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Parental Support, Depressive Symptoms, and LGBTQ Adolescents: Main and Moderation Effects in a Diverse Sample

Roberto L. Abreu ^a, G. Tyler Lefevor ^b, Kirsten A. Gonzalez ^c, Manuel Teran^d, and Ryan J. Watson^e

^aDepartment of Psychology, University of Florida; ^bDepartment of Psychology, Utah State University; ^cDepartment of Psychology, University of Tennessee; ^dDepartment of Psychology, University of California; ^eDepartment of Human Development and Family Sciences, University of Connecticut

ABSTRACT

Objective: Research has documented the importance of parental support as a protective factor against depressive symptoms among lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth. In this study, we assessed the relations between LGBTQ-specific parental support and depressive symptoms.

Method: Participants were 6,837 LGBTQ youth (ages 13–17) with diverse racial and ethnic, gender, and sexual identities. Main effect and moderation analyses examined interactions between LGBTQ-specific parental support with demographic variables on depressive symptoms, considering demographics as moderators.

Results: We found that participants of color reported less LGBTQ-specific parental support than their White counterparts, that transgender and genderqueer participants reported less LGBTQ-specific parental support than their cisgender counterparts, and that non-monosexual participants reported less LGBTQ-specific parental support than their monosexual counterparts. Disparities in depressive symptoms were found for individuals who identified as Native American and Latinx, non-monosexual, and transgender and genderqueer, such that these groups reported higher levels of depressive symptoms. Further, we found a significant interaction between LGBTQ-specific parental support and ethnicity, with LGBTQ-specific parental support being less strongly associated with participants who identified as Latinx compared to those who did not identify as Latinx. We also found a significant interaction between LGBTQ-specific parental support and gender identity, with LGBTQ-specific parental support being more strongly related to depressive symptoms among participants who did not identify as boys compared to cisgender boys.

Discussion: We discuss how to assess the impact of interlocking systems of oppression when working with LGBTQ youth and their parental figures.

Research suggests that lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth experience disproportionate levels of depressive symptoms compared to their cisgender and heterosexual counterparts (e.g., Centers for Disease Control and Prevention, 2011; Kosciw et al., 2018; The Trevor Project, 2021). A growing body of research indicates that harassment, bullying (in-person and cyberbullying), and violence is associated with higher levels of depressive symptoms among LGBTQ youth (Kosciw et al., 2018). Furthermore, scholarship focused on the importance of parental support related to well-being of LGBTQ youth has largely excluded youth of color, transgender and genderqueer youth, and non-monosexual youth. In the present study, we fill this gap by examining the influence of LGBTQ-specific parental support on depressive symptoms in a sample of LGBTQ youth that includes diversity in relation to youth's race and ethnicity, gender identity, and sexual orientation.

We utilize minority stress and intersectionality as guiding frameworks for this study. We provide an overview of the literature about the importance of parental support in the well-being of LGBTQ youth, with a focus on the available literature about the effects of LGBTQ-specific parental support on depressive symptoms among diverse LGBTQ youth.

Minority Stress, Intersectionality, and Parental Support of LGBTQ Youth

The current LGBTQ literature does not provide a concrete and unifying definition of what constitutes LGBTQ-specific parental support toward one's LGBTQ child. This literature has focused on exploring specific behaviors parental figures engage toward their child (e.g., verbal and emotional abuse, pride) after learning or suspecting the child's sexual and/or gender identity,

and the consequences of these behaviors on the physical and emotional well-being of the LGBTQ child (Abreu et al., 2022; see review in Bouris et al., 2010). In addition, this body of literature encompasses supportive and unsupportive behaviors as reported by both the LGBTQ child and the parental figure themselves (Bouris et al., 2010; Chrisler, 2017). For the purpose of this study, we define LGBTQ-specific parental support as behaviors that show love, affection, and care toward one's LGBTQ child after learning (from the child or someone else) about their non-normative sexual and/or gender identity or after becoming aware of non-normative behaviors that could be attributed to a person's sexual and/or gender identity (e.g., believing that a child that was assigned male at birth is gay because they choose to dress in male atypical clothing such as dresses). We define LGBTQ-specific parental lack of support as behaviors that are opposite to love, affection, and care (e.g., negative comments about being LGBTQ; mocks the person for being LGBTQ).

Minority stress theory proposes that LGBTQ people, including youth, experience unique stressors as a result of their minoritized sexual and gender identities (Brooks, 1981; Meyer, 2003). Research demonstrates that minority stress results in greater health disparities among LGBTQ youth compared to their heterosexual and cisgender counterparts, including depressive symptoms (e.g., Barnett et al., 2019; Gallegos et al., 2011; McLaughlin et al., 2012). In addition, research shows that minority stress as a result of LGBTQ-specific parental lack of support is common among LGBTQ youth, leading to increased adverse mental health outcomes for LGBTQ youth such as symptoms of depression (e.g., Katz-Wise et al., 2016; Newcomb et al., 2019; Pollitt et al., 2017). Similar to their cisgender and heterosexual counterparts, LGBTQ youth may depend on their parental figures for support when they experience stress. Thus, when LGBTQ youth experience LGBTQ-specific parental lack of support they may both experience greater difficulties coping with stress *and* increased stress from the lack of support, both of which may lead to greater depressive symptoms (Brooks, 1981; Meyer, 2003).

Intersectionality, first coined to contextualize the experiences of Black women within the legal system, sets forth a framework that aims to understand the ways in which people exist within interlocking systems of oppression (e.g., racism, heterosexism, cissexism; Combahee River Collective, 1995; Crenshaw, 1989). Importantly, parental figures interact with their child within larger systems of oppression that have oftentimes shaped their own understanding of what it means to be an LGBTQ person. The complexity of this experience is

heightened when considering the intersection of parenting a LGBTQ child who also identifies as a racial and ethnically diverse person, among other oppressed identities. For example, a Latinx parental figure's negative reaction to their child identifying as transgender might stem from their own perception of how their child would need to exist within racist, xenophobic, and transphobic systems. Thus, we urge readers to keep in mind the "power and social-structural factors as drivers of inequities across intersectional positions" (Del Río-González et al., 2021, p. 33) as we explore the role of parental support on depressive symptoms among LGBTQ youth.

