

DIRECT AND INDIRECT MINORITY STRESS EXPERIENCES OF PARENTS
WITH GAY, LESBIAN, OR BISEXUAL CHILDREN

by

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ABSTRACT

The present study investigated how parental experiences of direct and indirect minority stress are linked to mental health outcomes of the parent and LGB child, parenting styles, and other parental behaviors. A total of 223 parents with at least one LGB child participated in the study. Results showed that parental minority stress is associated with higher rates of mental health problems for parents and their LGB children, and were linked to higher rates of parental authoritarianism, less authoritativeness, less acceptance, and less conflict resolution between parent and child. Parental authoritarianism was found to mediate the link between direct parental minority stress and child mental health, as well as partially mediate the link between indirect parental minority stress and child mental health problems. These findings suggest that there are two different types of parental minority stress – one concerning the parents' own experiences of marginalization and one regarding their concerns for their LGB child – and that each form has meaningful implications on parental behavior and the psychological wellbeing of parents and their LGB children.

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INTRODUCTION

Lesbian, gay, and bisexual (LGB) adolescents and young adults (i.e., youth) are at increased risk for numerous negative psychological and physical health outcomes compared to their heterosexual peers, including higher rates of depression and anxiety (Fergusson, Horwood, & Beaurais, 1999; Udry & Chantala, 2002), increased risk for suicidal ideation and attempts (Almeida et al., 2009; Birkett et al., 2009; Udry & Chantala, 2002), higher rates of smoking (Easton et al., 2008), marijuana use (McCabe et al., 2005), alcohol consumption (Wong et al., 2008), and drug abuse (Russell et al., 2002). As a result, the U.S. Department of Health and Human Services, the Institute of Medicine, and the Gay and Lesbian Medical Association (GLMA) have separately called for research that explains these health disparities and can offer possible strategies to reduce them (GLMA, 2001; Institute of Medicine, 2011; U.S. Department of Health and Human Services, 2009). To that end, it has been found that the relationship dynamic between LGB youth and their parents is critical to their health (Bouris et al., 2010; Ryan, Huebner, Diaz, & Sanchez, 2009; Ryan et al., 2010;), suggesting that the parents of LGB children, their experiences and behaviors are important areas of inquiry.

Among the many unexamined factors that might influence parental interactions with their LGB children, are the parents' own experiences of social marginalization and discrimination, due to having an LGB child, an experience we denote as *parental minority stress*. Parental minority stress is comprised of a parent's concern about being

stigmatized for having an LGB child in addition to worries about the discrimination or marginalization their LGB child has experienced or will experience due to their non-heterosexuality. Such parental minority stress likely influences how parents interact with their LGB child, potentially altering the family environment in profound ways. For example, a parent wrestling with their own fears of stigmatization may be less supportive towards their LGB child or utilize a more authoritarian parenting style, which may put the child at greater risk for anxiety, depression, and other negative outcomes.

The present study investigates how parental experiences of direct and indirect minority stress are linked to mental health outcomes of the parent and the LGB child, parenting styles, and other parental behaviors. Results show that parental minority stress is associated with higher rates of mental health problems for parents and their LGB children, and was linked to higher rates of parental authoritarianism, less authoritativeness, less acceptance, and less conflict resolution between parent and child. Parental authoritarianism was found to mediate the link between direct parental minority stress and child mental health, as well as partially mediate the link between indirect parental minority stress and child mental health problems. These findings suggest that there are two different types of parental minority stress – one concerning the parents' own experiences of marginalization and one regarding their concerns for their LGB child – and that each form has meaningful implications on parental behavior and the psychological wellbeing of parents and their LGB children.

Minority Stress

Minority stress theory is a collection of theories proposing that the chronic experience, expectation, and/or perception of social stigmatization and discrimination

(whether on the basis of sexuality, ethnicity, socioeconomic status, gender, religion, etc.) maintain a state of chronic stress among socially marginalized individuals, causing long-term negative consequences for mental and physical health (Allison, 1998; Clark, Anderson, Clark, & Williams, 1999; Link & Phelan, 2001; Meyer, 1995; Mirosky & Ross, 1989).

Minority stress theories share a number of key assumptions: First, minority stress is unique, such that marginalized individuals experience this distinct form of stress in addition to the general stressors of everyday life, thereby increasing their overall stress exposure and the amount of energy and resources expended to cope on a day-to-day basis. Second, minority stress is chronic, given that it results from relatively stable sociocultural conditions. Third, minority stress is primarily outside a person's direct control, because it is socially based, originating in societal and cultural norms, institutions, and processes that are highly specific to the individual's particular social context.

Originally, minority stress emerged from research on the experiences of racial and ethnic minorities. In 2003, Ilan Meyer extended minority stress theory in important ways to describe experiences specific to *sexual* minorities (i.e., gay, lesbian, and bisexual people), arguing that antihomosexual stigma plays a unique and important role in shaping the health and wellbeing of individuals with same-sex attractions. In his conceptualization of sexual-minority stress, he makes an important distinction between *distal* and *proximal* stressors. Distal stressors include objective experiences of discrimination, including harassment and victimization, while proximal stressors are more subjective and depend on an individual's perception and appraisal of a given situation. For example, if a gay man is passed up for a promotion, it may be difficult for

him to objectively discern whether this was due in part to his sexual orientation or something else. Meyer theorized that *both* proximal and distal stressors have a negative impact on the wellbeing of sexual-minority individuals. In addition, Meyer proposed a set of stress processes that are especially relevant to sexual minorities, including (1) *expectation of rejection*, which is a tendency to become hypervigilant to cues of social rejection due to past experiences of discrimination; (2) *concealment*, which is the additional stress that comes from a perceived need to chronically hide one's sexual-minority identity to avoid harm or rejection; and (3) *internalized homophobia*, whereby sexual-minority individuals internalize negative societal beliefs and stereotypes about nonheterosexual people, increasing their own experiences of shame, guilt, and other negative emotions.

Research on minority stress and its health implications for sexual-minority individuals reliably shows associations between sexual minorities' mental and physical health and their exposure to social stigmatization, marginalization, and victimization (Diaz, Ayala, Bein, Jenne, & Marin, 2001; Kimmel & Mahalik, 2005; Meyer, 1995; 2003; Waldo, 1999). Much of this work focuses on the negative impact of internalized homophobia which has been linked to numerous negative mental health outcomes, including higher rates of depression, eating disorders, risky sexual behavior, and suicidal ideation and behavior (Meyer & Dean, 1998, Meyer, 1995, 2003; Remafedi, French, Story, Resnick, & Blum, 1998; Williamson & Hartley, 1998).

Minority Stress Theory and Parents of LGB Children

All previous research on minority stress has focused primarily on the LGB individuals' own experiences of marginalization. Yet of course, LGB individuals are

embedded in multiple social contexts, and the family context plays an especially critical role for LGB youth. Hence, just as an LGB teenager may experience stress as a result of his/her social stigmatization, so too, might his or her mother and father experience stress, either because they are concerned about their child's wellbeing or because they are concerned about their own stigmatization and marginalization. Understanding parents' minority stress is paramount, because it may influence how parents interact with their LGB child, in either supportive or unsupportive ways. Additionally, LGB youth are disclosing their sexuality to their parents at younger and younger ages (Grov et al., 2006; Savin-Williams, 1998), increasing the time they live at home under the influence of their parents, who may or may not be supportive.

Research involving parents with LGB youth is limited, but there is evidence that parents are well-aware of the unique needs of their LGB children (LaSala, 2007) and understand that their behavior has important implications for their children's health (Ryan et al., 2009). Bouris and colleagues (2010) completed a systematic review of over 30 studies investigating parental influences on the health and wellbeing of LGB youth. Overall they concluded that LGB youth with positive parental interactions (i.e., high in connectedness, warmth, and support) show fewer sexual risk behaviors (Ackard et al., 2008; Garofalo et al., 2008; Resnick et al., 1997), lower rates of substance use (Needham & Austin, 2010; Resnick et al., 1997), fewer experiences of violence and victimization (D'Augelli et al., 2008), fewer suicidal thoughts and behaviors (Eisenberg & Resnik, 2006; Friedman et al. 2006; Needham & Austin 2010; Proctor & Groze 1994; Resnick et al. 1997; Teasdale & Bradley-Engen 2010), and fewer mental health problems, including depression and psychological distress (Floyd et al. 1999; Homma & Saewyc 2007; Needham & Austin 2010; Resnick et al. 1997; Savin-Williams 1989a, b; Sheets & Mohr

2009; Teasdale and Bradley-Engen 2010; Ueno, 2005). Conversely, LGB youth who report unsupportive parents and negative parental interactions have higher rates of sexual risk behavior (Ford et al., 2005; Ryan et al., 2009), greater risk of substance abuse (Ryan et al., 2009), greater victimization both inside and outside the family (D'Augelli et al. 1998, 2005a, b, 2006), more mental health problems (D'Augelli 2002; D'Augelli et al. 2006; Ryan et al. 2009; Savin-Williams 1989b) and increased risk for suicidal ideation and behaviors (D'Augelli et al. 2001; Ryan et al. 2009). Clearly, one of the most important potential influences on LGB youth are their parents.

