (2021), and so should be considered preliminary and interpreted with caution. Further research is required into the theoretical underpinnings of these behaviours, as well as to develop and validate measures of eating disorder symptomology that capture weight control behaviours for gender-affirming purposes. Potential protective factors were identified, including Asian American and African American ethnicity, identifying as a lesbian and having a positive parent-child relationship for SM individuals, and gender-affirming treatment for GM individuals. Gender-affirming care as a protective factor against disordered eating for GM youth corresponds with research into broader mental health outcomes in transgender individuals (Almazan & Keuroghlian, 2021). Trans youth who accessed interventions such as pubertal suppression or hormone therapy were found to show improved body satisfaction, psychological wellbeing and decreased disordered eating (Coelho, Suen & Clark, 2019; Sequeira et al., 2017). Moreover, Testa et al.’s (2017) mediation model revealed that gender confirming medical interventions reduced experiences of non-affirmation, which in turn increased body satisfaction and thus decreased eating disorder symptomology for both transmen and transwomen. Together, this highlights the potential pivotal protective role of accessing gender-affirming care for trans individuals. Categorising SM status as a protective factor for females is supported by a portion of the literature (Parker & Harriger, 2020; Shearer et al., 2015) and may be explained by reduced sociocultural pressure for thinness for lesbians, in accordance with Objectification Theory. Alternatively, lesbian females may be utilising other coping mechanisms out with disordered eating to manage their minority stress (Katz Wise et al., 2015). It is notable, however, that bisexual females were found to be at increased risk of disordered eating in this review. This could be attributed to increased internalisation of ideals and objectification relating to male partners, as well as additional minority stress from biphobia within the
LGBTQ+ community (Brewster & Moradi, 2010). Broadly, these findings indicate that SM status as a protective factor for females is too broad a statement and warrants further investigation. Moreover, findings around ethnicity as a protective factor must be considered with caution. Only one study recorded a non-White majority sample. There appeared to be little consideration of the impact of differing or clashing cultural appearance ideals reported (Flynn, 2019). As such, generalising findings is challenging and the need for more ethnically diverse research is highlighted once again (Katz Wise et al. 2015). Protective factors should be explored directly to better inform the evidence base and to improve community resilience by informing resources, support groups and policies (Parker & Harriger, 2020). Doing so is particularly important for LGBTQ+ youth, due to their increased risk of eating pathology, mental ill-health and suicidality (Russell & Fish, 2016). The findings of this review contribute to the evidence-base informing disordered eating and eating disorder interventions. Exploring these risk and protective factors further could improve physical and mental health outcomes for LGBTQ+ youth. In some cases, for transgender individuals for example, traditional eating disorder treatment may not be effective until gender-affirming treatment is provided (Ristori et al., 2020). Desired gender should be considered in the development of treatment plans for transgender youth with eating difficulties (Goldhammer, Maston & Kauroghlian, 2019; McClain & Peebles, 2016), highlighting the need for interdisciplinary collaboration across specialities. The relevant services should screen query eating disorder patients for sexuality and or gender-related concerns, and in turn patients presenting with sexuality and or gender-related distress for eating disorder symptomology. Clinicians should remain mindful of diagnostic criteria being skewed towards stereotypical female presentations, potentially neglecting concerns around muscularity relevant for male and some LGBTQ+ individuals (Murray, Griffiths & Mond, 2016). Particularly relevant for monitoring eating pathology and establishing treatment goal weights, the use of growth charts based on sex for transgender individuals may be challenging (Nagata, Ganson & Austin, 2019). Goldhammer, Maston and Kauroghlian (2019) detailed several recommendations for reflecting sexuality and gender inclusivity within clinical services. They state that clinicians should ask open questions about sexual orientation and gender identity to allow individuals to self-identify (Coelho, Suen & Clark, 2019). Assessment of minority stress, in particular experiences of acceptance or victimisation at home and school, should be conducted, and involve family members in assessment and treatment only after enquiring about family acceptance of SM or GM status. Evidence-based interventions, such as cognitive behavioural therapy (CBT), could also be adapted using minority stress principles and including inclusive settings, resources and promotional imagery. Blashill et al. (2017), for example, conducted a randomised control trial of 12 sessions of CBT adapted to improve body image and self-care in HIV-positive SM males which demonstrated positive preliminary results. Finally, administrative and clinical staff should be appropriately trained on communicating respectfully and effectively with SM and GM individuals, validating their gender identity throughout, providing a safe space and facilitating their access to gender-affirming care (Bowman, 2018; Goldhammer, Maston & Keuroghlian, 2019; McClain
Greater government funding of mental health services, particularly eating disorder services (Katzman, 2021), is required to facilitate these improvements. The need for evidence-based, accessible and targeted interventions for disordered eating and eating disorders is becoming increasingly urgent. Over the COVID-19 pandemic, rates of diagnosed eating disorders have risen significantly. Largely US data revealed a 15.3% increase in diagnosis over 2020 compared to previous years, with notable spikes for teenage females with AN (Taquet, Geddes, Luciano & Harrison, 2021). In a survey of 830 LGBTQ+ adults, the majority of participants reported an increase in disordered eating behaviours over the pandemic (Hart, Rubin, Kline & Fox, 2022). This was weakly but significantly associated with minority stressors, such as living with someone not affirming of one’s identity (Hart, Rubin, Kline & Fox, 2022). Risk factors for eating disorders are thought to have risen alongside prevalence of diagnosis. Fear of contagion, disrupted daily routines and increased exposure to anxiety-provoking media as a result of the pandemic are among the possible risks for adults and young people (Katzman, 2021; Rodgers et al., 2020). Moreover, protective factors such as social support, physical and emotional availability of caregivers and adaptive coping strategies are likely to have been compromised. This perfect storm has enhanced young people’s vulnerability to declining mental health and the manifestation of eating disorder symptomology. Katzman (2021, p. 2) emphasised the unpreparedness of services to manage this increase, stating that “the COVID-19 pandemic has unmasked a global eating disorder public health crisis that was already building... The longstanding underinvestment, inadequate eating disorder services and limited eating disorders resources coupled with the diversion of healthcare resources toward fighting the COVID-19 pandemic, has left young people at risk or those with pre-existing eating disorders vulnerable.”. Unrecognised and untreated eating pathology increases risks of chronic health problems, greater mortality (van Hoeken & Hoek, 2020) and lower quality of life for SM and GM populations (McClain & Peebles, 2016). Post-pandemic could be a valuable opportunity to reorganise prevention and intervention services to be better serve at-risk young people (Katzman, 2021), such as those in the LGBTQ+ community.

A notable limitation of this review is the inability to draw conclusions around risk factors for clinically diagnosed eating disorders. Only one paper made use of standardised diagnostic criteria and none utilised a clinical sample. Exploration of risk and protective factors for disordered eating remains very valuable, as subclinical presentations are also associated with physical and mental health risks (Hudson, Hiripi, Pope Jr & Kessler, 2007), disordered eating can escalate above clinical thresholds with age (Field et al., 2012), and preventative approaches have been found to be very effective (Stice, South & Shaw, 2012). Nevertheless, those individuals with diagnosed eating disorders are at greatest risk of negative health outcomes including death and remain neglected in the literature. Further research into risk and protective factors should examine how those factors identified for disordered eating generalise to individuals with diagnosed eating disorders. Doing so would inform clinical interventions, as well as preventative approaches.
The heterogenous nature of the measures of disordered eating and sexual orientation, the presence and characteristics of control groups and prohibited quantitative analysis somewhat limits the validity of the findings (Miller & Luk, 2020). Conclusions should therefore be interpreted with caution. Notably, eight of the 19 reviewed studies measured disordered eating using the YRBSS (Kann et al., 1996), a large-scale survey developed in the US to examine health behaviours in secondary school-age children. The YRBSS measures disordered eating using two binary-response questions; ‘‘During the past 30 days, did you exercise, eat less food, fewer calories, or foods low in fat to lose weight or to keep from gaining weight?’’ and ‘‘During the past 30 days, did you go without eating for 24 hours or more (also called fasting), vomit, or take laxatives, any diet pills, powders, or liquids (without a doctor’s advice) to lose weight or to keep from gaining weight?’’. The reliability of this measure in its entirety has improved with revisions (Brener et al., 2002; Zullig, Pun, Patton & Ubbes, 2006), yet the validity of the eating behaviour questions appears to only have been partially validated against bulimic behaviours measured by a semi-structured clinical interview (Field, Taylor, Celio & Colditz, 2002). It’s validity as a measure of disordered eating beyond symptoms of bulimia nervosa is unknown. As noted by Austin et al. (2013), the YRBSS does not capture several indicators of eating disorders, including fasting and psychological symptoms. Whilst the measure benefits from gathering valuable demographic data and details of potential confounds from a large representative sample, findings stemming from use of the YRBSS may not accurately capture disordered eating and are likely to underestimate prevalence within the tested population. A focus of future research could be to validate existing measures of disordered eating with LGBTQ+ youth populations to identify the most appropriate measure for the investigation of subclinical eating pathology going forward (Coelho et al., 2019).

Moreover, there is a risk of potential bias within the review due to the second author only reviewing 25% of the studies at each stage of the screening and quality assessment process. Reviewing 25% was judged to minimise bias and was within the scope of the review. However, to better control for researcher bias, a second author would review all records returned from the search. Another limitation may lie in the study inclusion criteria. Only including English-language articles, for example, limits the generalisability of findings and perpetuates the existing focus on western-only populations in this field. Only including literature from 2010 onwards could also be judged as limiting and potentially overlooking vital findings. However, acceptance of LGBTQ+ identities has largely shifted positively over the last decade (Flores, 2021) and there has been a significant rise in research into mental health for LGBTQ+ people (Mongelli et al., 2019). The inclusion of gender expansive and non-binary individuals is particularly recent (Matsuno & Budge, 2017). It was felt that findings from research conducted since 2010 would be more likely to represent current attitudes towards and within LGBTQ+ youth, and therefore may be more relevant when generalising results.
Conclusion

To our knowledge, this is the first systematic review to explore the risk and protective factors for disordered eating in LGBTQ+ youth. A majority of the reviewed literature reported an increased prevalence of disordered eating among SM and GM young people compared to heterosexual and cisgender peers. Despite the sparsity of literature directly addressing this area, findings suggest that body dissatisfaction, appearance pressure, bisexuality and victimisation and bullying are important risk factors for SM young people. Emotional distress, drive for femininity and body dissatisfaction stemming from gender incongruence were identified as important risk factors for GM young people. Similarly, particular ethnicities, sexual orientations and positive parent-child relationships were tentatively found to be protective factors for SM youth and access to gender-affirming environments and care appeared to be protective for GM youth. This review highlights several directions for next steps within the research. Investigation is required to further identify and explore risk and protective factors, as well as validating standardised disordered eating measures with LGBTQ+ youth populations. Minimising heterogeneity, applying mixed method and longitudinal study designs and utilising more diverse and clinical samples are important steps for future studies. Doing so would provide an invaluable contribution to the evidence base and inform prevention and intervention approaches for this at-risk population.
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“He doesn’t understand but I know he'll always support me”: An Interpretative Phenomenological Analysis of Young People Coming Out to Their Parents

Abstract

Background: ‘Coming out’ can be a stressful and transformative experience for many lesbian, gay, bisexual, transgender and queer (LGBTQ+) young people. This population is at increased risk of discrimination, minority stress and negative health outcomes compared to heterosexual and cisgender peers. Positive relationships with parents can be protective against such outcomes. This study aimed to examine LGBTQ+ young peoples’ experiences of coming out to their parents or carers.

Method: Using Interpretative Phenomenological Analysis, data was collected from semi-structured interviews with eight LGBTQ+ young people in the UK.

Results: Participant narratives revealed three superordinate themes; the nature of the parent-child relationship (involving closeness verses distance, a generation divide and teaching and learning), navigating identity and expression (involving coming out to oneself, post coming out and the pains and privileges of passing) and selective disclosure (involving concerns for safety, the impact of culture and being out online).

Conclusion: Despite evidence of increasing acceptance of one’s own sexuality and gender, this study suggests that coming out remains a multi-faceted and challenging process for young people to navigate, particularly for those with complex family relationships and cultural considerations. Further research is required to inform resources, support and clinical practice for LGBTQ+ young people.

Key words: LGBTQ+; Coming Out; Parents; Young People
Introduction

“Coming out” is a process by which individuals recognise and accept their non-heterosexual or non-cisgender identity and begin to represent this identity openly to others (Alonzo & Buttitta, 2019; Campbell, Zaporozhets & Yarhouse, 2017; Rust, 2003). It is often considered an important milestone for LGBTQ+ (lesbian, gay, bisexual, transgender, queer, and other sexual and gender identities) individuals and a vital step in existing more genuinely in the world (Savin-Williams & Cohen, 2015). More people identify as a gender or sexual minority, and at younger ages, now than previously recorded (Bridges & Moore, 2018; Russel & Fish, 2016). Despite growing numbers, these individuals face unique challenges amid the expectations, discriminations and social norms inherent in a heteronormative society (Meyer, 2003; Rondahl, 2011). The onus is largely on them to navigate the complicated coming out process (Mills-Koonce, Rehder & McCurdy, 2018).

Coming out been conceptualised in several ways over the late 20th and early 21st century. The earliest psychological models of identity described the development and disclosure of one’s sexual identity in unidirectional stages. The assumed goal was typically a stable homosexual identity and integrating their homosexual lifestyle into a heterosexual society (Coleman, 1982; Troiden, 1989). Cass’ (1979) model for homosexual identity, for example, outlined six stages from ‘identity awareness’, where the individual is aware of being different, to ‘synthesis’, where the individual fully accepts themselves and is open with others. Though stage based models reportedly reflected qualitative group-level trends at the time, they under-represented the experiences of middle to older age individuals who did not participate in urban gay culture (Harry, 1986; 1993). These models have also been critiqued for their failure to represent the heterogenous nature of coming out, their Eurocentrism, the assumption that the aim was outward disclosure in early adulthood and the lack of acknowledgement of new and fluid sexual identities (Guittar & Rayburn, 2016; Jhang, 2018; Rust, 2003). Subsequent models were less bound to stages; rather, they tended to emphasise identity milestones and allowed for varying degrees of ‘outness’ (D’Augelli, 1994; Rust, 1993; Savin-Williams, 2005). Coming out could be considered a non-linear process whereby, throughout one’s lifetime, the individual decides to disclose their sexual or gender minority identity to others depending on situational and social context (Brumbaugh-Johnson & Hull, 2019). This has been referred to as “strategic outness” (Orne, 2011), or a “career” (Guittar & Rayburn, 2016). These models appear to capture the idiosyncratic nature of coming out for each person. Guittar and Rayburn (2016, pg. 337) provided a succinct summary: “The experiences associated with coming out are as numerous as the people who engage in coming out.” More recently, there has been a greater focus on the importance of self-affirmation and the role of intersecting identities (Guittar, 2013; Harper & Swanson, 2019; Kelleher & Murphy, 2022).