Parental Support and Depressive Symptoms Among LGBTQ Youth

Among LGBTQ youth, fear of stigmatization, lack of support from peers and family, victimization, and humiliation are related to elevated depressive symptoms (Katz-Wise et al., 2016). Research shows that support from parental figures is one of the greatest mitigating factors for depressive symptoms among LGBTQ youth (Abreu et al., 2019; Hall, 2018; Plöderl & Tremblay, 2015). Also, LGBTQ-specific parental support protects against negative mental and physical health outcomes (e.g., Dickenson & Huebner, 2016; Ryan et al., 2009, 2010). For example, in a meta-analysis of 35 studies, researchers found that lower levels of parental support led to higher levels of depressive symptoms among LGBTQ youth (Hall, 2018). These findings are consistent with other studies that have found that when LGBTQ youth experience higher levels of LGBTQ-specific parental support, they report lower levels of depressive symptoms, distress, and suicidal ideation (e.g., Dickenson & Huebner, 2016; Ryan et al., 2009).

Parental Support and Depressive Symptoms Among LGBTQ Youth of Color

There has been paucity of research about the role of family support on LGBTQ youth of color health outcomes (Newcomb et al., 2019). Researchers have suggested that minoritized racial and ethnic identities, sexual orientation, and gender identity may interact to influence LGBTQ-specific parental support, or the perception of LGBTQ-specific support among LGBTQ youth (e.g., Abreu, Gonzalez et al., 2020; Abreu, Riggle et al., 2020). For example, in a study using data from The Family Acceptance Project (where over 50% of participants identified as Latinx), researchers found an interaction between race and ethnicity and sexual

orientation, such that Latinx youth who endorsed lower levels of LGBTQ-specific support also reported lower levels of self-worth (Snapp et al., 2015). Specific to depressive symptoms, to the authors' knowledge, researchers have yet to explore the association between LGBTQ-specific parental support and depressive symptoms among LGBTQ youth of color.

Despite these gaps, the general literature about the role of family support on the well-being of LGBTQ people of color might provide some insight about the importance of parental support on depressive symptoms among LGBTQ youth of color. Overall, research shows that unique factors such as cultural homophobia and parent-child conflict related to the child's intersectional experiences as an LGBTQ person of color contribute to mental health outcomes such as depressive symptoms among LGBTQ racial and ethnic minority people (e.g., Ghabrial, 2017; Ghabrial & Andersen, 2021; Sarno et al., 2015; Santos & VanDaalen, 2016). For example, in a study of 208 LGB ethnic and racial minority people, Santos and VanDaalen (2016) found that conflicts in allegiances (CIA), or people's perceived tension between one's ethnic and racial identity and one's LGB identities was related to depressive symptoms, including within their family interactions.

Some qualitative studies have analyzed the role of cultural processes related to the impact of LGBTQ-specific parental support on physical and emotional well-being among LGBTQ ethnic and racial minority youth. For example, in a study with Latinx parental figures of sexual minorities, Gattamorta et al. (2019) found that cultural processes such as religion, *familismo*, and gender norms (e.g., *machismo*) influenced the reactions of participants after learning that their child was a sexual minority. Similarly, in a study with African American gay men and their parental figures, researchers found that adherence to traditional gender role expectations (e.g., exaggerated masculinity within the Black community) and parental figures' fear of their child being a target of racism and homophobia played an important role in the parent-child relationship between gay men and their parental figures (LaSala & Frierson, 2012). Studies have not specifically named how systemic oppression might influence parental figures of color interaction with their LGBTQ child.

Parental Support and Depressive Symptoms Among Gender Minorities

An increasing number of studies have noted that transgender and genderqueer people begin to show gender atypical behaviors from a young age, with most transgender and genderqueer people coming

out to their parental figures before adulthood (Abreu et al., 2019). While some studies have shown similarities among parental reactions to cisgender sexual minorities and transgender and genderqueer people (e.g., feelings of shock, confusion, and loss; Hill & Menvielle, 2010), there are important differences to consider. For example, in a systematic review of 32 studies, Abreu et al. (2019) found that unlike parental figures of cisgender sexual minority youth, parental figures of transgender and genderqueer youth reported elevated negative mental health consequences (e.g., hypervigilance, anxiety, depressive symptoms) related to helping their transgender and genderqueer child navigate multiple settings.

Research shows that girls consistently report higher rates of depressive symptoms than boys (see review in Marshal et al., 2013). Specific to cisgender sexual minority girls, research shows that this group reports higher levels of depressive symptoms compared to heterosexual girls and cisgender sexual minority boys (e.g., Lucassen et al., 2017; Marshal et al., 2013). Research has also explored differences in depressive symptoms between gender binary and gender non-binary youth. This research found that compared to their gender binary counterparts, non-binary youth consistently reported higher levels of depressive symptoms (e.g., Newcomb et al., 2020; Thorne et al., 2019).

Emerging evidence suggests that depressive symptoms are higher among transgender and genderqueer people because of lack of LGBTQ-specific parental support when compared to their cisgender counterparts (e.g., Katz-Wise et al., 2016; Klein & Golub, 2016; Simons et al., 2013). In fact, research suggests that compared to support from community and close friends, parental support has the greatest impact on transgender and genderqueer people's well-being (see, Weinhardt et al., 2019; Wilson et al., 2016). For example, in a study with 73 transgender and genderqueer children, researchers found that participants who reported that their parental figures were supportive of their transition (e.g., allowing them to pick their own clothes), endorsed less symptoms of depression compared to their cisgender counterparts (Olson et al., 2016). Overall, this body of research suggests that parental support may buffer transgender and genderqueer youth's negative mental health outcomes such as depressive symptoms (e.g., Klein & Golub, 2016; Simons et al., 2013). Given research that documents differences between the experiences of parental figures of cisgender versus transgender and genderqueer youth, further research is needed to better understand how LGBTQ-specific parental support affects depressive symptoms on transgender and genderqueer people differently than their cisgender counterparts.

Parental Support and Depressive Symptoms Among Non-monosexual People

For the purpose of this study, we define non-monosexuality as a broad term that “describes all individuals who report being physically and/or romantically attracted to individuals of more than one gender, including individuals who identify with various identity labels (e.g., asexual bisexual, pansexual, polysexual, omnisexual)” (Dyar et al., 2020, p. 16). Non-monosexual people are often questioned about the legitimacy of their sexual orientations and romantic relationships and are rendered invisible in heterosexual, cisgender, and LGBTQ spaces (Dyar et al., 2020; Roberts et al., 2015). Scholarship suggests that compared to their heterosexual and lesbian and gay counterparts, non-monosexual people, including youth, experience greater health disparities such as higher levels of depressive symptoms and anxiety (see, Feinstein & Dyar, 2017 for a review of the literature; Pollitt et al., 2017; Roberts et al., 2015; Ross et al., 2018). Furthermore, specific to non-monosexual people of color, research shows that this group experiences higher rates of negative mental health outcomes such as depressive symptoms and anxiety compared to their White non-monosexual counterparts (Flanders et al., 2019; Ghabrial & Ross, 2018).