Importantly, the findings reviewed above should not be interpreted to suggest that parents and their behavior can be described on a single continuum between supportive and unsupportive, or accepting and rejecting. Rather, such behaviors can co-occur in a family, especially as parents adjust to their new awareness that they have an LGB child. Ryan and colleagues found that rejecting parental behaviors were uniquely associated with higher levels of depression, substance use, unprotected sexual intercourse, and increased likelihood of attempting suicide (Ryan et al., 2009), while parental acceptance uniquely predicted greater self-esteem and social support, along with lower levels of depression, substance use, and suicidal ideation and behavior (Ryan et al., 2010). Given these findings regarding the distinct repercussions of supportive and unsupportive behaviors, it is important to investigate whether they also have distinct predictors at the parental level. This is important, because similar behaviors can result from entirely different motivations. For instance, consider a mother asking her lesbian daughter to stop dressing “so masculine.” The mother might make this request because she is concerned for her daughter’s safety. Alternatively, she might make this request because she is embarrassed by her daughter and is worried others will judge her parenting ability based

on her daughter's appearance. Differentiating between these motivations also has important relevance for clinical intervention. For instance, if the mother's concern is primarily for the safety of her child, then interventions aimed at helping the parents identify more positive and accepting ways to ensure their child's wellbeing would likely be helpful. Yet such approaches would not be appropriate if the mother is motivated by her own shame or embarrassment. In this case a clinician would need to focus on the mother's own fear of social rejection in order to help her to develop strategies for coping with those anxieties without stigmatizing her child.

Direct and Indirect Parental Minority Stress

We propose that the distinct parental motivations outlined above – concern about one's own stigmatization versus concern about one's child's stigmatization – can be conceptualized as *direct* versus *indirect* minority stress, and these two forms of stress have different and distinct implications for parental behavior.

Direct parental minority stress revolves around the parent's feelings and experiences of their own marginalization, conceptualized as the worry or expectation of rejection from other people in one's own social network (i.e., other family members, friends, colleagues, members of one's religious community) for having an LGB child (proximal stressors) and experiences of bias or discrimination perceived to occur as a result of having an LGB child (distal stressors). This form of stress is most similar to that originally proposed by Meyer, simply applied to parents who have an LGB child.

Indirect parental minority stress revolves around a parent's concern for their LGB child's marginalization. It includes worry and expectations that their child will be rejected from his or her social network, and worry about the child's emotional and

physical wellbeing in response to real or imagined discrimination. Of course, parents may experience both direct and indirect minority stress, but the fundamental differences between these two forms of stress require that they be conceptualized separately.

Direct Parental Minority Stress

Evidence that parents with an LGB child may experience direct minority stress comes from studies of parental reactions after their child discloses that he or she identifies as lesbian, gay, or bisexual. Such research shows that initial reactions are characterized by intense emotionality that can last for months and even years. Common emotions are shock, denial, fear, sadness, guilt, and confusion (Beeler & DiProva, 1999; Bernstein, 1990; Goodrich, 2009; Phillips & Ancis, 2008; Saltzburg, 2004; Wakely & Tuason, 2011). Parents may report feelings of grief surrounding a perceived loss of their hopes and dreams for their child's future, including marriage and grandchildren (Beeler & DiProva, 1999; Bernstein, 1990; Goodrich, 2009; Phillips & Ancis, 2008; Saltzburg, 2004; Wakely & Tuason, 2011). Parents also have been shown to report feelings of guilt or regret that they did something wrong as parents, causing their child to become gay or lesbian (Beeler & DiProva, 1999; Bernstein, 1990; Phillips & Ancis, 2008). It is perhaps because of such negative beliefs that many parents report higher stress and anxiety, including worry about how, and to whom, they disclose their child's sexuality (Beeler & DiProva, 1999; Bernstein, 1990; Goodrich, 2009; Phillips & Ancis, 2008; Saltzburg, 2004; Wakely & Tuason, 2011). Some parents even disengage from their normal social networks out of fear that they will be judged negatively (Phillips & Ancis, 2008; Saltzburg, 2004).

Indirect Parental Minority Stress

Research shows that parental feelings of fear for their LGB child's safety are quite common postdisclosure, along with beliefs that being gay or lesbian will increase their child's experiences of pain and suffering (Beeler & DiProva, 1999; Bernstein, 1990; Goodrich, 2009; Phillips & Ancis, 2008; Saltzburg, 2004; Wakely & Tuason, 2011). Although this is likely related to parental perceptions of cultural homonegativity, as described earlier, many LGB individuals do experience objective discrimination. As parents hear of and/or witness discriminatory acts against their LGB child, they may experience a unique form of minority stress whereby perceived stigma experienced by their child is indirectly experienced by the parent as well. There is evidence that such transference of pain occurs in parents. For instance, when dealing with grief related to the pain and suffering of a child, caused by circumstances such as prolonged illness or hospitalization, parental caregivers often experience greater anxiety, along with feelings of fragility and loss of control (Barakat & Alderfer, 2011; Coffey, 2006).

Similar constructs exist in nonfamilial relationships, further supporting the idea that people can experience significant distress, when those they care about, or are responsible for, suffer. One such phenomenon is referred to as compassion fatigue, which is thought of as extreme feelings of sorrow or sympathy to the point of exhaustion, caused by a deep desire to alleviate the pain or suffering of another person (Polin, 1996; Tunajek, 2006). It is often referred to as the "cost of caring" (Figley, 2003) and is described as an early form of burn-out or long-term stress (Figley, 2003; Hernandez et al., 2007; Polin, 1996; Tunajek, 2006). In circumstances involving more severe instances of suffering, secondary trauma or vicarious traumatization can occur. These phenomena are described as negative changes experienced by those who care for or treat survivors of

serious trauma (Bell, Kulkarni, & Dalton, 2003; VanDeusen & Way, 2006). The cumulative effects of vicarious traumatization include altered beliefs about the relative danger in the world, higher levels of distress, lowered self-esteem and self-efficacy, and increase in symptoms similar to post-traumatic stress disorder (Dunkley & Whelan, 2006; Hernandez, Gangsei, & Engstrom, 2007; Peralman & MacIan, 1995; Salston & Figley, 2003; VanDeusen & Way, 2006). Such constructs are typically studied as an occupational hazard in the context of helping professions, such as nurses or mental health professionals (Bell et al., 2003; Tunajek, 2006). Forms of vicarious traumatization and/or secondary traumatic stress are fairly common in many occupations. Among social workers rates are reported at 15.2% (Bride, 2007), 16.3% in oncology staff (Quinal, Harford, & Rutledge, 2009), 19% in substance abuse counselors (Bride, Hatcher, & Humble, 2009), 32.8% among emergency nurses (Dominguez-Gomez & Rutledge, 2009), 34% among child protective services case workers (Bride, Jones, & MacMaster, 2007), to as high as 39% in juvenile justice case workers (Hatcher, Bride, Oh, King, & Catrett, 2011).

Parental Minority Stress and Parenting Style

Among research on general parental stressors, it has been shown that parenting practices can be affected by stressful conditions, such as divorce (Simons, Beaman, Conger, & Wei, 1993). Increased chaos in the family system has been shown to predict lower levels of parental support (Valiente, Lemery-Chalfant, & Reiser, 2007), as well as greater parental discipline and control (Dumas et al., 2005). Relatedly, depressive symptoms in either mothers or fathers have been linked to negative interactions, such as irritability and hostility toward their child (Lovejoy, Graczyk, O'Hare, & Neumwn, 2000; Simpson, Nee, & Endicott, 1997).

Hence, it is possible that parental experiences of direct or indirect minority stress may influence parenting styles overall. Parenting styles are thought of as the attitudes, behaviors, and interactions parents use with their children that coalesce into an overall style through which family interactions unfold (Darling & Steinberg, 1993; Vandeleur et al., 2007). Following the seminal work of Baumrind (1966), four styles of parenting have been identified: authoritative, authoritarian, permissive, and neglectful. Authoritative parents are more likely to make developmentally appropriate demands on their children and exert control when needed, but in a responsive and supportive way that utilizes effective communication with the child. Alternatively, authoritarian parents are typically more demanding, exercise strong control over their children, show limited affection, and do not communicate often. Permissive parenting is conceptualized as placing few demands on the child, while being highly responsive to their wants and needs, often without concern for the consequences of the child's actions. Lastly, neglectful parenting, is exemplified by low involvement with the child overall, showing minimal emotional support, control, or supervision.