Being a sexual or gender minority individual in a heteronormative society can constitute a minority stress, which has been linked to poor mental health outcomes. Meyer (1995; 2003) utilised Minority Stress Theory to explain the disproportionate prevalence of mental health difficulties in LGBTQ+ populations. Overt prejudice, vigilance against discrimination, internalised stigma and concealing one’s
sexual orientation were proposed to result in increased stress and negative physical and mental health outcomes for LGB people. Moreover, there are legal and structural barriers for LGBTQ+ individuals (Morgan, 2013), which prevent access to necessities such as employment, relationships and healthcare. A review of 18 studies found that sexual minority (SM) young people are more likely than heterosexual peers to experience bullying and school-based victimisation (Russell & Fish, 2016). These social-based stressors negatively impact coping, resilience and emotional functioning (Hatzenbuehler, 2009), thereby increasing vulnerability to mental health difficulties, substance abuse and suicidality (Diaz et al., 2001; Mereish, O’Cleirigh & Bradford, 2014).

Evidence of the coming out process relieving minority stress and associated mental health difficulties is mixed (Rothman, Sullivan, Keyes & Boehmer, 2012). Whilst being out about one’s sexuality has been associated with personal and relationship wellbeing (Beals et al., 2009), Baams et al. (2015, pg. 690) identified a “perceived burdensomeness and thwarted belongingness” resulting from coming out within particular family and society contexts. It is notable that Minority Stress Theory has recently been applied to trans and gender non-conforming individuals (Hendricks & Testa, 2012) and that their experience of developing and disclosing their gender identity is very distinct from sexual minority individuals (Bockting & Coleman, 2016). This currently appears to be under-explored in the literature (Brumbaugh-Johnson & Hull, 2019). Trans people are further minoritised and face greater discriminatory attitudes and behaviours than cisgender peers (McCann & Brown, 2018). This therefore increases their experience of minority stress and the resulting risk of poor health outcomes (Higgins et al., 2021; Perez-Brumer, Day, Russell & Hatzenbuehler, 2017). For LGBTQ+ people, especially trans and gender non-conforming individuals, recognising and disclosing their minoritised identity is likely to be a complex and challenging experience with possible implications for their mental wellbeing.

LGBTQ+ adolescents and young adults are particularly at risk of negative health outcomes compared to cisgender heterosexual peers (Russell & Fish, 2016). The nature of an LGBTQ+ adolescent’s relationship with their parent or caregiver is among the strongest predictors of adjustment (Mills-Koonce, Rehder & McCurdy, 2018). This is unsurprising given the fundamental importance of the parent-child relationship (Baumrind, 2005). Attachment theory posits that the quality of care and nature of attachment style in early childhood impacts how an individual thinks about themselves, navigates stressors and builds and maintains social relationships (Ainsworth et al., 1978; Bowlby, 1973). The parent-child relationship becomes more complex during adolescence (Rosenblum & Lewis, 2006), which coincides with an intense period of biopsychosocial development for individuals, particularly around sexuality (Kar, Choudhury & Singh, 2015). Attachment style largely remains stable across the lifespan, though significant attachment-related life events can alter attachment models (Hamilton, 2000). Coming out to a parent could be a significant challenge within the parent-child relationship, with implications for care going forward and the security of attachments in future relationships (Carnelley, Hepper, Hicks & Turner, 2011).
As an extension of this, family systems theory (Broderick, 1993) proposes that a family is a dynamic team of interconnected individuals and dyads that bidirectionally influence each other and the functioning of the whole unit. The family aims to maintain an equilibrium between challenges and resources. Just as an adolescent coming out could impact an attachment, the disclosure of their LGBTQ+ identity might create a destabilising ripple effect within a family (Mills-Koonce, Rehder & McCurdy, 2018). According to family systems theory, a family with strong and healthy relational ties would best adapt their rules and dynamics to restore equilibrium. If equilibrium and the sense of wholeness remains out of reach, it can be assumed that the wellbeing of the family, particularly of the LGBTQ+ adolescent, would be compromised (Hoang, 2021).

In line with the assumptions of attachment and family systems theory, an LGBTQ+ young person’s decision to come out to their family, as well as parental acceptance or rejection, has been found to relate to the existing nature of the parent-child relationship (Tamagawa, 2018; Tilton-Weaver et al., 2010). SM individuals who experienced sensitive parenting in childhood have been found to report more supportive parent reactions to their coming out (Mohr & Fassinger, 2003), and LGBTQ+ individuals are more likely to come out to a parent with whom they are securely attached (Carnelley, Hepper, Hicks & Turner, 2011; Holtzen, Kenny & Mahalik, 1995). Carnelley et al. (2011) speculated whether this was due to parents who encouraged independence, exploration and development of identity in early childhood are more likely to be accepting of sexual minority status. Moreover, just as secure attachments can buffer against the effects of negative life experiences, parental support can attenuate the negative effects of LGBTQ+-related victimisation (Ryan et al., 2010; Shilo & Mor, 2014). If the parent-child relationship is insecure, the disclosure may exacerbate an already challenging dynamic and result in a strained or broken relationship (Savin-Williams & Ream, 2003). In a study of gay and bisexual adolescent males, 56% reported perceiving that their coming out strained their relationship with the parents (Feinstein et al., 2018). Within the family system, Alonzo and Buttitta (2019) noted that family relationships are likely to shift after a coming out. The SM individual may experience a sense of otherness and parents and siblings may struggle to understand (Baams, Grossman & Russell, 2015; Jhang, 2018). In an attempt to regain equilibrium in the family following an LGBTQ+ family member’s coming out, a sample of Conservative Christian families were found to employ several strategies, including open communication, distancing from family members, passage of time and ignoring LGBTQ+ topics completely (Drumm et al., 2020). If the family system is unable to reorganise around the new LGBTQ+ identity, the individual may be excluded (Mills-Koonce, Rehder & McCurdy, 2018). It is notable that, when examining the impact on family systems, it enhances validity to examine both the youth and parent perspective (Lloyd Allen, 2021). The literature indicates that the decision to come out should be considered in the context of ongoing relationships within the family system (Ali & Barden, 2015).

The nature of the relationship with the parent is an important factor to consider for an LGBTQ+ young person when deciding to come out to their family. The role of ethno-cultural background is beginning
to be examined in greater depth (Halton & Ratcliff, 2020). Potoczniak, Crosbie-Burnett and Salzburg (2009) conducted focus groups with an ethnically diverse LGBTQ+ US sample, including 53% Hispanic and 35% Black or African American participants, to explore adolescent experiences of coming out to parents. They identified common experiences of fear of emotional and physical rejection, religion and culture-based responses to sexual orientation and shock followed by acceptance. Within this sparse area of research, additional factors have been found to be particularly relevant for LGBTQ individuals from ethnically minoritised backgrounds when coming out to their families (Alonzo & Buttitta, 2019; Ryan, Legate & Weinstein, 2015; Siraj, 2017). LGBTQ+ people of colour may experience direct and indirect racism, homophobia and transphobia as a result of occupying multiple minoritised identities in a discriminatory society (Jhang, 2018). Intersecting identities, such as race, culture, gender and sexuality, must be addressed in the exploration of coming out processes (Gattamorta & Quidley-Rodriguez, 2018; Parent, DeBlare & Moradi, 2013). Indeed, in line with Minority Stress Theory (Meyer, 1995), Nealy (2019) highlighted that parents in ethnically minoritised families, such as in Latin American cultures, may struggle with how their child’s LGBTQ+ identity may compound the family’s existing experience of discrimination and oppression. The LGBTQ+ individual themselves is also vulnerable to greater internalised stigma (Szymanski, Kashubeck-West & Meyer, 2008). Consequently, an LGBTQ+ individual from an ethnically minoritised background may consider concealing their sexual or gender minority status to maintain a sense of belonging and safety (Alonzo & Buttitta, 2019).

A sample of British Pakistani lesbians, for example, reported fear of being ostracised and needing to preserve family honour. Their decision to remain ‘in the closet’ was a source of conflict, strain and anxiety for them, though they managed this by accentuating other aspects of their personality, such as ethnic and religious identities, to the extent that some knew they would never come out to their families (Siraj, 2017). It appears that, though for many the decision to come out is taken with a hope of reducing long-term distress, for LGBTQ+ individuals from ethnically minoritised backgrounds, their stress may be compounded by culturally-specific considerations (Alonzo & Buttitta, 2019).

The treatment of the LGBTQ+ young person following their coming out to their family is likely to directly impact their adjustment, health and wellbeing (Chaudoir & Fisher, 2010; Mills-Koonce, Rehder & McCurdy, 2018). LGBTQ+ youth are at highest risk of depression and suicide immediately post-disclosure (D’Augelli & Hershberger, 1993). Parental rejection or acceptance may be conditional (Carastathis et al., 2017; Jadwin-Cakmak et al., 2015; Mena & Vaccaro, 2013), or change with time (Diamond & Shpigel, 2014). Some LGBTQ+ individuals experience acceptance, support, validation and security following their coming out (Mills-Koonce, Rehder & McCurdy, 2018). This is positively associated with self-esteem, reduced depression and fewer suicide attempts in sexual and gender minorities (Grossman, D’Augelli & Frank, 2011; Ryan et al., 2010). Young people were also more confident about subsequent disclosures if they had received support from parents (D’amico, Julien, Tremblay & Chartrand, 2015; Snapp et al., 2015). Others, however, may experience rejection, emotional abandonment, isolation, discrimination or violence (Carastathis et al., 2017; Carnelley et al.,
Small scale qualitative studies revealed that trans youth are at particular risk of family rejection, with many sharing experiences of parents enforcing conformity with their gender assigned at birth (McGuie, Kuvalanka, Catalpa & Toomey, 2016; Reczek, 2020). Rejection, and anticipated rejection, of one’s LGBTQ+ identity by family increases risks of psychological ill health (Bregman et al., 2013). Mills-Koonce, Rehder and McCurdy (2018, p. 5) emphasise the significance of this for LGBTQ+ youth as “experiencing rejection at that level is overwhelming because it is a rejection of who an adolescent is, not just a criticism of something they have done”. Negative parent reactions have been found to predict negative health outcomes including depression, substance abuse, risky sexual behaviours and suicidality in LGBTQ+ young people (Russell & Fish, 2016; Willoughby, Doty & Malik, 2010). Young people may also experience increased internalised homonegativity, which reinforces identity struggles, psychological distress and increases their likelihood of remaining ‘in the closet’ (Baiocco et al., 2014; D’amico, Julien, Tremblay & Charrand, 2015; Taylor & Neppl, 2021). Though remaining ‘in the closet’ is preferable or necessary for some (Siraj, 2017), studies have found that doing so can negatively impact cognitive resources (Critcher & Ferguson, 2014), limit access to social support (Pachankis, 2007) and perpetuate poor health outcomes (Rothman, Sullivan, Keyes & Boehmer, 2012). In sum, it appears that parental response to coming out plays a pivotal role in mental health and wellbeing for LGBTQ+ individuals (D’Amico et al., 2015), and has implications more widely for the family and public health (Ghosh, 2019).

Whilst not minimising the distressing experiences and outcomes for LGBTQ+ individuals, Russell (2005) noted that when examining challenging phenomena, studies of resilience are as important as studies of risk. The field of positive psychology has been critiqued for neglecting exploration of LGBTQ+ experiences (Lytle et al., 2014). A small number of studies report SM participants showing stress-related growth and perceiving themselves as stronger following adverse coming out events, particularly when supported by wider LGBTQ+ communities (Bonet, Wells & Parsons, 2007; Vaughan & Waehler, 2010). Brownfield et al. (2018), for example, found that bisexual individuals experienced three forms of growth following coming out, including intrapersonal growth where they lived more authentically, interpersonal growth where relationships became more satisfying and increased critical consciousness where they became more knowledgeable of their oppression and privilege. This limited research suggests that, despite negative coming out experiences, a silver lining for LGBTQ+ individuals may lie in the opportunity to live more authentically and the social intelligence, resilience and strength developed through adversity which may equip them for managing the highs and lows of their minority status (Carastathis, Cohen, Kaczmarek & Chang, 2017; Vaughan & Rodriguez, 2014; Zavala & Waters, 2021).

Recent publications have highlighted that societies globally are gradually becoming more accepting of LGBTQ+ identities (Flores, Park & Badgett, 2018). Young generations are identifying more with sexual and gender minority status’ and display more accepting attitudes (Guittar, 2013). Lesbian and gay participants reported that their parent’s acceptance of their identity related to changing societal and
familial attitudes and seeing more LGBTQ+ representation on TV (Samarova, Shilo & Diamond, 2014; Trussell, Xing & Oswald, 2015). This has led some to speculate that minority-related stress and homophobia may cease to be a reality for LGBTQ+ young people (McCormack, 2016) and that they may no longer need to come out to their families (Alonzo & Buttitta, 2019).

According to minority stress theory, if society is generally becoming more accepting, positive systemic changes are being made and LGBTQ+ identities are less minoritised, minority-specific stressors and the resulting disparities in health outcomes for this population should be declining (Meyer, 2003; Russell & Fish, 2016). However, it appears this is not yet the case (McCann & Brown, 2018). Alonzo and Buttitta (2019) described how sexual and gender minority individuals might celebrate a legal victory for rights one day but be faced with hate crimes or rulings that reinforce discrimination and internalised stigma the next. There is still great progress to be made, particularly for trans individuals who face increasing rates of discrimination and hate crime (Walters, Paterson, Brown & McDonnell, 2020). Moreover, despite a possible shift in attitudes, the supports and protections for LGBTQ+ individuals remain undeveloped (Mills-Koonce, Rehder & McCurdy, 2018). Carliile (2020) noted, for example, several shortcomings in the experience of healthcare services for trans people in the UK. There are relatively few empirically based resources for practitioners and parents to support optimal parenting and family functioning around an LGBTQ+ family member (Mills-Koonce, Rehder & McCurdy, 2018).

There is some evidence of family-based treatments adapted for LGBTQ+ adolescents reducing suicidal ideation and depression (Diamond et al., 2012), but these interventions and the staff who deliver them need to be kept informed of shifting attitudes and discourse, and the impact of this on the LGBTQ+ individuals they work with. In addition, it may be vital for parents to better understand the experiences of their LGBTQ+ offspring. Evolving empirically based resources for parents are required, as parent support remains one of the strongest determinants of adjustment for LGBTQ+ youth (Snapp et al., 2015).