The available literature that exclusively focuses on the experiences of non-monosexual individuals suggests that this group experiences less family support than their monosexual counterparts (see review in Flanders et al., 2019; Ghabrial, 2019; Muñoz-Laboy et al., 2009). For example, in a study of 348 bisexual women and gender diverse people of Color, Ghabrial (2019) found that family lack of acceptance was a source of stress for participants who often felt they had to prove their non-monosexual identity and fight family pressures to align with binary expectations such as marrying someone of the opposite sex or gender. While this research has focused on the experiences of bisexual adults within their families, to our knowledge research has yet to tease apart the experiences of non-monosexual youth with their parental figures specifically. Also, there is a dearth of research that explores differences in LGBTQ-specific parental support among non-monosexual youth, and whether there are key differences in their experiences compared to monosexual youth. Given the dominant, more accepted monosexual societal narratives, it might be harder for parental figures to understand non-monosexuality compared to more socially accepted monosexual narratives of sexuality.

Current Study

Research indicates that parental figures play an important role in the emotional well-being of LGBTQ youth, including among LGBTQ youth of color. Specifically, research shows that LGBTQ-specific parental lack of support serves as a source of minority stress for LGBTQ youth. Additionally, research with sexual minorities has found that non-monosexual people experience depressive symptoms at higher rates than their monosexual counterparts and that they may experience less family support. The literature has yet to provide a clear understanding of the role of LGBTQ-specific parental support among LGBTQ youth of color compared to their White counterparts, transgender, and genderqueer youth compared to their cisgender counterparts, and non-monosexual compared to their monosexual counterparts. To begin to address these research gaps, we utilized a subset of data from a large national survey of LGBTQ youth in the United States ($N = 17,112$). Our research questions are divided into three broad areas of inquiry:

R1: Does parental support vary as an effect of racial and ethnic, gender, or sexual orientation identity?

R2: Do depressive symptoms vary as an effect of racial and ethnic, gender, or sexual orientation identity?

R3: Does parental support function in similar ways for individuals who are marginalized on the basis of their race and ethnicity, gender, or sexual orientation identity as it does for those who are not marginalized?

Based on previous literature, we expected that those who identify as White, cisgender, and monosexual will report higher levels of LGBTQ-specific parental support. We also expected that these individuals will report the lowest levels of depressive symptoms because within interlocking systems of oppression, their identities are the most privileged. Because marginalized individuals experience a multitude of stressors not experienced by those with majority identities due to the interplay of power, privilege, and oppression of the systems where they exist, we further hypothesized that the relationship between LGBTQ-specific parental support and depressive symptoms may be strongest among participants who hold racial and ethnic minoritized identities, transgender and genderqueer identities, and non-monosexual identities.

Method

Study Design and Participant Recruitment

We performed secondary data analyses using the *LGBTQ National Teen Survey*, collected between April and December 2017. The anonymous, online survey focused on a multitude of experiences and relationships for sexual and gender minority youth. To be eligible, participants needed to identify within the LGBTQ umbrella, be 13–17 years of age, and live in the United States.

Multiple methods were utilized to recruit participants: 1) Twitter, Instagram, and Facebook were used to advertise the study; 2) social influencers, or LGBTQ celebrities (i.e., Jazz Jennings, Tyler Oakley) shared about the study on their personal social media pages; and 3) the Human Rights Campaign (HRC) utilized their network of community partners (e.g., Youth Link, Trevor Project). When youth completed the survey, they were both offered HRC wristbands and given the opportunity to enter a drawing for 10 gift cards valued at \$50 each. The chances of winning depended on the number of youth who indicated they wanted to enter the drawing.

The University of Connecticut Review Board approved all aspects of the study. The Review Board granted a parental waiver of consent. All participants provided assent to participate prior to proceeding, and reported demographic information (e.g., age, race and ethnicity, state of residence). Measures were randomized and arranged into blocks according to topic areas (e.g., school experiences, social supports) to produce a more complete dataset without problematic patterns of missingness. Youth took an average of 43 minutes to complete the survey.

Data Screening and Cleaning Procedures

Before data cleaning, 29,291 youth consented to take the survey. Some of these responses were excluded from an analytic dataset because those participants were not eligible to complete the survey (30.67%) or they answered less than 10% of the survey (14.8%). For example, the majority of this 30.67% of participants who were not eligible to complete the survey only answered demographic questions and then exited the survey, which did not provide enough data to consider multiple imputation or other advanced missing data techniques. Multiple steps were created to avoid participants who did not meet criteria and bots from completing the survey. First, several questions were put in place to prevent ineligible participants from moving forward and completing the survey by asking questions such as

age and country of residence. Second, a post-hoc mischievous responder's sensitivity analysis was conducted with all respondents in order to eliminate respondents who were not LGBTQ or who provided patterns of non-plausible responses on multiple questions, such as choosing the same answer for several survey instruments (e.g., strongly agree to both positively and negatively worded items of the same scale; see, Robinson-Cimpian, 2014). A total of 74 problematic responses were deleted. Third, open-ended questions were screened by the researchers and suspicious entries were deleted (e.g., entered the name of a politician as one's gender identity). In addition, duplicate surveys, where a participant failed to complete a survey and then reentered a new survey, were deleted ($n = 22$). This cleaning process resulted in the deletion of 175 cases. These procedures are reported elsewhere (Watson et al., 2020).

Participants

Although 17,112 individuals started the survey, fewer completed the entire survey ($n = 9,460$). Of those who completed the survey, 1,461 were excluded from analysis because they were not out to at least one of their parents and including them would confound the meaning of LGBTQ-specific parental support. An additional 1,162 did not provide data on either LGBTQ-specific parental support ($n = 480$), depressive symptoms ($n = 995$) or both ($n = 313$). They were similarly excluded because the analysis would retain sufficient power by using only participants who completed the survey and all variables of interest. A total of 6,837 participants were thus included in the analytic sample. Little's MCAR test was conducted for this dataset and suggested that the data were not missing completely at random (see details in Watson et al., 2021).

For many items, participants were given the opportunity to "select all options that applied" to them. This approach more faithfully represents the experiences of individuals holding multiple oppressed identities by including these individuals in analyses for *each* of their identities rather than grouping participants together in an "other" or "multiracial" category (Charmaraman et al., 2014). For example, in this approach, an individual could identify as both a cisgender girl and genderqueer (as is the case for many transfeminine individuals) or as both Black and Latinx (as is the case for many Dominican Americans). Consequently, percentages for demographics do not add up to 100%.