Overall, children raised by authoritative parents show better outcomes than those raised by authoritarian, permissive, or neglectful parents. Authoritative parenting has been positively associated with better child adjustment (Steinberg, Lamborn, Darling, & Mounts, 1994), resiliency (Kritzas & Grobler, 2005), secure attachment (Karavasilis, Doyle, & Markiewicz, 2003), school competence and achievement (Boon, 2007; Lamborn, Mounts, Steinberg, & Dornbusch, 1991), and prosocial behaviors (Hastings, McShane, & Parker, 2007). It is possible parents who experience greater minority stress as a result of having an LGB child may be more likely to parent using an authoritarian style, making higher demands and exerting more control over their LGB child, while

engaging in less effective communication. If this is the case, such behaviors might be motivated from either their own fears of marginalization for having an LGB child (direct minority stress) or concern for the LGB child's safety (indirect minority stress).

Present Study

The present study investigates how parental experiences of direct and indirect minority stress are linked to mental health outcomes of the parent and the LGB child, as well as parenting styles and behaviors towards the LGB child. The specific hypotheses that were tested are outlined below.

Hypothesis 1: Parental reports of direct and indirect minority stress will be associated with higher levels of reported mental health problems for the parent and their LGB child. This hypothesis is based on research showing that LGB individuals who report higher minority stress also report higher levels of depression and anxiety (Kimmel & Mahalik, 2005; Meyer, 1995, 2003). Therefore, it is reasonable to theorize that parents of LGB children may also be at risk for similar outcomes. Furthermore, research has shown that when parents face significant stressors, their children often suffer negative outcomes as well (Frye & Garber, 2005; Goodman et al., 2011; Hammen et al., 1987; Marmorstein & Iacono, 2004). Hence parental experiences of minority stress may also affect mental health outcomes in the LGB child. Multiple meta-analyses support a “spillover hypothesis” whereby stress and dysfunction in the parental dyad can ultimately spill over and negatively alter aspects of the parent-child relationships (Erel & Burman, 1995; Krishnakumar & Buehler, 2000). For instance, prospective studies have shown that relationship stress between parent and child predicts a youth's risk for conduct problems, depression, and ADHD symptoms (Burt et al., 2003; Marmorstein & Iacono,

2004), and overall family chaos has been linked with more behavior problems among children (Duman et al., 2005). These findings persist, even in situations where a parent must provide support and care for their child, due to complications that are out of the child's control. For instance, parental stress associated with caring for children with genetic disorders/disabilities has been linked to negativity towards the child (Neely-Barnes & Dia, 2008). Such negativity has been associated to greater symptom severity among children with autism spectrum disorders (Hastings & Johnson, 2001), Down's syndrome (Dabrowska & Pisula, 2010), cerebral palsy (Sipal et al., 2010), and sickle cell disease (Barakat, Patterson, Daniel, & Dampier, 2008).

Hypothesis 2: Parents who report higher levels of direct and indirect minority stress will endorse higher levels of authoritarianism and less authoritativeness, as well as lower rates of acceptance and conflict resolution towards their LGB child. This hypothesis is supported by past research that shows many parents react to the news that their child is LGB with shock, denial, fear, sadness, guilt, and confusion (Beeler & DiProva, 1999; Bernstein, 1990; Goodrich, 2009; Phillips & Ancis, 2008; Saltzburg, 2004; Wakely & Tuason, 2011). In related work focusing on more general parental stressors, it has also been shown that increased chaos in the family system is associated with lower levels of parental support (Valiente, Lemery-Chalfant, & Reiser, 2007) and greater parental discipline and control (Dumas et al., 2005). Similarly, depressive symptoms in either mothers or fathers have been linked to negative interactions, such as irritability and hostility towards their child (Lovejoy, Graczyk, O'Hare, & Neumen, 2000; Simpson, Nee, & Endicott, 1997). Thus it is possible that increased experiences of direct and indirect minority stress may increase a parent's likelihood of engaging in more authoritarianism and less authoritativeness while

parenting their LGB child, which includes less acceptance towards their child, and lower rates of conflict resolution.

Hypothesis 3: Parental authoritarianism will mediate the link between parental experiences of minority stress (both direct and indirect) and reports of their LGB child's mental health. Assuming the associations in hypotheses 1 and 2 are true, it is reasonable to hypothesize that the link between parental minority stress and parent report of child mental health problems is at least partially mediated by parental behaviors and interactions with the LGB child, specifically, more controlling and less responsive parental strategies, which are traditionally thought of as defining features of parental authoritarianism.

METHODS

Participants

Parents. A total of 223 parents with at least one LGB child participated in the study. All participants lived in the United States. Participants were 85.2% female ($N = 190$) and 14.8% male ($N = 33$), 91% Caucasian ($N = 203$), ranged in age from 20 to 80 years old ($M = 53.28$; $SD = 10.02$), and were generally well educated, with 87.9% reporting at least some college education (20.2% some college, 12.6% associate's degree, 21.5% bachelor's degree; 8.1% some graduate degree, 18.8% master's degree, and 6.7% doctoral degree). The median household income was between \$50,000 and \$99,999. Well over half of participants reported being married (66.8% married, living with spouse, 4% married but separated, 17.3% divorced; 4.5% widowed, 4% never been married. 2.2% other), and 61% had between 2-3 children (12.1% one child, 39% two children, 22% three children, 11.3% four children, and 15.1% five or more children). Participants were somewhat religious, with 74.9% reporting that their religion/spirituality was at least somewhat important to them (10.8% not at all important, 9% very unimportant, 4.9% somewhat unimportant, 25.6% somewhat important, 30.5% very important, and 18.8% extremely important) and predominantly Christian (51.1% Christian, 9.4% Mormon/LDS, 4.5% Jewish, 0.9% Muslim, 0.4% Buddhist, 11.7% other, 11.7% agnostic, and 9% atheist). Regarding political beliefs, participants were mostly moderate on economic and financial issues (4.5% very conservative, 17.5% conservative, 30.9% moderate, 22.9%

liberal, 17.5% very liberal, and 5.4% I don't know/no opinion) and mostly liberal on social issues (3.6% very conservative, 7.6% conservative, 19.7% moderate, 32.7% liberal, 32.3% very liberal, and 4% I don't know/no opinion).

Children. While completing the survey, participants were asked to answer questions about their LGB child (or *youngest* LGB child if they had more than one child who identified as LGB). Children were 51.6% male ($N=115$) and 48% female ($N=107$) at birth, and identified as 48.4% male ($N=108$), 40.4% female ($N=90$), and 10.7% other ($N=24$) at the time of the survey. Participants' children ranged in age from 5 to 52 ($N=23.5$; $SD = 8.9$), with most living outside the participant's home (62.5% not living at home). 65.9% of the children were described as identifying as gay or lesbian ($N=147$), 18.4% bisexual ($N=41$), and 14.3% other ($N=32$). Furthermore, 53.8% of participants became aware of their child's sexuality within the last 5 years (6.7% 1-6 month ago, 7.2% 7-12 months ago, 19.3% between 1-2 years ago, 27.8% 3-5 years ago, 18.4% 6-10 years ago, 18.4% 11 or more years ago, 1.8% child has not yet come out of the closet) and 47% were in a romantic relationship at the time of the survey (47.5% in a romantic relationship, 44.8% not in a romantic relationship, 7.2% unknown).

Procedures

Participants were recruited using three methods. The first method utilized online ads that briefly described the study and provided a link to the study website. These ads were posted on Craigslist sites for the 40 most populated cities in America. This method was used to recruit 46.2% of participants ($N=103$) were recruited through this method. The remaining participants were recruited via mass emails that described the study and explained how to participate. Two separate emails were sent to PFLAG organizations

throughout the country, resulting in 43% ($N=96$) of the participants. The remaining 10.3% ($N=24$) of participants were recruited through an email list gathered by the psychology department at the University of Utah; it was composed of consenting adults who were interested in research at the university. Generally, no statistical differences were found between participants based on recruitment sources. However, education level was positively correlated with being recruited from PFLAG organizations ($\beta = 1.206, p < .001$).

Data were collected via an online survey, which was constructed using Qualtrics, a popular online survey management system. The questionnaire took approximately 40-50 minutes to complete, and all participant responses were confidential and anonymous. To qualify, participants had to have at least one child who identified as gay, lesbian, or bisexual. Only one parent per household was permitted to participate.

Measures

Demographic and family information. Participants provided general demographic information including, age, gender, race-ethnicity, state, highest level of education, income, marital status, number of children, number of LGB children, age of youngest LGB child, and time since their youngest LGB child disclosed his or her sexual orientation. Respondents also answered questions regarding their religious and political beliefs.