As the social and cultural understanding of LGBTQ+ identities shift, so too might the discourse around people’s identities and how or if they come out to their families (Russell, Clarke & Clary, 2009). Guittar (2013, p. 184-185) wrote, “As these sexualities continue to emerge, we will likely see the meaning of coming out change across time… Perhaps in coming years we will see an increase in the volume of people who perceive coming out as a purely personal journey”. Notably, in a review of literature published between 2010 and 2020, Reczek (2020) commented on a lack of research attention dedicated to the experiences of those with less common sexual and gender identities, such as asexual, pansexual, intersex, gender non-conforming and queer individuals (Ghosh, 2019). Moreover, very few studies acknowledge the fluidity of sexual and gender minority identities. The process for the individual of coming out to family as multiple or evolving sexual or gender minority identities is largely unexplored (Tyler & Abetz, 2020). In light of mixed reports of increased societal acceptance, ongoing inequalities and health disparities and the concept of coming out changing or possibly decreasing in relevance, it
appears that the field may benefit from further exploration of the experiences of sexual and gender minority identity disclosure to parents for LGBTQ+ young people.

The present study was designed to contribute to the existing research by providing a deeper understanding of the experiences and perspectives of LGBTQ+ young people in the UK coming out to their parents through their own reflections. As this was an exploratory study examining the individual meaning made of specific experiences, Interpretative Phenomenological Analysis (IPA; Smith, 2011; Smith, Flowers and Larkin, 2009) was utilised.

Two research questions guided this work:

1. What are the experiences of LGBTQ+ young people in the UK of coming out to their parents?
2. How do these people make sense of their experience?

Method

Design

A qualitative approach was used, with IPA selected as an appropriate framework. IPA provides a means of examining how a homogenous group of people make sense of subjective significant life experiences (Mercer, 2012; Pietkiewicz & Smith, 2014). The approach is grounded in three areas of the philosophy of knowledge: phenomenology, hermeneutics and idiography, and reflects a social constructionist position. The concept of being ‘double hermeneutic’ is key within IPA, whereby it is assumed that any conclusions drawn are a reflection of the researcher’s interpretation of the participant’s understanding and retelling of their experience (Smith, Flower & Larkin, 2009). As such, IPA assumes that we cannot understand phenomena as a ‘single truth’; rather, there are multiple interpretations of the meaning of a phenomenon depending on individual, social, cultural, economic and political context (Willig, 2013). The approach has been utilised effectively with LGBTQ+ populations (Siraj, 2017; Tan & Weisbart, 2022). The assumptions aligned with the research aims of examining individuals’ understanding and experience of the significant life event of disclosing, or not, one’s sexuality or gender identity. Semi structured interviews were undertaken to generate rich data for analysis.

Participants

A purposive, snowball sampling method was appropriate for this study design (Guittar, 2013). Participants were recruited based on characteristics relevant to the research question. Inclusion criteria involved participants identifying as LGBTQ+, being aged between 16 and 25 years-old, living in the UK and being fluent in English. The age criterion was defined as such to capture the experiences of young people, in line with the research question, and to enable participants to provide informed consent. Participants were initially recruited via a social media advert. In an effort to not dissuade closeted individuals from participating, the advert specified that participants did not need to be ‘out’ about their sexuality or gender to take part. As is common in IPA research, snowball sampling from early participants supported recruitment and contributed to the homogenous nature of the sample (Smith,
It is notable that recruitment via social media and snowball sampling was in part necessitated by the restrictions imposed on research practice and on wider society during the COVID-19 pandemic and lockdown. Initial plans to approach LGBTQ+ organisations and charities in Scotland to recruit participants in person were adjusted according to changing public health guidelines, resulting in greater reliance on social media and word of mouth.

Eight young people participated in the study. Four participants identified their gender as female, two as male and two as nonbinary. When asked for their sexual orientation, three participants described themselves as bisexual, two as gay, one as lesbian, one as asexual lesbian and one as queer. The final sample was aged between 22 and 25 years, \( M = 23.13, \ SD = 1.27 \). Finally, six participants reported their ethnicity as white British, one as white South African and one as Greek Cypriot.

IPA research aims to gather data from a fairly homogenous sample to best capture detailed experiences of a particular phenomenon from a specific group of individuals. This sample was homogenous in that participants stemmed from a tight age range and shared the experience of being LGBTQ+ and coming out about their gender or sexual identity to themselves or others. Notably, there is variation in the sample in terms of gender and sexual orientation and the limited demographic information collected means that homogeneity across other characteristics, such as socioeconomic status and physical and mental health, cannot be assumed.

When considering the homogenous nature of the sample, it is pertinent to reflect on the inclusion of both sexual and gender minority individuals in this single study, when the coming out experiences of sexual minority individuals and gender minority individuals are understood to differ in several important ways (Zimman, 2009). There are comparatively fewer studies examining the experiences of coming out of trans, non-binary and gender non-conforming individuals compared to sexual minority individuals (Brumbaugh-Johnson & Hull, 2019). Consequently, examining gender minority experiences in the research is arguably more urgent. When reflecting on their positionality, as encouraged in IPA, the researcher acknowledged that, as a cisgender sexual minority individual, they may not be best placed to conduct research exclusively examining the experiences of gender minority individuals. Throughout data analysis, the researcher recognised the impact of their own experiences of coming out to family members on their interpretation of participant’s data and managed this through supervision and the use of memos and a reflexive diary. Interpreting narratives from trans, non-binary or gender non-conforming participants whilst not being a trans, non-binary or gender non-conforming researcher would likely mean that certain insights and meaning making would be overlooked. Nevertheless, it felt important to not exclude trans, non-binary and gender non-conforming participants, as excluding them would omit valuable narratives and perpetuate the widening gap in the literature between sexual and gender minorities. As Galupo (2017, pg. 3) writes, “True representation and better science demands that, as cisgender researchers, we actively acknowledge our “cis-ness” and intentionally engage with trans perspectives.” As such, the decision was taken to include a sample comprised of both sexual and gender minority individuals. It was considered that IPA as an approach
would be appropriate as it allows for acknowledgement of the positionality of the researcher and, rather than summarising commonalities to develop a generalisable model, it highlights distinct experiences and individual meaning-making.

**Procedure**
Participants were recruited via social media. The researcher contacted organisations across the UK requesting that the study advert be shared to their social media audience, including LGBT youth organisations, University LGBT societies, LGBT community pages and LGBT charities, and the advert was shared on the researcher’s personal social media account. Participants made initial contact by emailing the researcher. Following initial contact, the Participant Information Sheet and Consent Form were shared via email (see Appendix C) and once informed consent had been returned, the interview was arranged at the participant’s convenience.

The researcher carried out all participant interviews between July 2021 and May 2022. Interviews were conducted virtually for cost and time efficiency, as well as to accommodate the infection control procedures during the COVID-19 pandemic. The semi-structured interview schedule (see Appendix D) was informed by existing literature. The interview was piloted prior to data collection with a trainee clinical psychologist colleague. This afforded the researcher an opportunity to practice facilitating a qualitative research interview and informal feedback was provided by the participant. Each interview was digitally recorded via a function on the Microsoft Teams platform. Recordings were uploaded to a secure network server only accessible to the research team.

Interviews began with informal discussion to build rapport, addressing any remaining questions and ensuring the participant was in a safe and comfortable environment. The recording was started and participants provided demographic information verbally. Each participant was asked if they had chosen to share information about their gender or sexuality with their parent or carer. The subsequent interview questions, (for example, “What was your experience of coming out or discussing [specific aspect of gender or sexuality] with your parent/carer?”) were designed to be open and flexible to facilitate discussion around the participant’s lived experiences of coming out, or not coming out, to parents and carers. Participants’ experiences of managing information about their sexuality and gender were also explored. Where required, prompts were used to encourage exploration of particular experiences and to provide specific examples. Participants were debriefed verbally and the debrief form was also emailed to participants following the interview (see Appendix E).

The interviews were transcribed verbatim by the researcher. Transcription was conducted following each interview to review interview technique and the schedule to inform subsequent interviews. The researcher made reflective memos throughout and following transcription (see Appendix D).
Ethics
The University of Edinburgh School of Health and Social Science Ethics Committee granted the study full ethical approval (Appendix F). This study adhered to principles of data protection and confidentiality, and all identifying information was removed or anonymised during transcription. Participants are referred to by pseudonyms.

Data Analysis
Data was analysed in accordance with the IPA inductive methodology. The primary aim was to understand and interpret meaning within the transcripts, without preconceptions and whilst noting the researcher’s own sense-making process (Smith, Flowers & Larkin, 2009). Analysis was conducted in accordance with Smith, Flowers and Larkin’s (2009) iterative and inductive cycle of analysis. All transcripts were first re-read at least twice for familiarisation. Initial line-by-line coding was conducted to highlight semantic content and language use. Conceptual coding was then undertaken to facilitate greater interpretation and extraction of themes (see Appendix G for example). The extracted themes were then examined for convergence and divergences within each case, and finally, across all cases. Codes, emergent themes and patterns were discussed in supervision.

Reflexivity
Qualitative research is influenced and shaped by the researcher (Willig, 2013). Reflexivity refers to the consideration of the impact of the researcher on the construction of meaning throughout all aspects of the research process (Berger, 2015). The researcher recognised their position as a white British cisgender member of the LGBTQ+ community with lived experience relevant to interpretation of participant data and addressing the research question. Moreover, these factors may have both facilitated or compromised the discussion of particular topics during data collection. A participant, for example, might have assumed a lack of shared experience of disclosing a non-cisgender gender identity to a parent or carer, which could have impacted their comfortability and level of disclosure during the interview. The decision to explore the experiences of and perspectives on coming out to family members for young people reflected an interest of the researcher based on personal experience and clinical observations of the impact of hidden identities and negative coming out experiences in mental health services. These factors influenced the design, analysis and reporting of the present study. In an effort to remain mindful of pre-conceptions and allow participant’s perspectives to be heard, reflection on the impact of personal experience was undertaken throughout the study via a reflexive diary (see extract in Appendix H) and supervision.

Results
Three superordinate themes emerged from the analysis of eight semi-structured interview transcripts, see Table 1. Two participants described having come out to their parents, one of whom did
so via a letter. Two participants reported having not planned to come out to their parents but had come out in response to direct questioning from a parent. Two participants stated that they had not come out to their parents and were unsure whether or how they would. One participant described having explicitly come out to their parent about their gender and being a lesbian but had not disclosed their asexuality. Finally, one participant described not wanting to explicitly come out to his parent but believed that his parent and siblings were already aware that he was gay “by virtue of me being who I am”.
<table>
<thead>
<tr>
<th>Superordinate theme</th>
<th>Sub-theme</th>
<th>Relevant extract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nature of parent-child relationship</td>
<td>Closeness verses distance</td>
<td>“I haven’t really been particularly close to my Dad, so I haven’t explicitly come out to my Dad… from my perspective it didn’t warrant needing to come out to him at all.”</td>
</tr>
<tr>
<td>A generational divide</td>
<td></td>
<td>“The older generation of parents kind of- I think there is this, um, not true understanding that there weren’t people who were queer or non-binary like on the same kind of scale.”</td>
</tr>
<tr>
<td>Teaching and learning</td>
<td>Coming out to self</td>
<td>“I just kind of went through a process of thinking about it and spending time just reflecting on it, I guess, and becoming more comfortable with the idea on my own for a few months.”</td>
</tr>
<tr>
<td>Post coming out</td>
<td></td>
<td>“I didn’t want to subscribe to, like, the heteronormative concept of it, and like, you know, straight people don’t do it, why should I have to do it?”</td>
</tr>
<tr>
<td>Pains and privileges of passing</td>
<td></td>
<td>“I think it’s quite easy for me to kind of seem like I am a straight cis person… it’s kind of double sided because in a way it kind of protects me, like when family and people are asking, because I don’t have to come out.”</td>
</tr>
<tr>
<td>Selective Disclosure</td>
<td>Concerns for safety</td>
<td>“She always fears that people are watching. So we’ll only sometimes hold hands in public.”</td>
</tr>
<tr>
<td>The impact of culture</td>
<td></td>
<td>“They’re so Greek and old school and Christian, I’ve definitely thought like, when I’m around them, I feel like a bit more like a sore thumb. Then sometimes I’m tempted to like, suppress who I am a little bit.”</td>
</tr>
<tr>
<td>Being out online</td>
<td></td>
<td>“So I think it was like a conscious decision because I was aware that would happen. But I thought I’m just going to like this page and I don’t mind if my friends on Facebook find out that I’m bisexual.”</td>
</tr>
</tbody>
</table>
The findings are organised according to Smith’s (2011) recommendations of providing extracts from three participants per theme for a sample of eight or more participants. Each theme is outlined and quotations provided to illustrate the essence of the theme from alternative perspectives.

**Superordinate Theme One: Nature of parent-child relationship**

The first superordinate theme illustrates the participant’s understanding of how different aspects of their relationship with their parent influenced their coming out decisions, experiences and outcomes. This emerged as a significant shared experience for all participants. Their narratives reflected common and contrasting understandings relating to (1) closeness verses distance, (2) a generational divide and (3) teaching and learning.

**Subtheme One - Closeness vs. distance**

This subtheme explores the pre-existing closeness of the participants’ relationship with their parent and the influence of that dynamic on coming out, as well as the impact of coming out, or not, on the parent-child relationship going forward. Notably, none of the participants described rejecting or hostile responses from a parent in response to their coming out. Several participants in fact, such as Jack, Chloe and Emma, described being assured of their parent’s acceptance of their sexuality. Alex, however, described choosing not to come out to their parents due to the perceived likelihood of a negative reaction following them “testing the waters” with references to LGBTQ+ media and friends. Overall, a pattern emerged of parents who were described as being close to or understanding of their LGBTQ+ child being largely accepting. Parents with whom the young person was less close appeared to be described as less understanding, with the subject of sexuality becoming “an elephant in the room” for some.

“My Dad’s always like, assumed and kind of like, realised and always been quite like open with us and, the kind of terms he’ll use, like partner or boyfriend… I was a bit like, ‘Oh you know what? Like, I think my Dad kind of gets it. I don’t really feel the need to.’ I think, you know, if he was using terms like ‘girlfriend’ to me or assuming I was straight or something, that would be a lot different.” – Thomas

Thomas’ account appears to demonstrate the comfortability that can result from a being raised in an open-minded and accepting environment. He believes that his Dad is sufficiently aware of his non-heterosexual sexuality without having to explicitly come out to him, and his Dad’s acceptance of this is communicated through the use of inclusive language. Him having non-heterosexual siblings is likely to have influenced this. Interestingly, Thomas later describes his relationship with his Dad as not being particularly close, more like that of an uncle, and yet his narrative gives the impression of a significant mutual understanding between parent and child which, for Thomas at least, feels positive and secure. Echoing this experience of an LGBTQ+ friendly upbringing, Emma outlines her experience of selectively coming out to one parent and not the other.
“She always tried to make it clear that, you know, if I wasn’t straight or cis, it would be okay and I could tell her. So I guess I kind of felt that it wouldn’t be a big deal and that she would always be open minded to it… I haven’t really been particularly close to my Dad, so I haven’t explicitly come out to my Dad… from my perspective it didn’t warrant needing to come out to him at all.” – Emma.

