Family Process

FAMILY PROCESS

ORIGINAL ARTICLE OPEN ACCESS

Parental In-Session Behaviors and LGBTQ+ Young Adults' Perceived Parental Rejection and Acceptance in Attachment-Based Family Therapy

Rotem Boruchovitz-Zamir | Eran Bar-Kalifa | Gary M. Diamond

Department of Psychology, Ben-Gurion University, Beer Sheva, Israel

Correspondence: Rotem Boruchovitz-Zamir (rotemboru@gmail.com)

Received: 14 December 2024 | **Revised:** 11 July 2025 | **Accepted:** 21 August 2025

Funding: This study was supported by a grant from the Israel Science Foundation (214/16) awarded to the last author.

Keywords: attachment | family therapy | LGBTQ+ | parental acceptance | parental rejection

ABSTRACT

This study examined whether decreases in parents' negative in-session behaviors predicted reductions in LGBTQ+ young adults' perceived parental rejection and increases in their perceived parental acceptance over the course of attachment-based family therapy for sexual and gender minority (ABFT-SGM) young adults and their nonaccepting parents. A total of 126 videotaped sessions from 22 families who participated in an open clinical trial of ABFT-SGM were coded to assess changes in parents' positive and negative in-session behaviors. Young adults' perceived parental rejection and acceptance were measured at baseline, 8 weeks, 16 weeks, 24 weeks, and 36 weeks. In line with findings from the open clinical trial, on average, perceived parental rejection decreased and perceived parental acceptance increased over the course of therapy. For both mothers and fathers, decreases in negative in-session behaviors moderated increases in young adults' perceived parental acceptance but not reductions in perceived parental rejection. Findings underscore the importance of reducing negative parental in-session behaviors, such as criticism and invalidation, during conjoint sessions with their LGBTQ+ young adult.

1 | Introduction

Despite increasing societal acceptance of LGBTQ+ individuals, many parents continue to fully or partially reject their young adult's sexual or gender minority identity, even years after disclosure (Beals and Peplau 2006; Grossman et al. 2019; Samarova et al. 2014). Such parental rejection can manifest in various ways. In extreme cases, parents may abuse, coerce, or cut off contact with their young adult. Less overt but still painful forms of parental rejection include disdain, disapproval, invalidation, emotional withdrawal, and expressions of shame and disappointment.

Parental rejection of their young adult's sexual or gender minority identity can have deleterious effects. Parental rejection predicts negative self-stigma, internalized trans/homophobia, maladaptive self-concealment, and expectations for future gay-related rejection by others (Carastathis et al. 2016; Pachankis et al. 2008; Willoughby et al. 2010). It is also associated with drug and alcohol abuse (Bouris et al. 2010; D'Amico and Julien 2012; Klein and Golub 2016; Rothman et al. 2012), anxiety, depression, and suicidal ideation (Budge et al. 2013; Hall 2017; Klein and Golub 2016; Pachankis et al. 2018; Ryan et al. 2009; Vance Jr et al. 2023). Moreover, parental rejection undermines the young adult-parent attachment bond and

thwarts LGBTQ+ young adults' sense of family acceptance and connectedness. This, in turn, can lead to a sense of isolation and diminish the young adult's sense of safety in the world (Diamond and Alley 2022).

In contrast, parental acceptance positively impacts the self of the LGBTQ+ young adult and the young adult-parent relationship. Parental acceptance can be demonstrated in many ways, such as when parents ask about and get to know their child's LGBTQ+ friends and romantic partners, explicitly express their acceptance of their child's identity, disclose their child's identity to their own friends and family, and advocate for their child. Parental acceptance is associated with lower rates of suicidal thoughts and suicide attempts, higher self-esteem, higher levels of perceived social support, lower levels of psychological symptoms, and better general health (Kibrik et al. 2018; Ryan et al. 2010). Parental support also buffers against the minority stress LGBTQ+ young adults are subjected to outside of their family system (e.g., at work, in public spaces). Indeed, research has shown that parental support moderates the negative effects of gay-related victimization (Evans et al. 2004; Shilo et al. 2015) and the association between minority sexual orientation and suicidal thoughts (Eisenberg and Resnick 2006; Needham and Austin 2010).

Given the dramatic and negative impact of ongoing parental rejection on LGBTQ+ individuals and their relationships with their parents, and the benefits of parental acceptance, the development and testing of family-based interventions designed to reduce parental rejection and increase parental acceptance is vital (Feinstein et al. 2014; Pachankis and Goldfried 2004). One such intervention is attachment-based family therapy for sexual and gender minority (ABFT-SGM) young adults and their persistently nonaccepting parents (Diamond and Boruchovitz-Zamir 2023; Diamond et al. 2022; Diamond and Shpigel 2014). ABFT-SGM is a time-limited, family-based, experiential treatment designed to promote parental acceptance and reduce parental rejection among parents of LGBTQ+ young adults, as well as improve the quality of young adult-parent relationships. The model is rooted in attachment theory (Bowlby 1988), structural family therapy (Minuchin 1974), multidimensional family therapy (Liddle 2009), and emotion-focused theory and therapy (Greenberg 2011) and is adapted from attachment-based family therapy for depressed adolescents (Diamond et al. 2014). Results from the seminal open clinical trial of ABFT-SGM (Diamond et al. 2022) found that both young adults and their mothers independently reported increases in mothers' acceptance. In addition, young adults reported decreases in both parents' levels of rejection. Also, mothers, but not fathers, reported decreases in their own levels of rejection. Finally, young adults reported a decrease in attachment avoidance in their relationships with both mothers and fathers, but not a decrease in attachment anxiety. Importantly, these treatment gains were maintained up to 3 months after the end of treatment.

In the first session of ABFT-SGM, therapists form an initial bond with each family member and establish relationship-building as the primary goal of treatment. Therapists then meet separately with the young adult and their parents for several individual sessions. In sessions alone with the young adult, the therapist helps them identify past incidents and current interpersonal dynamics contributing to their experience of feeling rejected or not accepted and process their associated negative emotions and unmet relational needs. Next, the therapist prepares the young adult to share these feelings and unmet needs directly with their parents in subsequent conjoint attachment sessions. In sessions alone with parents, the therapist helps them process their experience of having an LGBTQ+ young adult and reflect upon how their nonacceptance and rejecting behaviors have negatively impacted their young adult and their relationship with them. Once parents have become more empathic and motivated to support and embrace their young adult, the therapist prepares them to listen to their young adult's negative emotions and unmet needs in the subsequent attachment task and respond in an open, caring, and validating manner.

