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May 23, 2011

Ms. Kimberley Tolhurst, Esq.
Acting General Counsel
U.S. Commission on Civil Rights
624 9th Street, NW, 6th floor
Washington, DC 20001

Dear Ms. Tolhurst,

I am writing to submit documentation for the Commission's hearing on inter-student violence against LGBT youth. I am a clinical social worker who has worked on LGBT health and mental health issues for more than 35 years. My training with children and adolescents, including in school settings.

I have worked with LGBT youth who have experienced school victimization because they were known or perceived to be LGBT since the early 1990s. I have studied their school experiences, including school victimization as part of a major research, intervention, education and policy initiative that I direct, affiliated with San Francisco State University – the Family Acceptance Project -- that helps diverse families support their LGBT children. I have also studied the experiences of their families, including how families are affected when their LGBT children are victimized in school.

My work has been recognized by many groups, including the National Association of Social Workers that named "Social Worker of the Year" in 1988; the Lesbian Health & Research Center at the University of California-San Francisco that named me "Researcher of the Year" in 2006; and the American Psychological Association, Division 44 that gave me the Distinguished Scientific Contribution Award in 2009 for critical research on LGBT youth and families. I am also a member of the scientific committee of the Institute of Medicine that has studied the research needs, gaps and opportunities for LGBT people across the life course, including school victimization of LGBT youth; and I am a member of LGBT Youth Suicide Prevention Task Force of the National Action Alliance for Suicide Prevention that is developing recommendations for federal, state, and local government agencies and nongovernmental partners to prevent and address high rates of suicidal behavior among LGBT youth.

For the past two decades research has documented the prevalence, scope and harmful effects of LGBT peer victimization. Schools are the primary site where peer victimization occurs and researchers have shown the pernicious impact of anti-LGBT victimization on students who are known or perceived to be gay and those who are gender non-conforming. This research has been conducted in qualitative studies and community surveys, as well as population-based school studies in several cities and states, including the Youth Risk Behavior Survey and the California Healthy Kids Survey.

An analysis of school victimization of LGBT students in the California Healthy Kids Survey (a state youth risk behavior survey) found that 7.5% of middle and high school students reported being bullied or harassed because they were known or perceived to be gay (California Safe Schools Coalition, 2004). This represents some 200,000 students in California or perceived to be gay (California Safe Schools Coalition, 2004). This represents some 200,000 students in California schools. LGBT students who were victimized were more than three times as likely to seriously consider suicide and to

develop a suicide plan (a signal of serious intent) or to miss school because they felt unsafe. They were also more than twice as likely to report depression and to use stimulants or inhalants as were heterosexual youth.

However, not all youth who are targets of LGBT victimization are gay. In the Seattle Youth Risk Behavior Survey—a school census of all students in grades 9-12—8% of students were targets of anti-gay harassment or abuse (Reis & Saewyc, 1999). This includes 6% of heterosexual students who were harassed or attacked because they were perceived to be gay, as well as one in three lesbian, gay or bisexual youth who were victimized because of their sexual orientation. The impact on both heterosexual and gay-identified youth who were victims of harassment was nearly identical. Both LGB and heterosexual students who were victimized because they were perceived to be gay were twice as likely to have missed school during the past month because they felt unsafe, more than twice as likely to have been injured or threatened with a weapon at school during the past year, and more than three-and-a-half times as likely to have attempted suicide during the past year as heterosexual students who were not targeted for anti-gay abuse.

Experts have finally recognized school bullying as a serious public health problem that appears to be increasing in terms of prevalence and severity, and involves more vicious behaviors and deadlier outcomes than in previous years. Multiple studies of school victimization of LGBT students have documented significant correlations between LGBT peer victimization and mental health problems, depression, suicidal ideation and attempts and substance abuse in adolescents. A study that examined experiences of LGB youth found that that school-based victimization of LGB students is widespread and is correlated with mental health symptoms and with post-traumatic stress. Moreover, LGB high school students reported higher rates of victimization and verbal harassment than college students reported when they were in high school (D'Augelli, Pilkington & Hershberger, 2002).

Lasting Effect of School Victimization

Most alarmingly, new research from the Family Acceptance Project shows that LGBT school victimization in middle and high school has lasting effects that persist into adulthood and are related to compromised health, mental health and well-being (Russell, Ryan, Toomey, Diaz & Sanchez, 2011). We found that LGBT young adults who were victimized in school because of their LGBT identity reported much higher health and adjustment problems, while LGBT students with low levels of school victimization had higher self-esteem and life satisfaction as young adults. In particular, LGBT young adults who reported high levels of LGBT school victimization during adolescence were 5.6 times more likely to report having attempted suicide, 5.6 times more likely to report a suicide attempt that required medical care, 2.6 times more likely to report clinical levels of depression, and more than twice as likely to have been diagnosed with a sexually transmitted disease and to report risk for HIV infection, compared with peers who reported low levels of school victimization.

In a second study we conducted -- that is also the first thoroughly analyze the relationship between the victimization suffered by gender non-conforming LGBT students and their psychosocial adjustment as young adults -- we found that LGBT young adults who did not socially conform to gender roles as adolescents reported higher levels of anti-LGBT victimization, with significantly higher levels of depression and decreased life satisfaction in young adulthood (Toomey, Ryan, Diaz, Card, & Russell, 2010). This research shows that the negative impact of LGBT school victimization affects both quality of life and the LGBT young adult's capacity to enjoy life.

Early Victimization Experiences: Isolation, Lack of Support & Negative Outcomes

Our overall research with LGBT youth and families has found that LGBT victimization begins early, typically in elementary and middle schools and can escalate, becoming more dangerous and more difficult to manage when young people enter high school. In case studies we conducted for the Family Acceptance Project on the impact of LGBT school victimization

on LGBT adolescents and their families, we found that name calling begins as early as kindergarten and initiates a series of humiliating affronts that later escalate into increasingly hostile, deprecating verbal and physical abuse. Our research has also found that an early indicator of LGBT abuse in children and adolescents that is typically overlooked by adults and care providers is somatic complaints (such as headaches, stomachaches and vomiting), coupled with school avoidance that signals the child's internal distress (Ryan, 2004).

In our research with the Family Acceptance, we found that few parents understood the significance or severity of anti-gay victimization their children were experiencing until it had escalated to serious levels, often years after the abuse began. Many were not aware that their children were being victimized since young people often tried to minimize or hide it from their families for a variety of reasons—because they were not open about their sexual orientation, felt humiliated or thought the situation would burden families who had to deal with other pressing concerns, or were fearful of how their family might respond.

Parents and caregivers, in turn, had little knowledge of how best to protect their children in schools, where to turn for help, or even what their child's rights were when they were victimized because they were known or presumed to be gay. These experiences are compounded for immigrant families who do not understand the U.S. educational system and for whom confronting authority may be culturally incongruent. Families and caregivers who were rejecting or ambivalent about their child's sexual orientation or gender non-conforming behavior blame their children's LGBT identity for precipitating the abuse. Rejection by families and caregivers compounds the victimization from peers which increases the young person's risk for serious negative health and mental health outcomes (Ryan, Huebner, Diaz, & Sanchez, 2009).

At the same time, however, we found that family acceptance is an important protective factor that protects against risk and promotes the well-being of their LGBT children (Ryan, Russell, Huebner, Diaz & Sanchez (2010). Our research identified and measured the impact of more than 100 family accepting and rejecting behaviors related to the health and well-being of their LGBT children in adulthood. We found that parental and caregiver advocacy in families and schools helps protect their LGBT children against risk and helps families prevent and respond to school victimization. However, we also found that LGBT school advocacy initiatives have not engaged families in their advocacy work. We are developing a new family intervention model to help ethnically and religiously diverse families support their LGBT children. To date, we have had limited interest from funders in supporting the development of cultural and linguistically competent materials to help families advocate for their LGBT children, based on our comprehensive research.

Impact on Academic Performance & School Success

In addition to having adverse consequences on a young person's health and mental health, LGBT victimization affects academic achievement and contributes to school failure. In interviews for our research for the Family Acceptance Project with LGBT youth who experienced high levels of school victimization, they reported that it negatively affected their grades, caused them to avoid school and change schools, limited their participation in school-related activities and caused them leave school for periods of time and to drop out of school. Students in Washington State who experienced LGBT related school victimization from kindergarten through 12th grade reported that it negatively affected their grades and evaluations, affected their concentration, caused them to change schools or drop out of school (Reis & Page, 1999). In a national study of LGBT students, youth who experienced higher levels of anti-gay harassment received lower grades and were twice as likely to report that they did not plan to attend college, compared with LGBT peers who reported lower levels of harassment (Kosciw, 2004). And in two population-based studies of adolescent risk behavior, LGB youth reported missing days of school because they felt unsafe (California Safe Schools Coalition, 2004; Garofalo et al., 1998).

In the California Healthy Kids Survey, for example, students who reported LGBT harassment who were known or perceived to be gay were more than three times as likely to miss days of school compared with peers who were not harassed

(California Safe Schools Coalition, 2004). They were also more likely to report lower grades than students who experienced other bias-related harassment based on ethnicity, gender or religion. Because children and adolescents spend a significant portion of their time in school, these disruptive and adverse experiences affect other important aspects of development that occur in schools including socialization, civic engagement and career development. Such marginalization of LGBT children and adolescents in school inhibits their ability to practice and develop important life skills that are needed to function as productive adults.

These deleterious, risk promoting and lasting effects of LGBT school victimization are all the more distressing since they are preventable through policy-related measures identified in multiple studies over the past 15 years. These include: clear and inclusive anti-discrimination and anti-harassment policies that include LGBT identity and gender expression; active dissemination of anti-harassment policies and access to information on LGBT concerns; staff training and intervention when bias-motivated harassment occurs; the presence of gay-straight alliances and other student-sponsored diversity clubs; and the inclusion of LGBT issues in the curriculum. Despite this knowledge, a large proportion of students across the country live in states without laws that include protections related to sexual orientation and gender identity and many attend schools with environments that endanger their health and negatively affect their educational attainment.

Connection to school is an important protective factor that helps prevent health and mental health risks and provides a critical context for adolescent development. However, youth who are targeted because of their known or perceived sexual orientation report less connection to school, community or supportive adults, less support from teachers, family and friends, and fewer resources for coping with problems than peers who are victimized because of their LGBT identity (California Safe Schools Coalition, 2004).

To underscore the powerful effect that LGBT school victimization has on the lives of these students, I will close with a description of the experiences we documented of a gay student who was victimized by his peers throughout his school career:

> Peter, age 5, brought his favorite toy horse to the first day of kindergarten. The bullies in the schoolyard called him faggot and sissy. They pinned him to the fence, pushed his stuffed horse and face into a mud puddle and didn't stop until 13 years later when Peter left school to live in a gay neighborhood and work as a clerk in a local store. A gifted student who was extremely artistic, Peter suffered years of abuse at the hands of school bullies that led to painful psoriasis at 7, losing 60 percent of his body weight from an eating disorder at 12; a suicide attempt; bouts of anxiety and depression throughout childhood and adolescence and posttraumatic stress as a young adult that bound him to the familiar streets of the historic gay neighborhood he was afraid to leave because groups of two or more men on the street filled him with dread. Peter knew he was gay at age 13 and his peers assumed he was, too. And the high levels of LGBT school victimization he sustained because of this marked his future in devastating ways.

Studies conducted by us and other researchers has shown that LGBT victimization is related to more serious problems than other bias-related school victimization. This is a preventable, deadly public health problem that shortens and forecloses the futures of untold numbers of students across the country each year.

Thank you for making this visible.

Sincerely,

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RESEARCH ARTICLE

Lesbian, Gay, Bisexual, and Transgender Adolescent School Victimization: Implications for Young Adult Health and Adjustment

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ABSTRACT

BACKGROUND: Adolescent school victimization due to lesbian, gay, bisexual, or transgender (LGBT) status is commonplace, and is associated with compromised health and adjustment. Few studies have examined the long-term implications of LGBT school victimization for young adult adjustment. We examine the association between reports of LGBT school victimization and young adult psychosocial health and risk behavior.

METHODS: The young adult survey from the Family Acceptance Project included 245 LGBT young adults between the ages of 21 and 25 years, with an equal proportion of Latino and non-Latino White respondents. A 10-item retrospective scale assessed school victimization due to actual or perceived LGBT identity between the ages of 13 and 19 years. Multiple regression was used to test the association between LGBT school victimization and young adult depression, suicidal ideation, life satisfaction, self-esteem, and social integration, while controlling for background characteristics. Logistic regression was used to examine young adult suicide attempts, clinical levels of depression, heavy drinking and substance use problems, sexually transmitted disease (STD) diagnoses, and self-reported HIV risk.

RESULTS: Lesbian, gay, bisexual, and transgender-related school victimization is strongly linked to young adult mental health and risk for STDs and HIV; there is no strong association with substance use or abuse. Elevated levels of depression and suicidal ideation among males can be explained by their high rates of LGBT school victimization.