Most youth identified as cisgender girls ($n = 3,056$; 43.9%) or cisgender boys ($n = 2,029$; 29.2%). Youth also identified as transgender girls ($n = 123$; 1.8%), transgender boys ($n = 1,320$; 19.0%), and gender non-binary,

genderqueer, or gender non-conforming ($n = 1,582$; 22.7%). Participants were mostly White ($n = 5,541$; 79.6%); some identified as Black ($n = 532$; 7.6%), Native American ($n = 301$; 4.3%), Asian American ($n = 397$; 5.7%), Latinx ($n = 1,077$; 15.5%), and other ($n = 250$, 3.6%). In terms of sexual orientation, most youth identified as gay/lesbian ($n = 2,821$; 40.5%) or bisexual ($n = 2,068$; 29.7%); some identified as pansexual ($n = 1,010$; 14.25), queer ($n = 356$; 5.1%), asexual ($n = 295$; 4.2%), heterosexual ($n = 94$; 1.4%), questioning ($n = 111$; 1.6%), or other ($n = 203$; 2.9%).

Measures

Gender

To measure gender, participants were asked whether they were a cisgender boy, cisgender girl, transboy, transgirl, gender non-binary, genderqueer/gender non-conforming, or something else. Participants could select as many response options as applied to them. Because “gender non-binary,” “genderqueer,” and “gender non-conforming” all entail a resistance to classification along the gender binary, we combined these mutually exclusive groups and labeled this group as “genderqueer.” Further, we included participants who responded, “something else” ($n = 358$) in the “genderqueer” category as the majority of participants in this group reported an identity that is often included in the genderqueer umbrella (Lefevor et al., 2019; $n = 214$, 59.8%); 112 identified as genderfluid (31.3%), 45 identified as agender (12.6%), and 57 identified as demigender (15.9%).

Racial and Ethnic Identity

To measure racial and ethnic identity, one item asked participants, “How would you describe yourself?” Participants could select as many response options as applied to them. Response options were, “White, non-Hispanic,” “Non-Latino Black or African American,” “Native American or Alaska Native,” “Asian or Pacific Islander,” “Latino, Hispanic, or Mexican-American,” and “Other.” We report and analyze data for each racial and ethnic identity as its own dichotomous variable, allowing for the possibility of participants holding multiple racial and ethnic identities, following best practices identified by Charmaraman et al. (2014).

Sexual Identity

To assess sexual identity, we used an item that asked, “How do you describe your sexual identity?” Participants could select, “gay or lesbian,” “bisexual,” “straight, that is, not gay,” or “something else.” If a participant chose “something else,” survey logic

presented another question that stated, “By something else, do you mean that . . .” and presented the following response options: “queer,” “pansexual,” “asexual,” “questioning,” and “other.” Unlike the race and ethnicity and gender identity questions, participants were only able to select a single answer to this question. In this paper, we considered youth who identified as heterosexual, gay, or lesbian as monosexual (coded as 0). We compared those youth to non-monosexual youth, which included those who identified as bisexual, queer, pansexual, and other (coded as 1). Individuals identifying as “other” ($n = 203$) largely identified as greysexual/asexual/aromantic ($n = 28$; 13.8%), demisexual ($n = 44$; 21.7%), biromantic/panromantic ($n = 42$; 20.7%), or polysexual ($n = 15$; 7.4%). Although there are many meaningful differences in these identities, they all share a similar experience of marginalization because of their non-monosexual orientation relative to gay/lesbian and heterosexual individuals and were, thus, included in the “non-monosexual” category.

LGBTQ-Specific Parental Support

To better understand the differential effects of LGBTQ-specific parental support, we utilized an 8-item measure (Miller et al., 2020). The original scale presented 4 items regarding LGBTQ-specific parental behaviors of support, and four items regarding LGBTQ-specific parental lack of support. LGBTQ-specific parental behaviors of support items were coded such that higher scores indicated higher amount of support, and lack of support items were reverse coded such that higher scores indicated higher amounts of support. LGBTQ-specific parental support included items such as, “How often do your parents say that they like you as you are in regard to being an LGBTQ person?” LGBTQ-specific parental lack of support included items such as, “How often do your parents or caregivers say negative comments about you being an LGBTQ person?” Participants were asked to rate the degree to which they perceive their parental figure to be accepting of their LGBTQ identity on a five-point scale with 1 (does not apply to me) and 5 (often) as anchors. For this study, the LGBTQ-specific parental support internal consistency was good ($\alpha = .84$).

Depressive Symptoms

To measure depressive symptoms, we utilized 10-items from the Kutcher Adolescent Depression Scale (LeBlanc et al., 2002). The original scale includes 11 items – we excluded the question of suicidality due to the anonymous nature of the survey and because we received a parental waiver of consent from the IRB, and, thus, it was deemed by the IRB that the suicidality item might

have posed too much risk for children without parental approval. Each of the 10 items measured the frequency of depressive symptoms reported in the past 7 days “on average” or “usually.” Questions began with the stem, “Over the last week, how have you been ‘on average’ or ‘usually’” and included the following behaviors: “Low mood, sadness, feeling blah or down, depressed, just can’t be bothered.” Response options included: “hardly ever, much of the time, most of the time, and all of the time.” Responses were averaged and ranged from 0 to 3 where higher scores indicated higher depressive symptoms. For this study, the scale demonstrated excellent internal consistency ($\alpha = .90$).

Analysis Plan

Prior to conducting analyses, we examined whether focal variables met assumptions for regression. We examined both depressive symptoms and parental support as the mean of all items of those scales. All variables evidenced acceptable skewness and kurtosis (between -1 and 1), and a visual inspection of histograms indicated no outliers were present. All continuous predictor terms were centered prior to creating interaction terms to reduce multicollinearity.

We conducted independent samples *t*-tests to examine whether LGBTQ-specific parental support and depressive symptoms varied across race and ethnicity, gender, and sexual orientation. Bonferroni corrections were used for independent samples *t*-test due to the large number of tests conducted (11 tests with an experiment-wide alpha of .05 yielded a test-wise alpha of .005). Because participants could select more than one race and ethnicity or gender identity, each racial and ethnic and gender identity was treated as a dichotomous

variable in analyses. For example, “boys” were compared against “not boys.” We interpret effect sizes following Cohen’s (1992) guidelines and also provide a 95% confidence interval for the effect size in Table 1 (Hedges & Olkin, 2014).

