

Do Parental Acceptance and Family Support Moderate Associations Between Dimensions of Minority Stress and Depressive Symptoms Among Lesbians and Gay Men?

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This study examined the extent to which parental acceptance of one's sexual orientation and more general family support moderated the associations between 3 dimensions of minority stress (internalized homonegativity, rejection sensitivity, and discrimination) and depressive symptoms in a sample of 414 self-identified lesbians and gay men who participated in an online survey. Results indicated that internalized homonegativity and rejection sensitivity were positively associated with depressive symptoms for those reporting less accepting parental attitudes, but they were not associated for those reporting more accepting parental attitudes. In contrast, parental acceptance did not moderate the association between discrimination and depressive symptoms, and general family support did not moderate any associations. Findings suggest that more accepting parental attitudes toward one's sexual orientation may protect individuals from distress in the face of their own negative thoughts and feelings related to their sexual orientation, but not overt discrimination. Further, parents' attitudes toward their child's sexual orientation may be more important than the extent to which they provide more general support. Interventions for parents struggling with their child's sexual orientation are encouraged to focus on the importance of parents expressing acceptance and support, which may directly impact well-being and act as a buffer in the face of minority stress.

Keywords: lesbian, gay, parental acceptance, family support, minority stress

Research has consistently demonstrated that lesbian, gay, and bisexual (LGB) individuals experience mental health problems at higher rates than heterosexuals (e.g., Cochran & Mays, 2009; Cochran, Sullivan, & Mays, 2003; King et al., 2008). Meyer (2003) proposed that these mental health disparities are due, in

part, to the stress that sexual minorities experience as a result of their socially marginalized status. Specifically, Meyer noted several dimensions of minority stress that LGB individuals are at risk of experiencing, including discrimination based on their sexual orientation, internalizing negative societal attitudes

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about nonheterosexuality (internalized homonegativity), and expecting to be rejected because of their sexual orientation (rejection sensitivity). In turn, these dimensions of minority stress are associated with a host of negative consequences, including depressive symptoms (e.g., [Feinstein et al., 2012](#); [Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010](#); [Mays & Cochran, 2001](#); [Newcomb & Mustanski, 2010](#)). Despite the well-documented association between minority stress and poorer well-being, not all LGB individuals who experience minority stress develop mental health problems. As such, research has begun to identify protective factors that contribute to resilience among LGB individuals.

It has been suggested that supportive family relationships may protect LGB individuals from mental health problems ([Goldfried & Goldfried, 2001](#)). In general, parental support is associated with improved well-being among adolescents (e.g., [Steinberg, 2001](#)) and young adults (e.g., [Holahan, Valentiner, & Moos, 1994](#)), suggesting that relationships with parents continue to play an important role in well-being into adulthood. It is particularly important to consider the impact that family relationships have on the well-being of LGB individuals, because many LGB individuals experience difficult relationships with their family members. For instance, parents often respond negatively to a child's disclosure of a minority sexual orientation ([D'Augelli, Hershberger, & Pilkington, 1998](#); [Savin-Williams, 2001](#)) and LGB individuals report higher rates of abuse from family members than do heterosexual individuals (e.g., [McLaughlin, Hatzenbuehler, Xuan, & Conron, 2012](#); [Saewyc et al., 2006](#)). Further, several studies have demonstrated that sexual minorities report lower levels of parental support than heterosexuals in adolescence ([Eisenberg & Resnick, 2006](#); [Russell, Seif, & Truong, 2001](#); [Saewyc, Homma, Skay, Bearinger, Resnick, & Reis, 2009](#); [Ueno, 2005](#)) and young adulthood ([Needham & Austin, 2010](#)), and several family relationship factors have been demonstrated to partially account for sexual orientation-related health disparities. These family factors include more problems with parents ([Ueno, 2005](#)), less family connectedness ([Eisenberg & Resnick, 2006](#)), less parental support ([Needham & Austin, 2010](#)), less closeness with parents, and less support from families ([Pearson & Wilkinson, 2013](#)).