CONCLUSIONS: Reducing LGBT-related school victimization will likely result in significant long-term health gains and will reduce health disparities for LGBT people. Reducing the dramatic disparities for LGBT youth should be educational and public health priorities.

Keywords: LGBT; sexual orientation; victimization; mental health; HIV; STDs; risk behavior; young adulthood; adolescents.

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The victimization of lesbian, gay, bisexual, and transgender (LGBT) students in middle and high schools is pervasive. Such victimization ranges from social interactions in which homophobic discourse is a routine part of everyday communication (eg, the use of ''that's so gay'' and ''fag'' as generalized derogatory comments among teens)[1,2] to verbal harassment[3,4] and physical violence.[5,6] In the last decade, a growing body of research documents the prevalence of LGBT victimization in US secondary schools.[7,8] More recently, results of a survey of LGBT youth from across the country[9] indicate that 90% of students reported hearing the word ''gay'' used in a derogatory way, and over 85% reported that they were verbally harassed because of their sexual orientation. Furthermore, 44% said that they were physically harassed because of their sexual orientation. What are the long-term implications of such victimization?

Prior research has identified strong associations between secondary school victimization (whether

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motivated by LGBT-related bias or not) and compromised health and adjustment during adolescence.[10] School victimization has been linked to compromised academic achievement and school absenteeism, aggressive behavior, compromised emotional health, and suicidal ideation.[11] In addition, physical victimization is linked to substance use, delinquency, and aggression, particularly for boys.[12] One recent study showed that adolescents who described their health as fair or poor were more likely to have also reported that they missed school because they felt unsafe; this effect was particularly pronounced for boys.[13]

One school-based study showed that the combination of LGB identity and school victimization predicted high levels of health risk behavior during adolescence. Using data from Massachusetts and Vermont *Youth Risk Behavior Surveys*, the study showed that at low levels of victimization, students that identified as LGB were similar to heterosexual students in health risk behavior.[5] However, at high levels of school victimization for both groups, LGB students reported more substance use, suicidality, and sexual risk behaviors. The authors suggest that the victimization experienced by LGB youth may have been attributable to their sexual minority status.

In fact, a growing body of research has shown that much of the victimization or bullying that takes place in schools is motivated by bias or prejudice. Furthermore, the negative consequences of bullying appear to be worse when bullying is motivated by bias or prejudice. A recent study found that high school boys who were bullied by being called gay had greater psychological distress and more negative attitudes about the school climate compared with boys who were bullied for other reasons.[4] Similarly, in a representative study of over 200,000 California 7th, 9th, and 11th grade students, the rates of compromised school grades and attendance, depression, and substance use were higher for students who had been bullied at school because of their race or ''because you are gay or lesbian or someone thought you were'' than for students who did not experience bias-related victimization. Both groups reported higher health risks than those who were not bullied at all.[8] Finally, another study directly compared LGB and heterosexual students' experiences of homophobic teasing.[3] The results showed that health risks were lowest for students who reported no teasing, but among those who experienced homophobic teasing, LGB and youth who were questioning their sexual orientation reported the highest levels of depression, suicidal feelings, and alcohol or marijuana use.

All of the research described thus far has considered school victimization and concurrent adjustment for adolescents. However, research on non-bias-related victimization and bullying shows consistent and strong links between victimization and later psychosocial adjustment for children and adolescents.[14] For example, an Australian cohort study showed that having a history of victimization predicted emotional problems in adolescence; specifically victimization at age 13 was linked to depression and anxiety a year later.[15] There have been only a small number of studies of the lasting influence of school victimization for health and well-being in the years after formal schooling and into young adulthood. A longitudinal study in Finland showed that having been a victim of bullying by age 8 was linked with anxiety 10-15 years later, when the study participants were young adults.[16]

Two retrospective studies conducted in the United Kingdom have examined the long-term consequences of LGB victimization for LGB adults. One compared LGB men and women in their late 20s who reported having been bullied at school with those who had not; results showed higher depressive symptoms (but not anxiety) among those who reported school bullying.[17] In a second study, also of LGB men and women in their late 20s, symptoms of posttraumatic stress were stronger among the subgroup that reported a longer duration (in years) of homophobic bullying at school.[18] Together these studies suggest that LGB school victimization, like non-bias-related victimization, has a negative effect on mental health that lasts into adulthood.

Taken as a whole, the prior research suggests that school-related victimization in middle and high schools has negative consequences, and that bias-motivated victimization, in particular, may compromise mental health. Moreover, at least a few studies show negative consequences for academic achievement and other health risks such as substance use. There are no known studies in the United States that examine the influence of LGB school victimization in middle and high schools for a range of mental and behavioral health outcomes in young adulthood: this study examines LGBT victimization in middle and high school and its influence on young adult social, emotional, and behavioral adjustment and health. Given the known health disparities faced by LGBT young people, evidence of lasting consequences of

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middle and high school victimization into young adulthood is particularly important for schools because it underscores the need to prevent and intervene in LGBT victimization.

METHODS

Subjects

The Family Acceptance Project is a network of research studies, intervention development, and policy activities aimed at increasing family acceptance and societal support for LGBT youth and young adults. Additional information about the Family Acceptance Project is available at the project's Web site (http://familyproject.sfsu.edu). The young adult survey included a convenience sample of 245 California-based LGBT young adults between the ages of 21 and 25 years (mean = 22.8, SD = 1.4). Among the young adults in the study, 46.5% identified as male, 44.9% as female, and 8.6% as transgender. This study was designed to include an equal number of Latino (51.4%) and White, non-Latino (46.8%) young adults.

Procedure

In 2005, participants were recruited from 249 LGBT venues, mapped for patronage by this population from among general social and community organizations as well as LGBT bars and clubs, within a 100-mile radius of the San Francisco Bay Area. Half of the sites were community, social, and recreational agencies and organizations that serve LGBT young adults, and half were from clubs and bars serving this group. Bilingual recruiters (English and Spanish) conducted venue-based recruitment from bars and clubs and contacted program directors at each agency to access all young adults who use their services. Using street-based outreach outside the venues to maximize representation and minimize bias, young adults were screened for eligibility through inclusion criteria that included age (21-25 years), ethnicity (White, Latino/a, or Latino/a mixed), self-identification as LGBT, homosexual, or related LGBT identity (eg, queer) during adolescence, disclosure about sexual orientation to at least 1 parent or guardian during adolescence, and at least part-time residence with at least 1 parent or guardian during adolescence. Participants were recruited in California; however, we do not know whether they attended middle and high school in California or in some other location. Of the individuals recruited for the study, 723 agreed to be screened for inclusion and 438 met the inclusion criteria; of those, 245 individuals participated in the study. The survey was made available to participants in English or Spanish, as well as in paper and pencil and computer-assisted formats. The survey took, on average, 1.5 hours to complete (duration ranged from 30 minutes to 4 hours). Participants received a $50 stipend for their participation.

Instruments

Adolescent School Victimization Due to Actual or Perceived LGBT Status. A 10-item retrospective scale assessed school victimization due to actual or perceived LGBT status between the ages of 13 and 19 years. This scale was adapted from the California Healthy Kids Survey measure on violence, safety, harassment, and bullying.[19] Sample items included ''During my middle or high school years, while at school, I was pushed, shoved, slapped, hit, or kicked by someone who wasn't just kidding around'' and ''During my middle or high school years, while at school, I had mean rumors or lies spread about me.'' These statements were followed by the question: ''How often did this occur because people knew or assumed you were LGBT?'' (0 = never, 3 = many times; mean = 7.59, SD = 7.75). The scale had excellent internal reliability ($\alpha = .91$). Participants were also asked whether victimization occurred due to reasons other than perceived or actual LGBT identity, such as race or weight; this strategy minimizes the possibility that the reported school victimization was attributable to other forms of bias. Levels of LGBT school victimization were trichotomized to compare levels of victimization: low (n = 91, range = 0-2, mean = 0.45, SD = 0.76), moderate (n = 75, range = 3-10, mean = 5.91, SD = 2.35), and high (n = 79, range = 11-28, mean = 17.41, SD = 4.73). Descriptive information revealed that the school victimization items were significantly skewed; square root transformation returned the variables into acceptable range (mean = 5.33, SD = 4.91).

Young Adult Depression. The 20-item version of the Center for Epidemiologic Studies-Depression Scale (CES-D)[20,21] was used to measure levels of depression in young adulthood. Consistent with prior studies, the measure had strong internal reliability ($\alpha = .94$). Prior to analyses, descriptive information revealed significant skewness in depression items; square root transformations returned the variables to acceptable ranges (mean = 12.41, SD = 8.24). For purposes of identifying respondents with clinical levels of depression (ie, scores at or above the accepted cutoff score [≥16]), a dichotomous variable was created from the untransformed sum of depression items (0 = score less than 16 and 1 = score greater than or equal to16 [44%]).

Young Adult Suicidal Ideation and Behavior. One item measured suicidal ideation in young adulthood: ''During the past 6 months, did you have any thoughts of ending your life. If yes, how often?'' (0 = never, 1 = once, 2 = a few times, and 3 = many times). This item had significant skewness levels; however,

a square root transformation shifted the variable into acceptable range (mean = 0.35, SD = 0.60). Suicide attempts were measured by 1 item: ''Have you ever, at any point in your life, attempted taking your own life?'' (0 = no and 1 = yes [41%]). In addition, we include a measure of serious attempts that required medical attention: ''Of these times, how many were serious enough to need medical attention?'' (0 = legitimate skip or none and 1 = one or more times [22%]).

Young Adult Adjustment. Life satisfaction was measured by an 8-item scale. Sample items included ''At the present time, how satisfied are you with your living situation?'' and ''At the present time, how satisfied are you with your friendships?'' (1 = very dissatisfied and 4 = very satisfied; mean = 22.78, SD = 4.19; $\alpha = .75$). The 10-item Rosenberg Self-Esteem Scale[22] was used and had strong internal reliability in this sample ($\alpha = .88$; mean = 2.80, SD = 0.38). The measure for social integration was based on the mean of 4 items: ''How often do you feel you lack companionship?'' ''How often do you feel there is no one you can turn to?'' ''How often do you feel alone?'' and ''How often do you feel left out?'' (0 = never and 3 = always). These items were reverse coded, such that a higher score indicates greater social integration. The scale had good internal reliability ($\alpha = .85$; mean = 2.07, SD = 0.65).

Substance Use and Abuse. Two measures assessed heavy drinking and problems due to substance use or abuse. Participants were asked the following 2 questions to obtain information about heavy drinking behavior: ''During the past 6 months, how often have you had any alcoholic beverages (such as beer, wine, liquor, or other drink)?'' (0 = never and 6 = at least one a day) and ''During the past 6 months, on a typical day when you drank some alcohol, how many drinks did you usually have (by 'drink' we mean a glass of wine, a can or bottle of beer, or a drink with a shot of hard liquor)?'' (response was open-ended). Participants who reported consuming alcoholic beverages 1-2 times a week or more and who reported having 3 or more drinks on a typical day were categorized as heavy drinkers (n = 100, 41%). Problems due to substance use and abuse were measured by 4 items: ''In the past 5 years, have you had problems with the law because of your alcohol or drug use?'' ''In the past 5 years, have you lost a job because of your alcohol or drug use?'' ''In the past 5 years, have you passed out or lost consciousness because of your alcohol or drug use?'' and ''In the past 5 years, have you had conflicts with family, lovers, or friends because of your alcohol or drug use?'' (0 = no and 1 = somewhat yes/yes). A summary variable was created as an indicator of problems due to alcohol or drug use (0 = never and 1 = any [56%]).

Sexual Risk. Sexual risk was assessed with 2 measures. First, participants were asked if they had ever been diagnosed with a sexually transmitted disease (STD). Of the respondents, 27% (n = 65) had been diagnosed with an STD. Second, participants were asked about their risk for HIV infection over the past 6 months: ''In the last 6 months, were you ever at risk of being infected with or transmitting HIV?'' (0 = no and 1 = yes [30%]).

Sociodemographic Characteristics. Information on 5 sociodemographic characteristics was collected, including gender (female, with male as the reference group), transgender (with non-transgender as reference group), sexual orientation (dichotomous variables for bisexual and queer, with gay or lesbian orientation as the reference group), immigrant status (0 = not immigrant and 1 = immigrant), ethnicity (White, non-Latino, with Latino/Mixed as the reference group), and family-of-origin socioeconomic status (SES). SES was measured by open-ended responses to the following question: ''What kind of work did your parents/caregivers do during your teenage years?'' Each participant was asked to report on their father's and mother's type of work. Participant responses were coded by 3 independent raters (1 = unskilled, 2 = semiskilled, 3 = skilled, and 4 = professional). A single indicator of SES was calculated by multiplying responses for both parents' work (1 = unskilled to 16 = professional; mean = 6.75, SD = 4.77).

