PERCEIVED PARENTAL ACCEPTANCE AND REJECTION, SELF-COMPASSION, AND PSYCHOLOGICAL DISTRESS IN LGB-IDENTIFIED INDIVIDUALS

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PERCEIVED PARENTAL ACCEPTANCE AND REJECTION, SELF-COMPASSION, AND PSYCHOLOGICAL DISTRESS IN LGB-IDENTIFIED INDIVIDUALS

By

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Abstract

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Abstract Title: Perceived Parental Acceptance and Rejection, Self-Compassion and Psychological Distress in LGB-Identified Individuals

Chair: Jennifer Waltz, Ph. D.

This study aimed to examine the relationship between general family support, sexual orientation-specific parental rejection, and self-compassion, as well as psychological distress and proximal minority stress for LGB-identified individuals. Three hundred twenty-four participants who identified as LGB were recruited online for the study and completed measures of general family support, sexual orientation-specific parental rejection, self-compassion, psychological distress, and proximal minority stress. The results showed that general family support was negatively associated with psychological distress, and that general family support was positively related to the self-kindness and common humanity facets of self-compassion, and negatively related to the self-judgment, isolation, and overidentification facets of self-coldness. Sexual orientation-specific parental rejection was found to be positively related to proximal minority stress; however, it was not found to be associated with psychological distress or self-compassion. The findings suggest that general family support and sexual orientation-specific parental rejection have effects on the development of self-compassion. The study also highlights the importance of exploring the relationship between family members' rejection of an individual's sexual orientation and the potential for developing internalized heterosexist attitudes.

Keywords: LGB, self-compassion, parent-child relationships
Introduction

People who identify as lesbian, gay, bisexual, or with another sexual minority identity (LGB) are at increased risk for mental health difficulties (Meyer, 2003). High rates of depression, anxiety, and other negative health outcomes are related to discrimination, prejudice, and stigma toward the LGB population, as postulated by Minority Stress Theory (Meyer, 2003). The Minority Stress Model suggests that LGB individuals are subject to a unique set of stressors related to their sexual orientation, which can lead to negative health outcomes. According to the model, LGB individuals face proximal and distal minority stressors that can increase the risk of psychological distress. Distal stressors are external experiences that are imposed on an individual by society, such as violence or discrimination, whereas proximal stressors are internal experiences that threaten an individual's self-concept and identity, such as fear of rejection or hiding one's sexual orientation (Meyer, 2003). Research has demonstrated that the tendency to respond to oneself with compassion, or self-compassion, can mediate the impact of minority stressors (Bowlen et al., under review). It is exciting to find that a coping strategy such as self-compassion can help protect against the effects of minority stressors.

This finding raises the question of what types of life experiences facilitate the development of self-compassionate responding for LGB-identified individuals, and what kinds of experiences may interfere with becoming a self-compassionate person. Supportive parental behaviors and parental attitudes related to sexual orientation may play an important role in this process.

Parents and caregivers respond with varying attitudes to the realization that their child is gay, lesbian, bisexual, or occupies another sexual minority status (LGB). Unfortunately, it is common for parents and caregivers to communicate reactions of shame, sadness, anger, fear, and
shock upon learning that their child identifies as a sexual minority individual (D’Augelli et al., 2010; Grafsky, 2014; Heatherington & Lavner, 2008; Robinson et al., 1989; Saltzburg, 2004; Savin-Williams & Dube, 1998). Despite some progress in societal acceptance of LGB individuals, parents and caregivers may be influenced by heterosexist messages that have been communicated and instilled throughout their lifetime. Fortunately, many parents and caregivers who are initially rejecting of their LGB children have been found to develop more accepting attitudes over time (Beals & Peplau, 2006; Cramer & Roach, 1988; McConnell et al., 2016; Savin-Williams & Ream, 2003). For their LGB children, however, this initial rejection can be painful and damaging, and often occurs during developmental stages that are important for identity formation. For some parents and caregivers, these rejecting attitudes persist over the course of the child’s lifetime and into adulthood, which can take a toll on the LGB individual’s health (McConnell et al., 2016).

Rejecting attitudes from parents and caregivers have been associated with negative health outcomes for LGB individuals, including depression and suicidal ideation (D’Augelli et al., 2005; Remafedi et al., 1991; Ryan et al., 2009), and drug and alcohol use difficulties (D’Amico & Julien, 2012; Padilla et al., 2010; Rothman et al., 2012). Additionally, rejecting attitudes from parents have been associated with stressors that are experienced in association with an LGB individual’s identity, such as internalized heterosexism (Bregman et al., 2013; D’Amico et al., 2015), as well as expectations of prejudice and rejection by others (Pachankis et al., 2008).

The current study will look at associations between general family support, parents’ rejection of one’s LGB status, and the extent to which one reports responding to distress with self-compassion. The study will explore the relationship between general family support, sexual orientation-specific parental rejection, self-compassion, and psychological distress. In addition,
the study will examine the relationship of general family support and sexual orientation-specific parental rejection to proximal minority stressors such as internalized heterosexism, concealment, and expectations of rejection in an adult sample of LGB individuals. Finally, potential differences in the experiences of general family support, sexual orientation-specific parental rejection, and self-compassion across monosexual (e.g., lesbian, gay) and plurisexual (e.g., bisexual, pansexual) individuals will be a focus.

**LGB-Identified Individuals and Health Disparities**

Estimates from the United States census put the size of the adult Lesbian, Gay and Bisexual (LGB) population in the United States at 11.3 million, or 4.5% of adults (Conron, 2020). Estimates put the size of the youth LGB population in the United States at 1.9 million, or 9.2% of youth aged 13-17 (Conron, 2020). LGB individuals are more likely to experience negative health outcomes than others (Conron et al., 2010; Drabble et al., 2005; McCabe et al., 2005; Meyer, 2003). Anxiety, mood, and substance use disorders are more prevalent and reported levels of hopelessness and depression are higher in LGB individuals than heterosexual individuals (Cochran, 2001; Fergusson et al., 1999; Meyer, 2003). LGB individuals’ higher rates of psychological difficulties and negative health outcomes are influenced by societal stigma, discrimination, and negative emotions and thoughts about the self (Meyer, 2003). The number of LGB individuals in the population, as well as the disproportionate health disparities that are seen, demonstrate the need for research focused on LGB individuals to explore potentially relevant risk and protective factors that may relate to negative health outcomes.

**Minority Stress**

The Minority Stress Model is a framework that has been put forth in an attempt to explain the health disparities in the LGB population, and suggests that LGB individuals
experience a unique set of stressors related to their LGB status, which can contribute to the negative health outcomes that are seen in this population (Meyer, 2003). The Minority Stress Model posits that there are proximal and distal stressors that can put an LGB individual at risk of experiencing psychological distress. Distal stressors can be categorized as experiences that are imposed upon the individual from an outside entity, such as violence at the hands of another, or stigma and discrimination from society. Proximal stressors represent experiences that may threaten an individual’s identity and self-concept, such as expectations of rejection from others, internalized heterosexism, and concealment of one’s sexual minority identity (Meyer, 2003).

The Minority Stress Model posits that there are factors that can be protective, or those that will decrease the impact of minority stress experiences. These protective factors include social support, individual coping efforts, and personal characteristics of the individual. In addition, connection to the LGBTQIA+ community, an aspect of social support, has been proposed as a factor that may be protective against the effects of minority stress (Meyer, 2003). A sense of belonging to the community has been associated with positive outcomes, and LGB individuals who connect with others in the LGBTQIA+ community may experience supportive relationships that can mitigate the effects of Minority Stress (Baumeister & Leary, 1995; Crocker & Major, 1989; Miller & Major, 2000).

Impact of Family Environment

There is an extensive body of literature on the associations between family relationships, in particular parent-child relationships, and psychological health and well-being for adolescents and young adults (Holahan et al., 1994; Homma & Saewyc, 2007; Rohner et al., 2003; Savin-Williams, 1989; Shilo & Savaya, 2011; Steinberg, 2001). Associations between family relationships and mental health outcomes are particularly important to consider in the context of
LGB individuals’ experiences, given that LGB individuals report higher rates of negative mental health outcomes compared to their heterosexual counterparts (Meyer, 2003). Research has found that supportive relationships with parents are associated with positive health outcomes for LGB individuals (Bregman et al., 2013; Floyd et al., 1999) and that parental acceptance related to sexual orientation in particular may serve as a protective factor against negative health outcomes (D’Augelli, 2002; D’Augelli, 2003; Padilla et al., 2010).

Both general family support as well as parental attitudes related to sexual orientation have been demonstrated to be important to mental health for LGB youth and young adults. General family support includes caring and affectionate behaviors that parents extend to their children, in addition to spending quality time, providing advice and help, and expressing interest in their children’s day-to-day lives (Rohner et al., 2003). Studies have found that sexual minority children with higher reported rates of general family support score higher on measures of self-esteem (Floyd et al., 1999), and report lower rates of psychopathology and suicidality (D’Augelli, 2002; Feinstein et al., 2014; Hershberger & D’Augelli, 1995; Needham & Austin, 2010; Ryan et al., 2010; Savin-Williams, 1989). General family support has additionally been found to buffer against the association between sexual minority status and psychological distress, including suicidal ideation and suicide attempts (D’Augelli, 2003; Diamond et al., 2011; Eisenberg & Resnick, 2006).

General family support has been found to be a protective factor for LGB youth in some circumstances related to discrimination and harassment. In a study conducted by Hershberger and D’Augelli (1995), it was found that for LGB youth who reported low levels of sexual orientation-based discrimination (e.g., verbal comments), that general family support was found to be a protective factor against negative outcomes. However, for LGB youth who reported
moderate to high levels of sexual orientation-based discrimination and harassment (e.g., property destruction and physical attacks), general family support was no longer found to be a protective factor (Hershberger & D’Augelli, 1995). General family support may be protective in instances in which sexual orientation-based discrimination does not result in physical harm (e.g., verbal comments), as in these experiences, an LGB individual may be able to use coping skills to protect against negative health outcomes.

Unfortunately, supportive parent-child relationships may be challenged by parents’ rejection of their child’s sexual orientation. Due to the fact that children will experience various degrees of love from caregivers and parents, the construct of parental support and rejection has been conceptualized as a continuum (Rohner, et al. 2003). The support end of this continuum relates to the bond between a parent and child, including physical and verbal behaviors of parents that express warmth, affection, care, comfort, concern, nurturance, support, and love to their children (Rohner et al., 2003). Conversely, the rejection end of the continuum is characterized by the withdrawal or absence of affection, in addition to the presence of physically and psychologically harmful parental behaviors and emotions (Rohner et al., 2003). Parental rejection can be shown by parents expressing coldness and a lack of affection (the opposite of warm and affectionate), being hostile and aggressive, and being indifferent and neglectful. Researchers have found that attitudes of support and rejection from family members are associated with self-esteem, self-efficacy, depression, and anxiety in the expected directions. A study conducted by D’Augelli et al. (2020) demonstrated that among a sample of LGBT-identified youth, those whose families were rejecting of their LGBT identity had higher rates of depression and anxiety symptoms, whereas those who experienced accepting family attitudes reported higher rates of self-esteem and self-efficacy.
Supportive attitudes and behaviors from parents and caregivers also may serve as a base from which LGB individuals are able to navigate challenges and stressors that arise throughout their lifetime. Pearson and Wilkinson (2013) posit that perceptions of love and support from parents contribute to the development of self-confidence and relational security, which could help LGB youth reject stigmatizing societal attitudes associated with their identity. Doty et al. (2010) additionally demonstrated that accepting attitudes from parents related to their LGB children’s sexual orientation buffered against the negative effects of sexual orientation-related stress in their children. Doty et al. (2010) found that this relationship did not hold true for general family support, suggesting that supportive parent-child relationships are particularly protective when parental support is related to the context in which the stressor is experienced (e.g., sexual orientation-specific acceptance against sexual orientation-based discrimination).

Even for parents who are accepting and supportive of their LGB child, they may fear for their child’s safety given societal stigma and prejudice, and wish to guard them against discriminatory experiences that their child may be exposed to in the outside world. This fear may contribute to parental behaviors that are perceived by the LGB individual to be rejecting. For example, a parent may discourage their gay son from being outwardly affectionate with his same-sex romantic partner outside of the home, for fear that he will be harmed in the outside community due to prejudicial attitudes related to his sexual orientation.

**Parental Attitudes and Internalized Heterosexism**

Research has found that parents’ stigmatizing attitudes related to sexual minority status (i.e., heterosexism) can influence the development of heterosexist attitudes in their children (O’Bryan et al., 2004). Even at an early age, an LGB child may internalize these negative messages from parents and caregivers, contributing to a sense of shame or disapproval at one’s
own sexual minority identity, also known as internalized heterosexism. These early negative messages can be difficult to combat, given that they are occurring during a child’s formative years, and can become integrated into the way that the child views themselves and their sexual minority status, even into adulthood.

Early experiences of rejection from parents and caregivers can also lead to internalized heterosexism for an LGB child. Early experiences of rejection related to sexual orientation may take the form of explicit rejection related to sexual orientation, such as the parent of a gay son disapproving of their son’s romantic interest in or relationships with men. Rejection from parents may also include less overt behaviors, such as a parent making negative comments about same-sex marriage or disapproving of depictions of same-sex relationships in the media. Early experiences of rejection based on one’s sexual minority status, such as negative reactions from parents and caregivers, may contribute to an LGB individual perceiving their identity in a negative light and internalizing stigmatizing attitudes as a result. These early experiences may relate to how an LGB child thinks about their own sexual orientation, and may contribute to shame and disapproval related to themselves and their sexual orientation.

Internalized stigma (referred to as internalized heterosexism when discussing sexual minority individuals) is conceptualized as an individual’s acceptance or adoption of societal prejudices against a stigmatized group of people despite being a part of the stigmatized group (Herek, 2009). According to the Minority Stress Theory, internalized heterosexism is thought to represent a proximal stress process that can put an LGB individual at risk of experiencing negative health outcomes such as low self-esteem and increased rejection sensitivity (Dyar et al., 2016; Pineles et al., 2006; Uysal et al., 2010).
A study conducted by Costa et al. (2013) found that higher sexual orientation-specific parental rejection resulted in higher levels of internalized heterosexism, suggesting an association between internalized heterosexism and parents’ acceptance or rejection of sexual orientation. In a study conducted by Tan et al. (2019), Filipino self-identified gay men reported on experiences of sexual orientation-specific parental rejection, internalized heterosexism, and suicidal ideation. They found that sexual orientation-specific parental rejection and internalized heterosexism were significantly correlated with suicidal ideation. These studies lend support to the idea that LGB individuals may develop negative attitudes toward themselves as a consequence of stigmatizing attitudes that they are exposed to in their family environments.