Although there is limited research on family relationships and well-being among LGB individuals, existing evidence supports the notion that supportive family relationships contribute to well-being. For instance, having a satisfactory relationship with one's parents ([Savin-Williams, 1989](#)), perceiving greater family support and acceptance ([Shilo & Savaya, 2011](#)), perceiving greater family caring ([Homma & Saewyc, 2007](#)), and perceiving greater parental acceptance ([Ryan, Russell, Huebner, Diaz, & Sanchez, 2010](#)) are all associated with greater well-being. In contrast, poor relationships with parents, rejecting attitudes toward one's sexual orientation from parents, and fear of verbal and/or physical abuse at home are all associated with greater depressive symptoms among LGB youth ([D'Augelli, 2002](#)). Experiences with family rejection are also associated with negative outcomes among LGB adults, including depressive symptoms, suicidal ideation, suicide attempts, illicit substance use, substance-related problems, and unprotected sex with a casual partner ([Ryan, Huebner, Diaz, & Sanchez, 2009](#)).

Most studies on social support and mental health in LGB samples have focused on the direct effects of social support on mental health outcomes. However, it has also been theorized that social support may buffer (i.e., moderate) the associations between stress and distress (e.g., [Cohen & Wills, 1985](#)) and research has demonstrated this effect in non-LGB populations (e.g., [Holt & Espelage, 2005](#); [Davidson & Demaray, 2007](#)). Only a few studies have examined this notion in LGB samples. [Szymanski \(2009\)](#) found that general social support did not moderate the associations between heterosexist events (harassment, rejection, and discrimination) and psychological distress among gay and bisexual men. [Hershberger and D'Augelli \(1995\)](#) found that family support significantly reduced the association between victimization and psychological symptoms among gay youth, such that high levels of support were beneficial for youth who experienced low levels of victimization (verbal comments), but not for those who experienced moderate (property destruction) or high (physical attacks) levels of victimization. Clearly, there are significant gaps in our understanding of the potential stress buffering effects of family support among LGB individuals. Specifically, because previous studies have focused on victimization, it remains unclear if family support moderates associations between other dimensions of minority stress (e.g., internalized homonegativity, rejection sensitivity) and their mental health consequences. In addition, it is important to examine aspects of family relationships that are specifically related to sexual orientation (e.g., parental acceptance of one's sexual orientation) as well as more general family support. A recent study has offered evidence for this notion by demonstrating that higher levels of sexuality-related support from friends and family members (i.e., support specifically for issues related to sexuality), but not general support, was related to decreased emotional distress and buffered against the negative effects of sexuality stress on emotional distress ([Doty, Willoughby, Lindahl, & Malik, 2010](#)).

The current study sought to extend previous research by examining the extent to which parental acceptance and family support moderated associations between dimensions of minority stress and depressive symptoms in a sample of lesbians and gay men. Consistent with minority stress theory ([Meyer, 2003](#)), we examined several dimensions of minority stress, including discrimination, internalized homonegativity, and rejection sensitivity. We hypothesized that parental acceptance would moderate associations between all three dimensions of minority stress and depressive symptoms, such that minority stress would be associated with depressive symptoms for those who reported lower levels of parental acceptance but not for those who reported higher levels of parental acceptance. In regard to family support, two alternatives are possible. Similar to parental acceptance, family support may moderate associations between dimensions of minority stress and depressive symptoms. However, in light of [Doty and colleagues \(2010\)](#), the moderation effect may be specific to parental acceptance of one's sexual orientation since it is specifically related to the type of stress. In sum, we predicted that parental acceptance and possibly family support would act as protective factors, buffering lesbians and gay men from the negative mental health consequences of minority stress.