Data Analysis

To maximize power and sample size, we used the expectation maximization algorithm in PRELIS, a component of LISREL 8.80, to impute missing data (total < 5%).[23] Analysis of covariance was used to examine group differences between victimization levels and experience of long-term health risk outcomes. Multiple regression analyses were used to examine the effect of LGBT school victimization on young adult outcomes while controlling for sociodemographic characteristics; logistic regression was used for dichotomous outcomes.

RESULTS

There were no statistically significant differences in LGBT school victimization based on ethnicity, immigrant status, or SES. However, between-group analysis of variance comparisons revealed that females reported less LGBT victimization when compared with males and transgender young adults, both male-to-female and female-to-male ($F_{(2,224)} = 18.73$, $p < .001$). Additionally, participants who identified as queer reported more LGBT-related victimization when compared with gay, lesbian, and bisexual participants ($F_{(2,224)} = 8.33$, $p < .001$).

Analyses that predict young adult mental health and social adjustment show the strong predictive

role of adolescent LGBT school victimization. Table 1 presents regression analyses in which background characteristics are presented alone in model 1; model 2 includes LGBT school victimization. Females generally reported lower negative mental health and higher positive adjustment when compared with males. Depression was higher and self-esteem was lower for immigrants and persons from low SES families. Family SES was also associated with life satisfaction and self-esteem. Non-Latino Whites reported lower self-esteem when compared with Latinos.

Females had lower depression (model 1) until LGBT victimization was taken into account (model 2): LGBT school victimization accounts for the strong difference between males and females in overall levels of young adulthood depression. A Sobel's test indicated that LGBT victimization fully mediated the association between gender and young adult depression ($z = -3.21$, $p < .01$). A similar pattern is seen for suicidal ideation; specifically, males have higher scores on average, but this difference is explained by males' higher rates of LGBT school victimization, which is strongly linked to young adult suicidal ideation. Again, a Sobel's test indicated that LGBT victimization fully mediated this prior association ($z = -3.19$, $p < .001$). In summary, LGBT school victimization mediates the strong link between gender and negative mental health. Lesbian, gay, bisexual, and transgender school victimization is also strongly linked to positive mental health and adjustment outcomes (lower self-esteem, life satisfaction, and social integration), but it does not fully account for gender differences; in general, females score higher on all 3 positive young adult adjustment measures.

Analyses of dichotomous mental health, substance use, and sexual risk behavior are presented in Table 2. We present the odds ratios for the 3-category LGBT school victimization variable—moderate and high victimization compared with low victimization—for each outcome. There was no statistical association between LGBT school victimization and heavy drinking or substance use-related problems in young adult. Furthermore, there were few statistically strong differences for those who reported moderate levels of LGBT school victimization compared with those who reported low levels. However, there were several strong differences between the groups that reported high vs low LGBT school victimization. Specifically, LGBT young adults who reported high victimization during adolescence were 2.6 times more likely to report depression above the clinical cutoff (CES-D $\geq$ 16), and 5.6 times more likely to report having attempted suicide at least once, and having a suicide attempt that required medical attention. Compared with those with low LGBT school victimization, respondents who reported high levels were more than twice as likely to report having had an STD diagnosis and to have been at risk for HIV infection. These dramatic differences are illustrated in Figure 1. Compared with moderate and low levels of LGBT victimization, almost twice as many young adults who reported high levels of LGBT school victimization reported clinical levels of depression and an STD diagnosis. One quarter of the participants at low levels of LGBT school victimization reported ever attempting suicide, compared with one third of those at moderate levels of victimization and two thirds at high levels of victimization. Finally, more than half of those who experienced high levels of LGBT school victimization reported HIV risk as young adults—a rate that was more than double the rate of those who reported low levels of victimization.

DISCUSSION

School bullying is a widespread public health problem. School victimization of LGBT students and those who are perceived to be gay or gender nonconforming has been reported for decades. Experts report that it appears to be increasing in prevalence and severity, and involves more vicious behaviors and deadlier outcomes than in previous years.[24] When

Table 1. **The Association Between Victimization and Young Adult Adjustment, Controlling for Background Characteristics (Ordinary Least Squares Multiple Regression, Standardized Estimates Shown)**

Outcome	Depression		Suicidal Ideation		Life Satisfaction		Self-Esteem		Social Integration	
Predictors	1	2	1	2	1	2	1	2	1	2
Female	−.16*	−.07	−.14*	−.05	.23***	.17*	.19**	.13^{+}	.26***	.21**
Transgender	.07	.07	.02	.01	−.11	−.10	.06	.07	−.03	−.03
Bisexual	−.11^{+}	−.09	.02	.04	.07	.06	−.07	−.08	.03	.01
Queer	−.002	−.05	.02	−.03	.01	.05	−.06	−.03	.02	.05
White	.09	.07	.08	.05	−.01	.01	−.15*	−.13^{+}	−.09	−.07
Immigrant	.14*	.15*	.11	.11^{+}	.03	.03	−.14*	−.15*	−.06	−.06
Family-of-origin SES	−.17**	−.13*	−.13^{+}	−.09	.19**	.17**	.16*	.13^{+}	.08	.06
LGBT victimization		.27***		.27***		−.19**		−.19**		−.16*

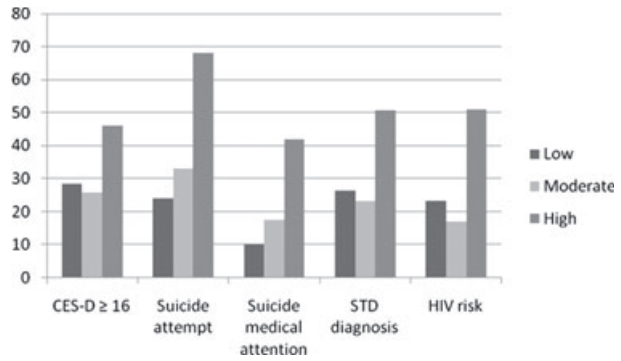
SES, socioeconomic status; LGBT, lesbian, gay, bisexual, and transgender.
$^{+}p < .10$; $^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$.

Table 2. **Odds Ratios of Young Adult Risk Levels Predicted by Teenage Victimization (All Effects Are Adjusted for Gender, Sexual Orientation, Ethnicity, Immigrant Status, and SES)**

Outcome	Moderate Victimization, OR (95% CI)	High Victimization, OR (95% CI)	Overall Effect (χ^2)
Mental health			
Depression (CES-D ≥ 16)	1.12 (0.57-2.19)	2.60 (1.29-5.25)**	28.62***
Suicide attempt (ever)	1.74 (0.84-3.59)	5.62 (2.65-11.94)***	50.79***
Suicide—medical attention (ever)	2.17 (0.83-5.64)	5.60 (2.26-13.87)***	33.82***
Substance use/abuse			
Heavy drinking (last 6 months)	1.01 (0.52-1.98)	0.70 (0.34-1.42)	19.16*
Substance use/abuse-related problems (ever)	0.93 (0.49-1.78)	1.54 (0.77-3.09)	16.85*
Sexual risk behavior			
STD diagnosis (ever)	1.01 (0.45-2.27)	2.53 (1.17-5.47)*	22.71**
Reported HIV risk (last 6 months)	0.61 (0.27-1.37)	2.28 (1.09-4.76)*	34.91***

SES, socioeconomic status; CES-D, Center for Epidemiologic Studies-Depression[20,21]; STD, sexually transmitted disease.
$^{+}p < .10$; $^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$.

Figure 1. **Percentage of Health Risks by Level of LGBT-Related School Victimization (Low, Moderate, and High)**



California middle school student Lawrence King was murdered in his classroom in February 2008, there was significant public attention to the ongoing and persistent victimization of LGBT students (and those who are perceived to be LGBT) at school.[25] More recently, there has been widespread attention to the number of suicides that are closely linked to anti-LGBT school victimization.

Although the immediate outcomes are not usually so extreme, for many LGBT and gender nonconforming adolescents, the simple, daily routine of going to school is fraught with harassment and victimization. Population-based studies have consistently shown that students who identify or are perceived to be LGB are at dramatically higher risk for a wide range of health and mental health concerns, including sexual health risk, substance abuse, and suicide, compared with their heterosexual peers. Although the long-term impact has been reported anecdotally, ours is the first-known study to document the strong negative effects of victimization at school during adolescence on multiple dimensions of young adult well-being.

A notable finding in our study is that LGBT school victimization mediates the strong link between gender and negative mental health—depression and suicidal ideation. Our results show that males' elevated depression and suicidal ideation scores can be explained once their disproportionate rates of victimization are taken into account. These findings are consistent with prior studies that highlight the link between homophobia and masculinity in the lives of adolescent boys.[1,2,8] The stakes of gender conformity are especially high for boys; undoubtedly, much of the LGBT school victimization that they experience is also rooted in a peer culture that demands conformity to masculine gender. In fact, other studies show that adolescent gender nonconformity is a source of significant risk in the lives of young people, particularly for boys and for LGB youth[26,27] and gender nonconforming LGBT youth.[28] Further research on the link between overall health and gender nonconformity at school is warranted.

Limitations

These novel results must be interpreted in the context of several limitations of the study. It is retrospective, and relies on LGBT young adults' recollections of experiences during their teenage years. To minimize recall bias, we used measures that asked specific questions about school victimization. Although the sample was drawn to study LGBT young adults from a wide range of sites, this is a hidden group and the sample is not representative of the population. The study focused on LGBT Latino and non-Latino White young adults—the 2 largest ethnic groups in California. Subsequent research should include greater ethnic diversity to assess potential differences related to ethnicity within these groups.

IMPLICATIONS FOR SCHOOL HEALTH

Our results suggest that even modest reductions in LGBT school victimization for those who experience

it most in middle and high school would result in significant long-term health gains. Reducing the dramatic disparities for LGBT youth who are the most victimized student group should be an educational and public health priority, and can play an important role in helping mitigate the well-documented adult health disparities that exist for LGBT adults in the United States.[29] As public health policies increasingly focus on social determinants of health and on developing structural interventions to address significant disparities, schools—which are the primary socializing institution where children and adolescents spend most of their time—provide a critical environment for intervention. Our findings of dramatically elevated levels of suicide attempts, risk for HIV infection, STD diagnoses, and depression provide a clear public health rationale for implementing safe school programs to prevent bias-related and anti-LGBT bullying. Awareness of this compelling relationship is especially important for school health programs that are funded by HIV funding streams. School climate clearly matters, and enumerating bias related to LGBT identity in school policies will help administrators to ensure that prevention funds are used effectively at both structural and individual levels.

Other research has documented the effectiveness of specific school policies and programs for promoting safe school climates for all students, both LGBT and heterosexual. Specifically, this work shows that schools have safer LGBT school climates when (1) they have and enforce clear and inclusive antidiscrimination and antiharassment policies that include LGBT identity and gender expression, (2) students know where to go for information and support about LGBT concerns, (3) school staff regularly intervene when bias-motivated harassment happens, (4) students have gay-straight alliances and other student-sponsored diversity clubs, and (5) LGBT issues are integrated into the curriculum.[8,26,27,30-32] In spite of such evidence, a recent national survey revealed that the politics of sexual orientation too often get in the way of the implementation of such policies and programs in US schools.[33] School administrators and educators must continue to advocate for and to implement LGBT inclusive policies and programs to promote safe and supportive learning environments where all students are protected from bias-motivated victimization and harassment and are free to learn and flourish in schools. For too many LGBT and gender variant students, school victimization has resulted in school failure, poorer grades, and restricted life chances that limit vocational and career development and undermine their human potential.

Human Subjects Approval Statement

San Francisco State University's institutional review board approved the study design and protocol.

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Gender-Nonconforming Lesbian, Gay, Bisexual, and Transgender Youth: School Victimization and Young Adult Psychosocial Adjustment

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Past research documents that both adolescent gender nonconformity and the experience of school victimization are associated with high rates of negative psychosocial adjustment. Using data from the Family Acceptance Project's young adult survey, we examined associations among retrospective reports of adolescent gender nonconformity and adolescent school victimization due to perceived or actual lesbian, gay, bisexual, or transgender (LGBT) status, along with current reports of life satisfaction and depression. The participants included 245 LGBT young adults ranging in age from 21 to 25 years. Using structural equation modeling, we found that victimization due to perceived or actual LGBT status fully mediates the association between adolescent gender nonconformity and young adult psychosocial adjustment (i.e., life satisfaction and depression). Implications are addressed, including specific strategies that schools can implement to provide safer environments for gender-nonconforming LGBT students.

Keywords: gender nonconformity, LGBT youth, victimization, safe schools

In 2008 Larry King was murdered by a fellow eighth grader during a class at school because of his gender expression and his openness about his gay sexual orientation (Pringle & Saillant, 2008). He was referred to as an "effeminate" boy by his classmates and various school personnel when they were interviewed by the media after the shooting (Setoodeh, 2008). King's murder is not an isolated case, and the association between gender nonconformity and victimization is at the forefront of the public awareness and discussions about school safety (Hoffman, 2009). King's murder is an extreme example of school victimization motivated by a student's gender nonconformity.