Parent mental health. The Adult Self-Report (ASR) scale was used to measure overall psychological and physical health of the parent. The ASR is a self-report questionnaire that assesses adaptive and problematic functioning for adults aged 18 to 59 years (Achenbach & Rescorla, 2003). Participants answered 123 items on a 3-point scale

(0 = not true; 1 = somewhat or sometimes true; 2 = very true or often true), which are combined into scores for two broad measurements of Internalizing Problems and Externalizing Problems, in addition to six empirically based syndromes derived by factor analysis (Achenbach & Rescorla, 2003). The Internalizing Problems scale ($\alpha = .922$) is comprised of three subscales: Withdrawn, Somatic Complaints, and Anxious/ Depressed Syndrome scales. The Externalizing Problems scale ($\alpha = .894$) is also comprised of three subscales: Rule-Breaking Behavior, Aggressive Behavior, and Intrusive Syndrome scales. These two subscales are combined to provide an overall measurement of parent mental health problems ($\alpha = .946$).

Parental report of LGB child's mental health. The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) was used to measure internalizing and externalizing behaviors of the LGB child based on the parent report. The SDQ was designed to assess positive and negative behavioral patterns in children and adolescents. There were 25 questions separated into five subscales, including emotional symptoms ($\alpha = .812$), conduct problems ($\alpha = .743$), hyperactivity/inattention ($\alpha = .81$), peer relationship problems ($\alpha = .592$), and prosocial behavior ($\alpha = .768$). Items are answered using three response categories (not true, somewhat true, and certainly true). Internalizing behaviors ($\alpha = .805$) were measured by combining scores on the emotional symptoms and peer relationship problems subscales, while externalizing behaviors ($\alpha = .840$) were measured by combining the conduct problems and hyperactivity/inattention subscales (Goodman et al., 2010). Internalizing and externalizing behavior items were combined to provide an overall measure of child mental health problems ($\alpha = .875$).

Direct and indirect parental minority stress. Because there were no preexisting measures of direct and indirect parental minority stress, scale items were

created in response to multiple focus groups held with parents who had at least one LGB child. Four 2-hour focus groups were held over the course of 8 weeks in community centers located in urban and rural areas in northern Utah. A total of 12 parents participated and shared their experiences and concerns about raising an LGB child while navigating issues of disclosure, social relationships, and parental strategies.

From the above methods, 21 items were created and presented in a Likert Scale format, whereby a declarative statement was presented followed by five response options endorsing varying frequencies of occurrence (i.e., *Never*, *Hardly Ever*, *Sometimes*, *Often*, and *Very Often*). To assess direct minority stress, two constructs were measured based on Meyers' distal and proximal stressors: Parent Discrimination (distal) and Expected Rejection of Parent (proximal). Similarly, to assess indirect minority stress, similar constructs were measured: Child Discrimination (distal) and Expected Rejection of Child (proximal).

Direct minority stress. Parental experiences of direct minority stress were measured as a combined score on two subscales, Parent Discrimination and Expected Rejection of Parent, described below. Internal consistency of the combined Direct Minority Stress scale was high ($\alpha = .898$).

Parent Discrimination was assessed with 5 items measuring what degree a parent has *experienced* various forms of discrimination, such as being treated unfairly, insulted, or harassed for having an LGB child. Example questions include, "I have been treated unfairly," "I have been harassed," and "People have made me feel that I'm a bad parent." Internal consistency of this scale was high ($\alpha = .887$).

Expected Rejection of Parent was assessed with 5 items that measured how often the respondent *worried* about experiencing various forms of rejection. Where appropriate,

items were written to match wording of the Parent Discrimination scale. Example questions include, “I worry about being insulted,” “I worry I will be rejected by others,” and “I worry that people will make me feel that I'm a bad parent.” Internal consistency of this scale was high ($\alpha = .912$). These are all the same.

Indirect minority stress. Parental experiences of indirect minority stress was also measured as a combined score on two subscales, parent reports of Child Discrimination and Expected Rejection of Child, described below. Internal consistency of the combined Indirect Minority Stress scale was high ($\alpha = .917$).

Child Discrimination was assessed with 6 items that measured how often the respondent’s LGB child had *experienced* various forms of discrimination. Parents were asked to answer these questions based on events they “know” happened. Where appropriate, items were written to match the wording of comparable items in the Parent Discrimination scale. Items were added to capture common types of discrimination LGB individuals have been shown to experience (GLMA, 2001; Institute of Medicine, 2011; U.S. Department of Health and Human Services, 2009). Example questions include, “My child has been treated unfairly,” “My child has been harassed,” “My child's property has been vandalized or destroyed,” and “My child has been physically harmed.” Internal consistency of this scale was high ($\alpha = .896$).

Expected Rejection of Child was assessed with 5 items that measured how often the respondent *worried* about their child experiencing various forms of rejection for identifying as LGB. Items were written to match wording of the Child Discrimination scale where appropriate. Example questions include, “I worry about how my child will be treated,” “I worry my child will have his property vandalized or destroyed.” and “I worry my child will be physically harmed.” Internal consistency of this scale was high ($\alpha =$

.925).

Parental style and dimensions questionnaire. The Parenting Styles and Dimensions Questionnaire (PSDQ; Robinson, Mandleco, Olsen, & Hart, 2001) is a 32-item instrument used to measure three different parenting styles: Authoritative, Authoritarian, and Permissive. Instructions for this measure stated: “Please rate how much you agree with the below statements based on your interactions with your LGB child. If an item does not apply because your child no longer lives at home, please answer the question based on how things were when that child was living at home.” Scores were computed for each parenting style by calculating the mean of the items. Cronbach's α in the current sample were .889 for Authoritative, .875 for Authoritarian, and .685 for Permissive.

Conflict resolution between parent and child. The Parent–Child Interaction Questionnaire Revised (PACIQ-R;) is a 21-item instrument on a 5-point Likert scale (ranging from “Never” to “Always”) that measures the quality of parent-child relationships across two subscales including parental acceptance, and conflict resolution. Scores were computed for each subscale by calculating the mean of the items. Cronbach's α in the current sample were .685 for Parental Acceptance, and .769 for Conflict Resolution.

RESULTS

Approximately 19.2% ($N=43$) of the participants had missing data for at least one item among the measures of interest. Comparisons between individuals with missing versus complete data revealed no systematic differences, suggesting that it was reasonable to treat the data as missing at random and Little's test for missing completely at random was not significant ($\chi^2(8635, N=223) = 8349.723, p = .986$). Therefore, it was justified to impute missing values using Expectation Maximization (EM) in SPSS version 22. EM is an effective technique often used in data analysis to manage missing data (see Schafer, 1997; Schafer & Olsen, 1998). The EM method uses an iterative algorithm to find maximum likelihood estimates of given parameters in statistical models. The algorithm first estimates the means, variance, and covariance of a sample using cases with complete data. Maximum likelihood procedures are used to estimate regression equations that relate variables to each other. These equations are then used to estimate the value of missing data. The above steps are repeated iteratively until estimates converge with the original estimated parameters of the sample.

Table 1 shows the means, standard deviations, and zero-order correlations of all relevant study variables. Analyses were run using logistical regression on the distribution of the outcome variable being analyzed. Each model controlled for participant recruitment source (two dummy coded variables, representing recruitment from PFLAG organizations and the University of Utah email list), parent's sex (dichotomous variable

such that if the parent was female, the value was one), parent's age, parent's household income, the LGB child's age, and the time since the LGB child disclosed his/her sexuality to the parent. Parent's education level was also controlled for in analyses via a dichotomous variable, such that if the parent endorsed having at least a 4-year college degree, the value was one. Because the parents in the sample were highly educated, with 87.9% reporting at least some college, dividing the sample based on whether or not the respondent completed a 4-year degree (56.1% had, 43.5% had not) provided greater power in our analyses. Results are described below using nonstandardized beta coefficients.

As shown in Table 1, the range of the reported age of LGB children was large, which might relate to meaningful differences in how parents with older children responded to survey questions, compared to those with younger children. Similarly, there are important developmental implications represented by the LGB child's age, time since the child disclosed his/her sexuality to the parent, and whether or not the child lived at home when the parent completed the survey. Simple slope tests of low, medium, and high levels of either, LGB Child Age or Time since Child Disclosure, were not shown to significantly predict any of the outcomes measured in this study. To test for possible moderation effects, separate regression models were run that predicted each of the outcome measures and included the control variables mentioned earlier, along with one of the following interaction terms: LGB Child Age by Time since Child Disclosure, LGB Child Age by LGB Child Lives at Home, or quadratic terms for either LGB Child Age or Time since Child Disclosure. None of the interaction terms significantly correlated with any of the outcomes measures.