The goal of the attachment task is to facilitate new, corrective emotional attachment experiences between young adults and their parents. Conducted in the context of conjoint sessions, this task is comprised of a series of in-session enactments (Davis and Butler 2004). During these enactments, the young adult is helped to express—directly to their parents—their hurt, fear, and assertive (rather than aggressive) anger deriving from their parents' rejection/nonacceptance, as well as their longing to be recognized, validated, loved, prized, respected, and accepted. At the same time, parents are helped to respond in a new and more positive manner than in the past. More specifically, parents are helped to be more open and curious, validate their young adult's feelings and unmet needs, express warmth and affection, take responsibility for their past and current rejecting or nonaccepting behaviors, and express a desire to change. These new, positive parental responses are thought to lead the young adult to feel heard, understood, validated, and accepted—often for the first time—and are considered to be a primary change mechanism in ABFT-SGM (Diamond and Boruchovitz-Zamir, 2023).

To date, no studies have empirically examined whether improvements in observer-rated parental in-session behaviors over the course of ABFT-SGM are indeed associated with reductions in LGBTQ+ young adults' perceived parental rejection and increases in their perceived parental acceptance. The only prior study examining the effects of changes in parents' in-session behaviors over the course of ABFT was conducted on a sample of depressed and suicidal (not necessarily LGBTQ+) adolescents. Findings showed that mothers' psychological autonomy granting increased from the first session of therapy through the attachment task, and that their psychological control decreased over the same time frame. While increases in observer-rated maternal psychological autonomy granting were associated with increases in adolescents' perceived maternal care from pre to mid-treatment, and decreases in adolescents' self-reported attachment-related anxiety and avoidance from pre to 3-months posttreatment, there were no such effects for reductions in maternal psychological control (Shpigel et al. 2012).

The purpose of this study was to examine whether parents' positive and negative in-session behaviors toward their LGBTQ+ young adult changed over time in ABFT-SGM, and whether such changes were associated with changes in young adults' perceived parental rejection and acceptance of their minority identity. We hypothesized that increases in observer-rated positive parental in-session behaviors, such

as psychological autonomy granting, validation, and warmth, from the beginning of therapy (i.e., first session) through the attachment task, would predict increases in young adults' perceived sexual orientation and gender-specific parental acceptance from the beginning of therapy to 3-month follow-up. Conversely, we predicted that decreases in observer-rated negative parental in-session behaviors, such as criticism and invalidation, would predict decreases in young adults' perceived sexual orientation and gender-specific parental rejection over the same time frames.

2 | Method

2.1 | Participants

2.1.1 | Clients

Data was drawn from 22 of the first 26 families enrolled in the seminal open clinical trial of ABFT-SGM (Diamond et al. 2022). Four of the first 26 families enrolled in the clinical trial were excluded because their first session was not conjoint. Families were recruited via social media platforms, LGBTQ+ organizations, and relevant listservs. To be included, the young adult needed to be at least 20 years old, identify as LGBTQ+, and have disclosed their minority sexual orientation or gender identity to their parents at least 1 year prior to the start of therapy. The criteria of 1 year was based on research indicating that many parents, even without intervention, become more accepting and less rejecting of their child's identity over the course of the first year to a year and a half after disclosure (Samarova et al. 2014). ABFT-SGM was designed for families in which parents remain persistently rejecting and/or nonaccepting even years after disclosure (Diamond and Boruchovitz-Zamir 2023). Additionally, at least one of the young adult's parents had to score above the median on the rejection dimension and/or below the median on the acceptance dimension of the Parental Acceptance and Rejection of Sexual Orientation Scale (PARSOS; Kibrik et al. 2018). Families were excluded if, during the screening interview and based on the Mini International Neuropsychiatric Interview (Sheehan et al. 1998), the young adult exhibited either an imminent risk of self-harm, psychotic symptoms, or severe cognitive impairment.

The average age of participating young adults was 26.11 (SD = 3.99), with a range between 20 and 35 years of age. Four young adults identified as cisgender and lesbian, two as cisgender bisexual women, 14 as cisgender gay men, one as a polysexual trans woman, and one as polysexual and genderqueer. Eighteen of the participating parents were fathers, and 22 were mothers. In 12 of the families, parents identified as orthodox Jews; in the remaining 10 families, parents identified as secular.

2.2 | Therapists

Treatment was delivered by eight therapists trained in ABFT-SGM and supervised by the last author—the primary developer of ABFT-SGM. Two of the therapists were licensed clinical psychologists, one was a licensed clinical social worker, and the remaining five were advanced graduate clinical psychology or social work interns. One of the therapists identified as a gay cisgender male, another as cisgender and lesbian, one as a cisgender heterosexual male, and the remaining five as cisgender heterosexual women.

2.3 | Measures

2.3.1 | Parental In-Session Behaviors

Parents' positive and negative in-session behaviors were observationally rated using nine items drawn from a previously adapted version of the Parent–Child Interaction Coding System-Revised (PCIC-R; Burks et al. 2002). Four positive parental behaviors were taken from the PCIC-R Autonomy granting scale: Encourages independence (e.g., "I have no doubt that you know what's right for you"); Solicits young adult's emotional reaction (e.g., "Did you think I was mad at you for that?"); Tolerates differences of opinion, which was adapted to include parental empathic, validating, and reassuring responses to their young adult's emotional expressions (e.g., "I can understand how you would feel abandoned, it's painful for me to even imagine how alone you were"); and Warmth and affection (e.g., "You are so brave to share this with me, I love you"). Five negative parental behaviors were taken from the PCIC-R Psychological control scale: Constrains verbal expressions (e.g., "No, stop, I know all that already! Let me ask you a simple question and just reply 'yes or no'"); Invalidates feelings (e.g., "Your anger is an exaggerated response, you are making it sound like a big deal!"); Personal attack (e.g., "If you would have made more of an effort to get along with men, maybe you wouldn't have run to women so quickly"); Guilt induction (e.g., "You are being selfish and tearing the family apart"); and Contempt and hostility (e.g., "I hate it when you become so whiny"). Previous research using the PCIC-R to code ABFT sessions produced reliability estimates ranging from moderate to excellent (Shpigel et al. 2012; Tsvieli et al. 2021). Changes in PCIC-R scores have also been shown to predict changes in adolescents' psychological symptoms, perceived maternal care, and attachment anxiety and avoidance among depressed and suicidal adolescents (Shpigel et al. 2012).