A growing body of literature suggests that young people who do not conform to heteronormative societal values are at risk for victimization during adolescence (Meyer, 2003; Oswald, Blume, & Marks, 2005). Lesbian, gay, bisexual, transgender (LGBT), and gender-nonconforming youth are at elevated risk levels for experiencing victimization (e.g., Kosciw, Diaz, & Greytak, 2008; O'Shaughnessy, Russell, Heck, Calhoun, & Laub, 2004) and negative psychosocial adjustment (e.g., suicidality, depression, anxiety; D'Augelli, Grossman, & Starks, 2006; Pilkington & D'Augelli, 1995). A number of studies document the direct effects of individual-level characteristics (i.e., gender nonconformity and sexual minority status) and social experiences (e.g., school victimization, negative family experiences) on psychosocial adjustment (Carver, Yunger, & Perry, 2003; D'Augelli, Pilkington, & Hershberger, 2002; Rivers, 2001a; Russell & Joyner, 2001; Yunger, Carver, & Perry, 2004). What remains unknown is whether experiences of victimization during adolescence are largely responsible for the elevated levels of negative psychosocial adjustment and health among gender-nonconforming youth and young adults.

This study extends prior research that documents the associations between gender nonconformity, victimization, and adjustment by directly testing the degree to which experiences of school victimization account for the link between adolescent gender nonconformity and young adult well-being. By examining both direct and indirect effects simultaneously, we were able to account for the unique association each predictor has on two psychosocial adjustment indicators: young adult life satisfaction and depression. Our goal was to build on previous research that separately documents the direct effects of gender nonconformity and victimization on psychosocial outcomes: We sought to provide an explanation of the mechanisms through which gender nonconformity influences young adult psychosocial adjustment.

One theoretical explanation that may help to explain the high prevalence of psychosocial problems that gender-nonconforming individuals experience is Meyer's (1995, 2003) minority stress model. Meyer's (1995, 2003) minority stress model posits that lesbian, gay, and bisexual individuals are at increased risk for mental health distress because of their stigmatized sexual identities. Meyer (2003) discussed that the unique stressors that sexual minority individuals experience range on a continuum from more

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distal processes that occur externally (i.e., actual experience of discrimination and/or violence) to proximal processes that occur internally (i.e., expectations of discrimination and/or violence, internalized homophobia). As explained by Meyer (2003), the experiences of distal minority stress processes (e.g., school victimization due to minority status) are likely to be associated with an increase in proximal minority stress processes (e.g., expectations of victimization). Combined with general life stressors, unique minority stress can plausibly cause poor psychosocial adjustment. That is, it is school victimization specifically due to gender nonconformity that is crucial in the model. Meyer (2003) suggested that these associations are modified by coping strategies, available social support, and other personal characteristics.

In this study, school victimization represents the distal process by which gender-nonconforming LGBT young people experience stigma. Our study is limited in that we cannot fully assess Meyer's (1995, 2003) minority stress model. Specifically, data were not collected about proximal minority stress processes (i.e., expectations of victimization). It is also beyond the scope of this article to examine potential moderators of the link between school victimization and psychosocial adjustment. Nonetheless, we expect that the unique social stigma experienced by gender-nonconforming LGBT young people in adolescence has lasting negative effects into young adulthood and that these lasting negative effects are the product of victimization based on gender nonconformity, not of their gender nonconformity. Further, it is victimization due to gender nonconformity rather than victimization for other reasons that should explain the association between gender nonconformity and negative effects in young adulthood.

Gender Nonconformity

Western culture engrains gender stereotypes within individuals during the earliest stages of life (S. E. Hill & Flom, 2007; Poulin-Dubois, Serbin, Eichstedt, Sen, & Beissel, 2002). By preschool, children understand gender categories and the social pressure to conform to the category associated with their biological sex (Carver et al., 2003; Yunger et al., 2004). Kessels (2005) defined gender stereotypes as "a set of specific beliefs about the characteristics that women and men are likely to possess" (p. 310). Gender identity refers to the "maleness and femaleness a person feels on the inside; how that identity is projected to the world; and how others mirror that identity back to the individual" (Israel, 2005, p. 55). Individuals are expected to assume the roles and characteristics (e.g., clothing, hobbies, mannerisms) associated with their respective biological sex (Grossman & D'Augelli, 2006). Those who do not assume the expected roles and characteristics of the gender associated with their biological sex often experience a myriad of negative consequences because of their nonconformity to these cultural rules.

Gender-nonconforming individuals, such as boys who are more feminine than other boys or girls who are more masculine than other girls, can be described as those who transgress social gender norms. These individuals, however, may or may not decide to label themselves as transgender, an umbrella category that includes individuals who identify as transsexuals, gender queers, cross-dressers, drag kings, drag queens, and other various labels (Israel, 2005).

A multidimensional framework proposed by Egan and Perry (2001) suggests that the construct of gender includes five major components including membership knowledge, gender typicality, gender contentedness, pressure to conform, and intergroup bias. Thus, this multidimensional framework not only incorporates the degree to which an individual feels nonconforming but also warrants attention to the pressure to conform to gendered norms from others. In this study, we sought to further understanding of two influences on adjustment: gender typicality and pressure to conform to gender norms through the experience of victimization by peers.

Gender Nonconformity and Young Adult Adjustment

Gender nonconformity is just one of the individual-level characteristics that previous research has linked to poor psychosocial adjustment and suicidality in adolescence (Carver et al., 2003; Morrow, 2004; Yunger et al., 2004) and adulthood (Sandfort, Melendez, & Diaz, 2007; Skidmore, Linsenmeier, & Bailey, 2006). Although the research on risk-taking behavior (e.g., risky sexual behavior, substance abuse) among gender-nonconforming and transgender individuals is growing, researchers know much less about the psychosocial adjustment (e.g., life satisfaction, anxiety, depression) experienced among this population (Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Kenagy, 2002, 2005; Kenagy & Hsieh, 2005a, 2005b). Of the research that does exist, most has been based on studies of adults. For instance, Skidmore et al. (2006) found that higher levels of gender nonconformity among adult gay men were associated with more psychological distress. Similarly, Sandfort et al. (2007) found that higher levels of gender nonconformity among gay and bisexual Latino men were associated with higher levels of mental distress. However, Sandfort et al. found that this association could be explained by experiences of homophobia during one's lifetime. We sought to examine how adolescent experiences of school victimization may account for the association between gender nonconformity and psychosocial adjustment.

Victimization at School

Peer reactions to gender nonconformity change across developmental stages. By middle childhood, children's cognitive development allows them to make social comparisons and to form an abstract concept of the self (Yunger et al., 2004). In adolescence, gender differences observed between girls and boys can be partially explained by the intense socialization of stereotypical gender roles prior to and during that developmental period (J. P. Hill & Lynch, 1983). Because of a heightened awareness and a sense of an imaginary audience during adolescence, shame often controls or holds in place strictly gendered rules (Ma'ayan, 2003). The shame felt by gender-nonconforming adolescents may be compounded by the reactions from their peers. Peer reactions to gender-nonconforming behavior are often negative, ranging from verbal questioning of another's biological sex to physical abuse (Grossman & D'Augelli, 2006).

Previous research documents the intersection between sexual orientation and gender nonconformity in Western culture (Ma'ayan, 2003). Because of this intersection, negative reactions toward gender-nonconforming adolescents may actually

be related to the perpetrator's perceptions that the adolescent is lesbian, gay, or bisexual (D'Augelli et al., 2006; Friedman, Koeske, Silvestre, Korr, & Sites, 2006; Pilkington & D'Augelli, 1995). In Pilkington and D'Augelli's (1995) sample of lesbian, gay, and bisexual adolescents, students who were gender atypical and more open about their lesbian, gay, or bisexual status to peers were more likely to report victimization than students who conformed to stereotypical gender norms. Thus, the more young people present as gender nonconforming, the more likely they will be victimized or abused at school (Grossman, D'Augelli, Howell, & Hubbard, 2005).

The abuse experienced by gender-nonconforming adolescents frequently occurs at school (D'Augelli et al., 2006; Henning-Stout, James, & Macintosh, 2000). The school context is one of the primary settings where social interactions occur during adolescence, and for gender-nonconforming and LGBT youth, school can be one of the most dangerous social contexts (Morrow, 2004). Previous research documents the high prevalence rate of harassment that occurs in schools because of actual or perceived lesbian, gay, or bisexual status (see Kosciw et al., 2008; Lasser & Tharinger, 2003; Russell, 2005; Ryan & Rivers, 2003; van Wormer & McKinney, 2003). Information about the prevalence of harassment in schools associated with gender nonconformity or transgender status, however, is lacking.

In a recent study, gender-nonconforming youth reported that school was the location of their first experience of physical victimization more than any other context (e.g., home or community; D'Augelli et al., 2006). Another recent study found that nearly two thirds of gender-nonconforming youth report verbal harassment and nearly one third report physical harassment at school (Kosciw et al., 2008). Within the category of gender-nonconforming youth, transgender young people are perhaps most at risk for experiencing victimization at school. Sausa (2005) found that 96% of transgender participants experienced physical harassment and 83% experienced verbal harassment at school. Furthermore, transgender youth are at risk for dropping out of school, running away from home, and becoming homeless (Grossman & D'Augelli, 2006). Thus, whereas the prevalence of victimization due to gender nonconformity or transgender status in school is underdocumented, it is clear that victimization does occur because of this personal characteristic and warrants further investigation.

Finally, biological sex may be a moderator in the backlash toward gender nonconformity: Biological men face more peer harassment and victimization than biological women. In fact, D'Augelli et al. (2006) found that male youth who were gender nonconforming were more likely to receive negative responses from parents than were gender-nonconforming female youth. Gender nonconformity by girls is generally accepted and even rewarded until puberty. However, once puberty occurs, girls who still project a masculine appearance are often characterized as immature (Carr, 2007) and face harassment from their peers (Carr, 2007; Ma'ayan, 2003). In fact, young people report hearing more negative remarks about gender nonconformity toward boys (53.8%) than girls (39.4%; Kosciw et al., 2008) and perceive their schools as safer for gender-nonconforming girls compared with nonconforming boys (O'Shaughnessy et al., 2004).

School Victimization and Young Adult Psychosocial Adjustment

Repeated negative responses from peer groups often leads to negative feelings about one's self (Ellis & Eriksen, 2002). Not only does victimization affect students emotionally at the time it occurs, victimization also negatively affects future psychosocial adjustment (Olweus, 1993; Rivers, 2001a). Recent research documents the lasting negative effects of victimization during adolescence into adulthood. For example, D'Augelli et al. (2006) found that gender-nonconforming individuals who experienced victimization due to sexual orientation status during childhood were at greater risk for developing posttraumatic stress disorder later in life than those who were not gender nonconforming. Similarly, Friedman, Marshal, Stall, Cheong, and Wright (2008) found that early violence (i.e., in adolescence) experienced by gay boys is predictive of young adult well-being above and beyond the effects of young adult violence. In a retrospective study, Friedman et al. (2006) examined the link between gender nonconformity and suicidality during adolescence and found that the experience of victimization mediated this association for boys. Similarly, Williams, Connolly, Pepler, and Craig (2005) found that school victimization mediated the association between sexual orientation and depression and externalizing problems in adolescence. We sought to extend the findings of these two studies through the inclusion of both male and female participants and the examination of multiple psychosocial adjustment indicators in young adulthood.

The Current Study

The purpose of this study was to expand understanding regarding the associations among adolescent gender nonconformity, school victimization, and young adult psychosocial adjustment experienced by LGBT individuals. Specifically, the hypotheses tested in this study include the following (see Figure 1 for hypothesized model):

Hypothesis 1: Higher levels of gender nonconformity during adolescence are associated with more instances of victimization specific to perceptions of LGBT status.

Hypothesis 2: Biological sex moderates the effects of gender nonconformity on LGBT school victimization, such that gender-nonconforming boys experience more victimization than gender-nonconforming girls.

Hypothesis 3: Experience of LGBT school victimization during adolescence mediates the direct effect of gender nonconformity on young adult psychosocial adjustment, such that victimization becomes the salient predictor of young adult psychosocial adjustment.

Method

Sample

This study used data from the Family Acceptance Project's young adult survey that included 245 LGBT young adult participants, who were recruited at multiple venues frequented by LGBT young adults within a 100-mile radius of the San Francisco Bay

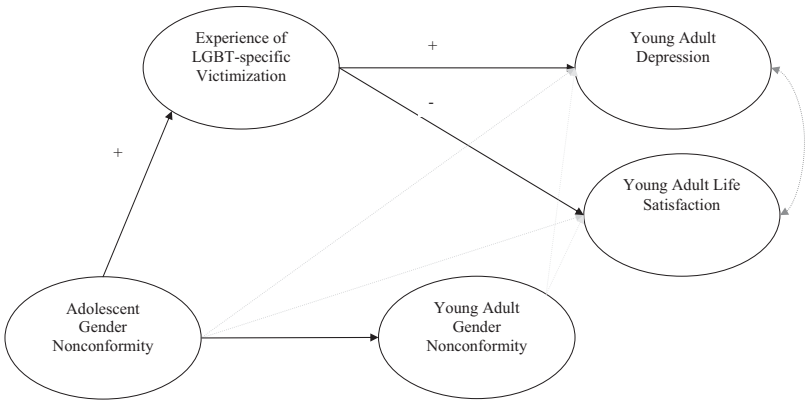

Figure 1. Conceptual model.