**Socio-political and Religious Factors and Family Attitudes**

Research has found that during times of sociopolitical change, particularly in the face of LGBT-related rights being threatened, that family relationships are particularly important (Levitt et al., 2009). In the United States, presidential administrations and executive orders have been used to restrict rights for gender and sexual minority (GSM) people (Gates & Saunders, 2016). Discriminatory legislation has been found to negatively impact GSM individuals, which has been demonstrated in multiple studies. Gonzalez et al. (2018) found that LGBT-identified individuals experienced an increase in depression, anxiety, daily heterosexist experiences, identity-related rumination, and vigilance as a result of the 2016 presidential election. In a study conducted by Veldhuis et al. (2017), LGBT-identified participants reported stigma-related concerns related to the U.S. 2016 presidential election, such as fear of harm from others, stress and hopelessness, fears of a rise in hate speech and violence, and concerns about loss of progress and rollback of rights.
Research suggests that family members’ attitudes and reactions are varied regarding anti-LGBT legislation (Levitt et al., 2009; Horne et al., 2021) and that they express a range of support regarding anti-GSM politics and policies (Horne et al., 2021; Lannutti, 2011; 2018; Maisel & Fingerhut, 2011; Rostosky et al., 2010). Political beliefs may vary amongst family members within the family unit, and politics may be a frequent topic of family discussion. A study conducted by Gonzalez et al. (2018) interviewed LGBT-identified participants related to family reactions to the 2016 presidential election and found themes of family division, family cohesion, and “no change” to family relations. Participants expressed the varied ways that they experienced divisions within their family, and reported that the election results negatively impacted ways in which they perceived, interacted with, and connected with family members. Participants shared that having family members vote for Donald Trump felt like a betrayal, and that they struggled to understand how a family member could support a presidential candidate who may restrict their rights. Other participants reported a sense of cohesion following the 2016 election, expressing that they felt their relationships with family members were strengthened as a result of shared voting habits. Participants who experienced “family cohesion” also reported that family members expressed care, concern, and support as a result of the election, which further enhanced feelings of connectedness. These findings emphasize the importance of family support, and that the political attitudes of family members may influence one’s perception of their family members as supportive.

Family support and attitudes from parents and caregivers may also be affected by religious and/or spiritual beliefs and values. For many LGB individuals, family value systems and spiritual or religious beliefs can contribute to messages that are communicated to the LGB individual regarding their sexual orientation. For example, in a sample of LGBT-identified
young adults, Ryan et al. (2010) found that family religiosity significantly predicted less perceived parental support. Another study found that in a sample of Seventh-day Adventist adults who identified as LGBT, 82.4% of participants expressed that religious beliefs made it difficult for their parents to be accepting of their LGBT identities (VanderWaal et al., 2017). Some parents of LGBT individuals state that while they are accepting of their child, that they cannot accept their child’s GSM identity due to religious beliefs (Bertone & Franchi, 2014; Freedman, 2008). Religious or spiritual teachings may lead parents to believe that sexual orientation and/or gender identity is a choice, and that it can be changed through religious teachings and practice. Parents also report negative responses from their church communities regarding their child’s LGB status, such as being advised to pray for a sexual orientation change (Sides, 2017).

LGB individuals who have grown up in certain types of religious environments may experience a significant conflict when confronted with these beliefs that do not match their experience of their identity. This can contribute to shame around their identity as well as difficulties associated with disclosing their sexual orientation. In a study conducted by VanderWaal et al. (2017), GSM-identified participants with strong religious backgrounds reported significant difficulties in feeling accepted by their families, especially after disclosing their sexual or gender minority identity.

It is important to note that religious attitudes and beliefs may also be relied on as a positive source of support for parents whose children have disclosed their LGB status. A study conducted by Sides (2017) found that parents reported using religious resources such as prayer, supportive clergy, and affirming faith communities to assist them in the process of accepting their child’s LGB identity. Another study examining perceived family functioning after a child’s
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disclosure of an LGBT identity found that religious commitment was associated with higher general family functioning (Goodrick & Gilbride, 2010). These studies lend support to the idea that LGB individuals are impacted by socio-political factors, and that experiences with family members can influence the ways in which they feel supported in the face of difficulties.

Family Communication and Subtle Forms of Rejection

Communication of support and rejection from parents and caregivers can at times be overt and direct, and at other times be more subtle and nuanced (Khaleque, et al., 2008; Senese et al., 2016). This is also true for communication about LGB status. In some cases, even parents who are overtly supportive may communicate rejection in less direct ways. For example, a parent may outwardly express “I love you no matter what” upon learning of their child’s LGB status but not welcome a child’s same-sex partner to family events in the same way they do for opposite-sex partners. Additionally, parents may have an overall positive relationship with their LGB child, but at the same time may avoid talking about their child’s sexual orientation in a manner that communicates feelings of shame.

An LGB individual’s perception of such experiences may contribute to the belief that their parents or caregivers do not really accept their LGB status, and thus, do not fully accept them overall. These perceptions of rejection can be damaging especially in the context of developmental processes, when a developing child or adolescent looks to parents or caregivers as a foundation from which to navigate their own identity exploration and experiences as they mature (Baumeister & Leary, 1995; Bowlby, 1973; Rohner, 1975, 1986, 2018). For example, younger sexual minority children may experience rejection from parents related to their style of dress, whereas for adolescents, parental rejection may be experienced in the context of dating and romantic relationships. For an LGB individual in particular, perceived parental or caregiver
rejection may also contribute to expectations of rejection from others regarding their sexual orientation, which may confer risk for negative health outcomes that are seen in this population. For example, a study conducted by Feinstein et al. (2014) found that sexual orientation-specific parental rejection served as a protective factor for sexual minority participants, however, general family support (e.g., supportive attitudes not related to sexual orientation) was not found to be a protective factor against negative health outcomes.

Multiple studies have examined the relationships between family support and rejection and mental health outcomes (Baumeister & Leary, 1995; Bowlby, 1973; Rohner, 1986, 2018), and have also specifically explored the construct of undifferentiated rejection and its relationship to health outcomes in the general population (Khaleque & Rohner, 2002; Rohner, 1986, 2016; Rohner & Khaleque, 2010). Rohner et al. (2003) defined the term undifferentiated rejection as “children’s beliefs that their parents do not really care about them or love them, even though there might not be clear behavioral indicators that the parents are neglecting, unaffectionate, or aggressive toward them (Rohner et al., 2003). As experiences of undifferentiated rejection are not measured on the basis of observable behaviors from a parental figure or caregiver, an exploration into an individual’s perception of rejection from one’s family members may capture more “subtle” rejecting attitudes that are remembered. Multiple studies have found an association between experiences of undifferentiated rejection and negative mental health outcomes. Ali et al. (2019) found in a meta-analysis of 102 studies that in the general population, children and adults’ experiences of undifferentiated rejection from their parents correlated significantly with psychological maladjustment.
Parents and caregivers can communicate support and rejection to their LGB children in various ways, and the process of an LGB individual perceiving more “subtle” rejecting attitudes from parents may contribute to the process of expecting rejecting attitudes from others.

**Identity Development, Self-Esteem, and Self-Efficacy**

Broadly, it has been found that family relationships are an essential part of a child’s identity formation, and contribute to the development of self-esteem and self-efficacy (D’Augelli et al., 2020). Identity development and integration for LGB individuals can be a challenging process to navigate due to societal stigma and discrimination, as messages about sexual minority status are frequently negative. In the face of threats stemming from stigma and discrimination in society, positive identity development can serve as a protective factor against proximal stressors such as internalized heterosexism and expectations of rejection from others. Research has demonstrated that family members’ support of their LGB relatives positively predicts self-esteem, as well as general health for the LGB individual (Ryan et al., 2010). Family support and rejection have also been found to be important in the development of self-efficacy, as family interactions can communicate to a child about the skills that they will need to be successful, as well as teach the child how to use these skills in order to effectively reach their goals. In a study conducted by Pearson and Wilkinson (2013), it was found that parental love and support may facilitate the development of self-confidence and relational security, which could help LGB youth reject the societal stigma associated with their sexual minority status.

Conversely, LGB children who experience parental rejection have been found to have lower rates of self-esteem and self-efficacy (D’Augelli et al., 2020). Even when a parent or caregiver is not explicitly rejecting, it may be that the parent or caregiver lacks knowledge regarding the ways in which they can support their LGB child, and thus may lack an awareness
of skills that an LGB child may benefit from in the face of prejudice and discrimination from society. Additionally, an LGB child who conceals their sexual orientation may not have the opportunity to connect with other LGB peers, thereby limiting access to social support and opportunities to interact with others in an authentic way. Connecting with other LGB peers has been found to be a protective factor broadly for LGB individuals, especially for LGB individuals who have experienced rejection and a lack of support from their family members (Goldfried & Goldfried, 2001; Weeks et al., 2001). For LGB individuals who choose to disclose their identity, this desire may be constrained by fears and threats of harm. Given the potential risks of disclosing one’s LGB status, LGB individuals often must weigh the benefits and consequences of whether they should disclose their identity, and with whom it may be safe to do so.

Plurisexual Individuals and Family Attitudes

Individuals who identify on the plurisexual spectrum (i.e., bisexual, pansexual, demisexual, etc.) may experience unique stressors related to their identity that are not necessarily shared by those on the monosexual spectrum (e.g., gay, lesbian). It has been found that individuals who identify on the plurisexual spectrum are often exposed to negative stereotypes and rejecting attitudes that contribute to negative health outcomes. These rejecting attitudes may occur in family systems, and in addition to societal messages and media depictions, an individual who identifies as plurisexual may receive negative messages related to their sexual orientation as being “just a phase” or “not being able to make up their mind” [regarding experiences with romantic relationships]. Further, inaccurate stereotypes are prevalent regarding identities on the plurisexual spectrum, such as thoughts that a bisexual sexual orientation equates to the bisexual individual being “promiscuous” (Dyar et al., 2014). Bisexual individuals have been found to be
at risk for negative health outcomes such as alcohol use disorders (Sandfort, 2001) and may conceal or deny their sexual minority identity as a result of stigma (Balsam & Mohr, 2007).

Additionally, plurisexual individuals who conceal their sexual minority identity due to stigmatized reactions from family and society may have limited access to other GSM-identified peers with whom they could rely on for social support. For example, it has been found in multiple studies that sexual minority individuals may create “families of choice” if they are cast out from their family systems (Goldfried & Goldfried, 2001; Weeks et al., 2001). These “families of choice” can be comprised of peers and friends who are able to support the individual even when family support may be absent. This has been found to be a protective factor, especially for sexual minority individuals who have experienced rejection and a lack of support from their family members (Goldfried & Goldfried, 2001; Weeks et al., 2001).

Plurisexual individuals may experience the unique challenge of their identity being framed by others in the context of whom they are (or are not) engaged in a romantic relationship with (Balsam & Mohr, 2007). For example, a bisexual woman may conceal her bisexual identity until she is involved in a romantic relationship with another woman, contributing to the belief that her bisexual identity is “just a phase.” Plurisexual individuals may also be involved in romantic relationships with partners of varying genders throughout their lifetime, and may find that their plurisexual identity is “erased” or “not taken seriously” in the process. For example, a bisexual woman who has disclosed her bisexual identity may find that her family members do not consider her to be bisexual when she is involved in a romantic relationship with a man. These unique experiences may contribute to negative health outcomes for a plurisexual individual, and parental rejection may represent a particularly relevant process for their identity development.

Concealment and “Coming Out”
It has been found that disclosure of sexual orientation to family members is common among sexual minority youth. One study found that 79% of sexual minority youth had disclosed their sexual orientation to at least one parent, and two-thirds of youth had disclosed their sexual orientation to at least one sibling and one extended family member (Rosario et al., 2009). Another study with sexual minority emerging adult participants found that 46% of men and 44% of women had disclosed their sexual orientation to their parents (Savin-Williams, 2003). This study found that participants were more likely to “come out” to their mothers than to their fathers, and disclosure of sexual orientation occurred around age 19 on average via a face-to-face encounter.

Heterosexual attitudes expressed by parents discourage youth from “coming out,” and lead to concealment. Many LGB individuals conceal their sexual minority identity for periods of time. Concealment has been found to predict negative mental health outcomes for LGB individuals, a process that can be further complicated by reactions from family members (D’Augelli et al., 1998; Ryan et al., 2009). LGB individuals may go to great lengths to conceal their sexual minority status, which can inhibit the expression of an authentic sense of self (Bosson et al., 2012) and redirect cognitive resources away from self-acceptance and toward further concealment (Critcher & Ferguson, 2014).

For LGB adolescents and young adults, the process of concealing one’s sexual minority identity from family members may prevent them from accessing important resources such as healthcare, supportive relationships with other LGB peers, and safe sex education (D’Augelli, 2005). Negative reactions from parents and family members may extend to negative consequences for the LGB individual, such as being cut off from material resources and social-emotional support upon disclosure of their LGB identity (D’Augelli et al., 2005; Ryan et al.,
Many LGB individuals will choose not to disclose their sexual minority status to family members for fear of negative consequences such as being kicked out of the family home, threats of violence, or being cut off from resources (Higa et al., 2012). Due to this fear of rejection and potential threat of negative consequences, many LGB individuals may wait to disclose their sexual minority status until they have left the family home or later in life (Ryan, 2009).

Multiple studies have examined the risk and protective factors for sexual minority individuals as they come out. A study conducted by Ryan et al. (2009) found that when sexual minority participants felt moderately rejected by family members when they came out, they were at greater risk for experiencing depressive symptoms and attempting suicide. They found that as family rejection increased, other negative health outcomes such as suicidal ideation, substance use difficulties, and risky sexual behaviors increased as well. An additional study by Ryan et al. (2010) examined levels of family support and their associations to various health outcomes in a sample of sexual minority youth who had “come out” to their parents. Participants who reported higher levels of family support were more likely to have higher self-esteem, social support, and general health, whereas depression, substance use, suicidal thoughts, and suicide attempts were negatively correlated. Other studies have found similar trends regarding the association between family rejection and the risk of experiencing negative mental health outcomes, while family support was found to be associated with lower rates of suicidality, depression, hopelessness, and distress (Bouris et al., 2010; Haas et al., 2010; Saewyc, 2011). These studies lend support to the idea that sexual minority individuals may internalize the negative physical, verbal, and symbolic behaviors of rejection and falsely equate these experiences as a representation of their own self-worth and value (Frost & Meyer, 2009; Meyer, 2003; Szymanski & Chung, 2001).
Mindfulness and Self-Compassion

Given the associations that are seen between Minority Stress and self-worth for LGB individuals, there is a need for protective factors to be identified, particularly those that may mitigate proximal minority stressors that can threaten an LGB individual’s self-concept.

Mindfulness is conceptualized as “…the self-regulation of attention so it is maintained on immediate experience” and “…adopting a particular orientation toward one’s experiences in the present moment, an orientation that is characterized by curiosity, openness, and acceptance” (Bishop et al., 2004). Research related to mindfulness has gained popularity in the field of psychology over the past two decades, often stemming from practices that are represented in Buddhist philosophy (Epstein, 1995; Molino, 1998; Nisker, 1998; Rubin, 1996; Watson et al., 1999). A great deal of research has confirmed the positive effects of mindfulness-based interventions and practices on mental health (Baer et al., 2012; Chiesa & Malinowski, 2011; Kabat-Zinn, 1982; Kiken et al., 2015).