In addition to the nine PCIC-R behaviors utilized, one negative parent behavior item was drawn from the Goal-Corrected Partnership Adolescent Coding System (GPACS; Lyons-Ruth et al. 2005). This item was Parent's role confused behavior (e.g., "Only you know how difficult things are with your grandma, I need you to be my shoulder to cry on"). Finally, for the purpose of this study, six additional parental behavior items were developed. These items were based on ABFT theory and practice. Four were positive parental behaviors: Encourages the young adult to express attachment/identity needs (e.g., "When you are feeling down, what would be the best way for me to support you?"); Expresses willingness to better fulfill the young adult's attachment/identity needs in the future (e.g., "I will do my best to be someone you can rely on"); Responsibility taking (e.g., "I understand now that what I said hurt you"); and Acknowledges the young adult's initiation of/participation in therapy (e.g., "It's so important you asked me to come here, it's so meaningful for me to be hearing all of this"). Two others were negative parental behaviors:

Premature problem solving (e.g., "Let's just agree that we won't fight anymore"); and Defensiveness (e.g., "I was after a long day. Of course I snapped at you when you started that conversation").

Coders watched entire sessions and rated the extent to which each parental behavior was evident. Scores ranged from 1 (*the parent did not exhibit the behavior at all*) to 5 (*the behavior was very characteristic of the parent's interaction style during the session*) and were determined for each parent separately. All coders' scores were averaged for each parental behavior and used for subsequent analyses.

2.3.2 | Young Adults' Perceptions of Parental Acceptance and Rejection

Young adults' perceptions regarding their parents' acceptance and rejection of their sexual or gender identity were measured using the PARSOS (Kibrik et al. 2018). This self-report measure, completed by the young adult, comprises two subscales: *Parental Rejection* (12 items) and *Parental Acceptance* (15 items). An example from the Parental Rejection subscale is: "My mother thinks I am not considerate enough of her and other family members, because of my desire to fully express my gender identity". An example from the Parental Acceptance subscale is: "My mother proudly identifies as being the mother of a lesbian daughter". Scores refer to parents' behaviors over the past month and range from 1 (*not similar at all*) to 5 (*very similar*). The measure was completed for mother and father separately. Data from previous research support the factor structure, reliability, and validity of the measure (Diamond et al. 2022; Kibrik et al. 2018). In this study, Cronbach's alpha reliability estimates were as follows: 0.95 for young adults' report of paternal rejection, 0.94 for young adults' report of paternal acceptance, 0.92 for young adults' report of maternal rejection, and 0.94 for young adults' report of maternal acceptance.

2.4 | Procedure

Participating families had received up to 26 weeks of therapy ($M = 21.23$, SD = 5.46) in the context of the open clinical trial, which was approved by Ben-Gurion University IRB (Diamond et al. 2022). As part of that trial, young adults completed the parental acceptance and rejection measure at five different time points: at baseline (prior to the first session of therapy), 8 weeks, 16 weeks, 24 weeks, and 36 weeks post baseline (i.e., 3-month follow-up).

2.4.1 | Coders and Coder Training

Six undergraduate students, who were not informed about the purpose of the study, the study hypotheses, or treatment outcomes, were trained to code parents' in-session behaviors. Coders ranged between 22 and 25 years of age. Five identified as female, and one identified as male. Coders were trained over the course of 6 weeks. Training included learning the coding manual, viewing paradigmatic examples of each positive and negative parental behavior, and practice scoring sessions not included in the clinical trial. Once coders reached sufficient inter-rater reliability (ICC > 0.70), they were assigned study sessions to code.

2.4.2 | Coding Procedure

Each case was randomly assigned to three of the six coders, using a matrix that allowed for the maximal permutation of combinations of raters. Coders rated all of the conjoint sessions for each of their assigned cases in order to understand parents' behaviors in context. Across the 22 cases, a total of 126 sessions were coded. Twenty-two were conjoint first sessions and 104 were conjoint sessions conducted during the attachment task. The mean number of conjoint sessions per case was 4.72 (SD = 2.02).

3 | Results

3.1 | Preliminary Analyses

We first examined the distribution of all parent behaviors. The distributions of six of the 16 parent behaviors were skewed and, thus, these items were excluded from further analyses. Excluded items were: Encourages independence; Guilt induction; Contempt and hostility; Encourages the young adult to express attachment/identity needs; Acknowledges young adult's initiation of/participation in therapy; and Premature problem solving.

We then estimated the reliability of the coding for the remaining 10 parental behaviors by calculating intraclass correlation coefficients (ICC). Overall reliability across all 126 sessions was $ICC_{(1,2)} = 0.84$. The estimated reliability for all parent behaviors except one reached moderate to high reliability: Solicits young adult's emotional reaction, $ICC_{(1,2)} = 0.79$; Validates, tolerates differences of opinion, $ICC_{(1,2)} = 0.71$; Warmth and affection, $ICC_{(1,2)} = 0.78$; Responsibility taking, $ICC_{(1,2)} = 0.76$; Constrains verbal expressions, $ICC_{(1,2)} = 0.62$; Personal attack, patronizing, and being judgmental, $ICC_{(1,2)} = 0.82$; Defensiveness, $ICC_{(1,2)} = 0.85$; Parent's role confused behavior, $ICC_{(1,2)} = 0.84$; and Invalidates feelings, $ICC_{(1,2)} = 0.76$. The reliability estimate for one parental behavior, Expresses willingness to better fulfill attachment/identity needs in the future, was low ($ICC_{(1,2)} = 0.40$) and, thus, this behavior was excluded from further analyses.