Area. The Family Acceptance Project is a network of research studies, intervention development, and policy activities aimed at increasing family acceptance and societal support for LGBT youth and young adults. Criteria for participation in the young adult study included age (21–25 years); ethnicity (White, Latino, or Latino mixed); self-identification as LGBT during adolescence; outness to at least one parent during adolescence; and at minimum, part-time residence with at least one parent during adolescence. The survey was available in both English and Spanish, as well as in paper-and-pencil and computer-assisted formats. The university's institutional review board approved the study protocol.

The mean age of the sample was 22.8 years ($SD = 1.4$). Participants self-identified their sexual orientation on the survey: 42.5% gay, 27.8% lesbian, 13.1% bisexual, and 16.7% other (e.g., queer, dyke, or homosexual). Participants reported on LGBT milestones: Average age of awareness was 10.7, labeling oneself as LGBT was 13.9, and coming out to anyone was 15.2. In terms of ethnicity, 51.4% identified as Latino, and 48.6% as White, non-Latino young adults. Trained interviewers obtained a measurement of biological sex that resulted in the following distribution: 51.4% male and 48.6% female. Participants also self-identified their young adult gender identity on the survey: 46.5% male, 44.9% female, and 8.6% transgender. To test for the sex moderation proposed in the model, we used biological sex instead of gender identity to examine the hypothesized negative effects of crossing gendered norms (i.e., male-to-female transgender individuals would be included with other boys instead of girls because they would be perceived by their classmates as breaking male gendered norms). Finally, a retrospective report of family-of-origin socioeconomic status was assessed (1 = *both parents in unskilled positions or unemployed*, 16 = *both parents in professional positions*; $M = 6.75$, $SD = 4.77$).

Measures

Adolescent and young adult gender nonconformity. One item assessed retrospective adolescent gender nonconformity: "On a scale from 1–9, where 1 is extremely feminine and 9 is extremely masculine, how would you describe yourself when you were a teenager (age 13–19)?" After reverse-coding male scores on this question, higher scores are reflective of greater levels of adolescent gender nonconformity, whereas lower scores represent greater levels of concordance.

The same item was also asked about current (young adult) gender nonconformity: "On a scale from 1–9, where 1 is extremely feminine and 9 is extremely masculine, how would you describe yourself at this point in your life?" To test the validity, we also included an item of comparative gender nonconformity: "Compared to other people who are your same age, do you see yourself as: Much more feminine (1), more feminine (2), about the same (3), more masculine (4), or much more masculine (5)?" The three items highly correlated with one another, such that adolescent gender nonconformity was significantly associated with young adult gender nonconformity ($r = .62$, $p < .001$) and with young adult comparisons to others regarding gender conformity ($r = .50$, $p < .001$). Finally, young adult gender nonconformity correlated with young adult comparison of gender conformity ($r = .65$, $p < .001$).

Self-reported past school victimization due to actual or perceived LGBT status. A 10-item retrospective scale measured school victimization due to actual or perceived LGBT status during adolescence (ages 13–19). A sample item includes "During my middle or high school years, while at school (in other words, while on school property or at a school event), I was pushed, shoved, slapped, hit, or kicked by someone who wasn't just kidding around." The 10 items were followed by "How often did this occur because people knew or assumed you were LGBT?" (0 = *never*, 3 = *many times*). All the items loaded onto one factor in preliminary exploratory factor analysis, leaving no distinct factors. The Cronbach α reliability coefficient for the 10-item scale was .91. For a structurally stable latent construct, three parcels were created to balance items with high and low factor loadings (Little, Cunningham, Shahar, & Widaman, 2002). Following the questions about LGBT school victimization, participants were asked whether school victimization occurred due to race, weight, or other reasons. The presence of this measure limits the possibility that reports of LGBT school victimization were due to other reasons and provides a counterpoint to allow us to compare LGBT school victimization to school victimization for other reasons.

Young adult depression. The 20-item version of the Center for Epidemiologic Studies Depression Scale (Radloff, 1977, 1991)

assessed young adult depression. The reliability for the complete measure was strong ($\alpha = .94$). The four factors identified in past research were consistent with the factor structure found in this sample: positive affect (four items, $\alpha = .83$), negative affect (seven items, $\alpha = .87$), somatic symptoms (seven items, $\alpha = .82$), and interpersonal (two items, $\alpha = .64$). The items that make up the four subscales of the Depression Scale were respectively parceled into four manifest variables used as the structure for the latent construct of depression (i.e., facet-representative parceling; Little et al, 2002).

Young adult life satisfaction. An eight-item scale evaluated young adult life satisfaction. A sample question includes "At the present time, how satisfied are you with your living situation?" (1 = *very dissatisfied*, 3 = *very satisfied*). The complete measure had acceptable reliability ($\alpha = .75$). An exploratory factor analysis revealed that the eight items loaded onto a single factor. To create a structurally stable latent construct, we used the item-to-construct balance approach and created three parcels (Little et al., 2002).

Covariates. We controlled for gender (two dichotomous variables were created for female and transgender; male was the reference group), sexual orientation (two dichotomous variables were created for bisexual orientation and "other" orientation; gay or lesbian orientation was the reference group), outness to others during high school (0 = *not out to no one at school*, 4 = *out to everyone*); immigrant status (0 = *not immigrant*, 1 = *immigrant*), ethnicity (0 = *White*; 1 = *Latino/mixed*), and family-of-origin socioeconomic status.

Results

Overview of Analysis

To maximize power and to minimize exclusion of participants due to missing data, we used PRELIS, a component of LISREL 8.80 (Jöreskog & Sörbom, 2006; Graham, Cumsille, & Elek-Fisk, 2003), to impute missing data (total < 5%). All numeric variables were entered into the expectation maximization algorithm for imputation. We used SAS to conduct all descriptive statistical analyses. Assumptions of normality were checked for all variables. Items from the depression and the adolescent LGBT school victimization measures were positively skewed, but after square-root transformations were performed, the items met assumptions of normality.

To test for associations between the variables of interest, we used structural equation modeling in LISREL. To test the predicted moderator, we conducted a multigroup confirmatory factor analysis (CFA) and examined latent differences in correlations and means (Little, Card, Slegers, & Ledford, 2007). Mediation analyses were performed after the multigroup CFA allowed for the collapse of all participants into one group. We used Sobel's (1982) products-of-coefficients approach to evaluate the indirect effects (MacKinnon, Lockwood, Hoffman, West, & Sheets, 2002). The eight covariates were entered after the completion of CFA multigroup analyses and were allowed to covary freely. In examining all structural equation model fit tests, we used standard measures of practical fit: root-mean-square error of approximation, comparative fit index, and nonnormed fit index.

Descriptive Statistics

See Table 1 for the bivariate correlations, means, and standard deviations of the manifest variables. The mean level of gender nonconformity for the sample was 4.44 ($SD = 1.80$). Female participants reported the lowest levels of adolescent gender nonconformity ($M = 4.17$, $SD = 1.77$), male participants ($M = 4.45$, $SD = 1.66$) reported higher levels than girls, and transgender participants reported the highest levels ($M = 5.86$, $SD = 2.15$), $F(2, 242) = 8.13$, $p < .001$. No significant mean-level differences on gender nonconformity were found for outness to others during high school, ethnicity, immigrant status, or socioeconomic status. Manifest variable correlations provide preliminary support of our hypotheses: Specifically, both adolescent and young adult levels of gender nonconformity and LGBT school victimization were positively correlated, both adolescent and young adult levels of gender nonconformity were associated with higher young adult depression and lower young adult life satisfaction, and adolescent LGBT school victimization was also associated with higher young adult depression and lower young adult life satisfaction.

Model Results: Hypotheses 1 and 2

Our model was first tested in a multigroup CFA framework to examine factorial invariance across male and female participants. See Table 2 for the model fit statistics for the multigroup CFA (i.e., configural invariance, weak factorial invariance, strong factorial invariance; Little, 1997). We allowed the constraints to be tenable for strong invariance, even though the change in comparative fit index was greater than .01, because the model fit indices still indicated good overall model fit. Thus, our hypothesis that biological sex would moderate the association between adolescent gender nonconformity and adolescent LGBT victimization was not supported.

Table 1
Manifest Scale Correlations, Means, and Standard Deviations

Variable	*M*	*SD*	1	2	3	4	5
1. Gender nonconformity (A)	4.44	1.80	—				
2. LGBT school victimization (A)	5.33	4.91	.33***	—			
3. Depression (YA)	12.41	8.24	.22**	.32***	—		
4. Life satisfaction (YA)	22.78	4.19	−.18**	−.29***	−.62***	—	
5. Gender nonconformity (YA)	4.40	1.87	.62***	.21***	.21***	−.19**	—

Note. A = adolescent; LGBT = lesbian, gay, bisexual, transgender; YA = young adult.
** $p < .01$. *** $p < .001$.

Table 2
Multigroup Factorial Invariance Comparisons

Model	χ^2	*df*	*p*	RMSEA	90% CI	NNFI	CFI	Constraint tenable
Configural	112.17	92	>.05	.031	[.000, .059]	.987	.991	
Weak	120.37	99	>.05	.032	[.000, .059]	.987	.990	Yes
Strong	158.06	106	<.05	.058	[.035, .079]	.971	.977	Yes

Note. RMSEA = root-mean-square error of approximation; CI = confidence interval; NNFI = nonnormed fit index; CFI = comparative fit index.

Table 3 shows the model fit indices for latent covariance, variance, and mean structure analyses. The latent variance and covariance structures could be equated, which allowed male and female participants to be combined into one group for all future analyses. Investigation of the latent mean structure indicated significant differences between male and female participants even though the means could be constrained to be equal. We calculated Cohen's *d* effect sizes for the mean difference scores on all latent constructs. In examining the difference in latent mean scores for the experience of LGBT school victimization, we found a medium effect size ($d = -0.66$) between male ($M = 0.00$) and female participants ($M = -0.61$). Differences in mean scores for male ($M_{\text{depression}} = 0.00$, $M_{\text{satisfaction}} = 0.00$) and female participants ($M_{\text{depression}} = -0.38$, $M_{\text{satisfaction}} = -0.58$) on depression ($d = -0.35$) and satisfaction ($d = 0.58$) are considered to be small to medium. The difference in reported adolescent gender nonconformity between male ($M = 0.00$) and female participants ($M = -0.07$) was minimal ($d = -0.06$). Similarly, the difference in reported adult gender nonconformity was minimal ($d = -0.09$, $M_{\text{male}} = 0.00$, $M_{\text{female}} = -0.09$).

After collapsing male and female participants into one group, the structural model was tested. The model achieved excellent model fit, $\chi^2(103, N = 245) = 147.19$, $p < .01$, root-mean-square error of approximation = .04 (.02|.06), nonnormed fit index = .97, comparative fit index = .99. Female and young adults from families with higher economic backgrounds reported less LGBT-related school victimization, whereas young adults who identified as queer, who were more out to others during high school, and who were White (non-Latino) reported more LGBT school victimization. Transgender young adults reported greater levels of adolescent and young adult gender nonconformity. Immigrants reported higher levels of depression, and female and young adults from higher economic backgrounds reported more life satisfaction. Outness to others during high school was associated with lower levels of depression and higher levels of life satisfaction. We found support for our first hypothesis: Higher levels of self-reported adolescent gender nonconformity were associated with more LGBT school victimization.

Model Findings: Hypothesis 3

Only the direct and indirect effects between latent constructs are shown on Figure 2 for clarity (see Table 4 for manifest variable factor loadings). The pathway between gender nonconformity and depression was mediated by the experience of LGBT school victimization ($z = 3.14$, $p < .01$). The proportion mediated (as calculated by the formula aβ/c) is 43.95%. Likewise, the experience of LGBT school victimization mediated the pathway between gender nonconformity and life satisfaction ($z = -2.70$, $p < .01$). The proportion mediated is 51.22%. The direct paths of adolescent gender nonconformity to both young adult outcomes were not significant. Thus, our third hypothesis was supported. The results indicate that gender nonconformity predicts victimization specific to perceptions of LGBT status and that victimization—not the characteristic of gender nonconformity—accounts for long-term psychosocial adjustment problems.[1]

Finally, we replicated the model using the measure of school victimization due to other (non-LGBT) reasons. Results (available from the authors upon request) were distinctly different: School victimization for other reasons did not mediate the pathway between gender nonconformity and depression or between gender nonconformity and life satisfaction. These results further strengthen the conclusion that it is LGBT school victimization that accounts for compromised long-term psychosocial adjustment.