Parental Minority Stress and Mental Health Outcomes

Our first hypothesis posited that *parental reports of direct and indirect minority stress will be associated with higher levels of reported mental health problems for the parent and their LGB child*. To test this assertion, four separate regression models were run. Two models were run for *direct* parental minority stress, the first predicting self-report of parent mental health problems and the second predicting parental reports of child mental health problems. Likewise, two models were run for *indirect* parental minority stress, predicting reported levels of parental and child mental health problems. To protect against type-II errors, these analyses were run with an adjusted significance level in mind, arrived at via a Bonferroni correction. The adjusted alpha was calculated by dividing the typical alpha value of .05 by 4 (representing the number of related analyses for this hypothesis), resulting in an adjusted alpha of .0125.

Direct minority stress. Table 2 presents the results of the four regression models showing how either direct or indirect minority stress predicted reports of both parental and child mental health problems. Direct minority stress was positively correlated with parental reports of child mental health problems. Among the control variables, whether or not the parent had a 4-year college degree was negatively correlated with the outcome.

Contrary to what was hypothesized, reports of direct minority stress were *not* significantly correlated to parents self-report of mental health problems based on corrected alpha levels for this hypothesis, although its *p*-value was less than .05. Among the control variables, parent age, parent college degree and household income were all negatively correlated with self-report of parent mental health problems.

Indirect minority stress. As hypothesized, parental reports of indirect minority stress were positively correlated with self-reports of parent mental health problems.

Among control variables, both parent age and household income negatively correlated with parent mental health problems. Similarly, reports of indirect minority stress were positively correlated with parental reports of child mental health problems. Whether or not the parent had a 4-year college degree was also negatively correlated with the outcome.

To better understand what predicted parental reports of child mental health problems, an additional regression analysis was run that included all control variables and measures of *both* direct and indirect minority stress simultaneously. This is the first of four ancillary analyses that were completed. Using a Bonferroni correction, analyses were run with an adjusted alpha level of .0125, as calculated by dividing the typical alpha value of .05 by 4 (the number of ancillary analyses). Interestingly, indirect minority stress remained positively correlated with parental reports of child mental health problems ($\beta = .244$, $t(203) = 3.616$, $p < .001$), while direct minority stress did not ($\beta = -.014$, $t(203) = -.186$, $p = .852$).

Another regression analysis was run predicting parental reports of child mental health problems that included the control variables and both subscales of indirect minority stress, child discrimination and expected rejection of child, to better understand which played a larger role in predicting the outcome. Reports of child discrimination were positively correlated with parental reports of child mental health problems ($\beta = .516$, $t(203) = 4.359$, $p < .001$), while expected rejection of child did not ($\beta = -.003$, $t(203) = -.027$, $p = .978$). Whether or not the parent had a 4-year college degree was negatively correlated with the outcome.

Minority Stress and Parenting Style

Our second hypothesis stated that *parents who report higher levels of direct and indirect minority stress will endorse higher levels of authoritarianism and less authoritativeness, as well as less acceptance and lower rates of conflict resolution towards their LGB child*. To test these claims, eight separate regression models were run. A model was run to show how parental reports of either direct or indirect minority stress predicted parental self-reports of authoritarianism, authoritativeness, acceptance, and conflict resolution. Using a Bonferroni correction, these analyses were run with an adjusted alpha level of .00625, as calculated by dividing the typical alpha value of .05 by 8 (the number of related analyses for this hypothesis).

Authoritarian parenting style. Table 3 presents the results of the two regression models that predict authoritarianism by including reports of either direct or indirect parental minority stress along with the control variables listed earlier. As hypothesized, reports of both direct and indirect minority stress were positively correlated to self-reported rates of authoritarianism.

To better understand what predicted authoritarianism, an additional regression analysis was run that included all control variables and measures of both direct and indirect minority stress simultaneously. Indirect minority stress remained positively correlated with parental authoritarianism ($\beta = .014$, $t(203) = 2.624$, $p = .009$), while direct minority stress did not ($\beta = .009$, $t(203) = 1.383$, $p = .168$).

Authoritative parenting style. Table 4 presents the results of two regression models that predict authoritativeness by including reports of either direct or indirect parental minority stress along with the control variables. As hypothesized, reports of indirect minority stress were negatively correlated to self-reported rates of

authoritativeness. However, reports of direct minority stress were not significantly correlated to authoritativeness, based on corrected alpha levels for this hypothesis, although its p -value was less than .05. Among control variables, whether or not the parent was female positively correlated with authoritativeness in the model that included indirect minority stress, but did not in the model that included direct minority stress.

Conflict resolution. Table 5 presents the results of two regression models that predict reported rates of conflict resolution between parent and their LGB child by including reports of either direct or indirect parental minority stress along with control variables. As hypothesized, reports of both direct and indirect minority stress were negatively correlated to self-reported rates of conflict resolution.

To better understand what predicted conflict resolution, an additional regression analysis was run that included all control variables and measures of both direct and indirect minority stress simultaneously. Neither direct minority stress ($\beta = -.012$, $t(203) = -2.191$, $p = .030$), nor indirect minority stress ($\beta = -.010$, $t(203) = -1.920$, $p = .056$) significantly predicted the outcome based on corrected alpha levels for ancillary analyses.

Acceptance. Table 6 presents the results of two regression models that predict reported levels of parental acceptance towards their LGB child, by including parental reports of either direct or indirect minority stress along with control variables. As hypothesized, reports of indirect minority stress were negatively correlated to self-reported levels of acceptance. However, reports of *direct* minority stress were not significantly correlated to the outcome, based on corrected alpha levels for this hypothesis, although its p -value was less than .05.

Parental Authoritarianism as a Mediator

In our third hypothesis, it was theorized that *parental authoritarianism will mediate the link between parental experiences of minority stress (both direct and indirect) and reports of their LGB child's mental health*. Mediation models were tested using the PROCESS macro in SPSS (Hayes, 2013), a widely used computational tool for mediation and moderation analysis freely downloadable from www.processmacro.org. PROCESS generates estimates of all included parameters in a mediation model via two separate OLS regression analyses and provides a bootstrap confidence interval (CI) for each of the indices of mediation as described in Preacher and Hayes (2004).

PROCESS was used to investigate if parental authoritarianism mediated the link between parental reports of direct minority stress and parental report of child mental health problems. Results indicated that direct minority stress was a significant predictor of parental authoritarianism ($\beta = .018$, $t(204) = 3.69$, $p < .001$), and that parental authoritarianism was a significant predictor of reported child mental health problems ($\beta = 4.47$, $t(203) = 5.51$, $p < .001$). These results support the mediational hypothesis. Direct minority stress was no longer a significant predictor of parental reports of child mental health problems after controlling for the mediator, parental authoritarianism ($\beta = .0697$, $t(203) = 1.16$, $p = .245$), consistent with full mediation (see Figure 1). Approximately 22% of the variance in parental reports of child mental health problems was accounted for by the predictors ($R^2 = .310$). The indirect effect was tested using a bootstrap estimation approach with 10,000 samples (Hayes, 2004; Shrout & Bolger, 2002). These results indicated the indirect coefficient was significant, ($\beta = .0825$, $SE = .0273$, 95% $CI = .0344$, $.1435$). Parental reports of direct minority stress were associated with approximately .0825 units higher scores on parental report of child mental health problems as mediated

by parental authoritarianism.

Similarly, PROCESS was used to investigate if parental authoritarianism also mediated the link between parental reports of *indirect* minority stress and parental reports of child mental health problems. Results indicated that indirect minority stress was a significant predictor of parental authoritarianism ($\beta = .019$, $t(204) = 4.35$, $p < .001$), and that parental authoritarianism was a significant predictor of parental reports of child mental health problems ($\beta = 3.99$, $t(203) = 4.95$, $p < .001$). These results support the mediational hypothesis. Indirect minority stress remained a significant predictor of parental reports of child mental health problems after controlling for the mediator, parental authoritarianism ($\beta = .159$, $t(203) = 3.02$, $p = .003$), consistent with partial mediation (see Figure 2). Approximately 31% of the variance in the parental report of child mental health problems was accounted for by the predictors ($R^2 = .308$). The indirect effect was tested using a bootstrap estimation approach with 10,000 samples (Hayes, 2004; Shrout & Bolger, 2002). These results indicated the indirect coefficient was significant, ($\beta = .0764$, $SE = .0256$, 95% $CI = .0354, .1394$). Parental reports of indirect minority stress were associated with approximately .0764 units higher scores on the parental report of child mental health problems as mediated by parental authoritarianism.