Self-compassion is a theoretical construct stemming from the broader construct of mindfulness and is conceptualized as extending kindness and understanding toward oneself in the face of difficulty (Neff, 2003). Research has begun to examine the associations between self-compassion and health outcomes such as well-being and psychological distress. Much of the research base focused on self-compassion has utilized Neff’s (2003) conceptualization of self-compassion and its accompanying measure, The Self-Compassion Scale, to study self-compassion and its associations with health outcomes. Neff’s (2003) conceptualization of self-compassion is posited to be comprised of multiple components, which are labeled as self-kindness, common humanity, and mindfulness. This conceptualization also includes the inverse of these components, which are labeled as self-judgment, isolation, and over-identification with
emotions. While some researchers have conceptualized self-compassion as a single overarching construct (Neff, 2003), other researchers have theorized that self-compassion is made up of two overall factors including a factor with the positive components, and a factor with the negative components (Brenner et al., 2017).

The component of self-kindness is conceptualized as the tendency to extend kindness toward oneself, particularly in the face of difficulty. Rather than being critical toward oneself in response to challenging events, self-kindness involves the tendency to respond to such challenges with understanding and care towards the self. Conversely, the component of self-judgment involves extending criticism and harshness towards oneself.

The component of common humanity involves the perspective that one’s experiences, including difficulties, are a part of the universal human experience, rather than viewing one’s experiences as something that one goes through alone. Common humanity includes the perspective that experiences of suffering are shared by everyone, rather than seeing such experiences as isolating. Conversely, the component of isolation involves viewing one’s difficulties as a stemming from personal inadequacies, or a sense that one is separate from others in their pain.

The component of mindfulness involves one’s tendency to take a balanced view of thoughts and emotions, rather than over-identifying with them. Conversely, the component of over-identification involves becoming overwhelmed with painful feelings and thoughts, such that it may be difficult to “step back” from emotions and thoughts that are distressing.

Research on the experience of self-compassion in gender and sexual minority (GSM) samples has been found to be related to health outcomes, including a positive relationship to general happiness and an inverse relationship to psychological distress. For example, Greene
and Britton (2015) found that, in a sample of GSM individuals, ratings of happiness and of personal mastery were positively correlated with self-compassion. Liao et al. (2015) examined expectations of rejection, anger rumination, and self-compassion as potential mediators in the relationship between perceived discrimination and psychological distress. In the sample of GSM individuals in their study, they found that perceived discrimination was related to higher expectations of rejection, which was associated with higher levels of anger rumination and lower levels of self-compassion, leading to more psychological distress. Thus, self-compassion may mediate the effects of perceived discrimination on psychological symptoms.

There is also research supporting the idea that self-compassion can be helpful to individuals during the “coming out” process. Levels of “outness” (i.e., the extent to which an individual has disclosed their sexual orientation to others) and self-compassion reported by LGB participants were assessed in a study by Crews and Crawford (2015). Participants who reported being “totally out,” defined as “no barriers as to who knows if they are gay or lesbian,” reported higher levels of self-compassion. In contrast, not being totally out was associated with higher levels of self-judgment and feelings of isolation. Jennings and Tan (2014) similarly found that self-compassion was related to “openness” (a measure of outness) in a sample of GSM individuals.

Research has also addressed the association between Minority Stress and self-compassion. Chan et al., (2020), in a study conducted in China, found evidence that self-compassion may mediate the effects of Minority Stress. Results of hierarchical regression analyses found significant interactions between stigma stress and self-compassion in predicting psychological symptoms. The relationship between stigma stress and psychological distress was
Running head: PERCEIVED PARENTAL ACCEPTANCE AND REJECTION, SELF-COMPASSION AND PSYCHOLOGICAL DISTRESS IN LGB-IDENTIFIED INDIVIDUALS

weaker for LGB individuals with high levels of self-compassion, compared to participants with lower self-compassion.

Bowlen et al. (under review) examined the relationships between self-compassion, Minority Stress, and psychological distress in a sample of 558 GSM-identified individuals. Participants were recruited online for the study and completed measures of day-to-day discriminatory experiences, psychological distress, and self-compassion (Bowlen et al., under review). Results from parallel mediation analyses indicated that discriminatory experiences were indirectly related to psychological distress through their relationship with the self-kindness, self-judgment, isolation, and over-identification facets of self-compassion. Of the positive facets of self-compassion, only self-kindness mediated the relationship between discriminatory experiences and psychological distress. All three negative facets of self-compassion (self-judgment, isolation, and overidentification) mediated the relationship between discriminatory experiences and psychological distress.

Development of Self-Compassion

Given that the tendency to respond with self-compassion has been found to be related to positive mental health outcomes, and to mediate the effects of Minority Stress, the question of what leads people to develop self-compassion arises. Developmental processes that may be implicated in understanding how and under what conditions an individual is able to utilize self-compassion have not been well-researched; however, several theories have been put forward to explain the occurrence of self-compassion. These have included applications of evolutionary theory, attachment theory, and learning and behavior theory.

One such perspective involves evolutionary psychology and social mentality theory (Gilbert, 2014). From this perspective, compassion is understood as a process that involves a
dynamic reciprocal process between self and others, and can be directed from 1) self-to-other, 2) other-to-self, and 3) self-to-self. This perspective stems from the view that compassion has developed out of evolved caring motivations that are found in mammals. In this view, compassion has emerged from a mammalian infant caring motivation “to be attentive to the distress and needs of another (e.g., infant), and then turn towards and approach distress signals in order to help alleviate the distress, whether it be via protection, feeding, supporting, or soothing” (Bowlby, 1969; Gilbert, 2019; Porges, 2007). This perspective suggests that this mammalian motivation has evolved and become more complex over the last two million years (Gilbert, 2019) and has been enhanced by:

- social intelligences of knowing awareness (i.e., ability to mentalize, have mental time travel, symbolic thinking); empathic awareness (i.e., insight into why we feel/think/act the way we do, and that of others); and knowing intentionality (i.e., deliberately choosing to cultivate specific motives and develop skills to enact the motives. (p. 415)

This perspective posits that mammals have the need to be attentive and take action when encountering suffering, as this signal response process is implicated in all motives, including feeding, sexuality, harm avoidance, and competing for resources (Buss, 2014; Gilbert, 2014; Keltner et al., 2014). This perspective also posits that the evolved motivational potential for compassion can be activated or inhibited, thereby increasing or reducing the likelihood of the motive being activated or “turned on.” Research has found that facilitators to compassion include engaging in meditation (Galante et al., 2014), completing compassion-based intervention programs (Kirby, 2016), and using self-assuring inner voice tones (Longe et al., 2010). However, utilizing and improving such facilitators does not necessarily result in compassionate behavior if there are inhibitors that are present (Gilbert & Mascaro, 2017). For example,
behaviors such as separating into groups and discriminating based on in- and out-group biases reduce the likelihood of the motive being activated or “turned on,” thereby influencing compassionate responding (Keller & Pfattheicher, 2013; Preston, 2013; van Kleef et al., 2008).

A growing body of research has found that inhibitors to compassion on the individual level include fears, blocks, and resistances to compassion. Fears of compassion are conceptualized as “the avoidance or fear response that individuals can have to compassion, which can exist for all three directions” including self-to-other, other-to-self, self-to-self (Kirby et al., 2019). For example, having the fear that extending compassion toward oneself or others is a weakness or self-indulgent, or fearing that efforts to extend compassion will be rejected or seen as unhelpful or manipulative by others (Gilbert & Mascaro, 2017). Blocks to compassion refer to circumstances in which an individual would like to extend kindness toward themselves or others, however, the person is unable to do so. For example, blocks to extending compassion toward oneself or others may include a lack of time, resources, or insight into the causes of suffering (Kirby et al., 2019). Resistances to compassion refer to circumstances in which an individual could be compassionate but is not. Rather than stemming from fears of compassion, resistances to compassion may stem from an individual believing there is no point to compassionate responses, or is focused on getting their own needs met. Resistances to compassion may occur for individuals who have increased power over others (Keltner, 2016), and are relevant to individuals with traits of narcissism (Basran et al., 2019).

Another perspective specifically related to fears of compassion draws upon attachment theory, evolutionary theory, and learning and behavior theory (Gilbert, 2019). This perspective suggests that parental affiliative behaviors (e.g., warm voice-tone, caring physical touch) can enable secure attachments between parent and child, and help regulate emotions when the child
is distressed (Bowlby, 1969; Gilbert, 2014; Yaman et al., 2010). However, if the child does not have the access or opportunity to learn how affiliative behaviors can help regulate distress, a secure attachment between parent and child may be interrupted. In other words, the parasympathetic nervous system is not activated in order to down-regulate threat processing, thereby leading to fear or anxiety towards affiliative behaviors (Porges, 2007; Thayer & Lane, 2000).

In addition, punitive parenting practices, particularly when a child is joyful or loud, can lead to a classically conditioned response in which a child’s positive emotions are paired with punishment. As a result, the child may perceive compassion as a potential threat due to these past experiences, thus leading to fight, flight, or shut-down responses from the child (Kirby, 2017). Fears of compassion have been studied in relation to psychopathology and mental health outcomes. A meta-analysis conducted by Kirby et al. (2019) found that across 19 studies with data from 4723 participants, fear of self-compassion and fear of receiving compassion were associated strongly with depression, shame, and self-criticism.

**The Rejection Sensitivity Model**

The Rejection Sensitivity Model has been posited as a complementary theory to build upon and extend the Minority Stress theory. Feinstein (2020) suggests that the Rejection Sensitivity Model (Downey & Feldman, 1996), which was initially developed to explore rejecting attitudes from significant others in close relationships, can be applied to stigmatized individuals such as those with a sexual minority status. Downey and Feldman (1996) defined rejection sensitivity as a cognitive-affective processing disposition that includes anxiously expecting, readily perceiving, and intensely reacting to rejection. Feinstein (2020) suggests that for sexual minority individuals, early experiences of rejection related to sexual orientation can
result in the development of anxious expectations that others will reject them as a result of their sexual minority status.

Feinstein (2020) suggests that this cognitive-affective process can function as a way for sexual minority individuals to detect and guard themselves against discriminatory experiences. Early experiences of rejection may initially occur in the context of rejecting attitudes and behaviors from parents and caregivers, and for a sexual minority individual, experiences of rejection may center around the individual’s sexual orientation. For example, if a sexual minority adolescent experiences rejection from their parents upon disclosing their sexual minority status, this may contribute to the adolescent anticipating similar negative reactions from others. The adolescent may employ behavioral processes such as concealing their sexual orientation. They may develop cognitions and beliefs such as an increased estimation of the likelihood of being rejected by others. They may also be affected in terms of affective processes, such as increased anxiety about being rejected by others. The changes are posited to serve the function of helping to protect the individual from discrimination and stigma by detecting and responding to social threat. The use of such processes can extend into adulthood, as monitoring for threats of rejection can keep the individual safe from discriminatory events in their environment and in society at large (Feinstein, 2020).

Rejection sensitivity has been hypothesized to take a psychological toll on the individual. This has been confirmed by research that has found rejection sensitivity to be associated with negative mental health outcomes including depression and anxiety. A study conducted by McDonald, et al. (2010) found in a sample of 277 youth that rejection sensitivity was related to depressive symptoms, though this relationship was found only in adolescents who reported a lack of social support from parents. For adolescents who reported a lack of social support from
friends, this was associated with increased social anxiety, even for adolescents who reported receiving support from parents. Research has also found that rejection from parents is associated with higher rates of rejection sensitivity. A study conducted by Rudolph and Zimmer (2014) found that in a sample of 659 early adolescents (aged 9-13), those who reported more negative parenting practices had higher rates of depression, social anxiety, and withdrawal behaviors in the face of rejection. Although rejection sensitivity may serve to protect the individual in certain ways, it ultimately is associated with mental health difficulties, and may develop in part as a response to rejecting attitudes that are present in the individual’s family system.

**Summary**

Unfortunately, many LGB individuals will face discrimination, stigma, rejection, concealment and/or disclosure related to their sexual minority identity. Family support may serve as a protective factor in the face of these challenges, and conversely, family rejection will likely contribute to these painful experiences. Explanations put forward by the Rejection Sensitivity Model and Minority Stress Theory highlight the need for a consideration of family processes that may be implicated in the associations that are seen between expectations of rejection, experiences of sexual-orientation specific parental rejection, and negative mental health outcomes for LGB individuals. Additionally, considerations of how family processes may be implicated in the development of individual coping efforts, such as self-compassion, could assist in better understanding points of intervention (e.g., resources for families and individuals) to mitigate the impacts of Minority Stress for LGB individuals. Despite the extensive research base that exists in the topic area of family support and rejection, there appears to be a gap in the literature exploring associations between family support and rejection, facets of self-compassion, and psychological distress, limiting research on this potentially important area of study.
Current Study

The purpose of the current study is to examine associations between the six facets of self-compassion, general family support, sexual orientation-specific parental rejection, proximal minority stress, and psychological distress in an LGB population in the United States. Previous studies have shown that family support and rejection are related to psychological distress and well-being for LGB individuals. The current study will address the following questions in a sample of LGB individuals:

1) What is the relationship between general family support, sexual orientation-specific parental rejection, and psychological distress?

2) What is the relationship between general family support, sexual orientation-specific parental rejection, and the six facets of self-compassion (self-kindness, mindfulness, common humanity, self-judgment, over-identification, isolation)?

3) Do facets of self-compassion mediate the relationship between general family support and psychological distress? Do facets of self-compassion mediate the relationship between sexual orientation-specific parental rejection and psychological distress?

4) What is the relationship between sexual orientation-specific parental rejection and proximal minority stressors (e.g., internalized heterosexism)? Does self-compassion mediate that relationship?

5) Do monosexual (e.g., lesbian, gay) and plurisexual (e.g., bisexual, pansexual) individuals differ in their experience of general family support or sexual orientation-specific parental rejection? In their level of self-compassion?

Methods

Procedure
After obtaining Institutional Review Board (IRB) approval for the study, participants were recruited from online-based survey links, Facebook groups, and online listservs and groups. Participation in the study required that the respondents be (a) at least 18 years old and (b) identify as lesbian, gay, bisexual, queer, questioning, or with another nonheterosexual sexual identity.

A power analysis, using a Monte Carlo simulation was used to determine that the minimum number of participants should be 253 to provide adequate power for the current study. A medium effect size was chosen based on research measuring similar relationships between self-compassion and well-being (Neff et al., 2007).

324 individuals participated in the study (70.1% gender minority individuals and 29.9% cisgender individuals). The ethnic breakdown of the sample was 81.2% white, 0.3% Native American, 2.2% Hispanic/Latino or Chicano, 1.5% Asian/Pacific Islander, 0.6% Middle Eastern, 11.7% multiracial, 0.9% Black/African American, and 1.5% chose not to respond to this question. The mean age of the sample was relatively young (M = 26.2). Regarding missing data, if fewer than 20% of the data points in a subscale were missing, the missing data point(s) was filled in by the average of the other data points in the subscale.