To reduce the number of potentially redundant variables, we conducted a principal component analysis (PCA) using the promax rotation method. Results yielded two components (EV > 1), confirmed by the scree test (Cattell 1966). The first component, labeled *Negative parental behaviors*, included five parental behavior items, had an Eigenvalue of 3.22, and accounted for 36% of the variance. The second component, labeled *Positive parental behaviors*, included the four remaining parental behavior items, had an Eigenvalue of 1.17, and accounted for 19% of the variance. All items on both components loaded at 0.58 or greater (see Table 1). Positive and negative parental behavior scale scores were calculated by averaging the scores of all items

TABLE 1 | PCA component loadings.

Item	Component 1	Component 2
Solicits emotional reaction	−0.10	**0.58**
Validates, tolerates differences of opinion	−0.11	**0.75**
Warmth and affection	0.09	**0.68**
Responsibility taking	0.14	**0.67**
Constrains verbal expression	**0.79**	−0.03
Personal attack, patronization and judgment	**0.77**	−0.01
Defensiveness	**0.81**	0.15
Role confused behavior	**0.80**	0.09
Invalidates feelings	**0.70**	−0.21

Note: Bolded values indicate loadings of corresponding components of each scale item.

on the given scale. The internal consistency for the negative parental behavior scale was good ($\alpha = 0.82$), and for the positive parental behavior scale, it was poor ($\alpha = 0.53$). The correlation between the two scales was −0.27. Because of the poor reliability of the positive parental behavior scale, we did not include this scale in subsequent analyses.

3.2 | Data Analytic Strategy

The data examined were hierarchically nested, with multiple measurements nested within young adults. To account for this non-independence (Krull and MacKinnon 2001; Laurenceau and Bolger 2012), we used multilevel regression models, with level 1 as the measurement level and level 2 as the case level. Given the small sample size, we did not include therapists as a third level. This is in line with findings from Falkenström et al. (2020) showing that omitting between-subject variables does not bias within-subject effects in cross-lagged models of psychotherapy change mechanisms. Analyses were run using the *nlme* package (Pinheiro et al. 2019) in R (R core team, 2019).

In a previous analysis of the entire sample from the open clinical trial, linear models showed the best fit for young adults' reports of perceived parental acceptance and rejection (Diamond et al. 2022). Therefore, we estimated a linear growth model, with week number as the Time effect. The Time effect was recoded into a 0–1 scale (i.e., 0 = week #0 assessment; 0.211 = week #8 assessment; 0.421 = week #16 assessment; 0.684 = week #24 assessment; and 1 = week #36 assessment). This allowed us to interpret the Time effect as representing the average linear change over the entire assessment period, while retaining the ratio between the five assessment points. We handled missing data using the maximum-likelihood estimator. In the context of multilevel growth models, the maximum-likelihood estimator can effectively handle nested unbalanced data by taking into account the number of observations contributed by each participant and incorporating a weighting mechanism for the varying degrees of information contributed by different participants (Hoffman 2015).

TABLE 2 | Descriptive statistics for perceived parental acceptance and rejection.

Variable	Fathers *N*	Fathers *M*	Fathers SD	Mothers *N*	Mothers *M*	Mothers SD
Assessment #1 (Baseline)						
Acceptance	18	2.12	1.02	21	2.52	1.01
Rejection	18	2.90	1.22	21	2.58	1.10
Assessment #2 (Week 8)						
Acceptance	17	2.23	0.92	20	2.85	0.88
Rejection	17	2.81	1.18	20	2.46	0.92
Assessment #3 (Week 16)						
Acceptance	17	2.31	0.98	20	2.97	1.03
Rejection	17	2.71	1.19	20	2.21	0.81
Assessment #4 (Week 24)						
Acceptance	17	2.57	1.20	21	3.17	1.05
Rejection	17	2.67	1.32	21	2.21	0.88
Assessment #5 (Week 36)						
Acceptance	15	2.76	1.14	18	3.51	0.86
Rejection	15	2.18	1.10	18	1.83	0.73

3.3 | Main Results

3.3.1 | Changes in Perceived Parental Acceptance and Rejection

Table 2 presents the descriptive statistics for young adults' reports of perceived parental acceptance and rejection at each measurement point. To examine changes in perceived parental acceptance/rejection over the course of the treatment, we evaluated a set of four multi-level growth models (two dimensions × two parents), in which the predictor was the week and the outcome was the young adult's reports of parental acceptance and rejection. In these models, the intercept and the predictor were estimated as both fixed and random effects.

Table 3 presents the results of the multi-level growth models for perceived parental acceptance and rejection. Similar to findings in the main outcome paper (Diamond et al. 2022), in this subsample young adults reported increases in parental acceptance and decreases in parental rejection, both for mothers and for fathers, from baseline to 3 months posttreatment.

3.3.2 | Changes in Observed Negative Parental In-Session Behaviors

To examine whether parents' negative in-session behaviors changed over the course of treatment, we calculated a change

TABLE 3 | Results of multi-level growth models.

Variable	Mother's acceptance	Mother's rejection	Father's acceptance	Father's rejection
Intercept	2.22 (0.22)***	3.08 (0.23)***	1.91 (0.19)***	3.24 (0.29)***
Week	0.22 (0.04)***	−0.22 (0.04)***	0.20 (0.04)***	−0.19 (0.05)***

***$p < 0.001$.

score based on the difference between each parent's negative behaviors during the first conjoint session of the treatment (i.e., Session 1) and their average scores over the course of all subsequent conjoint attachment sessions. A paired t test revealed that these differences were not significant, $t_{mothers}(21) = 0.45$, $p = 0.66$; $t_{fathers}(17) = 0.36$, $p = 0.72$, suggesting that, on average, parents' negative in-session behaviors during conjoint sessions did not change over the course of treatment.

3.3.3 | Moderating Effect of Parents' In-Session Behaviors

To examine whether changes in negative parental in-session behaviors moderated changes in young adults' perceived parental acceptance/rejection, we evaluated a set of four moderated multi-level growth models (parental rejection or acceptance for each parent). In these models, we used the change scores of parents' negative behaviors, calculated in the manner described above, and entered them as level-2 moderators. The predictor was week and the outcomes were young adults' reports of parental rejection and acceptance. In these models, the intercept and the predictor were estimated as both fixed and random effects.