Table 1
Means, Standard Deviations, and Bivariate Correlations of Study Variables

	Mean	SD	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. Mother Respondent	0.85	0.36															
2. Parent Age	53.28	10.03	-.049														
3. College Degree (4+ Years)	0.56	0.50	.091	.163*													
4. Household Income	5.30	1.53	.075	-.032	.412**												
5. LGB Child Age	23.52	8.90	-.006	.787**	.030	-.029											
6. LGB Child Lives at Home	5.63	0.49	.066	.496**	.085	-.037	.630**										
7. Time since Child Disclosure	4.14	1.59	.059	.444**	-.091	-.050	.563**	.477**									
8. Direct Minority Stress	18.63	7.28	.058	-.152*	-.047	.021	-.155*	-.090	.021								
9. Indirect Minority Stress	27.99	8.24	.145*	-.139*	-.134*	-.004	-.126	-.136	.024	.624**							
10. Parent Mental Health Problems	1.27	0.24	-.044	-.263**	-.350**	-.384**	-.164*	-.008	-.094	.163*	.209**						
11. Child Mental Health Problems	9.92	6.85	.047	-.235**	-.251**	-.094	-.258**	-.133	-.195**	.206**	.328**	.322**					
12. Authoritarianism	1.95	0.57	.014	-.287**	-.147*	-.199**	-.310**	-.068	-.079	.269**	.298**	.391**	.423**				
13. Authoritativeness	4.19	0.52	.151*	.101	-.004	.075	.127	.083	.060	-.129	-.239**	-.188**	-.312**	-.275**			
14. Conflict Resolution	4.02	0.50	.015	.250**	.070	.141*	.296**	.157*	.139*	-.307**	-.278**	-.440**	-.525**	-.555**	.523**		
15. Acceptance	4.22	0.52	.058	.192**	.043	.079	.229**	.171*	.176**	-.159*	-.209**	-.278**	-.504**	-.461**	.773**	.725**	

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

Table 2
Multiple Regression Analyses Predicting Parent and Child Mental Health Problems

Variable	Parent Mental Health Problems						Child Mental Health Problems					
	Direct Minority Stress			Indirect Minority Stress			Direct Minority Stress			Indirect Minority Stress		
	B	SE B	t ^a	B	SE B	t ^a	B	SE B	t ^a	B	SE B	t ^a
Constant	1.885	.120	15.676**	1.832	.123	14.914**	13.534	3.634	3.724**	10.009	3.626	2.760**
PFLAG Recruitment	.051	.033	1.546	.054	.032	1.673	1.322	.990	1.336	1.432	.955	1.499
Email Recruitment	.030	.051	.603	.040	.049	.809	.046	1.527	.030	.328	1.459	.225
Mother Respondant	-.020	.042	-.478	-.035	.042	-.844	1.124	1.255	.895	.330	1.233	.268
Parent Age	-.007	.002	-2.821*	-.007	.002	-2.826*	.015	.073	.205	.018	.071	.256
LGB Child Age	.003	.003	.982	.003	.003	.980	-.122	.087	-1.398	-.116	.084	-1.383
Parent College Degree	-.093	.035	-2.668*	-.085	.035	-2.428†	-3.645	1.054	-3.458*	-3.191	1.029	-3.100*
Household Income	-.056	.011	-5.026**	-.056	.011	-5.133**	-.168	.335	-.501	-.204	.324	-.628
Time Since Child Disclosure	-.012	.011	-1.046	-.011	.011	-1.029	-.728	.339	-2.145†	-.736	.328	-2.245†
Direct Minority Stress	.004	.002	1.919†	-	-	-	.152	.062	2.455*	-	-	-
Indirect Minority Stress	-	-	-	.005	.002	2.626*	-	-	-	.236	.053	4.418**

Note. A Bonferroni correction was used to adjust alpha levels for the above analyses to .0125.

† $p < .05$. * $p < .0125$. ** $p < .001$. ^a $df = 204$.

Table 3
Multiple Regression Analyses Predicting Authoritarian Parenting Style

Variable	Direct Minority Stress			Indirect Minority Stress		
	<i>B</i>	<i>SE B</i>	<i>t^a</i>	<i>B</i>	<i>SE B</i>	<i>t^a</i>
Constant	2.567	.293	8.757**	2.408	.298	8.078**
PFLAG Recruitment	.051	.080	.640	.069	.079	.881
Email Recruitment	-.182	.123	-1.479	-.132	.120	-1.102
Mother Respondant	-.024	.101	-.236	-.084	.101	-.827
Parent Age	-.006	.006	-1.076	-.006	.006	-1.071
LGB Child Age	-.015	.007	-2.192†	-.016	.007	-2.315†
Parent College Degree	-.064	.085	-.758	-.033	.085	-.389
Household Income	-.066	.027	-2.431†	-.069	.027	-2.578†
Time Since Child Disclosure	.034	.027	1.227	.036	.027	1.350
Minority Stress Type	.018	.005	3.690**	.019	.004	4.347**

Note. A Bonferroni correction was used to adjust alpha levels for the above analyses to .00625.

† $p < .05$. * $p < .0125$. ** $p < .001$. ^a $df = 204$.

Table 4
Multiple Regression Analyses Predicting Authoritative Parenting Style

Variable	Direct Minority Stress			Indirect Minority Stress		
	<i>B</i>	<i>SE B</i>	<i>t^a</i>	<i>B</i>	<i>SE B</i>	<i>t^a</i>
Constant	3.859	.291	13.278**	4.194	.288	14.549**
PFLAG Recruitment	-.017	.079	-.221	-.023	.076	-.297
Email Recruitment	.093	.122	.760	.081	.116	.701
Mother Respondant	.261	.100	2.601†	.327	.098	3.333**
Parent Age	.002	.006	.277	.001	.006	.232
LGB Child Age	.006	.007	.810	.005	.007	.714
Parent College Degree	-.051	.084	-.608	-.090	.082	-1.099
Household Income	.025	.027	.931	.028	.026	1.075
Time Since Child Disclosure	-.008	.027	-.302	-.006	.026	-.235
Minority Stress Type	-.010	.005	-1.960†	-.019	.004	-4.463**

Note. A Bonferroni correction was used to adjust alpha levels for the above analyses to .00625.

† $p < .05$. * $p < .0125$. ** $p < .001$. ^a $df = 204$.

Table 5
Multiple Regression Analyses Predicting Conflict Resolution

Variable	Direct Minority Stress			Indirect Minority Stress		
	<i>B</i>	<i>SE B</i>	<i>t</i> ^a	<i>B</i>	<i>SE B</i>	<i>t</i> ^a
Constant	3.600	.262	13.733**	3.670	.271	13.561**
PFLAG Recruitment	-.137	.071	-1.924	-.157	.071	-2.208†
Email Recruitment	.018	.110	.159	-.039	.109	-.356
Mother Respondant	.072	.091	.799	.121	.092	1.314
Parent Age	.003	.005	.500	.003	.005	.497
LGB Child Age	.013	.006	2.003†	.014	.006	2.174†
Parent College Degree	-.002	.076	-.030	-.026	.077	-.343
Household Income	.061	.024	2.537†	.064	.024	2.645†
Time Since Child Disclosure	.000	.024	.013	-.004	.024	-.157
Minority Stress Type	-.019	.004	-4.196**	-.016	.004	-4.052**

Note. A Bonferroni correction was used to adjust alpha levels for the above analyses to .00625.

† $p < .05$. * $p < .0125$. ** $p < .001$. ^a $df = 204$.

Table 6
Multiple Regression Analyses Predicting Acceptance

Variable	Direct Minority Stress			Indirect Minority Stress		
	<i>B</i>	<i>SE B</i>	<i>t</i> ^a	<i>B</i>	<i>SE B</i>	<i>t</i> ^a
Constant	3.773	.293	12.875**	3.963	.297	13.346**
PFLAG Recruitment	-.073	.080	-.909	-.081	.078	-1.041
Email Recruitment	.076	.123	.621	.053	.119	.442
Mother Respondant	.117	.101	1.159	.166	.101	1.642
Parent Age	.002	.006	.316	.002	.006	.293
LGB Child Age	.008	.007	1.132	.008	.007	1.139
Parent College Degree	.009	.085	.107	-.018	.084	-.214
Household Income	.032	.027	1.178	.034	.027	1.283
Time Since Child Disclosure	.028	.027	1.010	.027	.027	1.019
Minority Stress Type	-.011	.005	-2.173†	-.015	.004	-3.358**

Note. A Bonferroni correction was used to adjust alpha levels for the above analyses to .00625.

† $p < .05$. * $p < .0125$. ** $p < .001$. ^a $df = 204$.