Table 1

Demographics: Sample of 324 Individuals

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender Identity</td>
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<td></td>
</tr>
<tr>
<td>Gender minority indiv.</td>
<td>227</td>
<td>70.1%</td>
</tr>
<tr>
<td>Cisgender indiv.</td>
<td>97</td>
<td>29.9%</td>
</tr>
<tr>
<td>Man</td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>Woman</td>
<td>114</td>
<td></td>
</tr>
<tr>
<td>Transgender</td>
<td>106</td>
<td></td>
</tr>
<tr>
<td>Non-binary</td>
<td>143</td>
<td></td>
</tr>
<tr>
<td>Genderqueer</td>
<td>83</td>
<td></td>
</tr>
<tr>
<td>Agender</td>
<td>36</td>
<td></td>
</tr>
</tbody>
</table>
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Another gender 30

Sexual Identity
Gay 26 8.0%
Lesbian 55 17.0%
Bisexual 89 27.5%
Pansexual 17 5.2%
Queer 77 23.8%
Questioning 4 1.2%
Asexual 34 10.5%
Another sexual identity 22 6.8%

Location
Northeast 83 25.6%
Midwest 67 20.7%
South 64 19.8%
West 110 33.9%

Age

<table>
<thead>
<tr>
<th>N</th>
<th>Min.</th>
<th>Max.</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>324</td>
<td>18</td>
<td>73</td>
<td>26.15</td>
<td>7.22</td>
</tr>
</tbody>
</table>

Materials

Participants were asked to give consent prior to participation. Consent was given by clicking a box on the first page of the survey, which indicated that the participant read and understood the statements of participant rights and could withdraw from the study at any time. Respondents completed demographic information first (e.g., sexual orientation, gender identity, age, relationship status, race/ethnicity) (see Appendix A). The remaining measures included in the survey were counterbalanced by varying the order of administration.

Self-compassion, Self-coldness, Facets of Self-compassion. Self-compassion and related constructs were measured with the Self-Compassion Scale (SCS) (Neff, 2003). The SCS is a 26-item measure that includes self-compassion items assessing three dimensions: self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-
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identification (Neff, 2003a). The items ask how respondents typically respond to themselves in difficult times. Items are rated on a 5-point Likert scale from “Almost never” to “Almost always.”

The self-compassion scale was separated into two components: self-compassion (SCS-S) and self-coldness (SCS-C), utilizing subscales developed by Brenner et al. (2017). The self-compassion score includes the three positive facets (self-kindness, common humanity, and mindfulness). The self-coldness score combines the three negative facets (self-judgment, common humanity, and over-identification). Test–retest reliability for the SCS were as follows: Self-Compassion Scale (overall score): .93; Self-Kindness subscale: .88; Self-Judgment subscale: .88; Common Humanity subscale: .80; Isolation subscale: .85; Mindfulness Subscale: .85; and Over-Identification subscale: .88. Internal consistency for the 26-item SCS was .92.

Internal consistency for the subscales were as follows: Self-Kindness Subscale: .78; Self-Judgment Subscale: .77; Common Humanity Subscale: .80; Isolation Subscale: .79; Mindfulness Subscale: .75; Over-identification Subscale: .81.

Cronbach’s alpha for the self-compassion scale in the current study was .94, while internal consistency for the subscales were as follows: self-kindness = .87; common humanity = .77; and mindfulness = .74. Cronbach’s alpha for the self-coldness scale in the current study was .91, while internal consistency for the subscales were as follows: self-judgment = .87; isolation = .78; and over-identification = .78 (see Appendix B).

General Family Support. A frequently utilized measure in the parental support and rejection literature is the Parental Acceptance-Rejection Questionnaire (PARQ; Rohner, 2005). The PARQ short form is a 24 item self-report measure that has respondents indicate their experiences of support and rejection from their parents retrospectively. Items are rated on a Likert-type scale from 1 “Almost never” to 4 “Almost always.” Some typical items on the PARQ
include “my mother/father made me feel wanted and needed,” “my mother/father seemed to dislike me,” “my mother/father punished me severely when s/he was angry,” and “my mother/father paid no attention to me as long as I did nothing to bother him/her.” Reliability for the PARQ ranges from .86 to .95 and has produced evidence of concurrent, convergent, and discriminant validity. Cronbach’s alpha for the PARQ in this study was .98. For ease of writing, this measure will hereto be referred to as “general family support” (see Appendix C).

Sexual Orientation-Specific Parental Rejection. The Perceived Parental Reactions Scale (PPRS; Willoughby, et al., 2006) is a 32-item self-report measure that examines perceived parental acceptance and rejection of sexual orientation. For the purpose of this study, a question was added to the demographics section of the survey related to whether the participant had disclosed their sexual orientation to their parents. If the participant indicated that they had disclosed their sexual orientation, survey skip logic presented them with a version of the PPRS that instructed them to answer the questions for the “parent or caregiver you first came out to.” If the participant indicated that they had not disclosed their sexual orientation, survey skip logic presented them with a version of the PPRS that instructed them to answer the questions for “the parent or caregiver with whom you have the closest relationship.” The items are rated on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). Internal consistency for the overall scale was .92. Test-retest reliability of the PPRS ranges from .95 to .97. Cronbach’s alpha for the PPRS in this study was .97. For ease of writing, this measure will be referred hereto as “sexual orientation-specific parental rejection” (see Appendix D).

Symptoms of Psychological Distress. Psychological distress was measured with the Brief Symptom Inventory (BSI; Derogatis et al., 1975). This measure includes 18 items related to symptoms of anxiety and depression, rated on a 5-point scale from 0 “Not at all” to 4
Proximal Minority Stress. The Lesbian, Gay, and Bisexual Identity Scale (LGBIS; Mohr & Kendra, 2011) is a 27-item measure designed to assess eight dimensions of lesbian, gay, and bisexual (LGB) identity. For this study, three subscales were utilized to assess proximal minority stress (Acceptance Concerns, Concealment Motivation, Internalized Heterosexism), each consisting of three items that are scored on a Likert-type scale from 1 (Disagree strongly) to 6 (Agree strongly). Example items include “I prefer to keep my same-sex romantic relationships rather private,” “If it were possible, I would choose to be straight,” and “I often wonder whether others judge me for my sexual orientation.” Test-retest reliability of the LGBIS is .70 to .92, while the internal consistency of the individual subscales are as follows: Acceptance Concerns: .83, Concealment Motivation: .70, Internalized Heterosexism: .92. Cronbach’s alpha for the LGBIS in this study was .83 (see Appendix F).

Results

Pearson correlations were conducted to test the relationships between Sexual Orientation-Specific Parental Rejection (PPRS), Psychological Distress (BSI), facets of Self-Compassion (SCS-S), facets of Self-Coldness (SCS-C), General Family Support (GFS), Proximal Minority Stress (LGBIS), and symptoms of Psychological Distress (BSI) (Table 2).
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Table 2

Correlation Matrix for the SCS, LGBIS, BSI, GFS and PPRS

| Scales | SCS    | SK     | CH     | M      | SCS-C  | SJ     | Iso    | OI     | LGBIS  | BSI    | GFS    | PPRS   |
|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| SCS    |        |        |        |        |        |        |        |        |        |        |        |        |        |
| SK     | .86**  |        |        |        |        |        |        |        |        |        |        |        |        |
| CH     | .83**  | .54**  |        |        |        |        |        |        |        |        |        |        |        |
| M      | .85**  | .64**  | .55**  |        |        |        |        |        |        |        |        |        |        |
| SCS-C  | -.68** | -.66** | -.49** | -.58** |        |        |        |        |        |        |        |        |        |
| SJ     | -.66** | -.74** | -.46** | -.48** | .87**  |        |        |        |        |        |        |        |        |
| Iso    | -.52** | -.45** | -.43** | -.43** | .86**  | .61**  |        |        |        |        |        |        |        |
| OI     | -.58** | -.53** | -.37** | -.59** | .87**  | .65**  | .62**  |        |        |        |        |        |        |
| LGBIS  | -.21** | -.16** | -.16** | -.23** | .30**  | .24**  | .27**  | .27**  |        |        |        |        |        |
| BSI    | -.36** | -.33** | -.27** | -.31** | .54**  | .44**  | .51**  | .44**  | .19**  |        |        |        |        |
| GFS    | .19**  | .19**  | .16**  | .13*   | .25**  | .23**  | .26**  | .15**  | .06    | -.35** |        |        |        |
| PPRS   | -.11   | -.05   | -.10   | -.12*  | .07    | .07    | .09    | .03    | .18**  | .18**  | -.56** |        |        |

SCS = Self-Compassion Scale; SK = Self-Kindness; CH = Common Humanity; M = Mindfulness; SCS-C = Self Coldness Scale; SJ = SelfJudgment; Iso = Isolation; OI = Over-Identification; LGBIS = Proximal Minority Stress; BSI = Psychological Distress; GFS = General Family Support; PPRS = Sexual Orientation-Specific Parental Rejection

*p < .05
**p < .01

Four parallel mediation analyses were conducted using the PROCESS macro in SPSS (Hayes, 2013). In the first mediation, Sexual Orientation-Specific Parental Rejection was entered as a predictor and facets of Self-Compassion (Self-Kindness, Common Humanity, Mindfulness) were entered as proposed mediators predicting Psychological Distress. In the second mediation, Sexual Orientation-Specific Parental Rejection was entered as a predictor and facets of Self-Coldness (Self-Judgment, Isolation, Overidentification) were entered as proposed mediators predicting Psychological Distress. In the third mediation, Sexual Orientation-Specific Parental Rejection was entered as a predictor and facets of Self-Compassion (Self-Kindness, Common Humanity, Mindfulness) were entered as proposed mediators predicting Proximal Minority Stress. In the fourth mediation, Sexual Orientation-Specific Parental Rejection was entered as a predictor and facets of Self-Coldness (Self-Judgment, Isolation, Overidentification).
were entered as proposed mediators predicting Proximal Minority Stress. To account for the variance explained by General Family Support, this variable was entered as a covariate in each regression analysis described below. Age, racial/ethnic status (coded as person of color or white), sexual orientation (coded as monosexual or plurisexual), and gender minority status (coded as gender diverse or cisgender) were entered as covariates for each step of the analysis.

**Model 1**

In the first mediation analysis, Sexual Orientation-Specific Parental Rejection was entered as the independent variable, with age, racial/ethnic status (coded as person of color or white), sexual orientation (coded as plurisexual or monosexual), gender minority status (coded as gender diverse or cisgender) and General Family Support entered as covariates. First, these variables were regressed on Psychological Distress (Table 3). Next, three separate regression analyses were conducted regressing covariates and Sexual Orientation-Specific Parental Rejection onto each facet of Self-Compassion (Self Kindness, Common Humanity, Mindfulness) (Tables 4-6).

In the first regression of Sexual Orientation-Specific Parental Rejection predicting Psychological Distress, age was negatively related to Psychological Distress ($\beta = -0.03, t = -4.93, p < .001$), gender was positively related to Psychological Distress ($\beta = .30, t = 2.90, p = .004$), and General Family Support was negatively related to Psychological Distress ($\beta = -0.26, t = -4.62, p < .001$). No other variables were related to Psychological Distress in this model. The variables in this model accounted for 24.17% of the variance in Psychological Distress ($F (6, 317) = 16.84, p < .001$).
Regression of Sexual Orientation-Specific Parental Rejection (SO Parental Rejection) on Psychological Distress (BSI)

Dependent Variable = BSI  \( F (6, 317) = 16.84, p < .001 \)

<table>
<thead>
<tr>
<th>Covariates</th>
<th>B</th>
<th>SE</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-.03</td>
<td>.01</td>
<td>-4.93</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Gender Identity</td>
<td>.30</td>
<td>.10</td>
<td>2.90</td>
<td>.004</td>
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<td>.17</td>
<td>.11</td>
<td>1.52</td>
<td>.13</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>.06</td>
<td>.10</td>
<td>.58</td>
<td>.56</td>
</tr>
<tr>
<td>General Family Support</td>
<td>-.26</td>
<td>.06</td>
<td>-4.62</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

Independent Variable
SO Parental Rejection  .07  .08  .87  .38

In the regression of Sexual Orientation-Specific Parental Rejection predicting Self-Kindness, General Family Support was positively related to Self-Kindness (\( \beta = .22, t = 3.49, p = .001 \)). No other variables were related to Self-Kindness in this model. The variables in this model accounted for 4.80% of the variance in Self-Kindness (\( F (6, 317) = 2.67, p < .05 \)).

Regression of Sexual Orientation-Specific Parental Rejection (SO Parental Rejection) on Self-Kindness

Dependent Variable = Self-Kindness  \( F (6, 317) = 2.67, p < .05 \)

<table>
<thead>
<tr>
<th>Covariates</th>
<th>B</th>
<th>SE</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
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<td>1.40</td>
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<tr>
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<td>.74</td>
</tr>
<tr>
<td>Racial/Ethnic Status</td>
<td>.11</td>
<td>.12</td>
<td>.90</td>
<td>.37</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>.02</td>
<td>.11</td>
<td>.15</td>
<td>.88</td>
</tr>
<tr>
<td>General Family Support</td>
<td>.22</td>
<td>.06</td>
<td>3.49</td>
<td>.001</td>
</tr>
</tbody>
</table>

Independent Variable
SO Parental Rejection  .09  .09  .96  .34

In the regression of Sexual Orientation-Specific Parental Rejection predicting Common Humanity, General Family Support was positively related to Common Humanity (\( \beta = .15, t = \)).
No other variables were related to Common Humanity in this model. The model was not significant \(F(6, 317) = 2.05, p = .06\) in explaining variance in Common Humanity.

**Table 5**

*Regression of Sexual Orientation-Specific Parental Rejection (SO Parental Rejection) on Common Humanity*

<table>
<thead>
<tr>
<th>Dependent Variable = Common Humanity</th>
<th>(F(6, 317) = 2.05, p = .06)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covariates</strong></td>
<td><strong>B</strong></td>
</tr>
<tr>
<td>Age</td>
<td>.01</td>
</tr>
<tr>
<td>Gender Identity</td>
<td>.07</td>
</tr>
<tr>
<td>Racial/Ethnic Status</td>
<td>.18</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>-.01</td>
</tr>
<tr>
<td>General Family Support</td>
<td>.15</td>
</tr>
<tr>
<td><strong>Independent Variable</strong></td>
<td></td>
</tr>
<tr>
<td>SO Parental Rejection</td>
<td>-.04</td>
</tr>
</tbody>
</table>

In the regression of Sexual Orientation-Specific Parental Rejection predicting Mindfulness, Age was positively related to Mindfulness \(\beta = .02, t = 3.04, p = .002\). No other variables were related to Mindfulness in this model. The variables in this model accounted for 4.87% of the variance in Mindfulness \(F(6, 317) = 2.70, p < .05\).

**Table 6**

*Regression of Sexual Orientation-Specific Parental Rejection (SO Parental Rejection) on Mindfulness*

<table>
<thead>
<tr>
<th>Dependent Variable = Mindfulness</th>
<th>(F(6, 317) = 2.70, p &lt; .05)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covariates</strong></td>
<td><strong>B</strong></td>
</tr>
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</tr>
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</tr>
<tr>
<td>Racial/Ethnic Status</td>
<td>.01</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>.02</td>
</tr>
<tr>
<td>General Family Support</td>
<td>.06</td>
</tr>
<tr>
<td><strong>Independent Variable</strong></td>
<td></td>
</tr>
<tr>
<td>SO Parental Rejection</td>
<td>-.12</td>
</tr>
</tbody>
</table>
Mediation was not present as Sexual Orientation-Specific Parental Rejection (SO Parental Rejection) was not related to Self-Kindness, Common Humanity, or Mindfulness. Self-Kindness, Common Humanity, and Mindfulness were not indirectly related to Psychological Distress through their relationships with Sexual Orientation-Specific Parental Rejection. Therefore, the analysis was ended, and no further regression analyses were performed.