Note that these analyses were conducted at the case level (i.e., examining whether the changes in negative parental behaviors over the course of treatment sessions predicted the trajectory of the young adult's report of parental acceptance and rejection over time). We conducted a sensitivity power analysis to determine the effect size our data were sufficiently powered to detect. Specifically, we performed a Monte Carlo simulation with 5000 repetitions using Mplus (Muthén and Muthén 2025). We specifically focused on the moderating effect of changes in negative parental behaviors on the time slope. Findings indicated that our data (~20 cases with 5 assessment points) were sufficiently powered ($1 - \beta = 0.852$) to detect a standardized effect size of $\beta = 0.533$.

Table 4 shows the results of the moderated multi-level growth models. We found a significant interaction between week and changes in mothers' negative behaviors over the course of treatment, such that the trajectories of young adults' perceived maternal acceptance differed according to the change in their mothers' observed in-session negative behaviors. To probe these interactions, we ran simple slopes analyses by computing the simple slope at low (−1SD), average, and high (+1SD) levels of change for each parental behavior.

Results showed that when mothers' in-session negative behaviors decreased at above-average rates, young adults' perceived maternal acceptance significantly increased over time, $b = 1.28$, SE = 0.29, $p < 0.001$. When mothers' in-session negative behaviors changed at average rates, young adults' perceived maternal acceptance also significantly increased, $b = 0.81$, SE = 0.20, $p < 0.001$. However, there was no significant change over time in young adults' perceived maternal acceptance when mothers' negative behaviors increased, $b = 0.34$, SE = 0.28, $p = 0.23$.

We also found a significant interaction between week and changes in fathers' in-session negative behaviors. Probing this interaction showed results similar to the effects found for mothers. When fathers' in-session negative behaviors decreased at rates above average, young adults' perceived paternal acceptance significantly increased over time, $b = 1.01$, SE = 0.20, $p < 0.001$. When fathers' in-session negative behaviors changed at an average rate, young adults' perceived paternal acceptance also significantly increased, $b = 0.72$, SE = 0.15, $p < 0.001$. Young adults' perceived paternal acceptance did not change over time when fathers' negative behaviors increased, $b = 0.42$, SE = 0.22, $p = 0.06$.

Finally, we found no effects for changes in parents' in-session negative behaviors on perceived maternal or paternal rejection.

4 | Discussion

Ample research attests to the adverse effects of parental rejection and the beneficial effects of parental acceptance on LGBTQ+ young adults' psychological well-being. ABFT-SGM aims to reduce parents' negative in-session behaviors, such as criticism and invalidation, in order to decrease young adults' perceived parental rejection of their minority sexual orientation and/or gender identity. At the same time, therapists work to increase parents' positive in-session behaviors, such as warmth and validation, in an effort to enhance young adults' perceived parental acceptance. The goal of this study was to examine whether LGBTQ+ young adults' perceived parental rejection and acceptance of their sexual orientation or gender identity changed over time in ABFT-SGM and whether these changes were moderated by changes in parents' positive and negative in-session behaviors during conjoint sessions. Results showed that, similar to findings from the original open clinical trial (Diamond et al. 2022), young adults reported decreases in parental rejection and increases in parental acceptance over the course of the treatment. Because of the poor internal consistency of the positive parental in-session behaviors scale, we could only analyze changes in negative in-session parental behaviors. In contrast to our expectation, observer-rated negative parental in-session behaviors, on average, did not change over the course of the therapy. There were, however, significant interactions between the degree of change in parents' in-session negative behaviors and the degree of change in young adults' perceptions of their parents' acceptance and rejection.

TABLE 4 | Results of moderated multi-level growth models.

Predictors	Estimates	Std. error	CI	*p*
Fathers' acceptance				
Intercept	2.05	0.18	1.69–2.41	< 0.001
Week	0.68	0.16	0.37–0.99	< 0.001
Changes in negative parental behaviors	−0.59	0.24	−1.10 to −0.07	0.03
Week × changes in negative parental behaviors	−0.40	0.20	−0.79 to −0.00	0.05
Random effects				
Residual variance (σ^2)		0.19		
Intercept variance (τ_{00})		0.50		
Slope variance (τ_{11})		0.09		
Intercept–Slope correlation (ρ_{01})		0.36		
N (cases)		18		
Observations		81		
Marginal R^2		0.351		
Conditional R^2		0.840		
Mothers' acceptance				
Intercept	2.57	0.20	2.17–2.98	< 0.001
Week	0.76	0.20	0.36–1.16	< 0.001
Changes in negative parental behaviors	0.22	0.22	−0.23 to 0.67	0.31
Week × changes in negative parental behaviors	−0.50	0.22	−0.94 to −0.06	0.03
Random effects				
Residual variance (σ^2)		0.17		
Intercept variance (τ_{00})		0.76		
Slope variance (τ_{11})		0.47		
Intercept–Slope correlation (ρ_{01})		−0.19		
N (cases)		22		
Observations		98		
Marginal R^2		0.089		
Conditional R^2		0.844		
Fathers' rejection				
Intercept	3.03	0.28	2.48–3.58	< 0.001
Week	−0.74	0.23	−1.20 to −0.28	0.002
Changes in negative parental behaviors	0.60	0.37	−0.18 to 1.39	0.124
Week × changes in negative parental behaviors	0.12	0.30	−0.48 to 0.72	0.684
Random effects				
Residual variance (σ^2)		0.39		
Intercept variance (τ_{00})		1.05		
Slope variance (τ_{11})		0.05		
Intercept–Slope correlation (ρ_{01})		−0.91		

(Continues)

TABLE 4 | (Continued)