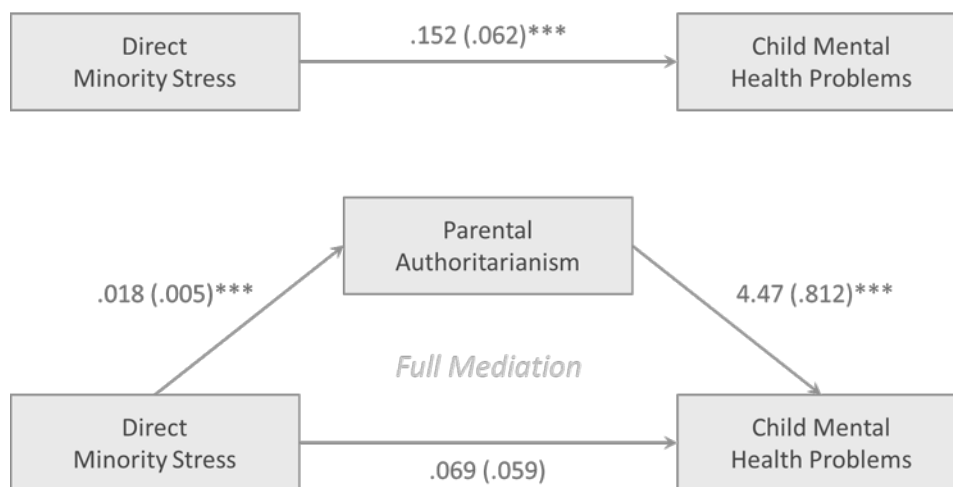


Figure 1. Authoritarianism as Mediator between Direct Minority Stress and Parent Report of Child Mental Health

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

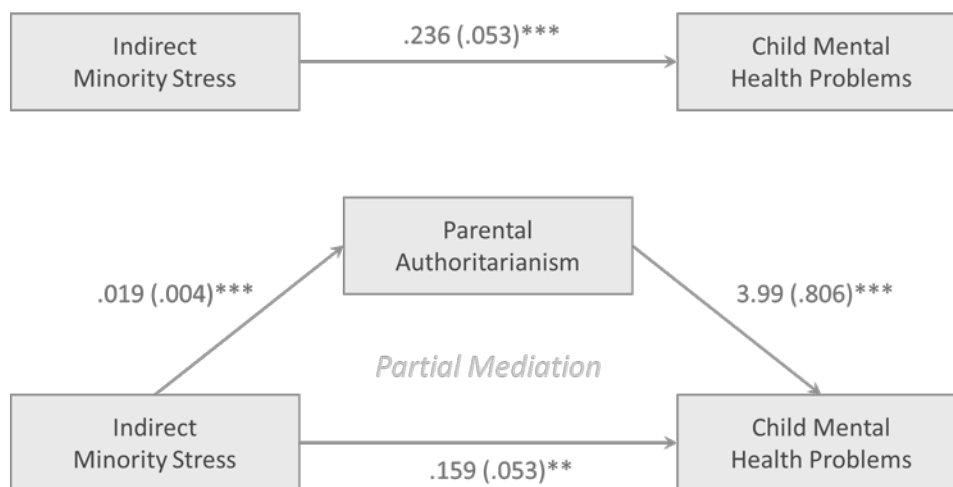


Figure 2. Authoritarianism as Mediator between Indirect Minority Stress and Parent Report of Child Mental Health

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

DISCUSSION

The primary focus of this study was to investigate experiences of minority stress among parents of LGB children and the implications of such experiences for both parent and child well-being. We proposed two separate types of minority stress that a parent can experience: direct minority stress, defined as experiences and expectation of rejection as a result of being a parent of an LGB child; and indirect minority stress, defined as a parent's knowledge of discrimination that their LGB child has experienced and expectations that their child will face such marginalization in the future.

Parental reports of direct minority stress were related to mental health outcomes, but not in the way we expected. Based on previous research on minority stress, we anticipated that parental experiences of direct minority stress would be associated with greater mental health problems. This was not supported by our data. No significant relationship was found between reports of direct minority stress and self-reports of mental health problems. One explanation for this is that discrimination towards parents for having an LGB child may not be that common. In our sample, the rate of discrimination endorsed by parents was significantly lower than that reported for their LGB children. For example, 32% of parents denied experiencing *any* form of discrimination, compared to only 9% of LGB children. It is possible that parents' *direct* experiences of minority stress may be of low enough frequency and/or intensity that they manage to cope successfully.

Furthermore, parents who do experience discrimination for having an LGB child may not experience such stigmatization in the same way that sexual minorities do. Meyer suggests that vulnerability to minority stress is likely moderated by the prominence, valence, and level of integration that minority status is incorporated into one's overall sense of self (Meyer, 2003). Hence, an LGB person who views their sexual orientation as fundamental to their identity would be particularly distressed by experiences of stigmatization related to that aspect of their identity. Parents of LGB children may not experience the status of "having an LGB child" as a fundamental part of their sense of self; in fact, some may actively resist integrating such a status into their core identity. Accordingly, any stigmatization parents may experience as a result of this status is likely less threatening and, therefore, less detrimental to their mental health.

Interestingly, parental reports of direct minority stress were linked to greater mental health problems in the LGB child, as reported by the parent. This partially supports our initial hypothesis, and suggests that a parent's experience of direct minority stress may have important implications for their LGB child. However, we cannot conclude from our findings that direct parental minority stress causes increased mental health problems among their LGB children directly. For instance, it is also possible that parents who observe signs of mental distress in their child may become increasingly worried about their own social rejection, perhaps because they fear that their child's problems will be interpreted as signs of their own failings as a parent.

As hypothesized, reports of indirect minority stress were associated with higher self-reported mental health problems among parents. These findings are consistent with our interpreting of minority stress theory as it pertains to parents of LGB children, the primary difference being that it is a parent's worry about the safety and wellbeing of their

LGB child that becomes a chronic stressor that is associated with negative mental health outcomes, instead of the parent's concern about their own marginalization. This has important implications for clinical intervention, as it suggests parents are emotionally invested in their child's wellbeing and are spending resources worrying about the increased risk their LGB child might face. However, we cannot conclude that this finding is causal in nature. For instance, it is also possible that parents who have higher levels of mental health problems are disproportionately worried about the safety of their child and are more likely to perceive and expect discrimination towards their LGB child. Disentangling the pathway between minority stress and mental health problems, both direct and indirect, remains an important direction for future research.

Parental reports of indirect minority stress were also associated with greater reports of their LGB child's mental health problems. This was expected primarily because the measure of indirect minority stress includes items that assess how often the child has been a victim of discrimination. Exploratory analyses confirmed that reports of child discrimination were the primary driver of the association between indirect minority stress and child mental health outcomes, a finding that corroborates the well-documented link between discrimination and increased risk for mental health problems among sexual minorities that was reviewed earlier.

The above findings suggest that parents of LGB children experience both direct and indirect forms of minority stress, which are linked to negative health outcomes in different ways. Parents who experienced higher levels of direct minority stress were more likely to report mental health problems among their LGB children, while parents who reported greater indirect minority stress were more likely to endorse mental health problems for themselves. These findings suggest that risks associated with societal

homonegativity are not confined to LGB people only, but may pertain to their parents as well. These findings suggest that a much larger population of people face increased health risks from coping with homonegative discrimination and marginalization than originally thought.

Implications of Minority Stress for Parent Behavior

The findings above show that parents' experiences of minority stress are related to their mental health and the mental health of their child. Yet, what are the mechanisms through which these associations operate? We posited that parental behavior towards their child played a critical role. Specifically, we theorized that *parents with higher levels of parental minority stress (direct and indirect) would also report higher levels of authoritarianism, less authoritativeness, and lower rates of acceptance and conflict resolution*. This hypothesis was supported. Parents who reported higher rates of either direct or indirect minority stress were more likely to endorse greater authoritarianism and reported lower rates of conflict resolution between parent and child. Similarly, parents who reported higher levels of indirect minority stress also reported less authoritativeness and lower levels of acceptance towards their LGB child.

Both direct and indirect minority stress were linked to higher reports of parental authoritarianism. As described earlier, parents have been shown to experience greater fear, confusion, and worry when they become aware that their child identifies as LGB (Beeler & DiProva, 1999; Bernstein, 1990; Goodrich, 2009; Phillips & Ancis, 2008; Saltzburg, 2004; Wakely & Tuason, 2011). In addition, past research has found that parents under stress are more demanding and less responsive to the needs of their children, especially under stress (Crnic, Greenberg, Ragozin, Robinson, & Basham, 1983;

Deater-Deckard, 1998; Deater-Deckard & Scarr, 1996). It is possible that as fears of rejection from others increase, parents become more demanding and exercise stronger control over their LGB child out of a desire to protect both themselves and their child from discrimination. Interestingly, in an analysis predicting authoritarianism that included both forms of minority stress simultaneously, parental reports of indirect minority stress continued to predict authoritarianism, while reports of direct minority stress did not. This suggests that although parents experience direct minority stress as a result of *having* an LGB child, concern about the rejection their child may experience by *being* LGB is uniquely related to authoritarian parenting strategies. This suggests that such parental strategies may be particularly motivated by a desire to protect their LGB child from perceived danger.