**Model 2**

In the second mediation analysis, Sexual Orientation-Specific Parental Rejection was entered as the independent variable, with age, racial/ethnic status (coded as person of color or white), sexual orientation (coded as plurisexual or monosexual), gender minority status (coded as gender diverse or cisgender) and General Family Support entered as covariates. First, these variables were regressed on Psychological Distress (Table 7). Next, three separate regression analyses were conducted regressing covariates and Sexual Orientation-Specific Parental Rejection onto each facet of Self-Coldness (Self Judgment, Isolation, Overidentification) (Tables 8-10).

In the first regression of Sexual Orientation-Specific Parental Rejection predicting Psychological Distress, age was negatively related to Psychological Distress ($\beta = -0.03, t = -4.93, p < .001$), gender was positively related to Psychological Distress ($\beta = 0.30, t = 2.90, p = .004$), and General Family Support was negatively related to Psychological Distress ($\beta = -0.26, t = -4.62, p < .001$). No other variables were related to Psychological Distress in this model. The variables in this model accounted for 24.17% of the variance in Psychological Distress ($F(6, 317) = 16.84, p < .001$).
Regression of Sexual Orientation-Specific Parental Rejection (SO Parental Rejection) on Psychological Distress (BSI)

**Dependent Variable = BSI**  
\[ F (6, 317) = 16.84, p < .001 \]

<table>
<thead>
<tr>
<th>Covariates</th>
<th>B</th>
<th>SE</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-.03</td>
<td>.01</td>
<td>-4.93</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Gender Identity</td>
<td>.30</td>
<td>.10</td>
<td>2.90</td>
<td>.004</td>
</tr>
<tr>
<td>Racial/Ethnic Status</td>
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<td>.11</td>
<td>1.52</td>
<td>.13</td>
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<tr>
<td>Sexual Orientation</td>
<td>.06</td>
<td>.10</td>
<td>.58</td>
<td>.56</td>
</tr>
<tr>
<td>General Family Support</td>
<td>-.26</td>
<td>.06</td>
<td>-4.62</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

**Independent Variable**  
SO Parental Rejection  
\[ .07 \quad .08 \quad .87 \quad .38 \]

In the regression of Sexual Orientation-Specific Parental Rejection predicting Self-Judgment, General Family Support was negatively related to Self-Judgment (\( \beta = -.26, t = 4.06, p = .001 \)). No other variables were related to Self-Judgment in this model. The variables in this model accounted for 7.03% of the variance in Self-Judgment (\( F (6, 317) = 4.00, p < .001 \)).

Regression of Sexual Orientation-Specific Parental Rejection (SO Parental Rejection) on Self-Judgment

**Dependent Variable = Self-Judgment**  
\[ F (6, 317) = 4.00, p < .001 \]

<table>
<thead>
<tr>
<th>Covariates</th>
<th>B</th>
<th>SE</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
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<td>-.52</td>
<td>.96</td>
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<td>-.13</td>
<td>.90</td>
</tr>
<tr>
<td>Sexual Orientation</td>
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<td>.12</td>
<td>.19</td>
<td>.85</td>
</tr>
<tr>
<td>General Family Support</td>
<td>.26</td>
<td>.07</td>
<td>4.06</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

**Independent Variable**  
SO Parental Rejection  
\[ .10 \quad .09 \quad -1.08 \quad .28 \]

In the regression of Sexual Orientation-Specific Parental Rejection predicting Isolation, Age was negatively related to Isolation (\( \beta = -.02, t = -2.67, p = .01 \)), and General Family Support was negatively related to Isolation (\( \beta = -.27, t = -4.07, p = .001 \)). No other variables were related
Running head: PERCEIVED PARENTAL ACCEPTANCE AND REJECTION, SELF-COMPASSION AND PSYCHOLOGICAL DISTRESS IN LGB-IDENTIFIED INDIVIDUALS
to Isolation in this model. The variables in this model accounted for 10.43% of the variance in Isolation ($F (6, 317) = 6.15, p < .001$).

Table 9

Regression of Sexual Orientation-Specific Parental Rejection (SO Parental Rejection) on Isolation

<table>
<thead>
<tr>
<th>Covariates</th>
<th>B</th>
<th>SE</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-.02</td>
<td>.01</td>
<td>-2.67</td>
<td>.01</td>
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<td>Gender Identity</td>
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<td>Sexual Orientation</td>
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<td>.12</td>
<td>.49</td>
<td>.63</td>
</tr>
<tr>
<td>General Family Support</td>
<td>-.27</td>
<td>.07</td>
<td>-4.07</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

In the regression of Sexual Orientation-Specific Parental Rejection (SO Parental Rejection) predicting Overidentification, Age was negatively related to Overidentification ($\beta = -.02, t = -2.88, p = .004$), and General Family Support was negatively related to Overidentification ($\beta = -.16, t = -2.43, p = .02$). No other variables were related to Overidentification in this model.

The variables in this model accounted for 5.28% of the variance in Overidentification ($F (6, 317) = 6.15, p < .001$).

Table 10

Regression of Sexual Orientation-Specific Parental Rejection (SO Parental Rejection) on Overidentification

<table>
<thead>
<tr>
<th>Covariates</th>
<th>B</th>
<th>SE</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-.02</td>
<td>.01</td>
<td>2.88</td>
<td>.004</td>
</tr>
<tr>
<td>Gender Identity</td>
<td>.02</td>
<td>.12</td>
<td>.14</td>
<td>.89</td>
</tr>
<tr>
<td>Racial/Ethnic Status</td>
<td>.01</td>
<td>.13</td>
<td>.11</td>
<td>.91</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>.01</td>
<td>.11</td>
<td>.06</td>
<td>.95</td>
</tr>
<tr>
<td>General Family Support</td>
<td>-.16</td>
<td>.06</td>
<td>-2.43</td>
<td>.02</td>
</tr>
</tbody>
</table>

Independent Variable
Mediation was not present as Sexual Orientation-Specific Parental Rejection was not related to Self-Judgment, Isolation, or Overidentification. Self-Judgment, Isolation, and Overidentification were not indirectly related to Psychological Distress through their relationships with Sexual Orientation-Specific Parental Rejection. Therefore, the analysis was ended, and no further regression analyses were performed.

**Model 3**

In the third mediation analysis, Sexual Orientation-Specific Parental Rejection was entered as the independent variable, with age, racial/ethnic status (coded as person of color or white), sexual orientation (coded as plurisexual or monosexual), gender minority status (coded as gender diverse or cisgender) and General Family Support entered as covariates. First, these variables were regressed on Proximal Minority Stress (Table 11). Next, three separate regression analyses were conducted regressing covariates and Sexual Orientation-Specific Parental Rejection onto each facet of Self-Compassion (Self-Kindness, Common Humanity, Mindfulness) (Tables 12-14).

In the first regression of Sexual Orientation-Specific Parental Rejection predicting Proximal Minority Stress, Sexual Orientation-Specific Parental Rejection was positively related to Proximal Minority Stress ($\beta = .27, t = 3.45, p = .001$), and age was negatively related to Proximal Minority Stress ($\beta = -.02, t = -3.14, p = .002$). No other variables were related to Proximal Minority Stress in this model. The variables in this model accounted for 6.35% of the variance in Proximal Minority Stress ($F (6, 317) = 3.58, p < .05$).

**Table 11**

*Regression of Sexual Orientation-Specific Parental Rejection (SO Parental Rejection) on Proximal Minority Stress (LGBIS)*
In the regression of Sexual Orientation-Specific Parental Rejection predicting Self-Kindness, General Family Support was positively related to Self-Kindness ($\beta = .22$, $t = 3.49$, $p = .001$). No other variables were related to Self-Kindness in this model. The variables in this model accounted for 4.80% of the variance in Self-Kindness ($F (6, 317) = 2.67$, $p < .05$).

### Table 12

**Regression of Sexual Orientation-Specific Parental Rejection (SO Parental Rejection) on Self-Kindness**

<table>
<thead>
<tr>
<th>Covariates</th>
<th>B</th>
<th>SE</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
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<td>.12</td>
<td>.34</td>
<td>.74</td>
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<td>Racial/Ethnic Status</td>
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<td>.12</td>
<td>.90</td>
<td>.37</td>
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<td>.02</td>
<td>.11</td>
<td>.15</td>
<td>.88</td>
</tr>
<tr>
<td>General Family Support</td>
<td>.22</td>
<td>.06</td>
<td>3.49</td>
<td>.001</td>
</tr>
</tbody>
</table>

In the regression of Sexual Orientation-Specific Parental Rejection predicting Common Humanity, General Family Support was positively related to Common Humanity ($\beta = .15$, $t = 2.28$, $p = .02$). No other variables were related to Common Humanity in this model. The model was not significant ($F (6, 317) = 2.05$, $p = .06$) in explaining variance in Common Humanity.
Table 13

Regression of Sexual Orientation-Specific Parental Rejection (SO Parental Rejection) on Common Humanity

<table>
<thead>
<tr>
<th>Covariates</th>
<th>B</th>
<th>SE</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
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<td>1.55</td>
<td>.12</td>
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<tr>
<td>Gender Identity</td>
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<td>.59</td>
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<td>Racial/Ethnic Status</td>
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<td>.16</td>
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<tr>
<td>Sexual Orientation</td>
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<td>.12</td>
<td>-.13</td>
<td>.90</td>
</tr>
<tr>
<td>General Family Support</td>
<td>.15</td>
<td>.06</td>
<td>2.28</td>
<td>.02</td>
</tr>
</tbody>
</table>

Independent Variable

SO Parental Rejection  
\(-.04 \pm .09\)  
\(-.41\)  
.68

In the regression of Sexual Orientation-Specific Parental Rejection predicting Mindfulness, Age was positively related to Mindfulness ($\beta = .02$, $t = 3.04$, $p = .003$). No other variables were related to Mindfulness in this model. The variables in this model accounted for 4.87% of the variance in Mindfulness ($F(6, 317) = 2.70, p < .05$).

Table 14

Regression of Sexual Orientation-Specific Parental Rejection (SO Parental Rejection) on Mindfulness

<table>
<thead>
<tr>
<th>Covariates</th>
<th>B</th>
<th>SE</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
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<td>.01</td>
<td>3.04</td>
<td>.003</td>
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<td>.13</td>
<td>.89</td>
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<tr>
<td>Racial/Ethnic Status</td>
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<td>.11</td>
<td>.09</td>
<td>.93</td>
</tr>
<tr>
<td>Sexual Orientation</td>
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<td>.10</td>
<td>.19</td>
<td>.85</td>
</tr>
<tr>
<td>General Family Support</td>
<td>.06</td>
<td>.06</td>
<td>1.11</td>
<td>.27</td>
</tr>
</tbody>
</table>

Independent Variable

SO Parental Rejection  
\(-.12 \pm .08\)  
\(-1.48\)  
.14

Mediation was not present as Sexual Orientation-Specific Parental Rejection was not related to Self-Kindness, Common Humanity, or Mindfulness. Self-Kindness, Common Humanity, and Mindfulness were not indirectly related to Proximal Minority Stress through their...
Model 4

In the fourth mediation analysis, Sexual Orientation-Specific Parental Rejection was entered as the independent variable, with age, racial/ethnic status (coded as person of color or white), sexual orientation (coded as plurisexual or monosexual), gender minority status (coded as gender diverse or cisgender) and General Family Support entered as covariates. First, these variables were regressed on Proximal Minority Stress (Table 15). Next, three separate regression analyses were conducted regressing covariates and Sexual Orientation-Specific Parental Rejection onto each facet of Self-Coldness (Self Judgment, Isolation, Overidentification) (Tables 16-18).

In the first regression of Sexual Orientation-Specific Parental Rejection predicting Proximal Minority Stress, Sexual Orientation-Specific Parental Rejection was positively related to Proximal Minority Stress ($\beta = .27, t = 3.45, p = .001$), and age was negatively related to Proximal Minority Stress ($\beta = -.02, t = -3.14, p = .002$). No other variables were related to Proximal Minority Stress in this model. The variables in this model accounted for 6.35% of the variance in Proximal Minority Stress ($F(6, 317) = 3.58, p < .05$).

Table 15

Regression of Sexual Orientation-Specific Parental Rejection (SO Parental Rejection) on Proximal Minority Stress (LGBIS)

<table>
<thead>
<tr>
<th>Covariates</th>
<th>B</th>
<th>SE</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
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<td>.01</td>
<td>-3.14</td>
<td>.002</td>
</tr>
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<td>.10</td>
<td>-1.18</td>
<td>.24</td>
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<td>.25</td>
<td>.81</td>
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<tr>
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<td>.10</td>
<td>.42</td>
<td>.67</td>
</tr>
<tr>
<td>General Family Support</td>
<td>.05</td>
<td>.06</td>
<td>-.83</td>
<td>.40</td>
</tr>
</tbody>
</table>
Independent Variable

| SO Parental Rejection | .27 | .08 | 3.45 | .001 |

In the regression of Sexual Orientation-Specific Parental Rejection predicting Self-Judgment, General Family Support was negatively related to Self-Judgment ($\beta = -.26, t = -4.06, p < .001$). No other variables were related to Self-Judgment in this model. The variables in this model accounted for 7.03% of the variance in Self-Judgment ($F(6, 317) = 4.00, p < .001$).

**Table 16**

*Regression of Sexual Orientation-Specific Parental Rejection (SO Parental Rejection) on Self-Judgment*

<table>
<thead>
<tr>
<th>Covariates</th>
<th>B</th>
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<th>t</th>
<th>p</th>
</tr>
</thead>
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<td>0.01</td>
<td>-1.85</td>
<td>.07</td>
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<tr>
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<td>0.12</td>
<td>-0.05</td>
<td>.96</td>
</tr>
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<td>0.13</td>
<td>-0.13</td>
<td>.90</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>0.02</td>
<td>0.12</td>
<td>0.19</td>
<td>.85</td>
</tr>
<tr>
<td>General Family Support</td>
<td>-0.26</td>
<td>0.07</td>
<td>-4.06</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

In the regression of Sexual Orientation-Specific Parental Rejection predicting Isolation, age was negatively related to Isolation ($\beta = -.02, t = -2.67, p = .01$), and General Family Support was negatively related to Isolation ($\beta = .27, t = 4.07, p < .001$). No other variables were related to Isolation in this model. The variables in this model accounted for 10.43% of the variance in Isolation ($F(6, 317) = 6.15, p < .001$).

**Table 17**

*Regression of Sexual Orientation-Specific Parental Rejection (SO Parental Rejection) on Isolation*

<table>
<thead>
<tr>
<th>Covariates</th>
<th>B</th>
<th>SE</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-0.02</td>
<td>0.01</td>
<td>-2.67</td>
<td>.01</td>
</tr>
<tr>
<td>Gender Identity</td>
<td>0.13</td>
<td>0.12</td>
<td>1.03</td>
<td>.30</td>
</tr>
</tbody>
</table>
In the regression of Sexual Orientation-Specific Parental Rejection predicting Overidentification, age was negatively related to Overidentification ($\beta = -0.02$, $t = -2.88$, $p = .004$), and General Family Support was negatively related to Overidentification ($\beta = -0.16$, $t = -2.43$, $p = .02$). No other variables were related to Overidentification in this model. The variables in this model accounted for 5.28% of the variance in Overidentification ($F (6, 317) = 2.94$, $p < .05$).