Predictors	Estimates	Std. error	CI	*p*
N (cases)		18		
Observations		81		
Marginal R^2		0.205		
Conditional R^2		0.759		
Mothers' rejection				
Intercept	2.65	0.21	2.24–3.06	< 0.001
Week	−0.61	0.20	−1.00 to −0.21	0.003
Changes in negative parental behaviors	0.05	0.22	−0.41 to 0.51	0.815
Week × changes in negative parental behaviors	−0.05	0.22	−0.49 to 0.39	0.836
Random effects				
Residual variance (σ^2)		0.22		
Intercept variance (τ_{00})		0.77		
Slope variance (τ_{11})		0.36		
Intercept–Slope correlation (ρ_{01})		−0.49		
N (cases)		22		
Observations		98		
Marginal R^2		0.048		
Conditional R^2		0.766		

The most robust finding was that, for both mothers and fathers, decreases in negative in-session behaviors, such as defensiveness, constraining, judgmentalism, and invalidation, were linked to increases in young adults' perceived parental acceptance. This finding is consistent with our hypothesis that decreases in parents' negative in-session behaviors would have positive effects on their young adult. It may be that when parents were less defensive, critical, judgmental, and invalidating, the young adult felt like they were being heard, perhaps for the first time. This experience of being heard may have led young adults to feel accepted in a manner unlike before.

Interestingly, and in contrast to our hypotheses, decreases in parents' negative in-session behaviors were not associated with decreases in young adults' perceived parental rejection, despite the fact that, on average, young adults' perceived parental rejection decreased over the course of therapy. There is no ready explanation for this non-finding. It is worth noting, however, that a previous study on ABFT with depressed and suicidal adolescents similarly found that decreases in observer-rated in-session maternal psychological control (e.g., invalidation, rejection) were not associated with decreases in adolescents' self-report of maternal control (Shpigel et al. 2012).

The fact that the positive parental in-session behavior scale had low internal consistency was disappointing but, in retrospect, understandable. Showing warmth to one's child is not necessarily correlated with validating their experience, particularly if parents do not believe in, or approve of, their child's minority identity. Parents who struggle to accept their child's LGBTQ+ identity, even while loving them, can be characterized as engaging in loving denial. Loving denial is when parents deeply love their child but, at the same time, are resistant to fully acknowledging or accepting their child's sexual orientation or gender identity. Such loving denial is not uncommon among parents presenting for ABFT-SGM (Kibrik et al. 2018).

Our findings should be interpreted in the context of other potential in-session and between-session factors that may impact young adults' perceptions of parental acceptance and rejection. For example, many of the young adults that we have worked with have said that just having their parents agree to participate in the therapy and show up made them feel more accepted. Also, it is not uncommon for young adults to report incidents that occurred between sessions, outside of the therapy room, that impacted their experience of feeling accepted or rejected. For example, some young adults in our clinical trials have reported that, between sessions, their parents stood up for them and confronted a family member making homophobic or transphobic comments. Others have reported that over the course of the treatment, their parents invited their partner to come to a family dinner or occasion for the first time. Such inter-session change events, which were not measured in this study, are not uncommon in ABFT-SGM and may have as much or more impact on young adults' experience of rejection and acceptance than do parents' in-session behaviors.

4.1 | Strengths and Limitations

The validity of our findings is bolstered by a number of methodological strengths of the study. First, ABFT-SGM is a manualized therapy and therapists were intensively trained and supervised, ensuring treatment adherence and a high level of internal validity. Indeed, the results from an analysis of observer-rated adherence data in the open clinical trial indicated that the treatment was delivered in the manner prescribed. Second, participants in this study reflected a range of sexual orientations and gender identities, socio-economic backgrounds, and degrees of religiosity, increasing the external validity of the findings. Third, the use of five measurement points allowed us to examine the trajectories of parental rejection and acceptance over time, including up to 3 months post-treatment. Finally, this study is unique in its focus on a relational outcome. Most studies on the impact of parental behavior focus on its associations with children's, adolescents', or young adults' psychological symptoms or negative behaviors (e.g., Dallaire et al. 2006; Hinshaw et al. 2000; Pinquart 2017; Wigderson et al. 2019).

This study also bears some methodological limitations. First, the sample is relatively small for conducting HLM analyses. Consequently, analyses of the interaction effects were underpowered and require replication using larger samples. Second, the reliability of the positive parent behavior scale was low and, therefore, we could not examine the effects of changes in positive parental in-session behaviors. Third, in-session parental behaviors and changes in young adults' perceptions of parental acceptance and rejection were measured across the same approximate timeframe, making it impossible to ascertain directionality. Future studies, measuring parental in-session behaviors at a greater number of time points and employing cross-lagged analyses, could begin exploring the directionality of the effects.

5 | Conclusion

This study presents the first data showing that decreases in parents' negative in-session behaviors are associated with increases in LGBTQ+ young adults' experience of parental acceptance. These findings partially support one of ABFT-SGM's purported core change mechanisms and underscore the importance of working to reduce negative parental behaviors, such as criticism and invalidation. Other processes contributing to increases in young adults' perceived acceptance and decreases in their perceived rejection, including between-session events and interactions, should be examined in future studies.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

References

Beals, K. P., and L. A. Peplau. 2006. "Disclosure Patterns Within Social Networks of Gay Men and Lesbians." *Journal of Homosexuality* 51, no. 2: 101–120. https://doi.org/10.1300/J082v51n02_06.

Bouris, A., V. Guilamo-Ramos, A. Pickard, et al. 2010. "A Systematic Review of Parental Influences on the Health and Well-Being of Lesbian, Gay, and Bisexual Youth: Time for a New Public Health Research and Practice Agenda." *Journal of Primary Prevention* 31: 273–309. https://doi.org/10.1007/s10935-010-0229-1.

Bowlby, J. 1988. *A Secure Base: Parent-Child Attachment and Healthy Human Development*. Basic Books.

Budge, S. L., J. L. Adelson, and K. A. Howard. 2013. "Anxiety and Depression in Transgender Individuals: The Roles of Transition Status, Loss, Social Support, and Coping." *Journal of Consulting and Clinical Psychology* 81, no. 3: 545–557. https://doi.org/10.1037/a0031774.

Burks, G., S. Siqueland, and G. S. Diamond. 2002. *Parent-Child Interactional Coding Manual*. Unpublished Manual.

Carastathis, G. S., L. Cohen, E. Kaczmarek, and P. Chang. 2016. "Rejected by Family for Being Gay or Lesbian: Portrayals, Perceptions, and Resilience." *Journal of Homosexuality* 64, no. 3: 289–320. https://doi.org/10.1080/00918369.2016.1179035.