However, authoritarianism is often described as a preoccupation by the parent with obedience, conformity, and maintaining order (Baumrind, 1991; Darling & Steinberg, 1993; Dornbusch et al., 1987), all of which involve concern about adhering to social norms and awareness of possible ramifications when those social norms are broken. Hence, an alternative explanation for the links between minority stress and higher authoritarianism may be that parents who rely on authoritarian strategies are more likely to worry about being judged negatively by others for having an LGB child and they may worry their child will be treated poorly for being a sexual minority. Alternatively, it may also be that measurements of authoritarianism are capturing aspects of general homonegativity held by parents, whereby, parents who have generally homonegative views, expressed as authoritarianism towards their LGB child, also worry about being rejected by others for having an LGB child and assume their child will be discriminated against for being nonheterosexual.

Parents who reported high levels of indirect minority stress were less likely to endorse authoritative parenting strategies and also reported lower levels of acceptance towards their LGB child. Relatedly, parents who reported higher levels of either direct or indirect minority stress more likely reported lower levels of conflict resolution between themselves and their LGB child. This is not particularly surprising, since authoritativeness, often described as supportive and developmentally appropriate expectations of a child maintained through effective communication, includes aspects of both acceptance and conflict resolution. Alternatively, authoritarianism is described as strong control and high demands of a child shown with limited affection or communication. In many ways the two parenting styles represent opposite ends of the spectrum (shown in Table 1 as being negatively correlated). Hence, such findings may simply be capturing the same dynamics proposed earlier to describe the link between minority stress and parental authoritarianism, only in this case they are reversed.

Given the various ways parental authoritarianism may capture aspects of parental behavior, which relate to mental health outcomes among their LGB children, it is not surprising that authoritarianism was found to fully mediate the link between parental experiences of direct minority stress and their reports of mental health problems in their LGB child. Similarly, authoritarianism partially mediated the link between indirect minority stress and reports of the LGB child's mental health. These findings suggest the risks associated with parental experiences of direct and indirect minority stress are likely transferred to the LGB child through parental behavior towards that child. This supports previous research showing that parental behaviors have important implications for their child's overall functioning (Burt et al., 2003; Duman et al., 2005; Marmorstein & Iacono, 2004) and suggests a valuable pathway for possible intervention.

Clinical Implications

The present study shows that parental experiences of direct and indirect minority stress that occur as a result of having an LGB child have important implications for the family system. These findings reveal important patterns that can be used to guide clinical decision making, while working with such families. However, the various ways in which minority stress, parent behavior, and mental health interact within a family system is likely very different for each family. For example, a father who has a preexisting anxiety disorder may be more likely to worry about, and expect, rejection from his neighbors for having a gay son, which may lead to an overreliance on authoritarian strategies when parenting his son in an attempt to limit who knows about his child's sexuality.

Alternatively, a mother may demand that her lesbian daughter dress "less gay" and restrict her from spending time with LGB friends out of fear for her daughter's safety.

Both examples show how parental experiences of direct and indirect minority stress play an important role in a parent's behavior, but in very different ways. Hence, it remains the clinician's responsibility to carefully assess how minority stress might impact a family system, if at all, and continually consider possible patterns of association. Doing so could inform case conceptualization and treatment targets in very meaningful ways.

A clinician must also consider that preexisting mental health problems can alter parental experiences of minority stress as well as maladaptive parenting behaviors. Hence, treating a parent's underlying psychological issues first may be required, before addressing experiences of minority stress. In these circumstances, assessing parental experiences of minority stress would still provide valuable information for the clinician. For instance, experiences of direct minority stress involve worry, fear, and preoccupation with being judged or mistreated by others as a result of having an LGB child. In such

cases, treating aspects of social anxiety could be especially powerful. This might include processing and challenging beliefs around the possible impact of negative judgments from others, or increasing interpersonal skills such as assertiveness and boundary setting. Direct parental minority stress may also be related to preexisting depression, such that feelings of shame, grief, or regret related to their LGB child are exacerbated. Parental experiences of indirect minority stress involve worry and fear about the safety and wellbeing of their LGB child. Such stress could be aggravated by a number of psychological conditions, including anxiety, obsessive-compulsive disorder, and past experiences of trauma.

Although not tested in the present study, it may be possible to reduce parental experiences of direct and indirect minority stress through clinical intervention. For instance, psychoeducation may decrease minority stress, or act as a protective force against it, by discussing information showing how societal views towards homosexuality are becoming more accepting over time. Examples of this include increased visibility of LGB characters in the mainstream media, the legalization of same-sex marriage, and recent legislation designed to protect individuals based on their sexual orientation. Alternately, a parent's experience of minority stress may be high due to an overestimation of how often sexual minorities, and those affiliated with them, are discriminated against. In such cases, a clinician could offer information about common forms of discrimination and how often they occur. A parent's fear of being rejected for having an LGB child might also be reduced if he or she believed they could handle such events effectively. Hence, a clinician might engage in role playing to increase a parent's sense of competency in responding to discrimination. Specific coping strategies could also be taught and practiced to reduce negative consequences, if acts of discrimination do

occur. Testing the effectiveness of such intervention strategies in reducing parental minority stress remains an important direction for future research.

It is also important for clinicians to consider that homonegativity is socially based and originates from societal and cultural norms that may differ among families.

Although clinicians are often trained to take an affirmative stance towards homosexuality, there are many environments where being public about one's sexual minority status comes with objectively higher risk. For instance, it has been argued that being Black and LGB puts individuals at an increased risk for compromised psychological and physical health (Greene, 1998; Martinez & Sullivan, 1998). These risks may arise from cultural factors widely held in the African-American community, including traditional family values and gender roles, religiosity, and prevalent homophobia (Greene, 1998; Martinez & Sullivan, 1998). Similarly, LGB individuals who reside in communities that are highly religious or politically conservative are at greater risk for negative health outcomes (Hatzenbuehler, Pachankis, & Wolff, 2012). Hence, parental experiences of direct and indirect minority stress may be an accurate assessment of their surroundings and parents may engage in behaviors, such as greater authoritarianism, that are protective for their LGB child.

Strengths, Limitations, and Future Directions

This study is the first to measure experiences of direct and indirect minority among parents of LGB children. While most previous research on parents of LGB children relies heavily on qualitative methods, this study is quantitative in nature, which is an important contribution, and our sample of 223 parents is among the largest surveyed to date. Also, because data were collected online, it allowed for respondents from across

the USA to participate.

A primary limitation of this study is that data were collected via self-report from one parent only, including outcome data about the LGB child. No data were collected from the child directly, or from other parental figures in the family system. This may have biased measures of child mental health, rates of discrimination, and rates of parental accepting and rejecting behaviors. Future research would benefit from gathering data from the LGB child in addition to each of the child's primary parental figures. This would provide a more accurate picture for each variable of interest and provide data from the LGB child's perspective, which may differ from those reported by parents. However, we expect parents involved in our study, similar to most respondents across psychological research, likely over-reported positive aspects about themselves and their children, while under-reporting negative aspects. Hence, it is possible that collecting data from additional sources in a family would capture greater negativity and thus increase the power and direction of our findings.

In hopes of increasing participation rates, no limitation was placed on the age of the LGB child or time since their disclosure of his/her sexuality to the parents. This means that some parents were answering questions retrospectively about their child's behavior and their own, which may have biased the data in meaningful ways. Furthermore, recruitment methods relied heavily on convenience sampling procedures, whereby a large portion of respondents learned about the study from local PFLAG chapters. However, each of the above variables were controlled for in all of the analyses used for this study, and no significant differences were shown to exist across the outcomes of interest, based on the child's age, time since disclosure, or whether the child was living at home at the time parents took the survey. Another limitation of this study,

which remains a common issue among research involving sexual minorities generally, is that our sample was disproportionately Caucasian (91%) and female (85.2%). Hence, it remains unclear how our findings might be generalized to parents who are not Caucasian mothers. Efforts were taken to gather data from ethnically diverse regions of the country, and both mothers and fathers were targeted for participation, but future research on this topic would benefit from samples that include greater diversity.

Lastly, participation in our study required that a parent was aware that one of their children was LGB *and* willing to disclose that fact, while completing an anonymous online survey. Thus, results cannot generalize to parents who are unaware that they have an LGB child, or parents unwilling to anonymously disclose that fact. Our sample also lacked a control group, so it is impossible for this study to clarify potential differences between parents with an LGB child and those with only heterosexual children.

Additionally, future work would benefit from longitudinal designs, since most of the processes being investigated in this study are developmental in nature. As societal norms and expectations regarding LGB issues continue to change, additional research will be needed to assess how the findings presented in this study might also change over time.

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