**Table 18**

*Regression of Sexual Orientation-Specific Parental Rejection (SO Parental Rejection) on Overidentification*

<table>
<thead>
<tr>
<th>Covariates</th>
<th>B</th>
<th>SE</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-0.02</td>
<td>0.01</td>
<td>-2.88</td>
<td>.004</td>
</tr>
<tr>
<td>Gender Identity</td>
<td>0.02</td>
<td>0.12</td>
<td>0.14</td>
<td>.89</td>
</tr>
<tr>
<td>Racial/Ethnic Status</td>
<td>0.01</td>
<td>0.13</td>
<td>0.11</td>
<td>.91</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>0.01</td>
<td>0.11</td>
<td>0.06</td>
<td>.95</td>
</tr>
<tr>
<td>General Family Support</td>
<td>-0.16</td>
<td>0.06</td>
<td>-2.43</td>
<td>.02</td>
</tr>
</tbody>
</table>

**Independent Variable**

SO Parental Rejection $-0.05$, $0.09$, $-0.57$, $0.57$

Mediation was not present as Sexual Orientation-Specific Parental Rejection was not related to Self-Judgment, Isolation, or Overidentification. Self-Judgment, Isolation, and Overidentification were not indirectly related to Proximal Minority Stress through their relationships with Sexual Orientation-Specific Parental Rejection. Therefore, the analysis was ended, and no further regression analyses were performed.
Exploratory Analyses

Independent samples t-tests were performed to evaluate whether participants’ level of General Family Support, Sexual Orientation-Specific Parental Rejection, Psychological Distress, Self-Compassion, Self-Coldness, and Proximal Minority Stress differed by sexual orientation (coded as monosexual or plurisexual). Results indicated that there was no significant difference between plurisexual individuals and monosexual individuals on General Family Support \[t(322) = 1.44, p = .15\], Sexual Orientation-Specific Parental Rejection \[t(322) = -.55, p = .57\], Proximal Minority Stress \[t(322) = -.37, p = .71\], Psychological Distress \[t(322) = -2.09, p = .06\], level of Self-Compassion \[t(322) = .26, p = .80\], and level of Self-Coldness \[t(322) = -.90, p = .37\] (Table 19).

<table>
<thead>
<tr>
<th>Measures</th>
<th>Plurisexual M</th>
<th>Plurisexual SD</th>
<th>Monosexual M</th>
<th>Monosexual SD</th>
<th>t (322)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Family Support</td>
<td>.75</td>
<td>.95</td>
<td>3.91</td>
<td>.96</td>
<td>1.44</td>
<td>.15</td>
</tr>
<tr>
<td>SO Parental Rejection</td>
<td>2.11</td>
<td>.67</td>
<td>2.07</td>
<td>.62</td>
<td>-.55</td>
<td>.57</td>
</tr>
<tr>
<td>Psychological Distress</td>
<td>2.65</td>
<td>.81</td>
<td>2.42</td>
<td>1.01</td>
<td>-2.09</td>
<td>.06</td>
</tr>
<tr>
<td>Self-Compassion</td>
<td>2.93</td>
<td>.70</td>
<td>2.96</td>
<td>.80</td>
<td>.26</td>
<td>.80</td>
</tr>
<tr>
<td>Self-Coldness</td>
<td>3.64</td>
<td>.75</td>
<td>3.54</td>
<td>.95</td>
<td>-.90</td>
<td>.37</td>
</tr>
<tr>
<td>Proximal Minority Stress</td>
<td>2.40</td>
<td>.79</td>
<td>2.37</td>
<td>.77</td>
<td>-.37</td>
<td>.71</td>
</tr>
</tbody>
</table>

A one-way between subjects ANOVA was conducted to explore change in parental acceptance over time related to participants’ sexual orientation (coded into three groups: increased parental acceptance over time, no change in parental acceptance over time, and decreased parental acceptance of sexual orientation over time). These groups were compared on levels of Psychological Distress, Self-Compassion, Self-Coldness, and Proximal Minority Stress. Results indicated that there was no significant difference between participants who reported
increased parental acceptance, no change, and decreased parental acceptance over time on Self-Compassion $[F(2, 318) = 3.00, p = .05]$, Psychological Distress $[F(2, 318) = 2.14, p = .12]$, Self-Coldness $[F(2, 318) = 2.48, p = .09]$, and Proximal Minority Stress $[F(2, 318) = 5.30, p = .01]$. There was a significant effect of change in parental acceptance over time on Proximal Minority Stress at the $p < .05$ level for the three conditions $[F(2, 318) = 5.30, p = .01]$. Equal variances were not assumed, and a Games-Howell correction indicated that there were no significant differences between the mean scores for decreased acceptance, no change, and increased parental acceptance over time related to sexual orientation on Proximal Minority Stress (Table 20).

**Table 20**

One-Way Analyses of Variance Table for Change in Parental Acceptance of Sexual Orientation Over Time

<table>
<thead>
<tr>
<th>Measures</th>
<th>Increased $M$</th>
<th>Increased $SD$</th>
<th>No Change $M$</th>
<th>No Change $SD$</th>
<th>Decreased $M$</th>
<th>Decreased $SD$</th>
<th>$F$ (2,318)</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Compassion</td>
<td>2.96</td>
<td>.68</td>
<td>2.96</td>
<td>.77</td>
<td>2.49</td>
<td>.56</td>
<td>3.00</td>
<td>.05</td>
</tr>
<tr>
<td>Proximal Minority Stress</td>
<td>2.26</td>
<td>.71</td>
<td>2.43</td>
<td>.78</td>
<td>2.90</td>
<td>1.11</td>
<td>5.30</td>
<td>.01</td>
</tr>
<tr>
<td>Psychological Distress</td>
<td>2.56</td>
<td>.92</td>
<td>2.56</td>
<td>.83</td>
<td>3.04</td>
<td>1.06</td>
<td>2.14</td>
<td>.12</td>
</tr>
<tr>
<td>Self-Coldness</td>
<td>3.54</td>
<td>.81</td>
<td>3.63</td>
<td>.82</td>
<td>4.02</td>
<td>.61</td>
<td>2.48</td>
<td>.09</td>
</tr>
</tbody>
</table>

A one-way between subjects ANOVA was conducted to compare levels of family religiosity on General Family Support, Sexual Orientation-Specific Parental Rejection, Psychological Distress, Self-Compassion, Self-Coldness, and Proximal Minority Stress. Levels of family religiosity were coded into three groups: “not at all religious” (low), “somewhat religious” (medium), and “very religious” (high). Results indicated that there was no significant difference in participants who rated their family religiosity as low, medium, and high on Psychological Distress $[F(4, 319) = 1.14, p = .34]$, Self-Compassion $[F(2, 321) = 2.49, p = .08]$, Self-Coldness $[F(2, 321) = .69, p = .50]$, and Proximal Minority Stress $[F(2, 321) = 1.28, p = .28]$. 


There was a significant effect of family religiosity on General Family Support at the $p < .05$ level for the three conditions [$F(2, 321) = 6.04, p = .003$]. Equal variances were not assumed and so the Games-Howell correction was used, which indicated that there were significant differences between the mean scores for the low religiosity group, and the high religiosity group on General Family Support. The medium religiosity group did not significantly differ from the low and high religiosity groups on General Family Support.

There was a significant effect of family religiosity on Sexual Orientation-Specific Parental Rejection at the $p < .05$ level for the three conditions [$F(2, 321) = 19.32, p < .001$]. Equal variances were not assumed and so the Games-Howell correction was used, which indicated that there were significant differences between the mean scores for the low religiosity group and the high religiosity group on Sexual Orientation-Specific Parental Rejection. Additionally, there were significant differences between the mean scores for the medium religiosity group and the high religiosity group on Sexual Orientation-Specific Parental Rejection. The medium religiosity group did not significantly differ from the low religiosity group on Sexual Orientation-Specific Parental Rejection (Table 21).

**Table 21**

*One-Way Analyses of Variance Table for Levels of Family Religiosity*

<table>
<thead>
<tr>
<th>Measures</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
<th>$F (2,321)$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$M$</td>
<td>$SD$</td>
<td>$M$</td>
<td>$SD$</td>
<td>$M$</td>
</tr>
<tr>
<td>Psychological Distress</td>
<td>2.52</td>
<td>.84</td>
<td>2.55</td>
<td>.87</td>
<td>2.72</td>
</tr>
<tr>
<td>Self-Compassion</td>
<td>3.01</td>
<td>.78</td>
<td>2.98</td>
<td>.64</td>
<td>2.80</td>
</tr>
<tr>
<td>Self-Coldness</td>
<td>3.59</td>
<td>.86</td>
<td>3.56</td>
<td>.73</td>
<td>3.69</td>
</tr>
<tr>
<td>Proximal Minority Stress</td>
<td>2.35</td>
<td>.75</td>
<td>2.34</td>
<td>.81</td>
<td>2.50</td>
</tr>
<tr>
<td>General Family Support</td>
<td>3.98</td>
<td>.87</td>
<td>3.71</td>
<td>.96</td>
<td>3.57</td>
</tr>
<tr>
<td>SO Parental Rejection</td>
<td>1.92</td>
<td>.55</td>
<td>2.05</td>
<td>.59</td>
<td>2.42</td>
</tr>
</tbody>
</table>
Discussion

This study sought to examine the relationship between general family support and sexual orientation-specific parental rejection, self-compassion, proximal minority stress, and psychological distress for LGB individuals. In the current sample, it was found that more general family support was associated with lower psychological distress, and higher levels of self-kindness and common humanity. People who reported their parents were more rejecting regarding their LGB status reported higher levels of proximal stress. After controlling for general family support, sexual orientation-specific parental rejection did not predict psychological distress or self-compassion. The current study adds to the literature by demonstrating the importance of family relationships in the development of self-compassion, with general family support predicting the self-kindness and common humanity facets of self-compassion and negatively predicting the self-judgment, isolation, and overidentification facets of self-coldness. The results of the study extend the literature related to the impacts of parental support and rejection for LGB individuals, emphasizing the role that family relationships may play in the psychological health and well-being of this population.

Family Support, Rejection, and Psychological Distress

The results of the present study suggest that having general family support is associated with lower psychological distress. Surprisingly, sexual orientation-specific parental rejection was not found to be associated with psychological distress in the mediation models of the present study. This is one of a few studies that has examined the relationship between family support or rejection and psychological distress in LGB individuals. This finding adds to the literature by
highlighting the importance of general family support as a protective factor against psychological distress in an adult sample of LGB individuals.

The current study further supports findings in the literature of the association between family support or rejection and mental health outcomes (Baumeister & Leary, 1995; Bowlby, 1973; Rohner, 1986, 2018). Previous research has found associations between parent-child relationships and the psychological health and well-being of adolescents and young adults broadly (Holahan et al., 1994; Homma & Saewyc, 2007; Rohner et al., 2003; Savin-Williams, 1989; Shilo & Savaya, 2011; Steinberg, 2001), and that supportive relationships with parents are linked to positive health outcomes for LGB individuals (Bregman et al., 2013; Floyd et al., 1999). Additionally, previous research has found that general family support can provide a buffer against the association between sexual minority status and psychological distress (D’Augelli, 2003; Diamond et al., 2011; Eisenberg & Resnick, 2006). Multiple studies have found that sexual minority children who report higher levels of general family support endorse lower rates of psychopathology and suicidal tendencies (D’Augelli, 2002; Feinstein et al., 2014; Hershberger & D’Augelli, 1995; Needham & Austin, 2010; Ryan et al., 2010; Savin-Williams, 1989). The current study lends further support for the association between general family support and psychological distress.

Several mechanisms may help to explain why general family support is associated with lower psychological distress for LGB individuals. General family support involves caring and affectionate behaviors from parents and caregivers, such as spending quality time, providing advice and assistance, and showing interest in their children's daily activities (Rohner et al., 2003). Such parental behaviors may prove to be protective for LGB individuals, as affectionate and supportive behaviors from parents and caregivers may provide a sense of security and
stability early in life that continues to benefit LGB individuals into the future. A baseline of
general family support may serve as a refuge against unsupportive societal attitudes and
behaviors that LGB individuals may experience related to their minority sexual identity. Indeed,
research suggests that general family support has been found to function as a protective factor
against low levels of sexual orientation-based discrimination (e.g., verbal comments) for LGB
youth (Hershberger & D'Augelli, 1995). While many studies have focused on samples of LGB
youth, the current study found a similar relationship between general family support and
psychological distress in an adult sample of LGB individuals. This finding suggests that the
benefits of general family support may serve as a protective factor against psychological distress
that can extend into adulthood.

Considering that LGB individuals report higher rates of negative mental health outcomes
compared to their heterosexual counterparts (Meyer, 2003), it is particularly important to
examine the associations between family relationships and health outcomes in the context of
LGB individuals' experiences. The findings of the current study suggest that it will be helpful to
continue to explore specific ways in which general family support is connected to psychological
distress. It will also be important to continue to explore ways in which parents and caregivers can
best support their LGB children given that general family support can serve as a protective factor
against negative health outcomes in this population. Additionally, it will be important to continue
to explore specific ways to support parents and caregivers of LGB individuals that may be
accessing services, such as family therapy or parent support groups. Further exploration into
specific ways that parents and caregivers can extend support to their LGB children could be
incorporated into family education and interventions if families are accessing such outside
supports. While identifying and enhancing supportive parental behaviors may not always be
possible (e.g., in the case of families who are unwilling or unable to adjust their parenting practices), better understanding the relationship between general family support and psychological distress may still have treatment implications for an LGB individual seeking therapy. For example, an LGB individual may benefit from discussing ways in which they felt supported or unsupported throughout life, and how early childhood experiences as well as more recent experiences with caregivers may contribute to current distress.

In the current sample, sexual orientation-specific parental rejection was correlated with psychological distress, with greater rejection being associated with more distress. In this study, sexual orientation-specific parental rejection was assessed by asking about how parents responded to participants when they came out. This correlation suggests that having parents respond to coming out in a supportive manner is associated with lower psychological distress later; however, sexual orientation-specific parental rejection was not a predictor of distress once general family support was accounted for. It may be that parents’ specific reactions to coming out are not as impactful in terms of later psychological distress as their overall supportiveness and the quality of the parent-child relationship. Of note, general family support and sexual orientation-specific parental rejection were highly correlated (r=-.56) so the lack of unique prediction by sexual orientation-specific parental rejection may have been due to the high degree of overlap between these two types of support.

This finding may reflect methodological issues. Sexual orientation-specific parental rejection is complicated to assess. Attitudes of sexual orientation-specific parental rejection or acceptance may change over time; the measure used in this study inquired about a specific point in time. Sexuality-specific parental rejection or acceptance can also differ across each parent or caregiver, and the impact of the rejection/acceptance by a given parent may vary depending on
the closeness or importance of that relationship. Additionally, it is difficult to determine whether participants’ responses may be affected by a recency effect or retroactive bias, such that their recall of experiences with sexual orientation-specific parental rejection may be impacted by particularly salient or more recent experiences with parents or caregivers.