We then examined whether the relationship between parental LGBTQ-specific support and depressive symptoms was moderated by ethnic and racial identity, gender, and sexual orientation. For each model, age was entered in the first step as a covariate, followed by parental LGBTQ-specific support and the target demographic variable. Interaction terms were entered in the final step to test for the presence of moderation.

Results

LGBTQ-specific parental support ($M = 2.49$, $SD = 0.74$, Range = 1–4) was related to depressive symptoms ($M = 1.34$, $SD = 0.76$, Range = 0–3; $r = -.30$, $p < .01$). Age ($M = 15.63$, $SD = 1.24$, Range = 13–17) was significantly but not substantially related to LGBTQ-specific parental support ($r = -.04$, $p < .01$) and significantly and minimally related to depressive symptoms ($r = -.08$, $p < .01$). Because age was related to moderator and outcome variables, we included age as a covariate in all models. We also examined whether age would moderate the relationship between LGBTQ-specific parental support and depressive symptoms but found no evidence to support this role ($b_{\text{support} \times \text{age}} = .01$, $SE = .01$, $t = 0.72$, $p = .47$).

Does Parental LGBTQ-specific Support Vary by Social Identities/Demographics?

Overall, group differences were observed in all categories assessed (see, Table 1); however, most group differences were between small and very small (average $d = .17$,

Table 1. LGBTQ-specific parental support by demographic variables.

	Focal Group		"Other" Group		<i>t</i>	<i>d</i>	95% CI for <i>d</i>
	<i>n</i>	<i>M</i> (<i>SD</i>)	<i>n</i>	<i>M</i> (<i>SD</i>)			
Race and Ethnicity							
White	1419	2.53 (0.73)	5541	2.32 (0.76)	−9.30*	.28	.22, .34
Black	532	2.32 (0.74)	6428	2.50 (0.74)	5.61*	.24	.15, .33
Native American	301	2.40 (0.77)	6659	2.49 (0.74)	2.10	.12	< .01, .24
Asian	397	2.36 (0.78)	6563	2.49 (0.74)	3.39*	.17	.07, .27
Latinx	1077	2.39 (0.76)	5883	2.50 (0.74)	4.53*	.15	.08, .22
Gender Identity							
Cisboy	2029	2.55 (0.71)	4931	2.46 (0.73)	−4.32*	.12	.07, .17
Cisgirl	3056	2.51 (0.71)	3904	2.47 (0.76)	−2.64	.05	< .01, .10
Transboy	1320	2.37 (0.80)	5640	2.52 (0.72)	6.23*	.20	.14, .26
Transgirl	123	2.62 (0.87)	6837	2.48 (0.74)	−1.74	.17	−.01, .35
Genderqueer	1582	2.42 (0.73)	5378	2.51 (0.74)	4.02*	.12	.06, .18
Sexual Orientation							
Monosexual	2915	2.56 (0.75)	4045	2.43 (0.73)	−7.23*	.18	.13, .23
Non-monosexual	4045	2.43 (0.73)	2915	2.56 (0.75)	7.23*	.18	.13, .23

* $p < .005$; “Other” refers to all participants who did not report the given identity

range = .05, .28). White individuals reported moderately more LGBTQ-specific parental support than nonwhite individuals ($d = .28$), while Asian, Black, and Latinx individuals reported a small to moderate amount less LGBTQ-specific parental support than non-Asian, non-Black, and non-Latinx individuals (d s range from .15 to .24). Cisboys reported a small amount more LGBTQ-specific parental support than those who were not cisboys ($d = .12$), while transboys and genderqueer reported a small amount less LGBTQ-specific parental support than those who were not transboys or genderqueer ($d = .12$ and $d = .20$ respectively). Finally, monosexual individuals reported a small amount more LGBTQ-specific parental support than non-monosexual individuals ($d = .18$). Taken together, these findings suggest that parental acceptance largely does not differ meaningfully by social identities/demographics, with the exception that youth of color experience substantially less parental acceptance than White youth.

Does Depressive Symptoms Vary by Social Identities/Demographics?

We next examined whether depressive symptoms varied across race and ethnicity, gender, and sexual orientation. Using the same strategy to the analyses by LGBTQ-specific parental support, we found significant group differences in all categories assessed (see, Table 2); however, these disparities were small on average (average $d = .22$, range = .04, .58). White individuals reported a small amount fewer depressive symptoms than nonwhite individuals ($d = .09$) while Native American and Latinx individuals reported moderate and small amount more depressive symptoms respectively than non-Native American and non-Latinx individuals ($d = .34$, $d = .12$). Cisboys reported a moderate amount of fewer depressive symptoms than those who

were not cisboys ($d = .34$), and cisgirls reported a fewer amount of less depressive symptoms than those who were not cisgirls ($d = .12$). Conversely, transboys and genderqueer individuals reported moderate to large amount of greater depressive symptoms than those who were not transboys or genderqueer individuals respectively ($d = .58$, $d = .36$). Finally, non-monosexual individuals reported a moderate amount of greater depressive symptoms than monosexual individuals ($d = .32$). Taken together, these analyses suggest minimal disparities between groups in depressive symptoms with the notable exception that transboys appear to experience a moderate amount more depressive symptoms than youth of other genders and that genderqueer youth experience a small-to-moderate amount more depressive symptoms than youth of other genders.

Do Social Identities/Demographics Moderate the Relationship between Parental LGBTQ-specific Support and Depressive Symptoms?

Models examining the effects of race and ethnicity on LGBTQ-specific parental support suggested the presence of main and interaction effects. We present the results of our analyses in Tables 3–5 and discuss key findings in the text. Main effects indicated that Native American sexual minority youth (SMY) experienced more depressive symptoms than other SMY and that both age and LGBTQ-specific parental support were negatively related to depressive symptoms. There was a statistically significant interaction between identifying as Latinx and LGBTQ-specific parental support (see, Figure 1). Simple slopes analyses indicated that the relation between LGBTQ-specific parental support and depressive symptoms was weaker for participants who identified as Latinx ($\beta = -0.21$) than for

Table 2. Depressive symptoms by demographic variables.