Discussion

Gender-nonconforming youth face many obstacles and challenges in school that they carry with them into young adulthood. This finding is consistent with a growing body of literature that suggests that adolescent experiences of gender-nonconforming and sexual minority individuals are important for understanding young adult health disparities among this population (Friedman et al., 2008; Sandfort et al., 2007). Consistent with previous studies (D'Augelli et al., 2006; Ma'ayan, 2003), the mean level of victimization experienced due to LGBT status in school was significantly different for boys and girls, with boys experiencing greater amounts of victimization at school. Also consistent with prior research and the minority stress model (D'Augelli et al., 2006; Friedman et al., 2006; Meyer, 1995, 2003; Morrow, 2004), victimization due to LGBT status was significantly associated with negative psychosocial adjustment. We also found that school victimization due to LGBT status between the ages of 13 and 19 fully accounts for the associations between gender nonconformity and young adult adjustment, measured as depression and life satisfaction. However, school victimization for other reasons does not mediate this association. On the other hand, we did not find support for our hypothesis that the strength between gender nonconformity and school LGBT victimization would be stronger for boys: The process through which early gender nonconformity

[1] We also tested the model without transgender participants. The findings (available upon request) were similar to the results based on the full sample (i.e., the indirect pathway was significant and all pathways were of similar strength and the same direction). On the basis of these results, and because our measure of LGBT school victimization was inclusive of transgender experiences, we present finding based on the full sample.

Table 3
Tests of Equivalence of Covariance, Variance, Latent Correlations, and Means

Model	χ^2	*df*	*P*	$\Delta\chi^2$	Δdf	*p*	Constraint tenable
Homogeneity of variances and covariances	134.67	114	>.05	14.30	15	>.05	Yes
Equality of variances	127.59	104	>.05	7.22	5	>.05	Yes
Equality of correlations	128.96	109	>.05	8.59	10	>.05	Yes
Equality of means	166.83	116	<.01	8.77	10	>.05	Yes

affects later psychosocial adjustment is similar for boys and girls. Overall, our results provide partial support for the minority stress model. We found that the negative impact of specifically homophobic school victimization continues into the young adult years and affects quality of life and capacity to enjoy life.

Because victimization due to perceived or actual LGBT status occurs within the school context, the results of this study have several implications for school administrators, teachers, school-based providers, and staff, as well as social service and mental health providers and other providers who directly work with LGBT and gender-nonconforming young people. Although boys experience victimization in school due to actual or perceived LGBT status and gender nonconformity at higher rates than girls, school policies and practices affect all students regardless of gender. Enactment of school policies that specifically prohibit victimization due to LGBT status, gender nonconformity, and other types of bias-related harassment can help reduce negative psychosocial outcomes in LGBT and gender-nonconforming young people. Thus, although it is clear that all victimization should be prohibited in schools, these findings specifically indicate the need for antibullying policies that enumerate categories often targeted by bullies.[2]

Recommendations for Safe Schools

In line with recent research and guidance on LGBT student safety (Chesir-Teran, 2003; Kosciw et al., 2008; O'Shaughnessy et al., 2004; Perrotti & Westheimer, 2001; Sausa, 2005), we recommend that schools implement policies and procedures to prevent harassment due to LGBT status and gender nonconformity. The most basic change schools can make includes adopting and implementing enumerated antiharassment policies to prevent harassment based on gender nonconformity and LGBT status. Antiharassment policies, however, need to have follow-up procedures and other policies and programs to further promote a safe school environment. Providing education about gender expression and LGBT issues to students, administrators, staff, and teachers is another key strategy for increasing safety in schools. Schools should provide the opportunity for a support or social group for gender-nonconforming and LGBT students, such as a Gay–Straight Alliance, to provide an institutional venue for social support, student involvement, and student voice (Goodenow, Szalacha, & Westheimer, 2006; Human Rights Watch, 2001). In fact, Goodenow et al. (2006) found that sexual minority youth in schools with Gay–Straight Alliances reported fewer suicide attempts than students without Gay–Straight Alliances in their schools. School administrators, teachers, and staff members should examine the physical structure of their schools to find new opportunities to create safer environments for gender-nonconforming and LGBT students (Chesir-Teran, 2003). For example, providing gender-neutral bathroom options for students, staff, and teachers and avoiding the use of gendered segregation in practices such as school uniforms, school dances, and extracurricular activities are structural ways to provide safer school environments.

Limitations

This study has several limitations. Although we used the best sampling strategies available to reach stigmatized populations (Diamond, 2003), the results cannot establish causality and cannot be generalized to all gender-nonconforming youth in other settings outside California. The data collection was retrospective, which does not allow for measurements to be taken at unique data points (Frazier, Tix, & Barron, 2004). The order of measurements in the survey may have led to measurement bias because participants were asked to report retrospectively on prevalence of LGBT school-related victimization prior to being asked about their current life situations. This order of questions may have prompted respondents to report more negative psychosocial adjustment. Our methods attempt to establish temporal order by asking participants to report retrospectively on gender nonconformity and victimization while reporting current life adjustment. Although this is a potential concern, prior research has found that results of retrospective reports of school bullying are stable over time, a finding that gives us confidence that reports of adolescent school victimization were not overly influenced by young adult mental health (Rivers, 2001b). Another limitation of our construct of LGBT school victimization and our test of the minority stress model is that we do not have a measure of expectations of victimization; those who expect more victimization may report more victimization experiences.

Our focus on school victimization as the sole context for our measure of LGBT-related victimization and violence is limited. A more comprehensive approach to studying the mechanisms that place LGBT and gender-nonconforming youth at greater risk for concurrent and later psychosocial maladjustment would include experiences of victimization and rejection from multiple contexts (e.g., family, community, work). Our measurement of gender nonconformity is also limited in that it was assessed only with a single item. Future work could examine the associations among gender nonconformity, victimization experiences, and adjustment

[2] For example, the Safe Schools Improvement Act (H.R. 2262), currently under consideration by Congress, is the first proposed federal school antibullying law that includes enumerated categories. Currently 10 U.S. states have enumerated school antibullying laws designed to protect students based on sexual orientation and gender identity or expression.

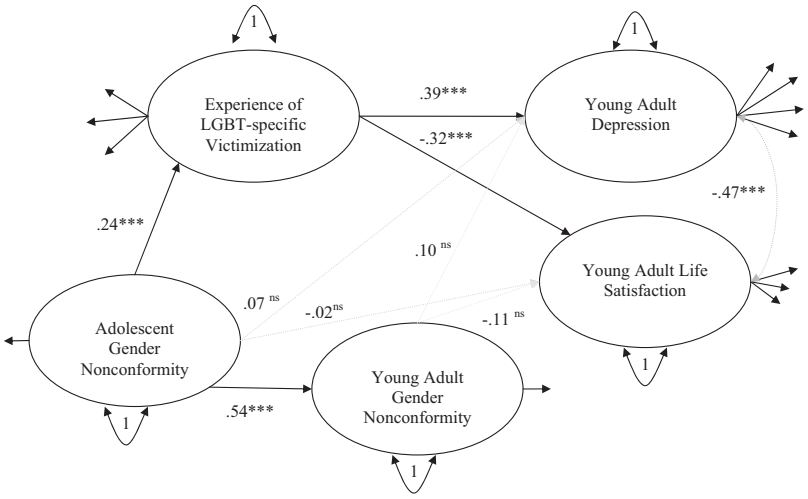

Figure 2. Model with standardized estimates.

from a multidimensional view of gender such as the one proposed by Egan and Perry (2001).

Conclusions

Despite the limitations, this study contributes new knowledge about the negative impact school victimization has for young adult well-being among gender-nonconforming LGBT young adults. Specifically, the direct effect of adolescent gender nonconformity on young adult adjustment was fully mediated by the experience of victimization. This finding is particularly important when framed in the context of the murder of Larry King (Pringle & Saillant, 2008). We acknowledge that this is only one recent example, but the media attention it received highlights growing public concern about the most extreme form of victimization that LGBT and gender-nonconforming youth experience in school. King's brutal experience with victimization because of his sexual orientation and gender nonconformity ended with his teenage murder, but our findings indicate that the experience of victimization has lasting consequences that fully account for any previous association between gender nonconformity and young adult adjustment.

Prior to this study, the authors are aware of no other studies that have attempted to examine simultaneously the associations between gender nonconformity, LGBT school victimization, young adult depression, and life satisfaction. The results of this study warrant future research to examine other factors that may be crucial in the lives of LGBT youth in preventing negative psychosocial outcomes. For instance, what other factors influence the association between victimization and psychosocial outcomes: family acceptance, family rejection, peer support, or other life situations (e.g., socioeconomic status, quality of other relationships, personality factors)? Finally, future research should examine the school context to gain a deeper understanding of effective protective measures that schools use to prevent the victimization and harassment of LGBT and gender-nonconforming students.

Table 4
Unstandardized and Standardized Factor Loadings

Construct	Unstandardized (*SE*)	Standardized
Adolescent gender nonconformity	1.73 (0.08)	1.00
Adolescent LGBT school victimization		
Parcel 1	0.40 (0.02)	.94
Parcel 2	0.37 (0.02)	.87
Parcel 3	0.36 (0.02)	.88
Depression		
Positive affect	0.35 (0.02)	.80
Negative affect	0.35 (0.02)	.91
Somatic symptoms	0.31 (0.02)	.88
Interpersonal	0.27 (0.02)	.66
Young adult life satisfaction		
Parcel 1	0.36 (0.04)	.64
Parcel 2	0.41 (0.04)	.76
Parcel 3	0.36 (0.03)	.70
Young adult gender nonconformity	1.34 (0.06)	1.00

Note. All factor ladings are significant at $p < .001$. LGBT = lesbian, gay, bisexual, transgender.

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ARTICLE

Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults

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What's Known on This Subject

To our knowledge, no other study has examined the relationship between family rejection of LGB adolescents with health and mental health problems in emerging adulthood.

What This Study Adds

This study expands our understanding of predictors of negative health outcomes for LGB adolescents and provides new directions for assessing risk and preventing health and mental health problems in LGB adolescents.

ABSTRACT

OBJECTIVE. We examined specific family rejecting reactions to sexual orientation and gender expression during adolescence as predictors of current health problems in a sample of lesbian, gay, and bisexual young adults.

METHODS. On the basis of previously collected in-depth interviews, we developed quantitative scales to assess retrospectively in young adults the frequency of parental and caregiver reactions to a lesbian, gay, or bisexual sexual orientation during adolescence. Our survey instrument also included measures of 9 negative health indicators, including mental health, substance abuse, and sexual risk. The survey was administered to a sample of 224 white and Latino self-identified lesbian, gay, and bisexual young adults, aged 21 to 25, recruited through diverse venues and organizations. Participants completed self-report questionnaires by using either computer-assisted or pencil-and-paper surveys.

RESULTS. Higher rates of family rejection were significantly associated with poorer health outcomes. On the basis of odds ratios, lesbian, gay, and bisexual young adults who reported higher levels of family rejection during adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse compared with peers from families that reported no or low levels of family rejection. Latino men reported the highest number of negative family reactions to their sexual orientation in adolescence.

CONCLUSIONS. This study establishes a clear link between specific parental and caregiver rejecting behaviors and negative health problems in young lesbian, gay, and bisexual adults. Providers who serve this population should assess and help educate families about the impact of rejecting behaviors. Counseling families, providing anticipatory guidance, and referring families for counseling and support can help make a critical difference in helping decrease risk and increasing well-being for lesbian, gay, and bisexual youth. *Pediatrics* 2009;123:346–352

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Key Words
LGB adolescents, risk factors, sexual orientation, gay youth, homosexuality

Abbreviations
LGB—lesbian, gay, and bisexual
FAP—Family Acceptance Project
CES-D—Center for Epidemiologic Studies Depression Scale
STD—sexually transmitted disease
OR—odds ratio

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SINCE STUDIES WERE first published on homosexual youth in the 1970s and 1980s,[1,2] serious health disparities[3–8] have been documented among lesbian, gay, and bisexual (LGB) adolescents compared with their heterosexual peers. Population-based and community studies have documented higher levels of suicide attempts,[9–11] substance use,[3,4,6] symptoms of depression and mental health problems,[12,13]and sexual health risks, including risk for sexually transmitted infections, HIV,[3,14,15] and adolescent pregnancy.[16–18] Similarly, population-based studies have reported high levels of negative health outcomes for LGB adults compared with heterosexuals.[19–22]

Both practitioners and researchers have noted that risks to physical, emotional, and social health for sexual minority adolescents are primarily related to social stigma and negative societal responses,[23–26] particularly in schools[3,25–29] In addition, several studies have linked minority stress (experiencing and internalizing negative life events and victimization in the social environment) with negative health outcomes in LGB adults, including depressive symptoms, substance use, and suicidal ideation.[30,31]

Pediatric providers are trained to work closely with families and to recognize that families have "a central and enduring influence" on a child's life.[32] Because parents and key caregivers are perceived to play a vital role in an

adolescent's health and well-being,[33] it is surprising that so little attention has focused on parents and caregivers' influence on their LGB children and adolescents' health and well-being.