Additionally, it may be that our chosen measure of sexual orientation-specific parental rejection did not fully tap into the connection between sexual orientation-specific parental rejection and psychological distress, as we chose to focus on sexual orientation-specific parental rejection at the time of coming out. The focus on sexual orientation-specific rejection at the time of coming out was chosen to attempt to capture early experiences of sexual orientation-specific rejection from parents and caregivers, however, assessing rejection in this manner may not represent participants’ experiences of their parents or caregivers as rejecting or accepting broadly. We were also unable to explore the experiences of LGB individuals who had not come out to parents or caregivers given this measurement strategy. It will be important to explore LGB individuals’ preconceived notions regarding whether their family members will be accepting or rejecting regarding coming out, as this may be further related to psychological distress.

Finally, the sample was largely composed of individuals who identified as gender diverse. While participants were encouraged to keep their sexual orientation in mind when answering questions about parent’s responses to them coming out, it may be that participants were unable to disentangle their experiences related to their minority gender identity versus their sexual orientation. As such, it may be that the chosen measure of parental rejection did not solely reflect experiences and distress related to participants’ sexual orientation.

**Family Support, Rejection, and Self-Compassion**
The results of the present study suggest that having more general family support is associated with having greater self-compassion. This was true across two positive facets of self-compassion, self-kindness and common humanity. General family support was associated with reporting lower levels of the negative facets of self-coldness, self-judgment, isolation, and overidentification. This is the only study of which we are aware that has examined the relationship between general family support and specific facets of self-compassion in an adult sample of LGB individuals. This study extends the current literature by providing evidence for an association between family relationships and self-compassion in this population. This finding adds to the literature by providing evidence of an association between supportive parent/caregiver behaviors and the development of self-compassion, suggesting that general family support is important in the development of self-compassion, and that the quality of family relationships influences self-compassion.

Several mechanisms may help to explain why general family support predicts self-compassion for LGB individuals. One perspective that seeks to explain the development of compassion is based on evolutionary psychology and social mentality theory (Gilbert, 2014). According to this view, compassion is a dynamic, reciprocal process between self and others that can be directed from self-to-other, other-to-self, and self-to-self. This perspective suggests that compassion has evolved from a mammalian infant-caring motivation to be attentive to the distress and needs of others and help alleviate their distress. Over time, this mammalian motivation has become more complex and has been enhanced by social intelligences such as mentalization, empathic awareness, and intentional action. This perspective posits that mammals have a basic need to respond to signals of suffering, as this response process is implicated in all motives, including feeding, sexuality, harm avoidance, and competing for resources. This
perspective also suggests that the potential for compassionate behavior can be either enhanced or inhibited based on the situation, which can increase or decrease the likelihood of activating the motive. However, even if individuals improve their facilitators of compassion, it may not necessarily result in compassionate behavior if there are inhibitors present (Gilbert & Mascaro, 2017). For example, behaviors such as discrimination based on in-group and out-group biases or separation into groups can reduce the likelihood of activating the motive and thereby affect compassionate responding (Keller & Pfattheicher, 2013; Preston, 2013; van Kleef et al., 2008). It will be important to continue to explore potential enhancers or inhibitors of self-compassion that may relate to LGB individuals, given the likelihood that they will encounter negative messages and minority stressors that could negatively impact self-compassionate ways of responding.

Another potential mechanism for the association between general family support and self-compassion relates to fear of compassion. Previous research indicates that individuals can experience fears, blocks, and resistances to compassion that inhibit their ability to act with kindness and empathy. Fears of compassion involve avoiding or responding fearfully to compassion in any of the three directions: self-to-other, other-to-self, and self-to-self. This fear may arise from viewing compassion as weakness, fearing rejection, or worrying that extending compassion will be seen as manipulative. Blocks to compassion refer to circumstances in which an individual wants to show kindness but is unable to do so because of a lack of time, resources, or insight into the causes of suffering. In contrast, resistances to compassion arise from an individual's belief that showing compassion is pointless or a focus on fulfilling their own needs. Previous literature has found that fear of compassion is associated with psychopathology and negative mental health outcomes, including depression, shame, and self-criticism (Kirby et al., 2019). For LGB individuals, it is possible that a fear of compassion may develop out of fears of
rejection from family members. Early experiences of rejection may contribute to fears of compassion, such that an LGB individual may experience difficulty extending compassion toward themselves in the future.

Another potential mechanism for the association between general family support and self-compassion relates to attachment experiences. The findings of the current study support the notion that the stage for self-compassionate attitudes may be set early on in life through attachment experiences with caregivers (Gilbert, 2019) and that affiliative or punitive behaviors from early caregivers may strengthen or interrupt secure attachments (Bowlby, 1969; Gilbert, 2014; Porges, 2007; Thayer & Lane, 2000; Yaman et al., 2010). Our finding that general family support is positively associated with facets of self-compassion supports the idea that self-compassionate attitudes may be influenced by the quality of family relationships. For example, affiliative behaviors from early caregivers may strengthen a secure caregiver-child attachment as well as provide a model for extending compassion toward oneself and others (Bowlby, 1969; Gilbert, 2014; Yaman et al., 2010). Conversely, punitive behaviors from early caregivers may interrupt a secure caregiver-child attachment, which may then contribute to a “fear of compassion” and difficulty accessing and utilizing self-compassionate attitudes (Porges, 2007; Thayer & Lane, 2000).

The results of the study did not support the notion that sexual orientation-specific parental rejection is associated with self-compassion. Our finding that sexual orientation-specific parental rejection and self-compassion are not related may reflect the idea that ways of responding to oneself with self-compassion may develop out of early childhood experiences, such that self-compassionate attitudes may have developed prior to an LGB individual coming to understand their sexual orientation.
The findings of the current study suggest that it will be helpful to continue to explore specific ways in which the quality of family relationships influences the development of self-compassion. It will be important to continue to explore ways in which parents and caregivers can promote the development of self-compassion given their potential protective effects broadly and for LGB individuals specifically. While identifying ways in which parents and caregivers can promote the development of self-compassion may be more or less possible depending on the family characteristics, better understanding the relationship between family relationships and the development of self-compassion may provide further ideas for interventions that can benefit individuals who may not have had the opportunity to develop self-compassion in the context of experiences with parents and caregivers. It is possible that interventions incorporating self-compassion may be less beneficial if an individual has developed a “fear of compassion” stemming from early experiences with parents and caregivers. Future research would benefit from further study into ways that self-compassion-focused interventions may need to be adapted to provide greater benefits for individuals who experience a “fear of compassion”.

**Family Support and Proximal Minority Stress**

The results of the current study suggest that sexual orientation-specific parental rejection is positively associated with proximal minority stress, such that higher ratings of sexual orientation-specific parental rejection were associated with higher ratings of proximal minority stress. This is one of a few studies that has examined this relationship in LGB individuals. The current study adds to previous research by discovering an association between sexual orientation-specific parental rejection and proximal minority stress in an adult population of LGB individuals. These results provide evidence to suggest that sexual minority individuals may internalize negative rejection behaviors from parents and caregivers, leading them to mistakenly
view these experiences as a reflection of their own self-worth and value, which may contribute to fears of rejection from others.

The adoption of societal prejudices against a stigmatized group by a member of that group, despite their personal affiliation with the group, is known as internalized stigma (Herek, 2009) or “internalized heterosexism” as related to sexual minority individuals. According to the Minority Stress Theory, internalized heterosexism is considered a proximal minority stress process that can lead to negative health outcomes for LGB individuals, such as low self-esteem and increased sensitivity to rejection (Dyar et al., 2016; Pineles et al., 2006; Uysal et al., 2010). Additionally, previous research has found associations between higher parental rejection and higher levels of internalized heterosexism (Costa et al., 2013), associations between experiences of perceived parental rejection, proximal minority stress, and suicidal ideation (Tan et al., 2019), and that parents' stigmatizing attitudes towards sexual minorities can influence the development of heterosexist attitudes in children (O’Bryan et al., 2004). Family acceptance and rejection has also been suggested to play a crucial role in the development of self-efficacy, self-confidence, and relational security (Pearson & Wilkinson, 2013; D’Augelli et al., 2020), which may assist LGB individuals in combating societal stigma associated with their sexual orientation. The current study adds to existing literature suggesting that sexual minority individuals may develop negative attitudes towards themselves due to the stigmatizing attitudes they encounter in their family environments, or conversely, may be protected against developing internalized heterosexist attitudes through experiencing supportive attitudes from family members regarding their minority sexual identity.

One potential mechanism for the association between sexual orientation-specific parental rejection and proximal minority stress may be related to an individual’s self-identity. Proximal
minority stressors can pose a threat to an individual’s self-identity and result in less effective coping strategies in the face of distal minority stressors (e.g., discrimination, prejudicial attitudes). At an early age, a sexual minority child may internalize negative messages from parents and caregivers regarding their minority sexual identity, contributing to a sense of shame or disapproval at one’s own sexual minority identity, also known as internalized heterosexism. These early negative messages can be difficult to combat, given that they are occurring during a child’s formative years, and can become integrated into the way that the child views themselves and their sexual minority status, even into adulthood.

Having a supportive family can provide a foundation that helps LGB individuals manage challenges and stressors that they encounter throughout their lives. According to Pearson and Wilkinson (2013), parental love and support play a crucial role in developing self-confidence and relational security, which can help LGB youth combat the stigmatizing societal attitudes associated with their LGB status. Doty et al. (2010) have also shown that parental acceptance of their child's minority sexual identity can mitigate the negative effects of sexual orientation-related stress. Interestingly, Doty et al. (2010) found that general parental support did not have the same protective effect, suggesting that parent-child relationships are particularly beneficial when the acceptance provided is related to the specific context of the stressor (e.g., sexual orientation-based acceptance in the face of sexual orientation-based discrimination).

Family relationships play a crucial role in a child's identity formation, influencing the development of self-esteem and self-efficacy (D’Augelli et al., 2020). For LGB individuals, identity development and integration can be especially challenging due to the negative messages they receive from society about their sexual minority identity. Given the threats posed by societal
stigma and discrimination, positive identity development can serve as a protective factor against proximal stressors such as internalized heterosexism and expectations of rejection from others.

Another potential mechanism for the association between sexual orientation-specific parental rejection and proximal minority stress may be related to experiences of rejection. Experiences of rejection from parents and caregivers during childhood may lead to internalized heterosexism for sexual minority children. Early experiences of rejection may cause an LGB individual to perceive their sexual orientation in a negative light, resulting in internalized heterosexist attitudes. Such experiences may shape the individual's thoughts about their own identity, leading to shame and disapproval of themselves and their sexual minority status. An LGB individual may perceive experiences of rejection from parents or caregivers, which may contribute to the belief that their sexual minority identity is not fully accepted and, therefore, they themselves are not fully accepted. These perceptions can be particularly harmful during developmental processes, as children and adolescents often rely on parents or caregivers as a foundation for exploring their own identity and experiences (Baumeister & Leary, 1995; Bowlby, 1973; Rohner, 1975, 1986, 2018). Additionally, parents may have a positive relationship with their LGB child overall, yet avoid discussing their child's sexual orientation in a way that conveys shame. Although parents may be accepting and supportive of their LGB child, they may still fear for their child's safety due to societal stigma and prejudice, causing them to act in ways that their child perceives as rejecting. Such perceptions of parental or caregiver rejection may also lead to the expectation of rejection from others regarding their sexual orientation, which may contribute to concealing one’s sexual orientation and not seeking out supportive networks that could buffer against negative outcomes associated with minority stress.
Another potential mechanism for the association between sexual orientation-specific parental rejection and proximal minority stress may be related to rejection sensitivity. Rejection Sensitivity has been defined as a cognitive-affective processing disposition that includes anxiously expecting, readily perceiving, and intensely reacting to rejection (Downey & Feldman, 1996). Previous research has found that higher rates of rejection sensitivity are associated with parental rejection and higher rates of withdrawal behaviors in response to rejection in an adolescent sample (Rudolph & Zimmer, 2014). While rejection sensitivity may serve to protect the individual in some ways, it may ultimately develop as a response to rejecting attitudes that exist within the individual's family system. Previous research has posited that early experiences of rejection related to sexual orientation can result in sexual minority individuals developing anxious expectations that others will reject them because of their sexual minority status (Feinstein, 2020). For instance, if a sexual minority adolescent receives rejection from their parents upon disclosing their sexual minority status, they may expect similar negative reactions from others. An LGB individual then may engage in behaviors such as concealing their sexual orientation, developing beliefs that overestimate the likelihood of rejection, and experience increased anxiety regarding the potential of being rejected by others.

General family support was not found to be related to proximal minority stress. It may be that while general family support provides protective factors, that it does not guard against proximal minority stress, given that behaviors of general family support are not necessarily focused on their LGB children’s experiences as a sexual minority. For example, an LGB individual may receive care and affection from their parents or caregivers, but still may be fearful of or experience rejection from parents related to their sexual orientation. Such an experience could motivate the LGB individual to conceal their sexual orientation, which then
may contribute to internalized heterosexism. Indeed, previous research has found that parents’ stigmatizing attitudes towards sexual minorities can influence the development of heterosexist attitudes in children (O’Bryan et al., 2004), which may extend to the development of internalized heterosexism. It is also possible that parents or caregivers may display behaviors of general family support, while at the same time expressing attitudes that are subtly or overtly rejecting of their LGB child’s sexual orientation, thereby potentially contributing to proximal minority stress (e.g., acceptance concerns, concealment, internalized heterosexism).

It will be important to continue to explore the relationship between sexual orientation-specific parental rejection and proximal minority stress, as proximal minority stressors such as experiences of rejection and internalized heterosexist attitudes can discourage LGB individuals from seeking out opportunities to connect with others. LGB individuals who conceal their sexual orientation may struggle to connect with other LGB peers, depriving them of social support and opportunities to interact genuinely with others. Connecting with other LGB peers has been found to be a protective factor for LGB individuals, especially those who have faced rejection and a lack of support from family members (Goldfried & Goldfried, 2001; Weeks et al., 2001). The current study adds to previous literature suggesting that parents and family members who react negatively to their child's LGB identity can cause negative consequences for an LGB individual, including internalized heterosexist attitudes that can extend into adulthood.

Given this finding, it will be important to continue to explore ways in which sexual orientation-specific parental rejection relates to proximal minority stress, as this may represent a potential treatment target for parents and caregivers of LGB individuals. Better understanding the relationship between sexual orientation-specific rejection and proximal minority stress may also represent a treatment target at the individual level. For example, LGB individuals who have
experienced sexual orientation-specific parental rejection may benefit from identifying and challenging negative messages regarding their sexual orientation that they may have received from family members throughout life and upon coming out.