Cattell, R. B. 1966. "The Scree Test for the Number of Factors." *Multivariate Behavioral Research* 1, no. 2: 245–276. https://doi.org/10.1207/s15327906mbr0102_10.

Dallaire, D. H., A. Q. Pineda, D. A. Cole, et al. 2006. "Relation of Positive and Negative Parenting to Children's Depressive Symptoms." *Journal of Clinical Child & Adolescent Psychology* 35, no. 2: 313–322. https://doi.org/10.1207/s15374424jccp3502_15.

D'Amico, E., and D. Julien. 2012. "Disclosure of Sexual Orientation and Gay, Lesbian, and Bisexual Youths' Adjustment: Associations With Past and Current Parental Acceptance and Rejection." *Journal of GLBT Family Studies* 8, no. 3: 215–242. https://doi.org/10.1080/1550428X.2012.677232.

Davis, S. D., and M. H. Butler. 2004. "Enacting Relationships in Marriage and Family Therapy: A Conceptual and Operational Definition of an Enactment." *Journal of Marital and Family Therapy* 30, no. 3: 319–333. https://doi.org/10.1111/j.1752-0606.2004.tb01243.x.

Diamond, G. M., and R. Boruchovitz-Zamir. 2023. *Attachment-Based Family Therapy for Sexual and Gender Minority Young Adults and Their Nonaccepting Parents*. American Psychological Association. https://doi.org/10.1037/0000352-000.

Diamond, G. M., R. Boruchovitz-Zamir, O. Nir-Gotlieb, et al. 2022. "Attachment-Based Family Therapy for Sexual and Gender Minority Young Adults and Their Nonaccepting Parents." *Family Process* 61, no. 2: 530–548. https://doi.org/10.1111/famp.12770.

Diamond, G. M., and M. S. Shpigel. 2014. "Attachment-Based Family Therapy for Lesbian and Gay Young Adults and Their Persistently Nonaccepting Parents." *Professional Psychology: Research and Practice* 45, no. 4: 258–268. https://doi.org/10.1037/a0035394.

Diamond, G. S., G. M. Diamond, and S. A. Levy. 2014. *Attachment-Based Family Therapy for Depressed Adolescents*. American Psychological Association. https://doi.org/10.1037/14296-000.

Diamond, L. M., and J. Alley. 2022. "Rethinking Minority Stress: A Social Safety Perspective on the Health Effects of Stigma in Sexually-Diverse and Gender-Diverse Population." *Neuroscience and Biobehavioral Reviews* 138: 104720. https://doi.org/10.1016/j.neubiorev.2022.104720.

Eisenberg, M. E., and M. D. Resnick. 2006. "Suicidality Among Gay, Lesbian and Bisexual Youth: The Role of Protective Factors." *Journal of Adolescent Health* 39, no. 5: 662–668. https://doi.org/10.1016/j.jadohealth.2006.04.024.

Evans, E., K. Hawton, and K. Rodham. 2004. "Factors Associated With Suicidal Phenomena in Adolescents: A Systematic Review of Population-Based Studies." *Clinical Psychology Review* 24, no. 8: 957–979. https://doi.org/10.1016/j.cpr.2004.04.005.

Falkenström, F., N. Solomonov, and J. Rubel. 2020. "Using Time-Lagged Panel Data Analysis to Study Mechanisms of Change in Psychotherapy Research: Methodological Recommendations." *Counselling and Psychotherapy Research* 20, no. 3: 435–441. https://doi.org/10.1002/capr.12293.

Feinstein, B. A., L. P. Wadsworth, J. Davila, and M. R. Goldfried. 2014. "Do Parental Acceptance and Family Support Moderate Associations Between Dimensions of Minority Stress and Depressive Symptoms Among Lesbians and Gay Men?" *Professional Psychology: Research and Practice* 45, no. 4: 239–246. https://doi.org/10.1037/a0035393.

Greenberg, L. S. 2011. *Emotion-Focused Therapy*. American Psychological Association.

Grossman, A. H., J. Y. Park, J. A. Frank, and S. T. Russell. 2019. "Parental Responses to Transgender and Gender Nonconforming Youth: Associations With Parent Support, Parental Abuse, and Youths' Psychological Adjustment." *Journal of Homosexuality* 68, no. 8: 1260–1277. https://doi.org/10.1080/00918369.2019.1696103.

Hall, W. J. 2017. "Psychosocial Risk and Protective Factors for Depression Among Lesbian, Gay, Bisexual, and Queer Youth: A Systematic Review." *Journal of Homosexuality* 65, no. 3: 263–316. https://doi.org/10.1080/00918369.2017.1317467.

Hinshaw, S. P., E. B. Owens, K. C. Wells, et al. 2000. "Family Processes and Treatment Outcome in the MTA: Negative/Ineffective Parenting Practices in Relation to Multimodal Treatment." *Journal of Abnormal Child Psychology* 28, no. 6: 555–568.

Hoffman, L. 2015. *Longitudinal Analysis: Modeling Within-Person Fluctuation and Change*. Routledge.

Kibrik, E. L., N. Cohen, D. Stolowicz-Melman, A. Levy, R. Boruchovitz-Zamir, and G. M. Diamond. 2018. "Measuring Adult Children's Perceptions of Their Parents' Acceptance and Rejection of Their Sexual Orientation: Initial Development of the Parental Acceptance and Rejection of Sexual Orientation Scale (PARSOS)." *Journal of Homosexuality* 66: 1513–1534. https://doi.org/10.1080/00918369.2018.1503460.

Klein, A., and S. A. Golub. 2016. "Family Rejection as a Predictor of Suicide Attempts and Substance Misuse Among Transgender and Gender Nonconforming Adults." *LGBT Health* 3, no. 3: 193–199. https://doi.org/10.1089/lgbt.2015.0111.

Krull, J. L., and D. P. MacKinnon. 2001. "Multilevel Modeling of Individual and Group Level Mediated Effects." *Multivariate Behavioral Research* 36, no. 2: 249–277. https://doi.org/10.1207/s15327906mbr3602_06.