Method

Participants and Procedure

A sample of 467 lesbians and gay men participated in an online survey about minority stress, social support, and mental health between October 2010 and January 2011. There were 53 individuals who did not complete the relevant measures for the current analyses, so the final sample included 414 individuals (199 lesbians and 215 gay men). The Stony Brook University Committee on Research Involving Human Subjects approved this research. Participants were recruited using advertisements that were posted on websites (e.g., Craigslist, Facebook) and sent to listservs targeting college LGB groups and groups for psychologists interested in LGB issues. These particular types of listservs were targeted in an effort to reach a range of individuals who were interested in LGB issues, including students and professionals. Individuals who received the recruitment advertisement were asked to participate in the study if they were eligible, rather than to send the advertisement to others. Each participant completed an online survey, which took approximately 30 min, and was offered the option of being entered into a raffle to win one of several gift cards in return. The mean age of the sample was 31.30 ($SD = 11.48$; range = 18–67) and the racial/ethnic composition of the sample was 79% White, 6% non-White Hispanic/Latino, 5% African American/Black, 4% Asian, and 6% other. In regard to education, 4% completed high school and no college, 33% completed some college, 37% completed a 4-year degree, and 26% completed a graduate degree. All participants were employed and the median income was between \$30,000 and \$39,999.

Measures

Discrimination. The LGB-inclusive version of the Heterosexist Harassment, Rejection, and Discrimination Scale (Szymanski, 2006) was used to assess discrimination. The scale includes 14 items that assess the frequency with which individuals report having experienced heterosexist harassment, rejection, and discrimination in the past year. For example, participants were asked, “In the past year, how many times have you been verbally insulted because you are a gay/lesbian person?” A 6-point Likert-type scale was used to rate each item, ranging from 1 (*the event has never happened to you*) to 6 (*the event happened almost all the time* [more than 70% of the time]) and total scores were computed by calculating the mean for the 14 items. Total scores could range from 1 to 6 and higher scores indicated more discrimination in the past year. Excellent internal consistency and adequate convergent and discriminant validity have been reported for lesbians (Szymanski, 2006) and gay/bisexual men (Szymanski, 2009). The alpha in the current sample was .94.

Internalized homonegativity. The internalized homonegativity/binegativity subscale from the Lesbian, Gay, and Bisexual Identity Scale (Mohr & Fassinger, 2003) was used to assess internalized homonegativity. The LGBIS includes 27 items that assess several components of LGB identity, five of which assess an individual’s negative feelings about his or her own minority sexual orientation. For example, “I would rather be straight if I

could” and “Homosexual lifestyles are not as fulfilling as heterosexual lifestyles.” A 7-point Likert-type scale was used to rate each item, ranging from 1 (*disagree strongly*) to 7 (*agree strongly*) and the total scores were computed by calculating the mean for the five items (with some items reverse-scored). Total scores can range from 1 to 7 and higher scores reflect more internalized homonegativity. Good internal consistency has been reported (Balsam & Mohr, 2007) and the alpha in the current sample was .81.

Rejection sensitivity. A modified version of the Gay-Related Rejection Sensitivity Scale (Pachankis, Goldfried, & Ramrattan, 2008) was used to assess rejection sensitivity. Participants were presented with 12 situations and asked how concerned or anxious they would be if the situation occurred because of their sexual orientation and the likelihood that it occurred because of their sexual orientation. For example, participants were presented with the following situation: “You’ve been dating someone for a few years now, and you receive a wedding invitation to a straight friend’s wedding. The invite was addressed only to you, not you and a guest.” Then, respondents were asked two questions: “How concerned or anxious would you be that the invite was addressed only to you because of your sexual orientation?” and “How likely is it that the invite was addressed only to you because of your sexual orientation?” Response options for the first question ranged from 1 (*very unconcerned*) to 6 (*very concerned*) and response options for the second question ranged from 1 (*very unlikely*) to 6 (*very likely*). Responses to those two questions were multiplied for each item and then the total score was computed by calculating the mean for the 12 situations. Total scores could range from 1 to 36 and higher scores indicated more rejection sensitivity. The original scale included 14 situations, but two of the situations were removed to make the scale appropriate for use with lesbians as well as gay men (for additional information on the modified scale, see Feinstein et al., 2012). The original scale demonstrated excellent internal consistency and adequate convergent and discriminant validity (Pachankis et al., 2008) and the modified scale also demonstrated excellent internal consistency (Feinstein et al., 2012). The alpha in the current sample was .93.