**Additional Factors Explored**

Our exploratory analyses aimed to examine possible differences in experiences of general family support and sexual orientation-specific rejection, self-compassion, proximal minority stress, and psychological distress between individuals who identified as plurisexual versus monosexual. Individuals who identify as plurisexual, including bisexual, pansexual, and demisexual, may face specific challenges related to their sexual orientation that are not necessarily shared by those who identify as monosexual, such as gay or lesbian. Research has shown that bisexual individuals, in particular, are often subject to negative stereotypes and rejection, which can contribute to negative health outcomes (Dyar et al., 2014). As a result of stigma and rejection, plurisexual individuals may experience negative health outcomes such as alcohol use disorders (Sandfort, 2001) and may conceal or deny their sexual orientation (Balsam & Mohr, 2007), which can further limit their access to social support from other GSM-identified peers, particularly if they are cast out from their family systems. Results indicated that there were no significant differences between plurisexual and monosexual participants across these areas. These results suggest that whether an individual is plurisexual or monosexual may not be relevant to the type of family support they receive, how accepting their parents are, or their own development of distress or self-compassion. Thus, being bisexual versus gay/lesbian may not be particularly salient in terms of how parents react to their child’s coming out, or to the impact of coming out around psychological distress or self-compassion. It may also be that the included
measures did not fully tap into unique stressors and negative health outcomes for plurisexual individuals, such that their experiences were not able to be fully captured in the current study.

Additionally, we sought to explore ways in which change in parental sexual orientation-specific acceptance over time may be related to psychological distress, proximal minority stress, and self-compassion. This question is important because, for example, some parents may have a negative initial reaction, but may become more accepting over time. A comparison of individuals who reported their parents became more accepting, less accepting, or stayed the same found no differences in levels of psychological distress, self-compassion, and or proximal minority stress. It is possible that initial reaction by parents is not mitigated by change over time. Proximal minority stressors may have developed early on in conjunction with initial rejecting attitudes of family members, such that increased acceptance later on does not fully mitigate negative outcomes related to early experiences of parental rejection. It is also important to note that the measure of change over time did not take into consideration the nature of the parent’s initial reaction, only whether/how it changed. Thus, parents who responded in an accepting manner and continued to be accepting would likely be rated as “unchanged,” whereas parents who responded in a negative manner and remained so would be rated the same. Future research would benefit from development of a more sensitive measure of change in acceptance over time.

We also sought to explore ways in which family religiosity may be related to general family support and sexual orientation-specific parental rejection, psychological distress, proximal minority stress, and self-compassion. Psychological distress, proximal minority stress, and self-compassion were not found to differ based on levels of family religiosity; however, our findings suggest that family religiosity is associated with level of general family support, such that participants who reported their families as “very religious” reported less general family
support than those who reported their families as “not at all religious.” Additionally, our findings suggest that family religiosity is associated with sexual orientation-specific rejection, such that participants who reported their families as “very religious” reported greater sexual orientation-specific rejection than those who reported their families as “somewhat religious” or “not at all religious.” Some religious traditions view minority sexual identities as sinful, and families rated as highly religious may be more likely to hold such beliefs, which could affect their reactions to their child’s LGB status. Individuals whose parents or caregivers are intolerant of their minority sexual identity may be less likely to support their children in various ways, such as kicking a child out of the home or withdrawing financial support upon being made aware of their minority sexual identity. This finding may also reflect measurement issues, as we asked for a broad rating of family religiosity and did not provide an opportunity for participants to specify which family members they were answering for, and whether religiosity directly affected the family member’s response to the LGB individual.

Limitations and Future Directions

There were various limitations to the current study. Firstly, it relied on correlational statistics, which restricts the ability to establish causality. Secondly, the study exclusively relied on self-report data, which may be inaccurate if participants lacked self-awareness regarding their response patterns. Thirdly, the sample was collected online, which may have resulted in a "snowball sample" effect where individuals with similar characteristics to the participants were recruited. This method of data collection could also mean that the participants' characteristics may not accurately represent the population as a whole, as those who are more comfortable sharing about their experiences online or who had the time and resources to complete the survey were more likely to participate. The sample in the current study was also skewed toward younger
participants (M = 26.2), such that these findings may not adequately reflect the experiences of middle-aged and elder LGB individuals. Additionally, online data collection makes it challenging to ensure that participants meet the inclusion criteria and testing conditions cannot be controlled.

Future research would benefit from exploring and identifying ways in which family support and parental rejection can be measured for LGB individuals, as support and rejection are unique for LGB individuals and can change over the course of their lives. Additionally, gaining a better understanding of the development of self-compassion could highlight the importance of supportive parenting practices and guarding against rejecting attitudes from family members that can contribute to negative mental health outcomes. Future studies would additionally benefit from including more varied samples, including young adult and adolescent participants who may be in greater proximity to their family system. Future studies could continue to explore the specific facets of self-compassion and how these facets may relate to the quality of family relationships and parenting practices.

**Conclusion**

LGB individuals may encounter various forms of discrimination, stigma, rejection, and concealment or disclosure difficulties related to their sexual minority identity. Family acceptance and support may serve as a protective factor in the face of these challenges. Conversely, family rejection is likely to contribute to the negative experiences of LGB individuals. Results from the current study suggest that family processes may be implicated in the associations observed between rejection expectations, experiences of sexual orientation-based rejection, and adverse mental health outcomes for LGB individuals. It will be important to continue to examine how family processes may be involved in the development of coping strategies such as self-
compassion to identify areas for intervention (e.g., resources for families and individuals) that may alleviate the impacts of Minority Stress for LGB individuals. Despite extensive research on family support and rejection, there appears to be a gap in the literature concerning the associations between perceived parental acceptance and rejection, aspects of self-compassion, and psychological distress, which limits research on this potentially crucial area of study.
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Appendix A

Demographic Information

Before we begin, we would like to gather some information about who you are, as well as how you describe your gender identity and sexual orientation.

1. What is your age? ______

2. Do you consider yourself LGBTQIA+ or part of the queer or transgender spectrum?
   a. Yes
   b. No

3. Do you reside in the United States?
   a. Yes
   b. No

4. In which state do you currently live? Please enter the full name or two-letter abbreviation.
   a. __________

5. What type of location do you live in?
   a. City or Urban community
   b. Rural community
   c. Suburban community
   d. Other (please specify): ______

6. How would you describe your gender? (Please select all that apply)
   a. Man
   b. Woman
c. Transgender

d. Non-binary

e. Genderqueer

f. Agender

g. Another gender ______

7. What group(s) do you belong to? (Please select all that apply)

a. Black/African American

b. Asian or Pacific Islander

c. European-American/White/Caucasian

d. Latino, Hispanic, or Chicano

e. Native-American/American Indian

f. Multi-racial

g. Other: -_______________

8. What was your assigned sex at birth?

a. Male

b. Female

c. Intersex

9. What is your current sexual identity?

a. Gay

b. Lesbian

c. Bisexual

d. Straight/Heterosexual

e. Pansexual
10. What is your highest level of education?
   a. Middle school, some high school.
   b. High school degree, or equivalent (i.e., GED)
   c. Some college, no degree
   d. Associate’s
   e. Bachelor’s
   f. Graduate degree/professional degree (M.S./M.A., Ph.D., M.D., J.D., etc.)

11. What is your current relationship status?
   a. Married/domestic partner with same sex partner
   b. Married/domestic partner with opposite sex partner
   c. Married/domestic partner with non-binary partner
   d. Dating same sex partner(s) only
   e. Dating opposite sex partner(s) only
   f. Dating non-binary partner(s) only
   g. Dating same and opposite sex partners
   h. Dating same sex, opposite sex, and nonbinary partners
   i. Committed relationship with same sex partner
   j. Committed relationship with opposite sex partner
   k. Committed relationship with nonbinary partner
1. Single (not currently dating)

12. What is your yearly income (estimations or expected incomes are okay)?

   a. _______________
Appendix B

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

<table>
<thead>
<tr>
<th>Almost never</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Almost always</th>
<th>5</th>
</tr>
</thead>
</table>

1. I’m disapproving and judgmental about my own flaws and inadequacies.
2. When I’m feeling down I tend to obsess and fixate on everything that’s wrong.
3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
5. I try to be loving towards myself when I’m feeling emotional pain.
6. When I fail at something important to me I become consumed by feelings of inadequacy.
7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.
8. When times are really difficult, I tend to be tough on myself.
9. When something upsets me I try to keep my emotions in balance.
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

11. I’m intolerant and impatient towards those aspects of my personality I don’t like.

12. When I’m going through a very hard time, I give myself the caring and tenderness I need.

13. When I’m feeling down, I tend to feel like most other people are probably happier than I am.

14. When something painful happens I try to take a balanced view of the situation.

15. I try to see my failings as part of the human condition.

16. When I see aspects of myself that I don’t like, I get down on myself.

17. When I fail at something important to me I try to keep things in perspective.

18. When I’m really struggling, I tend to feel like other people must be having an easier time of it.

19. I’m kind to myself when I’m experiencing suffering.

20. When something upsets me I get carried away with my feelings.

21. I can be a bit cold-hearted towards myself when I’m experiencing suffering.

22. When I’m feeling down I try to approach my feelings with curiosity and openness.

23. I’m tolerant of my own flaws and inadequacies.

24. When something painful happens I tend to blow the incident out of proportion.
25. When I fail at something that's important to me, I tend to feel alone in my failure.

26. I try to be understanding and patient towards those aspects of my personality I don't like.
Appendix C

PARQ Short Form

These questions relate to experiences you may have had with your parents or caregivers during your childhood. Read the following statements and indicate how much you agree or disagree with each statement by indicating a number on the provided scale.

| Almost never true | 1 | 2 | 3 | Almost always true | 4 |

1. My mother/father/caregiver said nice things about me.
2. My mother/father/caregiver paid no attention to me.
3. My mother/father/caregiver made it easy for me to tell him/her things that were important to me.
4. My mother/father/caregiver hit me, even when I did not deserve it.
5. My mother/father/caregiver saw me as a big nuisance.
6. My mother/father/caregiver punished me severely when s/he was angry.
7. My mother/father/caregiver was too busy to answer my questions.
8. My mother/father/caregiver seemed to dislike me.
9. My mother/father/caregiver was really interested in what I did.
10. My mother/father/caregiver said many unkind things to me.
11. My mother/father/caregiver paid no attention when I asked for help.
12. My mother/father/caregiver made me feel wanted and needed.
13. My mother/father/caregiver paid a lot of attention to me.
14. My mother/father/caregiver went out of her/his way to hurt my feelings.
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15. My mother/father/caregiver forgot important things I thought s/he should remember.

16. My mother/father/caregiver made me feel unloved if I misbehaved.

17. My mother/father/caregiver made me feel what I did was important.

18. My mother/father/caregiver frightened or threatened me when I did something wrong.

19. My mother/father/caregiver cared about what I thought and like me to talk about it.

20. My mother/father/caregiver felt other children were better than I was no matter what I did.

21. My mother/father/caregiver let me know I was not wanted.

22. My mother/father/caregiver let me know s/he loved me.

23. My mother/father/caregiver paid no attention to me as long as I did nothing to bother him/her.

24. My mother/father/caregiver was warm and soft-hearted to me.
INSTRUCTIONS:

Version 1: Indicate below the parent or caregiver you first came out to:

Version 2: Indicate below the parent or caregiver with whom you have the closest relationship:

( )  MOTHER  ( )  FATHER  ( )  OTHER: _____________

Think about the parent or caregiver you indicated above when filling out this questionnaire.

Think about how your parent or caregiver CURRENTLY feels about your sexuality as you respond to the following questions. Read the following statements and indicate how much you agree or disagree with each statement by circling a number. Remember, there are no right or wrong answers. These are your opinions. Some of you may prefer to use labels other than ‘lesbian, gay, and bisexual’ to describe your sexual orientation (e.g., pansexual, demisexual, etc.). We use the term LGB in this survey as a convenience, and we ask for your understanding if the term does not completely capture your sexual identity.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

When thinking about how my parent or caregiver currently feels about my sexuality, he/she/they:

1. supports me
2. is worried about what his/her/their friends and other parents think of him/her/them
3. has the attitude that lesbian/gay/bisexual people should not work with children
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4. is concerned about what the family thinks of him/her/them

5. is proud of me

6. believes that marriage between same-sex individuals is unacceptable

7. is concerned about the potential that he/she/they won’t get grandchildren from me

8. realizes that I am still ‘me’, even though I am gay/lesbian/bisexual

9. believes that being gay/lesbian/bisexual is immoral

10. thinks it is great

11. has problems seeing a same-sex couple together in public

12. is concerned about having to answer other peoples’ questions about my sexuality

13. has currently kicked me out of the house

14. doesn’t believe me

15. yells and/or screams

16. prays to God, asking Him to turn me straight

17. blames himself/herself/themselves

18. calls me derogatory names, like ‘faggot’ or ‘queer’

19. pretends that I am not gay/lesbian/bisexual

20. is angry at the fact I am gay/lesbian/bisexual

21. wants me not to tell anyone else

22. cries tears of sadness

23. says I am no longer his/her/their child

24. tells me it is just a phase

25. is mad at someone who he/she/they thought has ‘turned me gay/lesbian/bisexual’

26. wants me to see a psychologist who can ‘make me straight’
27. is afraid of being judged by relatives and friends
28. withholds financial support
29. brings up evidence to show that I must not be gay/lesbian/bisexual, such as “You had a girlfriend/boyfriend, you can’t be gay/lesbian/bi.”
30. is mad at me for doing this to him/her/them
31. wants me not to be gay/lesbian/bisexual
32. is ashamed of my sexual orientation
Appendix E

**Brief Symptom Inventory (BSI)**

Please rate how much you have been bothered by the following *in the past 2 weeks* from 0 “not at all” to 4 “extremely”.

1. Faintness or dizziness
2. Feeling no interest in things
3. Nervousness or shakiness inside
4. Pain on heart or chest
5. Feeling lonely
6. Feeling tense or keyed up
7. Nausea or upset stomach
8. Feeling blue
9. Suddenly scared for no reason
10. Trouble getting one’s breath
11. Feeling worthless
12. Spells of terror or panic
13. Numbness or tingling in parts of one’s body
14. Feeling hopeless about the future
15. Feeling so restless one could not sit still
16. Feeling weak in parts of one’s body
17. Thoughts of ending one’s life
18. Feeling fearful
Appendix F

Lesbian, Gay, and Bisexual Identity Scale

For each of the following questions, please mark the response that best indicates your current experience as an LGB person. Please be as honest as possible: Indicate how you really feel now, not how you think you should feel. There is no need to think too much about any one question. Answer each question according to your initial reaction and then move on to the next. Some of you may prefer to use labels other than ‘lesbian, gay, and bisexual’ to describe your sexual orientation (e.g., ‘queer,’ ‘dyke,’ ‘questioning’). We use the term LGB in this survey as a convenience, and we ask for your understanding if the term does not completely capture your sexual identity.

1 = Disagree Strongly
2 = Disagree
3 = Disagree Somewhat
4 = Agree Somewhat
5 = Agree
6 = Agree Strongly

1. I prefer to keep my same-sex romantic relationships rather private.
2. If it were possible, I would choose to be straight.
3. I keep careful control over who knows about my same-sex romantic relationships.
4. I often wonder whether others judge me for my sexual orientation.
5. I can't feel comfortable knowing that others judge me negatively for my sexual orientation.
6. I think a lot about how my sexual orientation affects the way people see me.

7. My sexual orientation is a very personal and private matter.

8. I wish I were heterosexual.

9. I believe it is unfair that I am attracted to people of the same sex.