Here, Emma describes feeling able to come out to her Mum in part due to the inclusive values shared and messages received throughout her upbringing. Her understanding appears to be that her bisexuality would be accepted by her Mum, and this feels reassuring. By contrast, Emma emphasises her more distant relationship with her Dad and how, for her, this lack of closeness justifies her not having to come out to him. Her final statement feels definitive; the distinction between her parents, the nature of her relationship with them and her readiness to come out to them is clear. This distinction between parent figures is mirrored in Charlie’s account, though more in relation to the aftermath of their coming out.

“I guess with my Mum it’s, I like how I can be so honest with her and open. Um, I feel like our relationship is kind of like, evolving to more of a friendship level, which is really nice. And then with her partner, we don’t really get on too well, but I feel like, yeah, I feel like it might have put like, what is it? A spanner in the works… I feel like it’s more of an elephant in the room.” – Charlie.

Charlie’s comparison to a “friendship” and warm reflections on the increased dialogue and closeness with her Mum highlight the potential for relationships to benefit and grow from an LGBTQ+ young person coming out. With regards to the male parental figure, whereas Emma’s distant relationship with her Dad dissuaded her from coming out to him, Charlie’s experience indicates that coming out to her Stepdad had a detrimental effect on their already strained relationship. This is evidenced by their reference to their coming out putting “a spanner in the works”. Moreover, use of the metaphor “elephant in the room” suggests an ongoing discomfort in Charlie’s relationship with their Stepdad, possibly impacting the whole family.

**Subtheme Two - A generational divide**

Some participants shared their beliefs that the disparity in understanding of LGBTQ+ issues, which was partly attributed to generational differences, impacted their experience of or decision to come out to their parent. This appeared distinct from the experience of varying levels of closeness with a parent. The narratives indicated that the participants felt they and their peers had greater knowledge of the LGBTQ+ community, more queries around labelling sexuality and were generally more accepting of LGBTQ+ identities than their parents or older generations.
“I think for them, if I suddenly said like, ‘Oh I’m dating a woman now’ or ‘I’m dating a trans man now’, my Mum would be like, ‘But what about grandchildren?’ Just like, all of the traditional stuff like that, and I think it would just take them a while to just go ‘Oh okay, let me just re-calibrate my expectations for my daughter here’. It’s not all just getting married to a man… because you know, they met when they were 17 and they’ve never dated anyone else, and now they’re like 60. So I think that the experience of dating is very different.” – Sophie

Sophie was not out about her bisexuality to her parents. Her account details her assumption that if she were to come out, her Mum would raise concerns around her heteronormative expectations around having a family and perhaps a lack of understanding around conceiving children outside of a heterosexual relationship. Sophie’s reference to “traditional stuff like that” seems to distance her own beliefs from her parents’. Mention of time to “re-calibrate” aligns with other participant’s views that parents often need time to process when their child comes out. Sophie also outlines the difference in hers and her parents’ experience of romantic relationships, emphasising a lack of shared experience and understanding which may contribute to her tentativeness to come out to her parents. Alex’s account highlighted an additional area where understanding of LGBTQ+ issues may differ by generation.

“The older generation of parent’s kind of- I think there is this, um, not true understanding that there weren’t people who were queer or non-binary like on the same kind of scale. And then someone says ‘Oh, you know, someone else has come out’, they’re like ‘Oh my gosh, like where’d all these people come from?’ They just start being disgusting about it.” – Alex

Here, Alex reflects on their perceptions of their parents’ belief that the less common LGBTQ+ identities are new or part of a recent ‘trend’. This highlights Alex’s perception of a lack of shared understanding and perhaps their own drive to normalise their non-binary and queer identities. The example of dialogue they provide and use of the term “disgusting” imply that they have experienced uninformed or negative responses before and may feel hurt or dissuaded from coming out as a result. Indeed, earlier in their narrative, they stated “the reaction that I’ve gauged from my parents has been maybe, like slightly negative. Kind of making light of it, kind of thinking that it’s all kind of like stupid or something like that”, which is indicative of some dismissal and lack of concordance. Unlike Alex and Sophie, Jack is out to his parents. His account reflects on factors that may contribute to a generational divide in understanding or acceptance.

“They really don’t go out and experience things, so they have a very set view and their views are kind of passed on from their parents who maybe lived in the town or the
surrounding area for, well, their whole lives. It’s like a continuous cycle of these, you know, kind of just passing down your values to your kids and they’re not going out experiencing the world… I think it definitely makes it more difficult because they are so set in their ways, and it was kind of, they didn’t really understand it.” – Jack.

In the context of discussing his insular feeling home town compared to his large and diverse University, Jack shares his perception of how misunderstandings of the LGBTQ+ community may get passed from generation to generation, as a result of not experiencing an LGBTQ+ community and expanding their knowledge. This appeared to contribute to Jack’s understanding of his experience of bullying, as discussed later in the interview. He highlights how coming out to family and friends who harboured ill-informed or entrenched views, particularly within a small or homogenous community, could be incredibly challenging.

**Subtheme Three – Teaching and learning**

The third subtheme encapsulates participants’ perspectives on parents improving their understanding of the LGBTQ+ community around their child coming out, perhaps serving to reduce the gap in knowledge between generations. They describe varying access to resources to support families, as well as debating whether the responsibility of educating lies with the parent or should be supported by the young person themselves. Many participants reflected that improving understanding was a fundamental step for parents and was indicative of support for their child.

“Obviously she’s older than I am and of a different generation, but she’s constantly learning and throughout the process of like even asking me, she’s learned so much and kind of, you know, developed her language and things throughout the past few years, which is mainly why she wanted to ask. She said it was because she wants to learn more about being gay and things like that.” – Jack

Jack’s account emphasises his Mum’s motivation to learn about the LGBTQ+ community and to empathise with his experience as a clear demonstration of support. Jack’s recollection about his Mum comes across as positive and appreciative. This experience may contribute to his feeling of belonging in both his family and the LGBTQ+ community. Charlie and Emma reported similarly positive experiences of their parents supporting them and educating themselves on LGBTQ+ issues, asking questions, reading LGBTQ+ literature and attending Pride parades. Notably, Jack’s reference to his Mum’s age and generation might seek to highlight the possible lack of knowledge and reference points for different generations. Alex addresses this in their reflections on actively educating their “older parents” about LGBTQ+ issues.
“I’ve got older parents as well, so that’s definitely the impression when they, when I say, ‘Oh, you know, someone’s come out’ or ‘Someone’s trans’ or ‘Someone’s using different pronouns’, or anything like that. One of the first things they kind of like jump to is that, ‘Oh everyone’s doing it’. Then I start picking that apart and explain that, you know, over the world there are so many different cultures where this has actually been completely okay and it was only relatively recently that this didn’t become okay. And then when I start picking that apart and giving them the facts and history behind it, then they start becoming like slightly less kind of- making remarks. They go a bit quieter and they kind of think a little bit.” – Alex.

Alex describes their experience of attempting to normalise LGBTQ+ identities within cultural and historical contexts. It appears they felt it necessary to take on an educator role and that countering their parent’s perspective is important to them. It is possible that Alex’s drive to educate them relates to them not being out to their parents and wanting to gage and improve the chances of acceptance by correcting misconceptions. They indicate some success by suggesting that their parents are becoming more contemplative. For Alex, the onus of improving parent understanding of LGBTQ+ issues lies with themselves. Thomas argues that, like Jack’s Mum, it is the responsibility of the parent to educate themselves as part of their support for their child.

“It’s fine to be ignorant, it’s fine not to know everything. But as long as you want to do the work yourself, and understand your child and like, their journey and their story, that’s all you can do as a parent.” – Thomas

In this brief but powerful excerpt, Thomas normalises a common parent experience whilst emphasising the importance of being motivated to develop a shared understanding with their LGBTQ+ child. Several participants highlighted the importance and personal significance of parents working to understand and create an accepting environment where they live comfortably and openly as LGBTQ+ young people.

**Superordinate Theme Two: Navigating identity and expression**

The second superordinate theme is reflective of participants’ experiences of recognising and exploring their own gender and sexuality, their understanding of their LGBTQ+ identity in the context of an existing relationship and their beliefs around coming out at all. Each of these factors appeared to impact individuals’ decision to come out, or not, to their parent. Participant’s reflections revealed common and contrasting experiences of (1) Coming out to self, (2) Post coming out and (3) Pains and privileges of passing.
Subtheme One - Coming out to self

All participants shared aspects of the experience of recognising and exploring their own LGBTQ+ identity. For many, this preceded coming out to their parent. For a few, however, their labelling and accepting of their gender or sexual minority identity was ongoing. There appeared to be a general consensus that coming out to oneself was challenging, empowering and a relief.

“I just kind of went through a process of thinking about it and spending time just reflecting on it, I guess, and becoming more comfortable with the idea on my own for a few months. And essentially like, ‘Is this a phase or is this like actually how I feel?’ and then, yeah, just sitting with it and then being fine with other people knowing about it as I, because I felt more certain that that was how I felt.” – Emma

Here, Emma outlines her process of reflecting on and becoming comfortable with her bisexual identity. Her understanding of her experience feels introspective and gives an impression of self-compassion. A common experience across participants was demonstrated with Emma’s description of feeling “fine” with others knowing about her bisexuality once she herself was “more certain” about it, implying coming out to oneself typically precedes coming out to others. Thomas shared the experience of having accepted his LGBTQ+ identity, but without having then explicitly come out to his parent and friends.

“I’ve always been very much a case of like, making jokes about my campness, my you know, femininity, and always talking about and being open about it… I’ve always kind of thought there’s power in it, and I want to be queer and take up space and like, be proud of it.” – Thomas

Whilst some participants recalled recognising their LGBTQ+ identity later in their teens and taking time to do so, Thomas’ narrative highlights him recognising and embracing his sexuality and identity from an early age. His description of finding “power” in being open and being “proud” to be so indicates strong self-acceptance, as well as his mention of using humour around his “campness” and “femininity” to demonstrate his comfort with himself. It is interesting to note that, despite or perhaps because of this self-acceptance and pride, Thomas reported not feeling the need to come out to his parent. In contrast to his experience, Charlie voiced their experience of still working to accept a facet of their LGBTQ+ identity.

“But as for the asexual part, I think that’s, I’m still like – I think you’re the first person I’ve actually told out loud. Yeah, because it’s, I don’t know. I’ve just got lots of shame like, with not wanting to have sexual relationships. So that’s in my head and that’s more of a tougher conversation.” – Charlie
In Charlie’s case, the asexual aspect of their identity has been more difficult to accept. The use of the term “shame” and reference to a “tougher conversation” indicates the depth of emotion around this issue for Charlie and the challenges they perceive in coming out about being asexual, despite already being out as non-binary and a lesbian. This may relate to asexuality being one of the lesser-understood LGBTQ+ identities and the significance placed on sexual relationships in the LGBTQ+ community and wider culture. It also felt significant that the interview was their first expression of their asexual identity aloud to another person, perhaps indicating a step forward in Charlie’s process of self-acceptance and coming out.

Subtheme Two – Post come out

Some participants voiced feeling that they shouldn’t need to come out to their parent, didn’t plan to come out to their parent, or hadn’t come out to their parent. All participants who shared this view made reference to heterosexual individuals not being expected to come out about their sexuality and consequently questioning why they should be expected to do so. It appeared that these individuals were advocating for taking acceptance of LGBTQ+ identities a step further, by normalising it and removing the need or obligation for an explicit coming out event. Thomas, for example, believed that the process of coming out was a product of heteronormativity, and passionately rejected it.

“I didn’t want to subscribe to, like, the heteronormative concept of it, and like, you know, straight people don’t do it, why should I have to do it? And I think if it, I think if my circumstances with him were a bit different, and I think if I didn’t have two queer brothers, then it would be different.” – Thomas.

Despite his assuredness in not feeling the need to explicitly come out to his parent, Thomas appeared to recognise factors in his family relationships, such as the nature of his relationship with his Dad and his two queer brothers, that support him in holding and acting on his beliefs and instead coming out more indirectly by living authentically. This is similar to Jack’s experience.

“I don’t, I didn’t personally feel the need to come out, because I was very comfortable with who I was and I knew my parents loved me either way and would support me… I don’t think that we should have to put a label on it. Like, people don’t come out as straight, so I don’t, I didn’t feel the need to come out as gay.” – Jack

Like Thomas, Jack acknowledges the privilege of feeling comfortable with his LGBTQ+ identity and being assured of acceptance and support from his family. He notes not endorsing the act of labelling sexuality, which is an opinion shared by Chloe. Considering this perspective more broadly, not feeling the need to come out might imply that Thomas and Jack feel LGBTQ+ identities are less minoritised
and more normalised, though as they suggest, this impression may simply reflect the perspectives of their close family and friend relationships. It is interesting to query whether LGBTQ+ young people who do not experience explicitly coming out to someone might be missing out on the positive emotions of relief and empowerment that other participants described having come out to their family. Jess particularly expressed her desire to explicitly come out to her parents first, before friends and other family members. This demonstrates the variety of perspectives among even a small sample of LGBTQ+ young people. Emma describes her intention to normalise discussion of a same-sex relationship with her parent.

“I just thought if I dated someone who isn’t a guy, I would just introduce them as normal and then they’ll know that I’m not straight… I didn’t want to do a sort of coming out, I guess, or I didn’t think it was necessary.” – Emma

Here, Emma indicates that she wished to introduce a girlfriend to her parent as she would a boyfriend, and this would act as her coming out. Her use of the phrase “as normal” illustrates her desire to normalise her experience and minimise the perceived difference between her heterosexual and homosexual-presenting relationships. However, Emma goes on to reveal that she perceived that her Mum preferred the unintentional yet explicit coming out experience that occurred, as it gave her “notice” and time to process her daughter’s bisexuality.