Depressive symptoms. The Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) was used to assess depressive symptoms. The CES-D includes 20 items that assess symptoms of depression. Participants are presented with symptoms (e.g., “I was bothered by things that usually don’t bother me”) and asked to indicate how often they have felt that way in the past week. A 4-point Likert-type scale was used to rate each item, ranging from 0 (*rarely or none of the time*) to 3 (*most or all of the time*) and total scores were computed by calculating the sum for the 21 items (after reverse-scoring some of the items). Total scores could range from 0 to 60 and higher scores indicated greater depressive symptoms. Good internal consistency and convergent and discriminant validity were reported (Radloff, 1977) and the alpha in the current sample was .94.

Parental acceptance. Two questions created by Pachankis et al. (2008) were used to assess parental acceptance of one’s sexual orientation. Participants were asked whether or not they had disclosed their minority sexual orientation to their mother (or closest female guardian) and father (or closest male guard-

ian). The majority of participants (85%) reported disclosing their sexual orientation to both their mother and father, whereas 12% had only disclosed to their mother and 3% had only disclosed to their father. Those who had disclosed their sexual orientation to their mother and/or father were asked, "How tolerant is she [or he] toward your sexual orientation currently?" A 7-point Likert-type scale was used to respond to each question, ranging from 1 (*completely tolerant and accepting*) to 7 (*completely hostile and rejecting*). Consistent with Pachankis et al., parental acceptance scores were computed by calculating the mean for maternal and paternal acceptance ($\alpha = .78$ for those who had disclosed to both their mother and father). Lower scores indicated more accepting parental attitudes and higher scores indicated less accepting parental attitudes.

Family support. The family subscale of the Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet, & Farley, 1988) was used to assess general family support. The scale includes four items that assess perceived social support from family. A 5-point Likert-type scale was used to rate each item, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*) and subscale scores were calculated by computing the mean for the four items. Total scores could range from 1 to 5 and higher scores indicated more perceived social support from family members. An example item is "I get the emotional help and support I need from my family." Good internal consistency and moderate construct validity have been reported (Zimet et al., 1988). The alpha in the current sample was .94.

Results

Table 1 presents the zero-order correlations among the main study variables as well as their means, standard deviations, and ranges.¹ There were significant associations among all three dimensions of minority stress (discrimination, internalized homonegativity, and rejection sensitivity), such that individuals who reported higher scores on one variable also tended to report higher scores on the other variables. Higher scores on each dimension of minority stress were also significantly associated with greater depressive symptoms. More accepting parental attitudes were significantly associated with less minority stress (across all three variables), lower depressive symptoms, and more general family support. Higher family support was also significantly associated with less discrimination and rejection sensitivity (but not internalized homonegativity) and lower depressive symptoms.

Parental Acceptance as a Moderator

To examine whether parental acceptance moderated the associations between the dimensions of minority stress and depressive symptoms, we conducted three hierarchical regression analyses (one for each dimension of minority stress). In each analysis, the main effects of the predictor variables were entered first and the interaction term was entered second. All predictor variables were mean-centered prior to computing interaction terms in order to reduce multicollinearity (Aiken & West, 1991). Although depressive symptoms are treated as the outcome variable in these analyses, in line with existing theory and research, the reader is cautioned to remember that the data are cross-sectional precluding tests of temporal associations. Results are shown in Table 2.

Although parental acceptance did not moderate the association between discrimination and depressive symptoms, it did moderate the associations between depression and both internalized homonegativity and rejection sensitivity. Regarding the association between internalized homonegativity and depressive symptoms, the full model was significant, as was the incremental effect of the interaction term. Following the recommendations of Aiken and West (1991), the significant interaction was decomposed by examining the association between the predictor and outcome variables at 1 *SD* above and below the mean of the moderator variable. For those who reported less accepting parental attitudes, internalized homonegativity was significantly associated with depressive symptoms ($\beta = .18, p = .002$), but this association was not significant for those who reported more accepting parental attitudes ($\beta = -0.06, p = .66$).