	Focal Group		"Other" Group		<i>t</i>	<i>d</i>	95% CI for <i>d</i>
	<i>n</i>	<i>M</i> (<i>SD</i>)	<i>n</i>	<i>M</i> (<i>SD</i>)			
Race and Ethnicity							
White	1419	1.40 (0.77)	5541	1.33 (0.76)	3.10*	.09	.03, .15
Black	532	1.37 (0.72)	6428	1.34 (0.77)	-1.00	.04	-.05, .13
Native American	301	1.59 (0.78)	6659	1.33 (0.76)	-5.69*	.34	.22, .46
Asian	397	1.35 (0.79)	6563	1.34 (0.76)	-0.17	.01	-.09, .11
Latinx	1077	1.42 (0.78)	5883	1.33 (0.76)	-3.46*	.12	.06, .19
Gender Identity							
Cisboy	2029	1.16 (0.76)	4931	1.42 (0.75)	13.09*	.34	.29, .39
Cisgirl	3056	1.29 (0.73)	3904	1.38 (0.78)	5.15*	.12	.07, .17
Transboy	1320	1.69 (0.74)	5640	1.26 (0.75)	-19.13*	.58	.51, .64
Transgirl	123	1.39 (0.76)	6837	1.34 (0.76)	0.48	.07	-.11, .25
Genderqueer	1582	1.55 (0.72)	5378	1.28 (0.77)	-12.90*	.36	.30, .42
Sexual Orientation							
Monosexual	2915	1.20 (0.76)	4045	1.44 (0.75)	12.90*	.32	.27, .37
Non-monosexual	4045	1.44 (0.75)	2915	1.20 (0.76)	-12.90*	.32	.27, .37

* $p < .005$; "Other" refers to all participants who did not report the given identity

Table 3. Regression examining if race and ethnicity moderates the effects of LGBTQ-specific parental support on depressive symptoms.

	Model 1		Model 2		Model 3	
	b(SE)	β	b(SE)	β	b(SE)	β
Age	-0.05** (0.01)	-0.08	-0.05** (0.01)	-0.09	-0.05** (0.01)	-0.09
Support			-0.31** (0.01)	-0.30	-0.33* (0.04)	-0.32
White			0.02 (0.03)		0.02 (0.09)	
Black			-0.04 (0.04)		-0.18 (0.11)	
Native American			0.22** (0.04)	0.06	0.27* (0.13)	0.07
Asian			-0.03 (0.04)		-0.10 (0.12)	
Latinx			0.06 (0.03)		-.16 (0.10)	
White x Support					-0.01 (0.04)	
Black x Support					0.06 (0.05)	
Native x Support					-0.02 (0.06)	
Asian x Support					0.03 (0.05)	
Latinx x Support					0.10* (0.04)	0.11
Model Fit Statistics						
F	39.98**		110.89*		65.75**	
R ²	.01		.10		.10	
F _{change}			122.01**		2.41*	
R ² _{change}			.10		< .01	

Support = Parental Support; Native = Native American; *p < .05; **p < .01.

those who did not identify as Latinx (β = -0.32). Altogether, the model explained 10% of the variation in depressive symptoms.

Models that examined the effects of gender on LGBTQ-specific parental support suggested the presence of both main and interaction effects. Main effects indicated that cisboys reported fewer depressive symptoms than those who were not cisboys while transboys, transgirls, and genderqueer individuals reported more depressive symptoms than those who were not transboys, transgirls, or genderqueer respectively. There was an interaction between identifying as a cisboy and LGBTQ-specific parental support (see, Figure 2). Simple slopes analyses indicated that the relation between LGBTQ-specific parental support and

depressive symptoms was stronger for participants who did not identify as cisboys (β = -0.31) than for those who did identify as cisboys (β = -0.231). Altogether, the model explained 17% of depressive symptoms.

Models that examined the effects of sexual orientation on parental support suggested the presence of only main effects. Non-monosexual individuals reported more depressive symptoms than monosexual individuals. No interaction effects between sexual orientation and LGBTQ-specific parental support were observed, suggesting that the relations between LGBTQ-specific parental support and depressive symptoms is similar for monosexual and non-monosexual individuals. Altogether, this model explained 11% of the variation in depressive symptoms.

Table 4. Regression examining if gender moderates the effects of LGBTQ-specific parental support on depressive symptoms.

	Model 1		Model 2		Model 3	
	b(SE)	β	b(SE)	β	b(SE)	β
Age	-0.05** (0.07)	-0.08	-0.04** (0.01)	-0.06	-0.04** (0.01)	-0.06
Support			-0.28** (0.01)	-0.27	-0.32** (0.04)	-0.31
Cisboy			-0.20** (0.03)	-0.12	-0.35** (0.08)	-0.21
Cisgirl			< 0.01 (0.01)		-0.06 (0.09)	
Transboy			0.41** (0.03)	0.21	0.47** (0.08)	0.24
Transgirl			0.14* (0.07)	0.02	0.24 (0.19)	
GQ			0.20** (0.03)	0.11	0.09 (0.08)	
Boy x Support					0.07* (0.04)	0.11
Girl x Support					0.03 (0.04)	
GQ x Support					-0.03 (0.03)	
Trans x Support					-0.04 (0.08)	
GQ x Support					0.05 (0.03)	
Model Fit Statistics						
F	39.98**		199.10**		116.94**	
R ²	.01		.17		.17	
F _{change}			224.34**		1.76	
R ² _{change}			.16		< .01	

Support = Parental Support; GQ = Genderqueer; *p < .05; **p < .01.

Table 5. Regression examining if sexual orientation moderates the effects of LGBTQ-specific parental support on depressive symptoms.

	Model 1		Model 2		Model 3	
	b(SE)	β	b(SE)	β	b(SE)	β
Age	-0.05** (0.01)	-0.08	-0.05** (0.01)	-0.08	-0.05** (0.01)	-0.08
Support			-0.30** (0.01)	-0.29	-0.29** (0.02)	-0.28
Non-monosexual			0.19 (0.02)	0.12	0.25** (0.06)	0.16
Non-monosexual x Support					-0.02 (0.02)	
Model Fit Statistics						
F	39.98**		289.41**		217.32**	
R ²	.01		.11		.11	
F _{change}			411.76**		1.04	
R ² _{change}			.11		< .01	

Support = Parental Support; **p* < .05; ***p* < .01.