“I didn’t expect that who I might date would matter, essentially. But apparently, like it seemed that the idea that I might date a woman was something that my Mum wanted to be prepared for. It seemed, in the way that she reacted, that she, she was glad that she found out in the way that I did it, instead of in the way that I was planning to do it, I guess.” – Emma

This narrative portrays a sense of disconnect between the coming out experience Emma envisioned and preferred and what had actually unfolded, as well as her perceptions about the source of her mother’s reaction. Her experience appears to have gone against her wishes and, rather than reinforcing her belief that coming out should not be “necessary”, it suggests that an explicit coming out conversation was preferable for her mother.

**Subtheme Three – Pains and privileges of passing**

This subtheme explores four participants’ experiences of relating to and expressing their non-heterosexual or non-cisgender identity within the context of a current or past heterosexual-presenting relationship. Two participants concerned were bisexual, one queer and one an asexual lesbian. Among many things, their reflections appeared to demonstrate a wider issue in and outside the LGBTQ+ community of bi-erasure, and the frustration that accompanies it.
“I’ve been in a long term relationship with my partner who is a guy and realised, you know, I’ve known these people for like four months now, and they all probably think I’m straight and realising that I feel a bit weird about that. And it feels strange to say that people not knowing my sexuality is odd. But it also is part of your identity I guess?” – Emma

For Emma, presenting as heterosexual or straight to colleagues feels uncomfortable. She understands this as stemming from increasingly familiar people in her life not perceiving an important part of her identity, yet recognises slight conflict when contemplating whether colleagues should be privy to her sexuality information. It is possible that as Emma’s relationships with her colleagues grow, it may feel increasingly uncomfortable or dishonest for their heteronormative assumptions about her to go uncorrected. Sophie shares aspects of this experience in that coming out to her parents would mean challenging their heteronormative assumptions and misconceptions around bisexuality.

“This is one of the biggest barriers to me telling my parents, is that just because somebody is in a heterosexual or heteronormative-appearing relationship, it doesn’t mean that that is just who they are. It’s a part of who they are… Someone can be in a heterosexual relationship but not be heterosexual. And, you know, that can be a different thing. It doesn’t invalidate that relationship. It doesn’t invalidate the love they have for that person. Like you know, if I publicly eat a lot of chocolate cake, I can still really like Victoria sponge. It doesn’t mean I don’t like chocolate sponge anymore. I just, you know, I’m in a public relationship with chocolate sponge.” – Sophie

Sophie’s mention of invalidation highlights what Emma may have experienced as a “weird” feeling. One’s sexuality or gender being invalidated, particularly if recognising and accepting it yourself has been challenging, may be hurtful and difficult to address in existing relationships. Sophie also delivers a cake metaphor to illustrate the validity of her bisexuality, perhaps in a manner that would resonate with her parents if she were to choose to come out to them. Whilst echoing aspects of Emma and Sophie’s experience, Alex’s understanding of their conflicted feelings around passing as heterosexual and cisgender relate in part to the protection passing can offer.

“I think it’s quite easy for me to kind of seem like I am a straight cis person, because I’m currently in a relationship with someone who’s male… it’s kind of double sided because in a way it kind of protects me, like when family and people are asking, because I don’t have to like come out to them. But in the other sense, it means that you
know sometimes, you know, I desperately don’t want to be just seen as someone who is straight, because it doesn’t reflect all of me, just being cis.” – Alex

In Alex’s case, the assumption of heterosexuality and them being cisgender appears to have benefited them by enabling them to avoid coming out to others when they prefer not to. Yet, they also experience the invalidation of not being accurately perceived by those around them. In addition to the discomfort of one’s sexuality being incorrectly labelled, being misgendered may trigger dysphoria and be incredibly hurtful. This is possibly reflected in Alex emphasising that they “desperately” do not wish to be assumed cisgender and heterosexual, despite the possible benefits.

Superordinate Theme Three: Selective Disclosure
The third superordinate theme is reflective of participants experiences and understand of managing their sexuality and gender information. This appeared to be relevant within their relationships with parents, but also in wider relationships such as friends, peers and strangers. Participants’ narratives revealed common experiences of navigating (1) concerns for safety, (2) the impact of culture and (3) being out online.

Subtheme One – Concerns for safety
This subtheme explores participants’ experiences of perceived threats to their safety and wellbeing that may be triggered by their coming out. Participants also describe situations where they have felt safe to disclose their identities. Their reflections on safety are indicative of ongoing inequalities and discrimination in society and highlight a form of cost/benefit analysis that young LGBTQ+ individuals may conduct when deciding to come out.

“It’s still quite difficult to this day sometimes, because [partner] is quite a closed book. She’s not one for public displays of affection. She, yeah, she gets quite, not put off by it, but she feels like people are always looking at her, even though they’re probably not because it’s like you say, it’s becoming more common now and people are living freely as whoever they want to be. But she always fears that people are watching. So we’ll only sometimes hold hands in public.” – Chloe

Chloe’s experience of her relationship with her girlfriend when out in public indicates that thoughts of being observed and possibly unsafe, and adapting behaviour accordingly, are a reality for some LGBTQ+ individuals. This appears to be a more prominent concern for her girlfriend, who may feel she has to manage and contain her identity, as she was metaphorically described as a “closed book”, to avoid judgement, confrontation or discrimination. Chloe describes these concerns impacting their behaviour as a couple, with reference to them “only sometimes” holding hands. There is a sense that they cannot be living entirely “freely” if concerns around safety arise when they are in public together.
This could contribute to feelings of otherness and isolation, which in turn could impact how comfortable an LGBTQ+ young person feels to come out. There was a sense of school and certain interactions with peers being stressful experiences for several participants.

“I feel like with being bisexual, you get the homophobia and you get biphobia, which is another whole thing. Like I mentioned, there was a boy who used my phone to look at something and he found out I was bisexual, and I remember he got kind of weird with me, not necessarily in a bad – well, it was a bad way, I think. He wasn’t being biphobic, but he like essentially sexualised me because I was bisexual… I feel unsure about being open with people who I don’t necessarily know that well, because they could be really strange about it.” – Emma.

Here, Emma describes a disclosure of her bisexuality that was out of her control and the change in her male peer’s behaviour towards her. In pausing and correcting herself (“not necessarily in a bad – well, it was a bad way, I think”), and describing a comparable situation as “really strange”, Emma’s narrative is suggestive of her discomfort or distress. Her dialogue suggests that being sexualised or receiving a “strange” reaction to her sexuality is not unusual. This gives an impression of frustration and hopelessness, so much so that Emma reflects how such experiences impact her readiness to come out to others.

By contrast, several participants reported that educational settings such as school and University were experienced as safe places where they could come out and express their identities. The presence of LGBTQ+ peers was a common positive factor and was associated with greater support and an easier experience of coming out. This may relate to more shared experiences with LGBTQ+ peers than with previous school peers and family members.

“When I went to University, it was a much more open and free space. Like, I went to a very diverse University where there were like, lots of other gay people that I could hang out with. That’s where I really became friends with a group of queer people. Uhm, I definitely think University kind of made me who I am today. It kind of gave me that nudge just to like push me into my real self, if that makes sense?” – Jack

Jack’s account outlines his positive experience of finding like-minded friends at University. It appears he gained a sense of belonging, highlighting the importance of an LGBTQ+ community for young people. His description of being nudged into being his “real self” is indicative of how fulfilling and affirming this experience felt for him. Moreover, Jack’s description of University being “a much more open and free space” is a stark contrast to Chloe and her girlfriend’s experience of feeling observed and possibly at risk in public spaces.
**Subtheme Two – The impact of culture**

The impact of culture captures participants’ experience of considering their family’s values, culture and religion when coming out to them or living authentically around family members. It is notable that only two participants, Thomas and Jess, shared their experience of this, though it appeared to feel significant for them. Another participant, Jack, also relayed his experience of adapting how he expressed himself and his sexuality when travelling.

“I grew up in South Africa and my parents are South African. So like, things like homophobia and racism are a lot more rife there, than it is here. So um, that made it a bit more hard for me because in South Africa, it’s not as accepting as it is here, so that made my coming out harder than say [partner]... When I first came out, I was just so worried about what my parents thought. It was, ‘what about all my family and friends over in South Africa?’ Because, obviously, the way things are there.” – Jess

Jess’ description of her coming out being “harder” than her English girlfriend due to “the way things are there” emphasise her understanding of the contrast between UK and South African culture or values, particularly in relation to homophobia and racism. Her narrative perhaps reveals some frustration at having to be concerned with factors that her girlfriend needn’t consider when coming out. She also makes reference throughout her interview of needing to show respect to her parents. Jess appears to experience a dissonance between wanting to come out and live openly with her girlfriend and worrying that her parents will hold the homophobic views that she believes are prevalent in South Africa and that they may reject her. Thomas’ account is suggestive of a possible negative response from family if he were to be himself in their company.

“I think in terms of the other side of my family, it’s definitely something that bothers me more. I don’t have much interaction with them, but when I’ve been to family events, because they’re so Greek and old school and Christian, I’ve definitely thought like, when I’m around them, I feel like a bit more like a sore thumb. Then sometimes I’m tempted to like, suppress who I am a little bit.” – Thomas.

He indicates that he perceives a barrier between himself and his family, partly as a result of their culture and religious beliefs. His use of the term “sore thumb” highlights his feelings of otherness and he appears to suggest that how he presents, such as his campness and femininity as mentioned later in the interview, would risk some kind of discomfort, conflict or rejection. Thomas describes suppressing “who I am” to manage this, demonstrating the impact on how ‘out’ he feels able to be around particular family members. It is evidence of the strong impact of a family’s cultural belief that Thomas still
experiences this otherness and need to suppress his identity, when in other situations he appears so secure in his outness, to the extent that, unlike Jess, he does not feel the need to come out to his parent. Whilst he does not refer to experiences with family, Jack echoes this suppression of his identity in the context of travelling to a country with an anti-LGBT political background.

“I went to Poland this year, this summer. Uhm, I definitely wasn’t open, as open about it there, just simply because of everything that is going on there with their far right government and the kind of, LGBT-free zones… I maybe dressed ever so slightly less [gesture] than I normally would. Not that I dress extravagantly or anything but, anything that could you know - I was there on my own, so anything that could, trigger something along those lines.” – Jack.

Relating back to the subtheme of safety, Jack appears aware of a potentially hostile political environment and his vulnerability of being alone. He presents his understanding of how it was necessary for him to strategically alter his identity via his clothing and not being as “open” about his sexuality in an effort to keep himself safe. His avoidance of naming the risk, saying instead “something along those lines”, may be indicative of his sense of threat around coming out or being recognised as LGBTQ+ in Poland.

Subtheme Three – Being out online

This subtheme captures participants selectively coming out on social media by managing who among their family and friends can see information pertaining to their LGBTQ+ status. Several participants made reference to detailing their pronouns, uploading photos and updating relationship status’ as methods of coming out online. Their reflections on use of social media largely demonstrate steps taken before coming out to parents.

“I think in my bio I put like the lesbian flag colours in like the little love hearts, so if someone did click on my profile they could see it, but my name is quite, it’s not my name. It’s like a different name. So um, if someone did see if, I wouldn’t mind, they don’t know that it’s me… It’s so empowering, because it’s like, you can, like I don’t know, it is so small, but it’s like ‘Oh that’s me, that’s out there’.” – Alex.

In Alex’s case, they chose to reveal their sexuality in a slightly abstract manner on their social media profile. Their description of using an anonymised name suggests they are not yet comfortable to come out to friends and family who may follow their account. Notably, Alex does not make mention of including identifiers of the non-binary and asexual aspects of their identity, indicating that they are selective about their outness in multiple ways. Nevertheless, they emphasise how affirming and “empowering” even detailing the lesbian flag colours in their bio feels, perhaps another step in their
comfortability with coming out to themself. When discussing including she/they pronouns and LGBTQ+ activism material on their social media, Charlie somewhat echoes this by highlighting the helpfulness of being able to select who sees their posts.

“You don’t have to like, come out fully, you can just be really selective and like control, you know, for example in your Snapchat stories, say if you did want to post something, you could control who’s going to see it on your story. So that way, if you like didn’t want a certain family member or certain friend to see that, then that’s definitely helpful.” - Charlie

Charlie stated that she is not out to her parents and her comments suggests a feeling of safety knowing that they are able to control whether family members would see their LGBTQ+ related social media. This manner of selectively disclosing one’s LGBTQ+ identity was not shared by Jess.

“I mean yeah, I have, we have a massive, or I do anyway, for my family, massive respect. I didn’t think it would be fair if they found out with everybody else. If someone got engaged, they don’t go and put it on Facebook before they tell their parents. If it’s such big news, you know, people, your family, they deserve to know first.” – Jess

Her account reveals the importance for Jess of coming out to her parents directly. Her comparison to an engagement appeared to emphasise the perceived significance of the event for the whole family system. Moreover, her reference to the “massive respect” she has for family and them not deserving to be informed alongside friends online is suggestive of a personal hierarchy for Jess in regards her coming out. Her interview reveals her acting accordingly by first coming out to her parents, followed by close friends in person and finally informing others by confirming her relationship on social media. While all three participants here shared an experience of controlling the disclosure of their LGBTQ+ identity online, they appear to have different priorities and degrees of comfortability with coming out.

**Discussion**

This research aimed to provide insight and depth into the experiences of disclosing sexuality and gender information to parents for LGBTQ+ young people in the UK. By adhering to the epistemological stance of IPA and not stating a priori hypotheses, the research questions were addressed through semi-structured interviews and the identification and exploration of themes. Three superordinate themes emerged within and across the narratives: (1) Nature of parent-child relationship, (2) Navigating identity and expression and (3) Selective Disclosure. The emergence of nature of the parent-child relationship as a superordinate theme was largely anticipated by the existing knowledge base (Mohr & Fassinger, 2003; Tamagawa, 2018; Tilton-
Weaver et al., 2020). The current participants reported varying degrees of closeness with different parent figures. Overall, it appeared that the closer the existing relationship, the easier coming out had been, the more accepting the parent had been or the more assured the young person was of parental support. Such conclusions are tentative as attachment was not directly measured or discussed from the parent perspective. Jack, for example, described a close relationship with his mother. Though he had not planned on coming out to her, now being out meant they shared positive experiences of LGBTQ+ media and Pride parades. This finding conforms to the assumptions of attachment and family systems theory (Ainsworth et al., 1978; Bowlby, 1973; Broderick, 1993), as it is implied that equilibrium had been maintained or restored following the ripples of the coming out event. Thomas offered a slight contrast in that he had not wanted to explicitly come out to his father, reported a somewhat distant relationship, and yet felt assured of his father’s understanding and acceptance of his sexuality. Despite this apparent distance, a secure attachment and feelings of safety are implied and Thomas was likely informed by his father’s treatment of his gay brother who had explicitly come out and been accepted. Attachment security in adulthood has been linked to effective emotion regulation and help seeking in stressful situations (Mohr & Fassinger, 2003), which are likely adaptive in combating minority stress. Considering those participants who had chosen not to come out to their parents, Charlie gave the impression of a mixed relationship with their parents where they could not be confident of acceptance and equilibrium if they were to come out, and so had chosen not to. This appears to align with attachment and family systems theory too. Sophie, however, contradicts this as she outlined a close relationship with her parents but still felt unable to disclose her bisexuality. This indicates that a strong parent-child relationship is likely not sufficient for a confident and comfortable coming out experience. It is notable also that the majority of ‘out’ participants reported having come out to their mother first and either had another relative inform their father or not having come out to their father or father-figure at all. This gender divide is interesting as findings seem very mixed as to whether mothers or fathers are more likely to respond negatively to their child coming out (Tayler & Neppl, 2021).