This article presents findings related to family rejection from the Family Acceptance Project (FAP), a research and intervention initiative to study the influence of family reactions on the health and mental health of lesbian, gay, and bisexual adolescents and young adults. To our knowledge, no other study has previously examined this relationship. The current study was designed to link specific family reactions to their children's sexual orientation and gender expression with health and mental health problems in emerging adulthood.

METHODS

Sampling and Recruitment

The FAP uses a participatory research approach advised at all stages by the population of interest (LGB adolescents, young adults, and family members), as well as health care providers, teachers, and advocates. Participatory research increases both the representativeness and the cultural competence of sampling and research strategies.[34] Providers, youth, and family members met regularly with the research team to provide guidance on all aspects of the research, including methods, recruitment, instrumentation, analysis, coding, materials development, and dissemination and application of findings.

We recruited a sample of 245 LGB young non-Latino white and Latino adults, ages 21 to 25 years, who were open about their sexual orientation to at least 1 parent or primary caregiver (including guardians) during adolescence. Twenty-one participants self-identified as transgender. Because of the small number of transgender participants, we only report here on outcomes from 224 LGB respondents. Participants were recruited conveniently from 249 LGB venues within 100 miles from our office. Half of the sites were community and social organizations that serve LGB young adults, and half were from clubs and bars serving this group. Bilingual recruiters conducted venue-based recruitment from bars and clubs and contacted each agency to access all young adults who use their services.

Study Procedures

Young adults who expressed interest in the study were screened for eligibility, and those meeting inclusion criteria were enrolled. Criteria included: age 21 to 25 years; ethnicity (non-Latino white, Latino, or Latino mixed); self-identification as LGB, homosexual, or queer/non-heterosexual during adolescence; knowledge of their LGB sexual orientation by at least 1 parent or guardian during adolescence; and having lived with at least 1 parent or guardian during adolescence at least part-time. LGB young adults, ages 21 to 25 years, were studied to assess the impact of family reactions to their LGB identity at an age when most young people have achieved greater independence and are more likely to be living on their own with fewer immediate parental buffers or behavioral restrictions.

The family rejection measures in the survey were developed based on a previous in-depth qualitative study conducted in English and Spanish among 53 socioeconomically and geographically diverse Latino and non-Latino white LGB adolescents and 49 completed families throughout California from 2002 to 2004. These in-depth individual interviews of 2 to 4 hours each generated 106 specific behaviors that families and caregivers used to express acceptance or rejection of their LGB children; 51 of these family reactions were rejecting (such as excluding their LGB child from family activities or events).

Measures

Family Rejection

On the basis of transcripts of in-depth interviews, we created 51 close-ended items that assessed the presence and frequency of each rejecting parental or caregiver reaction to participants' sexual identity and gender expression when they were teenagers, creating at least 3 close-ended items for each type of outwardly observable rejecting reaction documented in transcripts. For example, "Between ages 13–19, how often did your parents/caregivers blame you for any anti-gay mistreatment that you experienced?"

For each survey item, participants indicated whether their parents or caregivers reacted in the way specified by the item "many times," "a few times," "once or twice," or "never." For the current analysis, however, we dichotomized responses to each item into never (0) or ever (1). We dichotomized item responses because, at this point in the research program, it is unclear whether the frequencies of different rejecting reactions are equivalent with respect to potential health impact. For example, are multiple acts of exclusion from family activities equivalent to multiple disparaging comments made by the family about LGB persons? We plan to address these questions in subsequent analyses. In addition, the dichotomous scoring of items facilitated comparison of the mean number of different types of family rejecting reactions for different gender and ethnic subgroups. Dichotomized scores were then added to create a family rejection score, with values ranging from 0 to 51 (mean: 20.91; SD: 15.84). Reliability analyses indicate that the FAP Family Rejection Scale has high internal consistency (Cronbach's $\alpha = .98$).

To facilitate use of the findings by pediatric providers, we also divided the sample equally into 3 subgroups based on the tertile in which their family rejection score fell: low rejection scores ($n = 76$; scores ranging from 0–11.00 [mean: 4.86]), moderate rejection scores ($n = 74$; scores ranging from 11.09 to 25.50 [mean: 17.48]), and high rejection scores ($n = 74$; scores ranging from 26.56 to 51.00 [mean: 40.83]).

Mental Health

We assessed 3 mental health outcomes: current depression, suicidal ideation in the last 6 months, and lifetime

TABLE 1 **Demographics**

Variable	Total ($N = 224$)	Male		Female		Statistically Significant Effects[a]
		White ($n = 52$)	Latino ($n = 62$)	White ($n = 55$)	Latina ($n = 55$)	
Mean age, y	22.82	22.88	22.74	23.09	22.58	None
Education, %						
Less than high school	9.8	13.5	11.3	5.5	9.1	None
High school graduate	18.3	19.2	19.4	18.2	16.4	
Some college	50.9	46.2	62.9	43.6	49.1	
College degree or higher	21.0	21.2	6.5	32.7	25.5	
Employment and income, %						
Currently employed	76.3	61.5	85.5	80.0	76.4	G[b], GxE[b]
In school	56.6	40.0	66.7	45.5	84.6	E[b]
Weekly income <$100	23.3	30.8	14.5	25.5	24.1	None
Weekly income $101[en]$300	32.7	19.2	33.9	40.0	37.0	
Weekly income $301[en]$500	28.3	34.6	29	21.8	27.8	
Weekly income $500+	15.7	15.3	22.6	12.7	11.1	
Sexual identity, mean ages, y						
Aware of same-sex attraction	10.76	9.54	9.74	11.47	12.36	G[c]
Came out to self	14.16	13.88	13.64	14.2	14.95	G[b]
Came out to others	15.32	15.21	15.34	15.21	15.73	None
Came out to family	15.82	15.27	15.81	16.24	16.13	None

G indicates gender effect; E, ethnicity effect; GxE, gender-by-ethnicity interaction.

[a] Results of logistic regressions testing gender, ethnicity, and their interaction as predictors of demographic variables.

[b] $P < .05$.

[c] $P < .001$.

suicide attempts. Level of current depression was assessed through the Center for Epidemiologic Studies Depression Scale (CES-D). We used the recommended cutoff point for adolescents and young adults[35] (>16 indicates probable depression). Suicidal ideation and suicide attempts were measured by single items that were scored dichotomously yes (1) or no (0).

Substance Use and Abuse

We assessed substance use and abuse in 3 ways: heavy alcohol drinking in the past 6 months, use of illicit drugs in the past 6 months, and substance use–related problems in the last 5 years. Heavy drinking was defined by drinking 1 to 2 times per week or more with 3 or more drinks on a typical day. Illicit drug use was assessed by a single item answered dichotomously about use in the past 6 months. Four items assessed the potential negative consequences of alcohol and/or drug use: problems with the law, loss of employment, loss of consciousness, and conflicts with family, lovers, or friends. Measure of substance use–related problems was scored dichotomously (≥1 substance use–related problems [1] versus none [0]).

Sexual Risk Behavior

We assessed sexual behavior in the last 6 months by asking about number, gender, and type of sexual partners, type of sexual activity, and whether condoms were used when activity involved anal or vaginal penetration. Based on these responses, we created 2 measures of sexual risk: Any unprotected anal and/or vaginal sex with a casual, nonmonogamous, or HIV-serodiscordant partner (1) at last intercourse, and (2) any time in the past 6 months. Because young lesbian and bisexual women experience their greatest risks for HIV infection through sexual behaviors with men, sex between 2 women was not categorized as "risky" for HIV infection. Significant percentages of young women reported unprotected vaginal sex with casual male partners. Finally, we asked whether participants had ever in their lives been diagnosed by a health care professional as having an STD. The 3 measures were scored dichotomously as yes (1) or no (0).

RESULTS

Demographic Profile of the Sample

Table 1 includes the demographic profile of the sample. The mean age was 22.82 years, with no significant age differences by gender or ethnicity. Forty-eight percent were non-Latino whites and 52% were Latino; 51% identified as male, 49% as female. Contrary to what would be expected for non-LGB populations, non-Latino white men were the least likely to be employed (61.5%) and were less likely to be in school (40%). The findings on sexual identity development indicate that, on average, men were aware of same-sex attraction 2 years earlier than women and self-identified as LGB ~1 year earlier than the women. No gender differences were found for disclosure of sexual orientation to family and others.

Negative Health Outcomes According to Gender and Ethnicity

Table 2 reports the prevalence of negative health problems for the sample according to gender and ethnicity. Rates are high for depression, suicidal ideation and at-

TABLE 2 **Health-Related Problems According to Gender and Ethnicity**

Variable	%					Statistically Significant Effects[a]
	Whole Sample	Male		Female		
		White	Latino	White	Latino	
Mental health problems						
Current depression (CES-D>16)	43.3	44.2	58.1	41.8	27.3	GxE[b]
Suicidal ideation	25.4	25.0	35.5	27.3	12.7	GxE[b]
Suicide attempts (any, ever)	40.6	44.2	54.8	34.5	27.3	None
Substance use and abuse						
Heavy drinking (past 6 mo)	41.5	48.1	58.1	32.7	25.5	None
Illicit substance use (last 6 mo)	54.5	47.3	43.6	63.5	62.9	None
Substance use[en]related problems (any, ever)	54.7	55.8	67.7	50.9	42.6	None
Sexual risk						
Unprotected sex with casual partner (last 6 mo)	27.2	40.4	45.2	7.3	14.5	G[c]
Unprotected sex with casual partner (at last intercourse)	20.7	13.7	32.3	20.0	14.8	GxE[b]
STD diagnosis (any, ever)	27.6	38.0	38.0	23.5	11.5	None

GxE indicates gender-by-ethnicity interaction.

[a] Results of logistic regressions testing gender, ethnicity, and their interaction as predictors of demographic variables.

[b] $P < .05$.

[c] $P < .001$.

tempts, substance use, and sexual health risks. More than half (54.7%) reported at least 1 substance use–related problem, and 40.6% reported at least 1 lifetime suicide attempt. Taken together, the data indicate that about half of this sample of young LGB adults show considerable mental health and substance use problems. Sexual risk behavior appears somewhat less frequently but still at a relatively high incidence.

To determine whether health outcomes differed according to gender and ethnicity, a series of logistic regression analyses were conducted, regressing each outcome onto gender (G: male, female), ethnicity (E: non-Latino white, Latino), and their interaction. Results of these analyses are presented in Table 2. For 2 of the 3 mental health outcomes, significant gender-by-ethnicity interactions were observed, with Latino men showing higher rates of depression and suicidal ideation. Latino men also showed higher levels of HIV risk behavior.

Family Rejection According to Gender and Ethnicity

Table 3 reports means and SDs for the FAP Family Rejection Scale according to gender and ethnicity. Because scale items were scored dichotomously (ever [1] versus never [0]), scale means reflect the mean number of different negative parental/caregiver reactions experienced during adolescence within each subgroup. Non-Latino white women reported the least (mean: 17.65), whereas Latino men reported the highest number (mean: 24.52) of negative family reactions to their sexual orientation in adolescence. To determine whether levels of family rejection differed by gender and ethnicity, a 2 (gender) × 2 (ethnicity) analysis of variance was conducted on the number of reported rejecting experiences (see Table 3). Statistically significant main effects were observed only for gender, indicating that men reported more rejecting reactions than women.

Family Rejection as Predictor of Negative Health Outcomes

The relationships between experiences of family rejection and the 9 negative health outcomes were analyzed in 2 different ways. First, we analyzed the relationship between continuous scale scores and health outcomes in logistic regressions where continuous scores were the independent variable controlling for gender and ethnicity. For this analysis, continuous scores were rescaled so that 1 unit equaled 1 SD. Resulting odds ratios (ORs) can be interpreted as the increased risk for an outcome, given a 1-SD increase in family rejection. A second series of logistic regression analyses were conducted in which each health outcome was regressed onto the trichotomized rejection score, also controlling for gender and ethnicity. These results are reported in Table 4, including the proportion of participants within each family rejection subgroup (low, moderate, and high) who experienced the given negative health outcome.

Greater experiences of family rejection were associated with poorer health outcomes. This was true for all but 2 of the 9 outcomes (heavy drinking in the past 6 months and lifetime history of STD diagnosis). In general, large statistically significant differences in health outcomes were observed when participants scoring in the upper tertile of family rejection were compared with those in the lower tertile. Fewer differences were observed when moderate levels of rejection were compared with low rejection. As Table 4 shows, LGB young adults who reported higher levels of family rejection during adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to report illegal drug use, and 3.4 times more likely to report having engaged in unpro-

TABLE 3 **Family Rejection**

Gender	White	Latino
Male	21.30 (17.03)	24.52 (17.12)
Female	17.65 (13.83)	19.74 (14.60)

Range of scale: 0 [en]51. Ethnicity: $F_{1220} = 1.58$, not significant; gender: $F_{1220} = 4.06$, $P < .05$; gender by ethnicity: $F_{2239} < 1$, not significant.