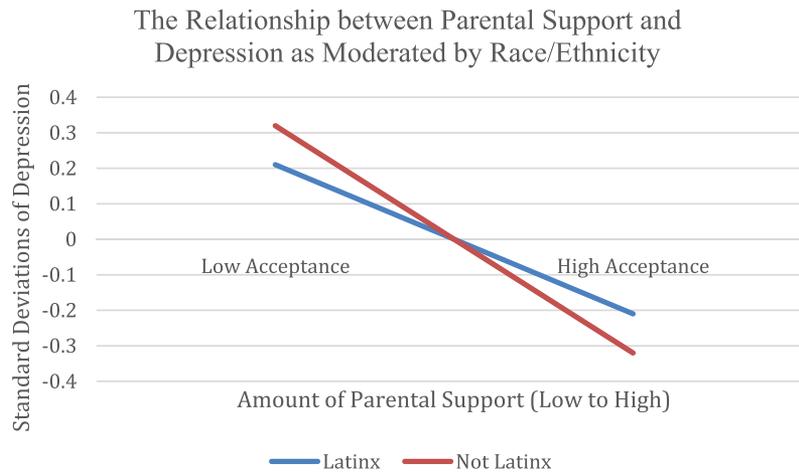


Figure 1. Interaction between race and ethnicity and LGBTQ-specific parental support on depressive symptoms.

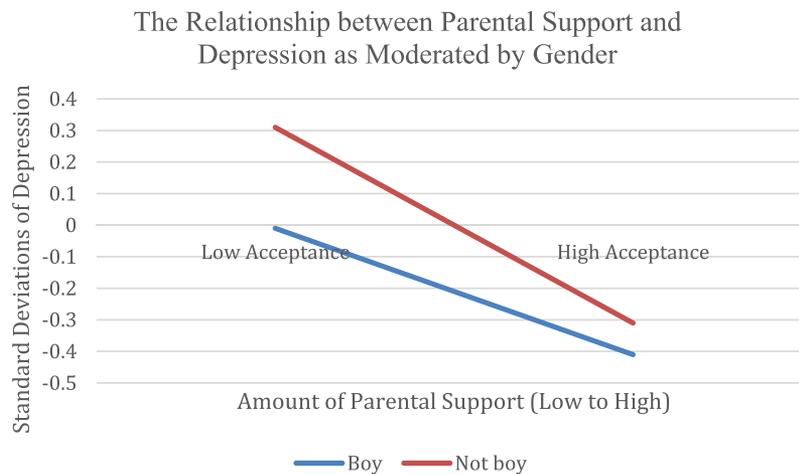


Figure 2. Interaction between gender and LGBTQ-specific parental support on depressive symptoms.

Discussion

Through this study, we sought to further the scholarship on parental support by understanding the role of LGBTQ-specific parental support in depressive

symptoms in a sample of LGBTQ youth with diverse ethnic and racial, gender, and sexual orientation identities. Our research shows a strong association between LGBTQ-specific parental support and depressive

symptoms among all youth. Although LGBTQ youth tended to report lower levels of depressive symptoms as they got older, we observed that the relationship between parental support and depressive symptoms remained consistent across age.

Regarding ethnicity and race, our findings show that White LGBTQ youth reported a small amount more LGBTQ-specific parental support than nonwhite LGBTQ youth. While some of these findings are consistent with comparative studies with White and Latinx samples (Ryan et al., 2009, 2010), to our knowledge the current literature has not investigated LGBTQ-specific parental support among Black, Asian, and Native Americans compared to their White counterparts. It may be that increased LGBTQ-specific parental support among White LGBTQ youth is reflective of racism within LGBTQ spaces, which provides access to resources for White parental figures while not providing the same resources to parental figures of color (Furman et al., 2018).

We also found a strong association between LGBTQ-specific parental support and depressive symptoms among LGBTQ youth of color. While some studies have established the importance of LGBTQ-specific parental support for Latinx LGBTQ youth (e.g., Ryan et al., 2009, 2010), to our knowledge, our study is among one of the first to establish that LGBTQ-specific parental support is being less impactful for Latinx youth than for other youth of color. It may be the case that these youth's strong emotional connection to the family might help buffer the effects of LGBTQ-specific parental lack of support on one's depressive symptoms. To illustrate, in a study with 25 Latinx bisexual men and women, participants shared that while they experienced great stress as a result of having to conceal their identity within their family, they expressed that lack of family support of their sexual identity did not affect their positive regard for their family (Muñoz-Laboy et al., 2009).

Our findings also show that transboys and genderqueer individuals reported a small-to-moderate degree less parental LGBTQ-specific support than LGBTQ youth who are not transboys or genderqueer. While some of these findings are consistent with the current state of the LGBTQ-specific parental support literature (e.g., Klein & Golub, 2016; Simons et al., 2013; Wilson et al., 2016), our findings indicate that the relation between LGBTQ-specific parental support and depressive symptoms is stronger for cisgender girls, transgender girls, and gender nonbinary individuals than it is for cisboys. This finding may be interpreted best in light that the masculine experience is most strongly represented in the overall LGBTQ narrative. Thus, others with less well-represented identities may experience greater variation

in LGBTQ-specific support, leading to a greater influence of LGBTQ-specific support on depressive symptoms when present. Regarding sexual orientation, we found that non-monosexual participants reported small to moderate amount of less LGBTQ-specific parental support and more depressive symptoms than monosexual participants. Although research suggests that non-monosexual people exhibit worse mental health outcomes compared to their monosexual counterparts, including depressive symptoms (see, Feinstein & Dyar, 2017; Pollitt et al., 2017), these findings make a significant contribution to research by demonstrating that non-monosexual youth also exhibit less support from parental figures specifically.

Consistent with minority stress framework, this study shows that LGBTQ-specific parental support serves as a stressor that affects the mental health of LGBTQ youth (e.g., Hall, 2018; Katz-Wise et al., 2016; Pollitt et al., 2017; Ryan et al., 2010). To date, however, researchers have been slow to explore within group differences regarding the effects of LGBTQ-specific parental support on different groups (e.g., Latinx vs. non-Latinx). Our findings contribute to minority stress research with LGBTQ youth by showing significant differences between LGBTQ-specific parental support and depressive symptoms among racial and ethnic minority youth, cisgender and transgender and genderqueer youth, and non-monosexual and monosexual youth. For example, although prior research has used minority stress framework to demonstrate that proximal and distal stressors contribute to higher depressive symptoms levels for gender minority youth, cisgirls, and non-monosexual youth compared to other groups of youth, our study contributes to this body of research by highlighting the importance of LGBTQ-specific parental support specifically on the depressive symptoms levels of LGBTQ youth. We also noted that the relationship between LGBTQ-specific parental support and depressive symptoms remained consistent across age. This finding suggests that parental support remains important for teens of all ages. In addition, aligned with intersectionality framework, it may be that the lack of support from racially and ethnically diverse parental figures is the result of their interaction within multiple systems of oppression where both them and their child experience oppression. That is, parental figures' unsupportive behaviors toward their LGBTQ child could stem from fear that their child's intersecting identities will increase their likelihood of being a target of discrimination and oppression. This fear, rooted in intersectional systems of oppression (e.g., racism and transphobia) could explain why parental figures engage in behaviors that are interpreted by LGBTQ youth of color as lack of support.