Similarly, a generational divide was highlighted by participants between themselves and their parents which was perceived as a barrier to coming out or being understood. Sophie reported her parent’s concerns about her being able to have a traditional marriage and family in the context of her bisexuality. Research appears to have focused its examination of generational differences within the LGBTQ+ community, rather than outside it, highlighting disparity in socialising and experience and understanding of the gay rights movement and the AIDS crisis (Russell & Bohan, 2005). Russell and Bohan (2005, p. 2) described how “older LGBT people often see youth as too radical, and LGBT youth often regard their elders as out of touch”. Such a dynamic seems to be reflected in the experiences of the current participants, with Charlie’s parents reported to be dismissing LGBTQ+ concepts and language that are new to them and Thomas and Jack emphasising the need for parents to educate themselves on LGBTQ+ issues. This relates directly to the theme of teaching and learning.
Participants perceived their parents being motivated to learn about the LGBTQ+ community as an indicator of acceptance, before and following coming out. There was divergence, however, over whose responsibility that learning was. Thomas and Jack argued that parents should effectively do their own homework as part of supporting their child. Alex reflected positively on their mother reading LGBTQ+ books she recommended. Charlie, on the other hand, felt it was their responsibility to correct and educate their parents, perhaps reflecting a difference in parents’ reported motivation to engage. Whether occupying the teacher role or not, there was a definite consensus from participants that a parent being open to learning about LGBTQ+ issues and adapting their behaviour to be more inclusive would make coming out easier.

The superordinate theme of navigating identity and expression encapsulated processes of self-acceptance and critically considered the concept of coming out. A common experience emerged from the participants’ narratives of reflecting on coming out to themselves, with some participants reporting still being in the midst of navigating and accepting aspects of their LGBTQ+ identity. Coming out to oneself was generally experienced as positive for this sample, though varied in time scale with Thomas recognising he was ‘different’ from a young age to Sophie who had recognised her bisexuality very recently. Despite recognising and accepting one’s sexual minority identity featuring in several early models of sexual identity development (Cass, 1979; Troiden, 1989), there appears to be little recent research exploring this introspective process. Possibly the focus remains on coming out being an external undertaking, communicating one’s LGBTQ+ identity with others. An avenue for future studies could be to examine coming out to oneself. In support of the literature though, the evolving nature of some participant’s identities nevertheless reflects coming out being a “complex, nonlinear, and never-ending process” (Chernin & Johnson, 2002, p. 9).

Adding to this complexity was the expression by half of the participants of not feeling the need to explicitly come out to their parents. Emma, Thomas and Jack variably described not wanting to hide their queer identities and aiming to normalise their non-heterosexuality by introducing same-sex partners to their parents as a heterosexual couple would. South African young adults reported similarly feeling that coming out perpetuates a heteronormative discourse around sexuality and prevents LGBTQ+ identities and relationships being normalised (Tamagawa, 2018). This contrasts with assumptions around the necessity of outwardly declaring one’s LGBTQ+ identity (Coleman, 1982) and hints at a ‘post-gay era’, where gender and sexual minorities enjoy the same rights, freedoms and autonomy as heterosexuals and coming out is no longer necessary (Ghaziani, 2014). Some posit that many societies are in this stage, whereas others argue that prevalent heteronormativity means coming out is still relevant for LGBTQ+ individuals, perhaps some more than others (Mathers, Sumerau & Cragun, 2018). Indeed, several of the studies proposing a ‘post-gay era’ discuss the perspectives of cisgender gay men and lesbian women, while bisexual and trans people, as well as rural, non-White and poor LGBTQ+ people, continue to be marginalised on a greater scale (Kampler & Connell, 2018; Mathers, Sumerau & Cragun, 2018). For the present sample, not needing to come
out appeared to be an aspiration, with Emma and Jack noting that their parents initiated direct conversations about their sexuality and seemed to require an explicit coming out moment. Moreover, other participants, such as Chloe and Jess, appeared set on explicitly coming out to their parents, and that being an important part of their relationships. This indicates mixed support for rejecting coming out in a ‘post-gay’ world.

As part of navigating identity and expression, bisexual participants were found to raise their discomfort with ‘passing’ as heterosexual. Notably, three of the bisexual participants were in straight-presenting relationships at the time of the interviews. They shared frustrations with their sexuality being overlooked as well as recognising the privileges of passing, for example, with regards to safety. Research into passing appears somewhat limited, though a study with LGBTQ+ focus groups revealed that passing allowed individuals to maintain privileges and power afforded to heterosexuals, though at a cost of reduced intimacy, increased isolation, observing homophobic interactions and limiting LGBTQ visibility (Fuller, Chang & Rubin, 2009). It appeared that passing related to the current participants’ experience of biphobia or bi-erasure, with Sophie referencing her parent’s possible concern that her being bisexual invalidated her relationship with her boyfriend. Weiss (2004) proposed that the privileges that come with passing as straight may also provoke negative reactions from gay and lesbian people, which perpetuates biphobia from within the LGBTQ+ community. Interestingly, the issue of passing was only raised by bisexual participants, indicating that this may be an experience more common for a subpopulation of LGBTQ+ young people.

The emergence of the superordinate theme of selective disclosure aligned with and added to the evidence from Orne (2011) and Guittar and Rayburn (2016), who respectively described ‘strategic outness’ and coming out as a ‘career’ for LGBTQ+ adults. Almost all participants revealed some form of debating and negotiating their coming out depending on relationships and context. For Chloe, this involved consideration of physical safety in public situations. The UK Home Office reported in 2021 that hate crimes against sexual and gender minorities had increased yearly since 2012, with 17,135 homophobic crimes and 2,630 transphobic crimes reported in 2020. Trans people have been found to be at proportionally increased risk of discrimination, harassment and violence compared to gay, lesbian and bisexual peers (Bayrakdar & King, 2021). Browne, Bakshi and Lim (2011) also revealed that LGBTQ+ people in the UK will often normalise much of the abuse they experience in order to carry on with day-to-day life. Such statistics appear to contradict the impression of increasing societal acceptance and go some way to explaining why remaining mindful of threat and judgement when expressing one’s LGBTQ+ identity in public remains relevant for some. As less than half of participants discussed selective disclosure in the context of safety and judgement, it would seem that such abuse was not a significant concern for this sample. Nevertheless, observing, anticipating and experiencing abuse likely contributes to minority stress for the LGBTQ+ community as a whole, and results in greater negative health outcomes (Meyer, 2003).
Relating to minority stress, two participants described how the cultural, ethnic and religious background of their families impacted their coming out and comfort with being ‘out’. Both highlighted the role of conservative views, and the impression that these family members may be less accepting of their LGBTQ+ identity. Indeed, parents with strong conservative political views or religious beliefs are more likely to reject their LGBTQ+ offspring (Baiocco et al., 2015). While both Thomas and Jess were living away from their families, for LGBTQ+ individuals very close to their parents, thinking about coming out can provoke conflict between safeguarding honour versus ostracization (Siraj, 2017). Some choose to uphold cultural norms and values over expressing their sexuality (Siraj, 2017). The findings from the current study provide a small insight into how young people might navigate their intersecting minority identities when managing their gender and sexuality information, though greater exploration is needed.

Finally, several participants highlighted the important step for them of detailing their sexuality or gender identity explicitly, such as through noting pronouns, or implicitly, such as through pride flag coloured emojis, on social media. For most, this appeared part of the development of their identity and comfort with it, as well as being an efficient way to communicate their gender and sexuality information with selected friends. This is mirrored in the literature, which suggests using social media helps LGBTQ+ young people to access resources, explore their identity and find like-minded people (Chester et al., 2016; Craig & McInroy, 2014; Dzurick, 2018). The LGBTQ+ internet space has been found to be especially valuable for people living in rural areas or in countries with homophobic norms and policies (Gruszczynska, 2007).

To address reflexivity as similar IPA studies have done, this section will be written in first person narrative (Tehara, 2020). During analysis and interpretation of data, supervision was sought and a reflexive diary kept in an attempt to remain aware and mindful of researcher assumptions (Pietkiewicz and Smith, 2014; Smith, Flower & Larkin, 2009). Nevertheless, it is understood that it is not entirely possible or desirable to separate the influence of researcher experience from the research process (Benson, 2013). Whilst conducting this research, I became aware of the difficulties with immersing myself in a research topic that was close to my own experiences of being LGBTQ+ with a complex experience of coming out to my parents. I found myself identifying with several events and emotions described by my participants, some of which were challenging to address. At the same time, I experienced a sense of discomfort with interpreting and drawing conclusions about experiences that differed significantly from my own, such as the experiences of my non-binary participants Charlie and Alex. I considered these factors when understanding my avoidance of examining confronting literature and writing up my findings. By way of managing the impact of this, random anonymised sections of transcript and coding were discussed with peer LGBTQ+ researchers to consider bias and alternative perspectives. Upon reflection, I was drawn to this area of research because, as an LGBTQ+ individual and as a clinician with experience of working with LGBTQ+ young people and families in
child and adult mental health services in the UK, I felt a need for LGBTQ+ young people to be better represented and understood.

When examining the findings of the present study, there are methodological limitations to be considered. This study, as with much research with stigmatised groups, demonstrates some shortcomings with sampling (Ritter & Terndrup, 2002). LGBTQ+ participants can be difficult to recruit, due to stigma and experiences of trauma (Cardenas et al., 2018). The sampling methods employed, particularly snowball sampling from existing participants, were not necessarily conducive to recruiting a diverse sample. Consequently, the experiences of trans-male, trans-female, non-White and non-University educated individuals are under-represented. There is a question as to whether a white, cisgender researcher is best placed to examine and interpret the experiences of these populations, but nevertheless the current analysis is limited in its ability to address the impact of different racial, cultural and religious values and the intersection of various minoritised identities. In addition, upon reflection the interview schedule would benefit from less structure and fewer specific prompts. Though the schedule was slightly broadened following each interview, it is possible that the direct questions included may have reduced the opportunity for wider reflections on participants’ experiences. Moreover, due to restrictions in place during the COVID-19 pandemic, interviews were conducted via virtual conference call. Data quality between telephone and face-to-face interviews is comparable (Block & Erskine, 2012), however opportunities to detect important non-verbal information may have been missed. Data collection and analysis were also carried out by a single researcher. Reflexivity is an integral part of IPA to ensure analysis is unencumbered by the researcher’s preunderstanding of the topic area or bias. Whilst the researcher made use of a reflexive diary and peer supervision to attempt to bracket pre-existing assumptions (Fischer, 2009; Smith, Flower & Larkin, 2009), analysis and interpretation of the data was conducted alone and may have been influenced by the personal assumptions and experiences of the researcher. Triangulation to increase the credibility and transferability of IPA findings (Alase, 2017) was not carried out due to time restraints. Ideally, participant feedback on themes would be sought to better ensure methodological rigour and validity of findings.

In using IPA, this study sought to examine and describe the in-depth personal experiences of participants to gain greater insight and understanding into their experience of a significant and personal process (Smith, 2011). The approach has been successfully utilised to facilitate insight into the life experiences of LGBTQ+ individuals previously (Chan & Farmer, 2017). Small sample sizes are common for such research and though this project did not strive to deliver a generalisable definitive conclusion, it can be perceived as a limitation, nonetheless (Guittar, 2013). A notable strength of this study is the capturing of rich data on the experiences of lesser-researched sexual and gender identities including non-binary, queer and asexual individuals, as well as the experiences of LGBTQ+ young people who were not or were only partially ‘out’ (Guittar, 2013). Moreover, effort was made to best ensure methodological rigour. Care was taken to ensure sensitivity to the context of
the existing knowledge base, by understanding relevant gaps and linking findings back to the literature, and to the context of participants sharing their experiences and the role and impact of the researcher. Commitment and rigour were addressed through gaining a sufficient sample size, having an LGBT research peer contributing towards analysis and presenting quotations and an example of coding to demonstrate the interpretive process. In addition, the detailed methodology and use of a reflexive diary to reflect on the researcher’s experience of and relationship with the participants and data analysis contribute towards coherence and transparency (Yardley, 2000).

The findings of the current study could prove relevant and useful to parents and carers with LGBTQ family members. As demonstrated by Jack, Charlie and Emma, parents being motivated to learn about the LGBTQ+ community to better empathise with and support their young person provoked positive emotions and was perceived as an expression of family acceptance. There is strong evidence for parental support and family connectedness significantly improving wellbeing outcomes for LGBTQ+ young people (Bouris et al., 2010; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). This makes it even more concerning that a recent large-scale research project has identified trends of decreasing levels of support for LGBTQ+ young people from their parents (Watson et al., 2019). Though not generalisable to wide populations, the current participants’ detailed narratives may provide valuable insight for parents into what an LGBTQ+ young person in the UK may be experiencing around coming out and inform them on how best to respond to and parent such an individual, thereby improving their wellbeing. This may be particularly pertinent for parents of adolescents whose LGBTQ+ child may be debating coming out during a sensitive developmental period, with fewer emotion regulation resources and where they are emotionally and financially dependent on their parents and compelled to attend school (Mills-Koonce, Rehder & McCurdy, 2018). By engaging with resources detailing the experiences of LGBTQ+ young people, parents and carers may improve their understanding and the likelihood of maintaining positive family relationships, re-establishing equilibrium (Willoughby, Doty & Malik, 2008) and facilitating the best possible outcomes for their young person.