Regarding the association between rejection sensitivity and depressive symptoms, the full model was significant, as was the incremental effect of the interaction term. For those who reported less accepting parental attitudes, rejection sensitivity was significantly associated with depressive symptoms ($\beta = 0.25, p < .001$), but this association was not significant for those who reported more accepting parental attitudes ($\beta = 0.06, p = .60$). In sum, the findings that internalized homonegativity and rejection sensitivity were associated with depressive symptoms for those who reported less accepting parental attitudes, but not for those who reported more accepting attitudes, suggests that parental acceptance may protect individuals from experiencing depressive symptoms in the context of minority stress.

Family Support as a Moderator

To examine whether general family support moderated the associations between the dimensions of minority stress and depressive symptoms, we conducted three hierarchical regression analyses (one for each dimension of minority stress), following the same procedures as in the parental acceptance moderator analyses. In contrast to the parental acceptance moderator findings, family support did not moderate any of the associations between the dimensions of minority stress and depressive symptoms (see Table 2 for results).

Discussion

Previous research, including our own, has demonstrated that the stress associated with identifying as a sexual minority puts individuals at risk for negative mental health outcomes (e.g., Feinstein et al., 2012; Hatzenbuehler et al., 2010; Mays & Cochran, 2001; Newcomb & Mustanski, 2010). The current study extended this work by focusing on protective factors in the family that may weaken these associations. Specifically, we examined the extent to

¹ The correlations among the three dimensions of minority stress and depressive symptoms as well as their means and standard deviations (presented in Table 1) were previously reported in Feinstein et al. (2012). They are reported in the current article as well so that readers do not have to refer to the other article if they are interested in these statistics. It should be noted that the values reported in this article are not identical to those reported in Feinstein et al. (2012), because the current analyses focused on a subset of the sample previously reported on (only those who had disclosed their sexual orientation to either their mother or their father).

Table 1
Zero-Order Correlations Among the Main Variables of Interest As Well As Means, Standard Deviations, and Ranges

	1	2	3	4	5	6
1. Discrimination	—	—	—	—	—	—
2. Internalized homonegativity	.34***	—	—	—	—	—
3. Rejection sensitivity	.55***	.25***	—	—	—	—
4. Depressive symptoms	.52***	.34***	.38***	—	—	—
5. Parental acceptance	.47***	.24***	.31***	.28***	—	—
6. Family support	-.28***	-.07	-.17***	-.33***	-.35***	—
<i>M</i>	2.11	2.17	13.01	14.76	2.57	3.47
<i>SD</i>	0.93	1.26	6.93	11.55	1.65	1.21

Note. For parental acceptance, lower scores indicate more accepting attitudes and higher scores indicate more rejecting attitudes.

* $p < .05$. ** $p < .01$. *** $p < .001$.

which parental acceptance of one's sexual orientation and more general family support moderated associations between three dimensions of minority stress—discrimination, internalized homonegativity, and rejection sensitivity—and depressive symptoms among lesbians and gay men.

Findings demonstrated that both parental acceptance and general family support were associated with lower depressive symptoms. This is consistent with previous research that has suggested that family relationships continue to play a role in well-being into adulthood (Holahan et al., 1994) and shows that this is true among lesbians and gay men as well. In addition, parental acceptance and general family support were associated with lower discrimination and rejection sensitivity, and parental acceptance was also associated with lower internalized homophobia. It is intriguing that general family support was associated with reduced depressive

symptoms, but not internalized homophobia, given the well-documented association between internalized homophobia and depressive symptoms (Newcomb & Mustanski, 2010), which was also observed in the current study. This suggests that a supportive family may have the potential to improve well-being, even if it doesn't influence one's feelings about one's sexual orientation. Mental health professionals may encounter clients whose families are not accepting of their sexual orientation but who are otherwise supportive (e.g., a client whose parents do not accept that they are gay, but who generally express warmth and support). In such cases, clients may need help maintaining self-acceptance in light of the complicated nature of their family dynamic. This may be particularly important if they do not have a supportive social network outside of their family. Although it may be possible to incorporate family members into treatment in an effort to increase