Strengths, Limitations, and Future Research Direction

This study demonstrated many strengths. First, regarding LGBTQ-specific parental support literature, to our knowledge, our study has one of the largest samples of ethnic and racial minority LGBTQ youth to date. This large sample made it possible to examine whether the relationship between LGBTQ-specific parental support and depressive symptoms was moderated by race and ethnicity among Latinx, Black, Asian, Native American, and White LGBTQ youth. Second, our study analyzed how LGBTQ-specific parental support may affect LGBTQ youth differently. Given that we found that transgender and genderqueer individuals are more affected by LGBTQ-specific parental support than cisgender sexual minority youth, these findings provide evidence for the need to further investigate the impact of LGBTQ-specific parental support on transgender and genderqueer youth. Third, our study utilized a multi-faceted LGBTQ-specific parental scale, which moves beyond the typical single-item measurement of this construct most commonly used in the LGBTQ-specific parental support literature.

Despite the several strengths of this study, there are a number of limitations that are important to acknowledge. First, although we found differences across ethnic and racial diverse groups, we are unable to examine the reasons for these differences. Future research should specifically measure for different cultural processes in order to begin to provide an explanation for these differences. For example, using acculturation and ethnic identity scales (e.g., Helms, 1990) and gender norms scales (e.g., Piña-Watson et al., 2014), might provide a better understanding of how cultural processes influence both the impact of LGBTQ-specific parental support on ethnic and racial minority LGBTQ youth and health disparities between these groups (Lefevor et al., 2020). Also, specifically to our findings about LGBTQ-specific parental support being less impactful for Latinx youth, future research should specifically use measures that assess for familism within Latinx communities. This is specifically important given that a recent meta-analysis found a link between familism and parental warmth/support among Latinx, as well as mental health outcomes (see, Cahill et al., 2021). Unfortunately that meta-analysis did not identify enough studies on familism with LGBTQ Latinx people. Second, while our results show that transgender and genderqueer youth are significantly more impacted by LGBTQ-specific parental support in relation to cisgender youth, it is unclear what about LGBTQ-specific parental support seems to

be affecting these youth more than their cisgender counterparts. Future research should consider using qualitative research approaches such as dyadic in-depth interviews with both transgender and genderqueer youth and their parental figures in order to inquire about what specific behaviors parental figures of transgender and genderqueer youth engage in.

Third, while we use minority stress theory as a framework for our study, we do not include measures of other types of minority-related stress. Future research should carefully consider including measures that captures other aspects of minority stress. Relatedly, we did not explore nuances regarding parental support of youth who may have multiple intersectional identities. For example, for a participant who identifies as pansexual and non-binary, their parental figure may be accepting of the pansexual identity but not the non-binary identity. Future research should consider selecting measures and using analyses that are able to assess for these intersectional experiences among participants.

Fourth, while we use an intersectionality framework to provide potential explanations as to why racial and ethnic and gender diverse youth report less support by their parental figures (e.g., exposure to multiple systems of oppression), a limitation of this study is the fact that analyses neglected to capture how the interplay of systems of oppression, such as racism (not race), heterosexism (not sexual orientation), and sexism and cissexism (not gender) informed the results of this study. While we acknowledge that the methodological challenge of documenting the impact of intersectionality in youth mental health research (e.g., limitations in conventional ways of interpreting interaction effects) is not unique to our study, future research should focus on the structural aspects that lead to varying amounts of parental support for their LGBTQ child (see review in del Río-González et al., 2021).

Implications for Clinicians

The findings in this study have important implications for clinicians. The results show that LGBTQ-specific parental support, and the consequences of LGBTQ-specific parental support on depressive symptoms varies across different demographic groups. Therefore, when working with parental figures and LGBTQ youth, it is important to know that a one-size-fits-all approach might not be effective. Specifically, from an intersectionality framework, it is important for clinicians to understand that parental figures are navigating their relationship with their LGBTQ child within an interlocking system of oppression that

informs their behaviors toward their child's identities. In addition, clinicians can use evidence-practices for working with parental figures of LGBTQ children such as Attachment-Based Family Therapy for LGBTQ youth (Diamond et al., 2012; Russon et al., 2021). This approach allocates up to five sessions with the parental figures of LGBTQ youth where they can explore feelings related to their child's sexual and gender identity. Furthermore, clinicians can also ask parental figures to write about their feelings related to their child's LGBTQ identity. Previous research (Abreu, Riggle et al., 2020) illustrates that when parental figures of LGBTQ people are able to process their feelings in writing about having an LGBTQ child, they are better able to reflect on positive aspects of their parent-child relationship (see Gonzalez et al., 2013) and, thus, process complex feeling of sadness, anxiety, grief, and pride.

When working with LGBTQ youth who report high levels of depressive symptoms, it is important for clinicians to assess their relationship and level of LGBTQ-specific support from their parental figures. From a developmental perspective, because puberty and adolescence bring unique challenges for LGBTQ youth, such as exploring and/or disclosing their sexual orientation and/or gender identity for the first time to others (see, Medico et al., 2020), it is imperative that clinicians are aware of the impact that parental figures have on the emotional well-being of LGBTQ youth. Clinicians should acknowledge that parental figures and their LGBTQ child will be affected differently depending on their positionality within multiple systems of oppression and, thus, should design interventions that addresses their unique needs.

Although parental support is ideal, for many LGBTQ youth this may not be possible. Clinicians should consider using documented evidence-based treatment specific for LGBTQ youth such as Affirmative Supportive Safe and Empowering Talk (ASSET) and Cognitive-behavioral therapy (CBT; Hobaica et al., 2018; Sheinfil et al., 2019). Furthermore, when working with LGBTQ youth and their parental figures (either as a dyad or individually), it is important to also focus on sharing stories of supportive parental figures. Research shows that parental figures of LGBTQ youth report positive emotions of pride and love and activism and advocacy as a result of having an LGBTQ child (e.g., Abreu et al., 2019; Gonzalez et al., 2013). Thus, it is crucial to provide counternarratives so that LGBTQ youth and their parental figures understand that they too can form healthy and thriving bonds in their parent-child relationship.

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ORCID

Roberto L. Abreu  <http://orcid.org/0000-0003-1305-2152>
 G. Tyler Lefevor  <http://orcid.org/0000-0003-4510-7306>
 Kirsten A. Gonzalez  <http://orcid.org/0000-0002-5499-6152>

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