Laurenceau, J. P., and N. Bolger. 2012. "Analyzing Diary and Intensive Longitudinal Data From Dyads." *Handbook of Research Methods for Studying Daily Life*: 407–422.

Liddle, H. A. 2009. "Multidimensional Family Therapy: A Science-Based Treatment System for Adolescent Drug Abuse." *Wiley-Blackwell Handbook of Family Psychology*: 341–354. https://doi.org/10.1002/9781444310238.ch23.

Lyons-Ruth, K., K. Hennighausen, and B. Holmes. 2005. *Goal-Corrected Partnership in Adolescence Coding System (GPACS): Coding Manual, Version 2*. Harvard Medical School.

Minuchin, S. 1974. *Families and Family Therapy (1974-21519-000)*. Harvard University Press. https://doi.org/10.4159/9780674041127.

Muthén, L., and B. Muthén. 2025. *Mplus [Statistical Software]*. Muthén and Muthén.

Needham, B. L., and E. L. Austin. 2010. "Sexual Orientation, Parental Support, and Health During the Transition to Young Adulthood." *Journal of Youth and Adolescence* 39, no. 10: 1189–1198. https://doi.org/10.1007/s10964-010-9533-6.

Pachankis, J. E., and M. R. Goldfried. 2004. "Clinical Issues in Working With Lesbian, Gay, and Bisexual Clients." *Psychotherapy: Theory, Research, Practice, Training* 41, no. 3: 227–246. https://doi.org/10.1037/0033-3204.41.3.227.

Pachankis, J. E., M. R. Goldfried, and M. E. Ramrattan. 2008. "Extension of the Rejection Sensitivity Construct to the Interpersonal Functioning of Gay Men." *Journal of Consulting and Clinical Psychology* 76, no. 2: 306–317. https://doi.org/10.1037/0022-006X.76.2.306.

Pachankis, J. E., T. J. Sullivan, and N. F. Moore. 2018. "A 7-Year Longitudinal Study of Sexual Minority Young Men's Parental Relationships and Mental Health." *Journal of Family Psychology* 32, no. 8: 1068–1077. https://doi.org/10.1037/fam0000427.

Pinheiro, J., D. Bates, S. DebRoy, and D. Sarkar. 2019. "Nlme: Linear and Nonlinear Mixed Effects Models." In *R Core Team. 2019*, 1–140. R package version 3. https://CRAN.R-project.org/package=nlme.

Pinquart, M. 2017. "Associations of Parenting Dimensions and Styles With Externalizing Problems of Children and Adolescents: An Updated Meta-Analysis." *Developmental Psychology* 53, no. 5: 873–932. https://doi.org/10.1037/dev0000295.

Rothman, E. F., M. Sullivan, S. Keyes, and U. Boehmer. 2012. "Parents' Supportive Reactions to Sexual Orientation Disclosure Associated With Better Health: Results From a Population-Based Survey of LGB Adults in Massachusetts." *Journal of Homosexuality* 59, no. 2: 186–200. https://doi.org/10.1080/00918369.2012.648878.

Ryan, C., D. Huebner, R. M. Diaz, and J. Sanchez. 2009. "Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults." *Pediatrics* 123, no. 1: 346–352. https://doi.org/10.1542/peds.2007-3524.

Ryan, C., S. T. Russell, D. Huebner, R. Diaz, and J. Sanchez. 2010. "Family Acceptance in Adolescence and the Health of LGBT Young Adults." *Journal of Child and Adolescent Psychiatric Nursing* 23, no. 4: 205–213. https://doi.org/10.1111/j.1744-6171.2010.00246.x.

Samarova, V., G. Shilo, and G. M. Diamond. 2014. "Changes in Youths' Perceived Parental Scceptance of Their Sexual Minority Status Over Time." *Journal of Research on Adolescence* 24, no. 4: 681–688. https://doi.org/10.1111/jora.12071.

Sheehan, D. V., Y. Lecrubier, K. H. Sheehan, et al. 1998. "The Mini-International Neuropsychiatric Interview (MINI): The Development and Validation of a Structured Diagnostic Psychiatric Interview for DSM-IV and ICD-10." *Journal of Clinical Psychiatry* 59, no. 20: 22–33.

Shilo, G., N. Antebi, and Z. Mor. 2015. "Individual and Community Resilience Factors Among Lesbian, Gay, Bisexual, Queer and Questioning Youth and Adults in Israel." *American Journal of Community Psychology* 55, no. 1: 215–227. https://doi.org/10.1007/s10464-014-9693-8.

Shpigel, M. S., G. M. Diamond, and G. S. Diamond. 2012. "Changes in Parenting Behaviors, Attachment, Depressive Symptoms, and Suicidal Ideation in Attachment-Based Family Therapy for Depressive and Suicidal Adolescents." *Journal of Marital and Family Therapy* 38: 271–283. https://doi.org/10.1111/j.1752-0606.2012.00295.x.

Tsvieli, N., C. Lifshitz, and G. M. Diamond. 2021. "Corrective Attachment Episodes in Attachment-Based Family Therapy: The Power of Enactment." *Psychotherapy Research* 32: 209. https://doi.org/10.1080/10503307.2021.1913295.

Vance, S. R., Jr., D. Chen, R. Garofalo, et al. 2023. "Mental Health and Gender Affirmation of Black and Latine Transgender/Nonbinary Youth Compared to White Peers Prior to Hormone Initiation." *Journal*

of Adolescent Health 73, no. 5: 880–886. https://doi.org/10.1016/j.jadohealth.2023.06.022.

Wigderson, S., K. M. Lindahl, and N. M. Malik. 2019. "Parental Responsiveness Toward GLB Children: Impact on Mental Health Two Years Later." *Journal of GLBT Family Studies* 15, no. 4: 326–341. https://doi.org/10.1080/1550428x.2018.1545620.

Willoughby, B. L. B., N. D. Doty, and N. M. Malik. 2010. "Victimization, Family Rejection, and Outcomes of Gay, Lesbian, and Bisexual Young People: The Role of Negative GLB Identity." *Journal of GLBT Family Studies* 6, no. 4: 403–424. https://doi.org/10.1080/1550428X.2010.511085.