Table 2
Hierarchical Regression Analyses Predicting Depressive Symptoms

Regression Analyses	<i>b</i>	<i>B</i>	<i>T</i>	<i>R</i> ²	ΔR^2	<i>F</i>
Analysis 1: Parental acceptance and internalized homonegativity				.17	.02**	28.55***
Parental acceptance	.20	1.38	4.24***			
Internalized homonegativity	.25	2.28	5.13***			
Parental Acceptance $\times$ Internalized Homonegativity	.14	.66	2.98**			
Analysis 2: Parental acceptance and rejection sensitivity				.18	.01*	30.60***
Parental acceptance	.16	1.10	3.29***			
Rejection sensitivity	.16	.51	1.83			
Parental Acceptance ν Rejection Sensitivity	.20	-.09	2.34*			
Analysis 3: Parental acceptance and discrimination				.27	.004	50.86***
Parental acceptance	.04	.27	.80			
Discrimination	.48	5.92	8.66***			
Parental Acceptance $\times$ Discrimination	.04	.21	.79			
Analysis 4: Family support and internalized homonegativity				.21	.001	36.42***
Family support	-.31	-2.95	-7.01***			
Internalized homonegativity	.32	2.90	7.15***			
Family Support $\times$ Internalized Homonegativity	.03	.17	.58			
Analysis 5: Family support and rejection sensitivity				.22	.000	38.34***
Family support	-.28	-2.63	-6.20***			
Rejection sensitivity	.34	.56	7.56***			
Family Support $\times$ Rejection Sensitivity	-.02	-.02	-.42			
Analysis 6: Family support and discrimination				.31	.001	60.88***
Family support	-.21	-2.00	-4.83***			
Discrimination	.46	5.71	10.75***			
Family Support $\times$ Discrimination	.03	.28	.74			

* $p < .05$. ** $p < .01$. *** $p < .001$.

support, it may be necessary for some clients to learn how to accept themselves regardless of the extent to which their family members accept their sexual orientation.

In line with our primary hypotheses, we found that parental acceptance of one's sexual minority status moderated the association between internalized homonegativity and depressive symptoms as well as the association between rejection sensitivity and depressive symptoms. Specifically, both dimensions of minority stress were associated with higher depressive symptoms for those who reported lower levels of parental acceptance. In contrast, these associations were not significant for those who reported higher levels of parental acceptance, suggesting that parental acceptance may act as a buffer against depressive symptoms subsequent to these more internal dimensions of minority stress. These findings are consistent with the suggestion that feeling loved and supported by parents may facilitate the development of self-confidence and relational security, which could help LGB youth reject the stigma associated with their identity (Pearson & Wilkinson, 2013). Based on our findings, it may be particularly important for this love and support to be in the form of parents expressing acceptance of their child's sexual minority identity. In contrast, parental acceptance did not moderate the association between discrimination and depressive symptoms. Although speculative, it is possible that parental acceptance can protect lesbians and gay men from distress in the face of their own negative thoughts and feelings about their sexual orientation, but not in the face of overt discrimination. The knowledge that your parents accept you as a sexual minority may have less of a beneficial impact if others make it clear through their discriminatory actions that they do not accept you. It is also possible that these findings speak to the severity of the minority stress being an important factor to consider. If explicit discrimination is perceived as more severe than one's own negative thoughts and feelings about one's sexual orientation, then findings are consistent with Hershberger and D'Augelli (1995) who found that family support was beneficial for LGB youth who experienced low levels of victimization, but not for those who experienced moderate to high levels of victimization. It will be important for future research to assess the perceived severity of different types of minority stress to address this possibility.