In a similar vein, insights provided by the current study could be beneficial for healthcare professionals who provide services to LGBTQ+ individuals. Heteronormativity in healthcare can lead to health disparities for LGBTQ+ patients, with healthcare professionals not having sufficient knowledge of LGBTQ+ mental and physical health issues (Stewart & O’Reilly, 2017; Torres et al., 2015) and anti-LGBT jokes and bullying occurring frequently between medical colleagues (Nama, McPherson, Sampson & McMillian, 2017). Transgender patients appear to face the most negative attitudes and ignorance (Higgins et al., 2021; McCann & Brown, 2018; Stewart & O’Reilly, 2017). Positive healthcare experiences for LGBTQ+ patients have been characterised by validation, understanding and affirmation (Benson, 2013). Learning about the coming out experiences of LGBTQ+ young people, perhaps as part of awareness training (Hughes, Rawlings & McDermott, 2018), may improve staff understanding and better support them to provide affirming and informed
care and adapted approaches. For example, for mental health professionals providing family therapy, Willoughby, Doty and Malik (2008) highlight the importance of considering coming out as having a ripple effect for all family members and the need to support family communication and problem solving as the family adjusts as a whole. Improving understanding of LGBTQ+ experiences could be a pressing concern, as the mental health of LGBTQ+ young people has been disproportionately impacted by the COVID-19 pandemic, potentially resulting in greatly increased presentations to healthcare services (Dawson et al., 2021).

To further progress the knowledge base, future research could examine in depth more homogenous groups; for example, the trans-male experience of coming out to parents, which appears especially under-represented. Limited research in the area reveals parental acceptance is associated with lower anxiety and depression for trans individuals (Budge, Adelson & Howard, 2013) and Brumbaugh-Johnson and Hull (2019) found that coming out for trans people is experienced as an ongoing strategic management of one’s identity, involving significant compromise in order to maintain social relationships, physical safety and economic security (Reczek, 2020). It is particularly pertinent to gain a greater understanding of the lived experience of trans individuals, as they are at increased risk of minority stress, rising discrimination and unique challenges within medical and mental healthcare (Ellis, Bailey & McNeil, 2015; Stonewall, 2018). For similar reasons, future research could focus on exploring the experiences of coming out for ethnically minoritized LGBTQ+ individuals. The complexity of the impact of ethnicity, culture and religiosity, particularly within the parent-child relationship, was very briefly touched on in the current study and a small number of recent IPA studies have provided valuable insight into the experiences of LGBTQ+ young people of colour (Ghabrial, 2017; Khatun, 2018; Tehara, 2019). Expanding this area of study could support the adaptation of LGBTQ+ resources for specific populations in an evidence-based manner (Mills-Koonce, Rehder & McCurdy, 2018). Finally, it would likely be beneficial to address possible sources of bias by developing studies with parent-child dyads. As highlighted by family systems theory (Broderick, 1993), the process and impact of coming out occurs in the context of family relationships. Neglecting parents’ perspectives, and the perspectives of other family members, limits understanding. Hearing from an LGBTQ+ young person’s family members may improve the validity of existing findings and provide an opportunity to explore how coming out is experienced within the family unit.

In conclusion, coming out to oneself and one’s family is a significant undertaking for an LGBTQ+ young person. Participants in the current study revealed complex experiences of coming out, centering around the nature of parent-child relationships, navigating identity and expression and selective disclosure. This was largely supported by existing literature. Coming out to one’s parents has often been considered a prerequisite of living authentically and happily for an LGBTQ+ person (Savin-Williams & Cohen, 2015), and an essential step for a parent’s acceptance of their child (Mattison & McWhirter, 1995). Not only does this assumption negate the experiences of those who for personal, cultural or religious reasons feel they cannot come out (Siraj, 2017), it also overlooks
individuals who, by contrast, feel so assured, understood and content with their identity or their family’s support that they do not feel the need to come out. The latter perspective perhaps reflects the positive shift individuals and societies have made regarding acceptance of the LGBTQ+ community. Nevertheless, even for those who reject explicitly coming out to their parents, the ongoing heteronormative nature of society means that non-heterosexual and non-cisgender identities remain minoritised, with individuals experiencing discrimination and various inequalities. Until this is no longer the case, coming out will likely remain a complex and transformative process for LGBTQ+ young people and their families (Alonzo & Buttitta, 2019; Guittar & Rayburn, 2016).
References


Berger, R. (2015). Now I see it, now I don’t: Researcher’s position and reflexivity in qualitative research. *Qualitative Research, 15*(2), 219-234.


Appendix

Appendix A

Systematic Review Protocol

Title
Risk and Protective Factors for Disordered Eating in LGBTQ+ Youth: A Systematic Review

Review question
The aim is to examine and summarise the risk and protective factors relating to clinically diagnosed eating disorders and subclinical disordered eating in LGBTQ+ young people from the available evidence in the literature.

The review question is what are the risk and protective factors for eating disorders and disordered eating in LGBTQ+ youth?

Searches
The search will be conducted within the following databases: CINAHL, Science direct, Proquest, Scopus, Pubmed, Psychinfo, Ovid medline, Embase. The review will follow PRISMA guidelines (BMJ, 2009). Only studies published in an English language peer-reviewed journal will be included.

The search strategy will apply the database-specific methods of using the following search terms: Eating disorde* OR Binge eating disorder OR BED OR Anorexi* OR AN OR Bulimi* OR BN OR ARFID OR Avoidant restrictive food intake disorder OR EDNOS OR Eating disorder not otherwise specified OR eating-related pathology AND Youth OR young people OR young adults OR adolescents OR teen* OR children OR student AND LGBT OR LGBT* OR queer OR lesbian OR gay OR bisexual OR trans* OR intersex OR asexual OR homosexual OR sexual minorit* OR gender minorit* OR non-binary OR gender expansive OR gender diverse OR gender non-conforming OR gender identity OR sexual orientation.

Types of study to be included
The types of study to be include will be quantitative and qualitative designs addressing eating disorders or disordered eating in LGBTQ+ youth.

Condition or domain being studied
The conditions being studied are eating disorders, specifically anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), Avoidant restrictive food intake disorder (ARFID), eating disorder not otherwise specified (EDNOS), and disordered eating.

Participants/population
Inclusion criteria:
- Participants identified as LGBTQ+
- Participants were reported to have a diagnosed eating disorder according to the DSM-IV, DSM-5 or ICD-10, or disordered eating behaviours operationalised using a standardised questionnaire measure or screening tool
- Participants were aged between 10 and 24 years-old
- The study offered quantitative and/or qualitative data addressing eating disorders or disordered eating in LGBTQ+ youth
- The study was published in an English-language peer-reviewed journal
- The study was published after 2010

Exclusion criteria:
- Participants had co-morbid medical conditions or somatic disorders, such as Diabetes Mellitus or Prada-Willi Syndrome
- The study took the form of a case study, case series, letter, commentary, poster, book or book chapter
- The full text was unavailable
- The study was published before 2010
- The study was not published in English
• The study was unpublished

Intervention(s), exposure(s)
The studies must involve quantitative or qualitative examination of eating disorders or disordered eating in LGBTQ+ youth.

Context
Studies in clinical or research settings.

Main outcome(s)
The main outcome will be to identify and describe risk factors for and protective factors against eating disorders and disordered eating in LGBTQ+ young people.

The narrative synthesis will describe emerging risk factors and protective factors. In the included studies, eating disorder symptomology will be measured against DSM-IV, DSM-5 or ICD-10 diagnostic criteria, or disordered eating behaviours will be operationalised using a standardised questionnaire measure or screening tool.

Data extraction (selection and coding)
Titles and/or abstracts of studies retrieved using the search strategy and those from additional sources will be screened independently by one review author to identify studies which potentially meet the inclusion criteria outlined above. The full texts of these potentially eligible studies will then be retrieved and independently assessed for eligibility by two review team members. Any disagreements between them over the eligibility of particular studies will be resolved through discussion with a third reviewer.

Criteria for data extraction will include:

1. Author(s), publication year, period of data collection, and country where research took place
2. Location
3. Study design
4. Research aims and/or research questions
5. Sample population and N
6. Inclusion and exclusion criteria
7. Recruitment strategy/method of sampling
8. Measures utilised
9. Comparison/control population
10. Analysis
11. Findings
12. Conclusions
13. Study limitations
14. Source of funding

Risk of bias (quality) assessment
A quality assessment will be conducted with the Quality Appraisal Checklist for Quantitative Studies and Quality Appraisal Checklist for Qualitative Studies from Methods for the Development of NICE Public Health Guidance (third edition; NICE, 2012). The quantitative checklist contains 19 items and the qualitative checklist contains 14 items. There are five possible response options for each item: ++ indicated that aspect was designed or conducted in such a way as to minimise the risk of bias, + indicated that either that aspect was unclear from the way the study was reported, or that the study did not address all potential sources of bias for that aspect of study design, - indicated that that aspect of study design was likely to be subject to significant bias, NR indicated that details were not reported and NA indicated not applicable.

Two examiners will conduct the quality appraisal - any discrepancies will be discussed between the two examiners and if agreement is not reached, discussion with an independent reviewer. The quality of studies included will be discussed within the discussion section of the narrative synthesis, for example, reflecting on the impact of the quality on the interpretation of the findings.
**Strategy for data synthesis**

A narrative synthesis will be conducted to explore both risk and protective factors associated with eating disorders/disordered eating among LGBTQ+ youth. A narrative synthesis is preferable to a meta-analysis due to anticipated heterogeneity across study designs.

The points of interest for the synthesis of results will be: prevalence of eating disorders/disordered eating among LGBTQ+ youth (particularly compared to a heterosexual or cisgender control population), how eating disorders/disordered eating present for LGBTQ youth and distal and proximal risk and protective factors associated with eating disorders/disordered eating for LGBTQ+ youth.

Text and tables will be used to provide a descriptive summary and explanation of study characteristics and findings.
Appendix B

Medline search terms for systematic review


Appendix C

Participant Information Sheet

Sexuality and gender identity information management and disclosure for young people

You are being invited to take part in research about how LGBTQ+ young people manage and disclose their sexuality and gender identity information within families. This research is led by Megan Spruce, Trainee Clinical Psychologist at the University of Edinburgh, and supervised by Dr Jessica Mirman. Before you decide to take part, it is important you understand why the research is being conducted and what it will involve. Please read the following information before deciding if you want to participate.

WHAT IS THE PURPOSE OF THE STUDY?
The purpose is to better understand how LGBTQ+ young people manage their sexuality and gender identity information, and discuss this information with their parents or carers.

WHY HAVE I BEEN INVITED TO TAKE PART?
Because you are an LGBTQ+ young person between 16 and 25 years-old, you live in the UK and are fluent in English.

DO I HAVE TO TAKE PART?
No. Your participation is voluntary. You can withdraw at any time and without giving a reason. You do not need to answer all questions. Deciding not to take part or withdrawing from the study will not affect any services or benefits to which you are entitled.

WHAT WILL HAPPEN IF I DECIDE TO TAKE PART?
You will be asked to complete and return the participant consent form by email. After you have given your consent, you will be sent a link to participate in a 1:1 interview over Microsoft Teams with the researcher. We encourage you to undertake the interview in a private location where you feel safe and comfortable. You will be asked questions about your experience as an LGBTQ+ young person. The interview should take approximately 30 minutes. The interview will be recorded so that the researcher can later transcribe the interview. You will be given the option to provide your email address to be contacted with the results.

WHAT IF I WANT TO WITHDRAW FROM THE STUDY?
You can stop your participation at any time and without giving a reason. We will keep the data you have provided up until the point that you withdrew, including your original decision to participate. We need to manage the data in specific ways for the research to be reliable. This means that the researchers will not be able to let you see or change the data we hold about you.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?
You will help us understand how families communicate about sexuality and gender identity.

ARE THERE ANY RISKS ASSOCIATED WITH TAKING PART?
There are no significant risks associated with participation. You may experience minor stress while talking about your experiences. You can ask to take a break at any time and any stress causes should be minimal and cease upon completion of the interview. We will electronically provide you with information about support or information services once you have completed the interview or indicated that you decline to participate.

DATA PROTECTION AND CONFIDENTIALITY
Your data will be processed in accordance with Data Protection Law. The researcher will conduct the interview in a quiet and secure location where they cannot be overheard. Headphones will be used. All information, including your email address, consent information, audio recordings and transcribed interview data, will be kept strictly confidential on a restricted-access University server. Your consent form will be stored separately from your responses. Your email address will be stored separately from your consent form and responses. Your email address will be stored in a password-protected document on the restricted-access University server and deleted following your participation. If you choose to receive a summary of findings, your email address will be retained in this manner and deleted upon distribution of the study summary. Your data will be referred to by a pseudonym. Your data will only be viewed by the researcher/research team. Upon completion of the project, all identifiable personal information will be permanently deleted. The remaining pseudonymised data will be stored on secure University software for a minimum of 5 years, after which it will be permanently deleted.

HOW WILL YOU USE INFORMATION ABOUT ME?
We will ask for information from you for this research project. This information will include demographic information (your age, sex assigned at birth, gender, sexual orientation and ethnicity) and details of personal experiences that you choose to share. People may use this information to do the research or to check to make sure the research is being done properly. We will keep all information about you safe and secure. The final report will be written in a way that means no single participant can be identified.

WHAT WILL HAPPEN WITH THE RESULTS OF THIS STUDY?
The results of this study will be summarised in reports and presentations and may be used to make materials for families with an LGBTQ+ young person. Quotes or key findings will always be pseudonymised in any formal outputs.

WHO HAS REVIEWED THIS STUDY?
The School of Health in Social Science ethical committee at the University of Edinburgh has reviewed and approved this study.

WHO CAN I CONTACT?
Please contact Megan Spruce at or Dr Jessica Mirman at if you have questions about the study.
If you want to ask any questions or advice from someone external to the study then please contact Dr Larry Doi:  .

If you wish to make a complaint, please contact The Head of School, Dr Matthias Schwannauer: headofschool.health@ed.ac.uk. In your communication, please provide the study title and detail the nature of your complaint.

For general information about how we use your data go to: https://www.ed.ac.uk/records-management/privacy-notice-research
Consent Form

Sexuality and gender identity information management and disclosure for young people

Researcher name: Megan Spruce
Researcher contact details: M.Spruce@sms.ed.ac.uk

Please READ AND INITIAL each of the following statements if you wish to participate in this research study.

☐ I confirm that I have read and understood the Participant Information Sheet (Version 1, 15/03/2021) for the above study.

☐ I have been given the opportunity to consider the information provided, ask questions and have had those questions answered to my satisfaction.

☐ I understand that my participation is voluntary and that I can ask to withdraw at any time without giving a reason and without my rights being affected.

☐ I understand that my pseudonymised data will be stored for a minimum of 5 years.

☐ I agree to take part in the above study.

Person giving consent

Name:
Signature: (can be electronic)
Date:

Person taking consent

Name:
Signature: (can be electronic)
Date:
Appendix D

Interview Schedule – Young person

Sexuality and gender identity information management and disclosure for young people

Confirm receipt of Informed Consent Form and give further opportunity for questions.

Demographic questions:

- Age
- Sex assigned at birth
- Gender
- Sexual orientation
- Ethnicity

Have you chosen to share information about your sexuality or gender with a parent/carer?