Further, although parental acceptance of one's sexual orientation and more general family support were correlated, they functioned differently with respect to their protective roles. In regard to family support, our findings suggested that it does not moderate associations between dimensions of minority stress and depressive symptoms. Minority stress was associated with higher depressive symptoms regardless of the extent to which individuals reported receiving support from their family members. These findings suggest that it may be more important to know that your parents accept your sexual orientation compared to perceiving that your family provides you with support more generally. This is consistent with the matching theory of social support, which suggests that support will be most beneficial when it is related to the specific domain of stress experienced (Cohen & Wills, 1985). Doty and colleagues (2010) found support for this theory, demonstrating that sexuality-related support, but not general support, buffered against the negative effects of sexuality-related stress. Thus, our findings that parental acceptance of one's sexual orientation, but not general family support, buffered against the negative effects of minority stress provide additional evidence that support needs to be related to the stress domain in order to be protective.

These findings have important implications for how mental health professionals can help parents who may be struggling with the knowledge that their child identifies as a sexual minority. Although it is important to encourage parents to provide their children with support in general, it may be particularly important for parents to express to their sexual minority child that they accept their sexual orientation. Although both parental acceptance and family support may have a positive influence on well-being, parental acceptance of one's sexual minority status may also act as a buffer against the negative effects of more internal dimensions of minority stress. Given accumulating evidence that domain-specific support is particularly beneficial for well-being (e.g., Cohen & Wills, 1985; Doty et al., 2010), parents could be encouraged to consider how they can provide support related to the stress that their sexual minority child may face because of their minority status. In addition, our findings underscore the continued importance of parents in the lives of lesbian and gay male adults. It is important for parents to know that the extent to which they accept their child's sexual orientation can have an impact on well-being even in adulthood, when parent-child relationships change considerably.

These findings should be considered in light of several limitations. First, the data are self-report and cross-sectional, precluding our ability to examine the directionality of associations. It is possible that the associations between minority stress and depressive symptoms are bidirectional. Given that we could not test bidirectionality using cross-sectional data, we decided to focus on depressive symptoms as the outcome in line with our interest in understanding protective factors related to minority stress and depression, as well as the strong theoretical and empirical basis for minority stress as a predictor of depression. It will be important for future research to implement longitudinal designs that allow for a better understanding of temporal order. Second, we recruited a convenience sample of self-identified lesbians and gay men, resulting in limited racial/ethnic diversity, limited socioeconomic diversity (all participants had completed high school and were employed), and the exclusion of individuals who identified as bisexual, queer, or another minority sexual orientation. It will be important for future studies to replicate these findings in more diverse samples and to test factors such as race/ethnicity, socioeconomic status, and sexual identity as potential moderators of the associations tested in the current study, as individuals who do not identify as White and those who identify with another minority sexual orientation may have different family experiences. For instance, in a sample of LGB young adults, Ryan, Huebner, Diaz, and Sanchez (2009) found that Latino men reported the highest number of negative family reactions to their sexual orientation in adolescence. In addition, because recruitment and data collection occurred online, individuals without computer access were not able to participate. However, online methods facilitate access to less visible populations such as sexual minorities (Riggle, Rostosky, & Reedy, 2005) and individuals may be more honest about sensitive topics such as discrimination when assessed online (Frankel & Siang, 1999). Finally, although the majority of our sample had come out to both their mother and father, 15% had only come out to one parent. It is possible that those participants chose to come out to the parent who they expected to be more accepting, thus contributing to higher parental acceptance scores. It will be useful for future research to examine parental acceptance in greater detail to better understand the ways in which support from parents influences well-being. Despite these limitations, the current study supports the notion that parental acceptance of one's sexual orientation may be a protective factor for lesbians and gay men who experience stress

associated with their minority status. It will be important for future research to continue to examine individual differences that influence the link between minority stress and mental health to identify other stress buffers for sexual minorities.

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