What was your experience of coming out or discussing [specific aspect of gender or sexuality] with your parent/carer?
  - Prompt: Can you tell me more about that?
  - Prompt: How did it make you feel?
  - Prompt: What factors did you consider?

What is your experience of choosing not to come out or discuss [specific aspect of gender or sexuality] with your parent/carer?
  - Prompt: Can you tell me more about that?
  - Prompt: How does it make you feel?
  - Prompt: What factors did you consider?

What is/would be the impact of you being ‘out’ to your parent/carer?
  - Prompt: Can you tell me more about that?
  - Prompt: How does it make you feel?
  - Prompt: Are there advantages or disadvantages of being ‘out’ for you?

What is your impression of how you manage your sexuality and gender information? (By manage, I mean how you might control what people know about your sexuality and gender, and how they came to know it).
  - Prompt: Some young people are ‘out’ in some situations or with certain people, and not with others. What is your experience of this?
• Prompt: Some young people make use of the internet and social media when thinking about coming out. What is your experience?

Has your experience of being ‘out’ changed over time? If so, how?

*The research team is aiming to develop resources to help young people talk with their parents and carers about their sexuality and gender. From your experience, what do you think those resources should include?

Is there anything else you want to share with me that I have not already asked you?
Appendix E

Participant Debrief Sheet

Sexuality and gender identity information management and disclosure for young people

Thank you for participating!

If you would like more information about LGBTQ+ support resources please visit:

- LGBT Health and Wellbeing - Scotland - https://www.lgbthealth.org.uk/services-support/helpline/
- Mermaids UK - https://mermaidsuk.org.uk/
- Young Stonewall - https://www.youngstonewall.org.uk/
- LGBT Youth Scotland - https://www.lgbtyouth.org.uk/

If you would like to be notified about the results of this study, or are willing to be contacted about participating in future research on this topic you can email: M.Spruce@sms.ed.ac.uk. Your information will never be distributed to a third party, not linked to interview data, and always kept on a secure server.

WHO CAN I CONTACT?
Please contact Megan Spruce at or Dr. Jessica Mirman at Jessica.hafetz@ed.ac.uk if you have questions about the study.

If you want to ask any questions or advice from someone external to the study then please contact Dr Larry Doi:

If you wish to make a complaint, please contact The Head of School, Dr Matthias Schwannauer: headofschool.health@ed.ac.uk. In your communication, please provide the study title and detail the nature of your complaint.

For general information about how we use your data go to: https://www.ed.ac.uk/records-management/privacy-notice-research
Appendix F

Screenshot of University of Edinburgh School of Health in Social Science Research Ethics approval

DClinPsy thesis project amendment request (CLIN752)

To: SPRUCE Meg < > Thu 10/06/2021 16:39
Cc: HISS Research Ethics

Dear Megan

Thank you for your revised application. Based on your responses the application meets the standards for favourable opinion from the Clinical Psychology, University of Edinburgh Ethics Committee. The signed ethical response sheet/application is attached – please note that this is fine to attach to your dissertation etc. If you require a formal letter of ethics approval (this is only required if you are approaching third parties, NGOs etc) then please contact the new ethics mailbox (ethics.hiss@ed.ac.uk) requesting this and a formal letter of approval will follow in due course. If you need to make any changes to the study, you should return your amendment to the new ethics email - ethics.hiss@ed.ac.uk, cc’d above with the changes clearly noted in the relevant section of the form.

Good luck with your project.

Best wishes,
Karri

All recordings will be uploaded from my password protected Microsoft teams account to the secure University server immediately following the interview, thereby removing the need for encrypted external devices. Once uploaded to the University server, the recording will be deleted from Microsoft Teams. I will access the University server from a password protected device.

Signature:

Date: 31/03/2021

CONCLUSION TO ETHICAL REVIEW OF AMENDMENT

The applicant’s response to our request for further clarification or amendments has now satisfied the requirements for ethical practice and the application has favourable opinion from Clinical Psychology Ethics Committee.

Signature:

Position: Lecturer in Applied Psychology/ Ethics and Integrity Lead

Acronyms / Terms Used

NHS: National Health Service

SHISS: School of Health in Social Science

IRAS: Integrated Research Applications System

Section: The SHISS is divided into sections or subject areas. These are Nursing Studies, Clinical Psychology, CHASS
Appendix G

Example of line by line and conceptual coding

SPRUCE Meg
OK. Could you describe your experience of coming out to that parent?
Pp08
It wasn’t 100% deliberate. Well, it wasn’t really deliberate to be fair. So my original intention had been, once I kind of was settled with the idea that I was bi, just kind of thought, for now I was thinking if I ever dated a woman, because that would not be what my parents would expect, I’d just introduce them, like anyone. I’m not- I say I’m bisexual, but it’s more that I don’t really care about gender because, you know like nonbinary people and stuff, it’s not really binary anyway. I just thought if I dated someone that’s not a guy, I would just introduce them as normal and then they’ll know that I’m not straight, I guess. But it was during Pride Month. I think there was something on the TV and it was something about experiences of gay people and we were talking about it. And I can’t remember what happened or what question was asked, but I think my mum said something under the assumption that I was straight and I sort of did a little [smile].
SPRUCE Meg
OK.
Pp08
Like a little smile like, like, ‘Yeah, sure’, and she looked at me like - Well, I was like, ‘Oh, I guess I’ll say it then’, like, actually, ‘I think I’m bisexual. I would date women as well, I’d date other people’. And she was like ‘Oh’,

Unintentional disclosure
Comfortable with bisexual identity - coming out to self
Defying parents’ expectation
Plan to come out by introducing same-sex partner
“Like anyone” and “as normal” implies not perceiving or wanting there to be a semantic difference between partners
Clarifying personal definition of bisexuality
Relying on parents to understand, quite passive
Significant time/event

LGBTQ+ media encouraging discussion
Parent assumption of heterosexuality

Tentative initiation of conversation
Decided to disclose
Direct disclosure
“I think” and “I would” still feels tentative
Perceived shocked reaction

Proceeding first coming out to
accepting myself

Unintentional disclosure
Comfortable with bisexual identity - coming out to self
Defying parents’ expectation
Plan to come out by introducing same-sex partner
“Like anyone” and “as normal” implies not perceiving or wanting there to be a semantic difference between partners
Clarifying personal definition of bisexuality
Relying on parents to understand, quite passive
Significant time/event
and she said something like, "Why haven't you told me?" Because it was obviously, it wasn't like particularly, I didn't like just sit down and say 'Look, I have this'. I just kind of, if I had intended to do it, just kind of that I'd intended to kind of introduce someone if I ended up dating someone, as you normally would if it was you, you know, anyone really. And she said, "Oh, well, I'm kind of glad that I found out this way out that way", because she said that she would have found that a bit, it would have caught her off guard, I guess. I think it is what she was trying to say.

SPRUCE Meg

OK

Pp08

To just be -- to have it kind of sprung upon her I guess, but, yeah. And she also did say something like, "I'm not sure whether you should tell your dad". And I can't remember why I don't. I still don't really get why, but yeah. That's essentially the scenario that happened.

SPRUCE Meg

So just to check my understanding then, it sounds like it was a kind of spur of the moment decision on your part in reference to a conversation that you were having.

Pp08

Yeah. It just kind of, almost like slipped out essentially. Like it wasn't that I had intended to -- I never really intended to hide it. I didn't want to do a sort of coming out. I guess I didn't feel like it was necessary.

SPRUCE Meg

I wonder if you can tell me a bit more about that, about not wanting to or not feeling like it was necessary?

Pp08

I guess it might partially be because my mum has always said and that like, "You know, by the way you know, if you ever feel that you identify differently, like than you feel like you love a woman, like, I would never judge you and I would accept that". It had always been something I think that she had wanted to ensure that I knew. If I ever felt that I think I don't know whether she's explicitly said if my gender identity was different or but with sexuality as well, she always tried to make it clear that, you know, if I wasn't straight or whatever, it would be OK and I could talk to her. So I guess I kind of felt that it wouldn't be a big deal and she would always be open minded to it. But I think that's because, partially because like my friendship group at the time, who have

Not a formal direct conversation

"as you normally would" implies not perceiving or wanting there to be a semantic difference between partners

Mum's perspective, preferring to have conversation "caught her off guard" implies something shocking

Uncertainty about Mum's perspective "sprung upon her" implies shock or discomfort

Understands that Mum was shocked/confronted. Guilty? Mum not wanting Pp to come out to Dad

Uncertainty about Mum's perspective

Questioning suggests lack of understanding, hurt feelings that Dad might not be supportive, and Mum is limiting disclosure.

Decision to disclose was impacted by context of Pride month, TV show, conversation

Not intending to formally or explicitly come out ("slipped out") implies not in control?

Not feeling coming out is necessary

Whilst also not hiding identity. Living authentically, without need for parent validation? This feels comfortable and normal.

Mum communicated openness during upbringing

Mum offering reassurance and acceptance

Understand that Mum values openness and acceptance

Distinction/difference between gender identity and sexuality

Reassured of acceptance from Mum.

"I guess I kind of felt that it wouldn't be a big deal" - hesitant, doubtful? Believed Mum would offer immediate acceptance

Mum believes it is significant/expected but doesn't want to "out" her kids from Mum's own experience.

Resonating with my personal experience.
on it. I was on a train, trying to remember where I was going with that. Uhm, I didn't expect that who I might date would matter, essentially. But apparently, it seemed that the idea that I might date a woman was something that my mom wanted to be prepared for. It seemed in the way that she reacted, that she was glad that she found out in the way that I did it instead of in the way that I was planning to do it. I guess. Because yeah, I found it odd that she wanted to be prepared for that idea because to me it doesn't make a difference.

SPRUCE Meg

OK.

Pp08

Because yeah, I guess it doesn't make a difference to me. So why would it make a difference? Like, it's still the same.

Introducing a guy or introducing a woman doesn't seem to make a difference to me, to my parents, if that makes sense?

SPRUCE Meg

But it was implied from your mum's reaction that for her, there was a bit of a difference that she wanted to prepare for.

Pp08

Yeah. She wanted to be prepared for the idea that I would date women.

SPRUCE Meg

OK.

Pp08

And I guess I still, I don't know. It does make sense I guess, maybe, for her generation.

SPRUCE Meg

Yeah. You mentioned her generation. What are your thoughts about any kind of generational differences or similarities?

Pp08

I think, I think my generation, well not everyone in my generation, but a lot of people in my year group, maybe it was just I was lucky with the kind of friends I was surrounded with, but people didn't really assume, you know? We were always open to the fact that anyone could—especially at that time in my life, I was 17, so when I was quite of realising my sexuality, 17 to 18 at that time everyone was very open-minded that anyone could be considered the usual sexualities or it could be anyone could not be assumed because people are at that age where they're just discovering things so no one assumed anything that way. Whereas, I think that is how I perceive my generation. And then I guess, with older generations I don't really know what I think.

Surprised that her sexuality mattered to Mum.

"But apparently, like it seemed that the idea that..." implies surprise, uncertainty, frustration. Mum preferred to have 'notice'. If not being cis/het is normal, why did Mum react that way?

Feels like Pp received contradictory messages. Mum reacted somewhat negatively despite normalising it, and Pp might feel cheated or confused.

LGBTQ+ status doesn't make a difference to Pp.

Rhetorical question—uncertainty. Wanting parents to share her opinion, because if they don't, they might not accept her. Relationship becomes conditional.

In Pp's experience, people of similar age/experience do not make assumptions about LGBTQ+ status.

Understanding of shared experiences and values and a safe environment with people her age. What Realising sexuality at 17?

"Usual sexualities" implies there is still a norm/majority.

Mid-late teens discovering sexuality and gender identity.

Uncertainty about other's POV. 

Pp's point about disparity between generations reflected in her being
Appendix H

Extract from Reflexive Diary

Diary largely kept in the form of voice memos so transcription is detailed below. The reflections below pertain to Participant 1.

Interview one on the 23rd of July. I felt like a that interview went quite well. I feel like I need to ask some more detail next time and encourage a bit more reflection but she shared some important insights with me. She shared that she identified as bisexual and that only she and her partner were aware of this. Her male partner. A lot of what she was saying about choosing not to disclose her bisexuality to her family seem to be dependent on her current relationship status and and hypotheticals about if she were to date somebody who was of a different gender then it would be more outwardly obvious that she was bisexual. She definitely reflected aspects of the erasure of bisexuality that I’ve seen in the literature just with straight presenting couples being assumed to be straight rather than potentially 1 or 2 bisexual individuals in a relationship. I felt somewhat sad that she thought her parents wouldn’t understand and would ask a lot of questions and be concerned about hair life in terms of marriage and children. But that being said she reflected that she thought they would not reject her and the response after time would be positive. That felt more hopeful. I found it interesting that she described addressing her sexuality even within herself as being still quite difficult for her. Given that she said how relevant it was to her and how she presented to the world. I think there seemed to be a degree of separation between coming out internally that self acceptance and coming out externally and to her family and to others. It felt like she was partially out in both those areas but in different ways. She was able turn label herself as bisexual and recognise its relevance for her but it still felt uncomfortable. And she was out to her boyfriend but not to her friends and family. It seemed like that was quite strategic and deliberate. Yeah strategic was also uncomfortable for her. Discussing information management I don’t know how helpful it was to give her an example but I felt I needed to to clarify the question. Interesting that despite her difficulties recognising her sexuality completing the census and writing bisexual was really important for her. I got a sense of pride from her about that. Her reflections on social media were interesting a sense of separation or comfort with people perhaps making assumptions about her sexuality based on the content she follows and then maybe addressing that with her indirectly in the future. She seemed a bit more comfortable about that perhaps less direct method of coming out. She was explicit about judging how relevant it is to come out to people more explicitly and how safe she feels. That fits with the career literature. With her advice she wanted to pass on she was keen to stress that. She was keen to emphasise that your current relationship doesn’t invalidate your sexuality even if you’re in a straight presenting relationship. And she emphasised the importance of supporting young people and informing them of the differing expectations for young people. The importance of queer representation and altering language so to not perpetuate heteronormative assumptions. Overall with this participant not being out to her parents I feel like I learned the importance of whether a young person feels it’s relevant for their parents to know details of their sexuality. How a young person adapts their disclosure to different situations and audiences and how bisexual young people might suffer more from the assumptions that they’re straight.
Appendix I

The systematic review adhered to the submission guidelines of the Adolescent Research Review.
https://www.springer.com/journal/40894/submission-guidelines

The empirical study adhered to the submission guidelines of the Journal of LGBT Youth, with the exception of the wordcount.
https://www.tandfonline.com/action/authorSubmission?show=instructions&journalCode=wjly20