TABLE 4 **Family Rejection as Predictors of Negative Health Outcomes**

Outcome Variable	Rejection Scale Score, OR (95% Confidence Interval)[a]	Percentage of Participants Experiencing Outcome			Moderate Rejection, OR (95% Confidence Interval)[b]	High Rejection, OR (95% Confidence Interval)[b]
		Low Rejection Scores	Moderate Rejection Scores	High Rejection Scores		
Mental health						
Suicidal ideation	2.13 (1.53–2.95)[c]	11.8	21.6	43.2	2.12 (0.86–5.18)	5.64 (2.42–13.14)[c]
Suicide attempts	3.09 (2.18–4.37)[c]	19.7	35.1	67.6	2.29 (1.08–4.83)[d]	8.35 (3.90–17.85)[c]
Depression (CES-D >16)	2.21 (1.62–3.01)[c]	22.4	44.6	63.5	2.92 (1.42–6.00)[e]	5.94 (2.86–12.34)[c]
Substance use/abuse						
Heavy drinking (past 6 mo)	0.84 (0.63–1.12)	40.8	47.3	36.5	1.34 (0.69–2.63)	0.71 (0.36–1.42)
Illicit substance use (past 6 mo)	1.83 (1.35–2.49)[c]	42.1	50.0	71.6	1.42 (0.74–2.72)	3.38 (1.69–6.77)[e]
Substance-related problems (any, ever)	1.60 (1.19–2.14)[e]	48.0	47.3	68.9	0.98 (0.51–1.88)	2.28 (1.16–4.50)[d]
Sexual risk behavior						
Unprotected sex with a casual partner (past 6 mo)	1.73 (1.25–2.40)[e]	23.7	12.2	45.9	0.41 (0.16–1.04)	2.50 (1.17–5.34)[d]
Unprotected sex with a casual partner (last intercourse)	1.72 (1.23–2.42)[e]	13.2	13.9	35.1	1.04 (0.41–2.69)	3.36 (1.47–7.67)[e]
STD diagnosis (any, ever)	1.32 (0.95–1.85)	24.0	27.1	32.8	1.25 (0.58–2.69)	1.49 (0.68–3.27)

All effects were adjusted for gender (female, male) and ethnicity (Latino, white).

[a] Continuous scale score, rescaled such that 1 unit = 1 SD; ORs can be interpreted as the change in odds of the outcome for a 1-SD change in rejection.

[b] Low rejection is the reference group.

[c] $P < .001$.

[d] $P < .01$.

[e] $P < .05$.

tected sexual intercourse, compared with peers from families with no or low levels of family rejection.

DISCUSSION

The results of this study show that negative family reactions to an adolescent's sexual orientation are associated with negative health problems in LGB young adults. As such, this study provides empirical evidence to begin addressing long-standing questions about the precursors of high levels of risk consistently documented in studies of LGB youth and young adults. Because families play such a critical role in child and adolescent development, it is not surprising that adverse, punitive, and traumatic reactions from parents and caregivers in response to their children's LGB identity would have such a negative influence on their risk behaviors and health status as young adults. This study begins to help us understand the important role that parents and caregivers of lesbian, gay, and bisexual youth play in contributing to health problems in their LGB children. Given that higher levels of family rejection and higher rates of negative mental health and HIV risk outcomes were found among Latino gay and bisexual men, our study suggests that this subgroup is particularly affected.

Our findings also underscore a key recommendation of the American Academy of Pediatrics Task Force on the Family: to expand practice to encompass assessment of family relationships and behaviors.[36] Although the current study does not determine causality, it establishes a link between specific parental and caregiver rejecting behaviors and negative health problems in LGB young adults. LGB young people from families with no or low levels of rejection are at significantly lower risk than those from highly rejecting families related to depression, suicidality, illicit substance use, and risky sexual behavior. So helping families identify and reduce specific rejecting behaviors is integral to helping prevent health and mental health problems for LGB young people.

Parents consider pediatricians[36] and other health providers to be important sources of guidance in childrearing. By asking LGB adolescents about their relationships with their families and experiences with family rejection, providers can obtain important information in determining the adolescent's risk profile. Anticipatory guidance offers a direct opportunity to advise parents of LGB youth on how to support their child's health and development.[23]

The current study also has important implications for identifying youth at risk for family violence and for being ejected from their homes or placed in custodial care because of their LGB identity. LGB youth are overrepresented in foster care, juvenile detention, and among homeless youth. Moreover, conflict related to the adolescent's sexual and gender identity is a primary cause of ejection or removal from the home. Early intervention to help educate families about the impact of rejecting behaviors is important to help maintain these youth in their homes.

There are several limitations to the study. This is a retrospective study that measures young adults' reported experiences that occurred several years earlier, which may introduce some potential for, recall bias. To minimize this concern, we created measures that asked whether a specific family event related to their LGB identity actually occurred (eg, verbal abuse), rather than asking generally about "how rejecting" parents were. Although we went to great lengths to recruit a diverse sample drawing from multiple venues, our sample is

technically one of convenience, and thus shares the limitations inherent in all convenience samples.[37] Thus, these data might not represent all subpopulations of LGB young adults, as well as individuals who are neither white nor Latino. The study focused on LGB non-Latino white and Latino young adults to permit more in-depth assessment of cultural issues and experiences related to sexual orientation and gender expression, so it did not include all other groups and drew from 1 urban geographic area. Subsequent research should include greater ethnic diversity to assess potential differences in family reactions. Lastly, given the cross-sectional nature of this study, we caution against making cause–effect interpretations from these findings.

RECOMMENDATIONS FOR PRACTICE

Pediatric providers can help decrease family rejection and increase support for LGB young people in several ways:

1. Ask LGB adolescents about family reactions to their sexual orientation and gender expression and refer to LGB community support programs and for supportive counseling as needed.
2. Identify LGB support programs in the community and online resources to educate parents about how to help their LGB children. Parents need access to positive parental role models to help decrease rejection and increase family support for their LGB children.
3. Advise parents that negative reactions to their adolescent's LGB identity may negatively influence their child's health and mental health.
4. Recommend that parents and caregivers modify highly rejecting behaviors that have the most negative influence on health concerns, such as suicidality.
5. Expand anticipatory guidance to include information on the need for support and the link between family rejection and negative health problems in LGB young people.

Unlike children and adolescents, in general, who receive services and care in the context of their families, LGB adolescents are typically served as adults as if they have no families, across a wide range of settings. These findings indicate that providers serving LGB young people must begin to assess family dynamics and consider the role of families when assessing an LGB adolescent's risk and making decisions about their care. Counseling families, providing anticipatory guidance, and referring families for counseling and support can help make a critical difference in decreasing risk and increasing well-being for many LGB youth who have limited support. Our preliminary work with families who are ambivalent and conflicted about their children's LGB identity indicates that they are receptive and interested to learn about how their words, actions and behaviors affect their children's health. Additional work is needed to demonstrate how to help families increase support for their LGB children by building on family strengths and the love they have for their LGB children.

APPENDIX: RESOURCES FOR FAMILIES WITH LGB CHILDREN

PFLAG

Education, information, and support for parents and families with LGB family members; referrals to LGB community resources and services: www.pflag.org

PFLAG for Families of Color & Allies (New York City)

Education, information, and support for families of color with LGB family members, including information, resources, and support in Spanish: www.pflagfamiliesofcolor.org

API Family Pride

Education, information, and support for Asian and Pacific Islander (API) families with LGB family members: www.apifamilypride.org

Family Acceptance Project

Research-based education and services for ethnically diverse families with LGB children in English, Spanish, and Chinese; currently developing provider assessment tools and interventions to help increase family support for ethnically diverse LGB children and youth: http://familyproject.sfsu.edu

Gender Spectrum Education & Training

Family information, support, and annual conference for families with gender-variant children; training on gender identity and expression for schools and providers for helping gender nonconforming and transgender children and youth: www.genderspectrum.org

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Family Acceptance in Adolescence and the Health of LGBT Young Adults

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ISSUE: *The role of family acceptance as a protective factor for lesbian, gay, bisexual, and transgender (LGBT) adolescents and young adults has not been established.*

METHODS: *A quantitative measure with items derived from prior qualitative work retrospectively assessed family accepting behaviors in response to LGBT adolescents' sexual orientation and gender expression and their relationship to mental health, substance abuse, and sexual risk in young adults (N = 245).*

FINDINGS: *Family acceptance predicts greater self-esteem, social support, and general health status; it also protects against depression, substance abuse, and suicidal ideation and behaviors.*

CONCLUSIONS: *Family acceptance of LGBT adolescents is associated with positive young adult mental and physical health. Interventions that promote parental and caregiver acceptance of LGBT adolescents are needed to reduce health disparities.*

Search terms: *Gender identity, homosexuality, LGBT adolescent, protective factors, sexual orientation, transgender*

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Extensive research has focused on the nurturing and protective role of families, in general, and connections to family have been shown to be protective against major health risk behaviors (e.g., Resnick et al., 1997). Although family relationships are understood to be a primary context for adolescent development, only a small number of studies have focused on the role of parent–adolescent relationships for lesbian, gay, and bisexual (LGB) youth and young adults. Literature addressing the family relationships for transgender adolescents and young people is miniscule. Given the crucial role of parents in promoting adolescent well-being, it is surprising that so little attention has focused on the parenting of lesbian, gay, bisexual, and transgender (LGBT) adolescents. Most existing research has focused on negativity in the relationships between LGB youth and their parents; no known research has considered the possible developmental benefits of family acceptance and supportive behaviors for LGBT youth. One study has assessed the relationship between LGB young adults' perceived family support (e.g., general closeness, warmth, and enjoying time together) and depression, substance use, and suicidality (Needham & Austin, 2010).

The lack of literature on family support is particularly surprising because LGB youth and adults (Cochran, Sullivan, & Mays, 2003; D'Augelli, 2002; Meyer, 2003) and youth with same-gender attractions (Russell & Joyner, 2001) are known to be at risk for compromised physical and emotional health. Research over the past decade has begun to trace the origins of health disparities associated with sexual identity; these studies have focused largely on the role of victimization and negative peer relationships during adolescence and associated health risks in adolescence and young adulthood

(Diamond & Lucas, 2004; Lasser & Tharinger, 2003; Russell, 2005; Russell, Seif, & Truong, 2001; Ryan & Rivers, 2003; van Wormer & McKinney, 2003).

Studies show that LGB adolescents' relationships with their parents are often challenged, particularly around the time of disclosure of sexual identity or "coming out" (D'Augelli, Grossman, & Starks, 2005; Patterson, 2000; Savin-Williams, 1998a, 1998b; Savin-Williams & Dubé, 1998; Tharinger & Wells, 2000) or when parents learn that their children are LGBT. Researchers in one study (Rosario, Schrimshaw, & Hunter, 2009) examined substance use among LGB youth and asked youth whether they perceived reactions to their LGB identity from a range of people (including family members, coaches, teachers, therapists, neighbors, and friends) to be accepting, neutral, or rejecting. The number of perceived rejecting reactions were reported to predict substance use; although accepting reactions did not directly reduce substance use, such reactions buffered the link between rejections and substance use.

Another recent study assessed the relationship between family rejection in adolescence and the health of LGB young adults (Ryan, Huebner, Diaz, & Sanchez, 2009). That study showed clear associations between parental rejecting behaviors during adolescence and the use of illegal drugs, depression, attempted suicide, and sexual health risk by LGB young adults. Prior research clearly points to the role of family rejection in predicting health and mental health problems among LGB adolescents and adults, yet at the same time, while it is known that initial parental reactions to the disclosure of LGB identity may be negative—sometimes including ejection from the home—research has also shown that after parents become sensitized to the needs and well-being of their LGB children, many family relationships improve (D'Augelli et al., 2005).

Reports about researchers who study family reactions to their children's LGBT identity indicate that parental acceptance and rejection are different constructs (e.g., Perrin et al., 2004); thus, accepting and rejecting behaviors can co-occur as families adjust to learning about their child's LGBT identity. Nevertheless, the focus of prior research has been largely on compromised parent–adolescent relationships for LGB young people. Yet given the changes in public visibility and attitudes about LGBT people and issues over the course of past decades (Savin-Williams, 2005), some families react to learning about their child's LGBT identity with acceptance (Ryan, 2009a).

Further, given the links between parental rejection and negative health outcomes (Ryan et al., 2009), we expect that affirmation or acceptance of LGBT adolescents will be associated with positive adjustment and decreased mental health and behavioral health risks in young adulthood: higher self-esteem, increased social support, and better general health status, along with decreased depression, substance abuse, sexual risk behavior, suicidal ideation, and behaviors.

This article presents findings related to family acceptance from the Family Acceptance Project (FAP), a research and intervention initiative to study the influence of family reactions on the health and mental health of LGBT adolescents and young adults. To our knowledge, no prior studies have examined the relationship between specific family reactions to their children's sexual orientation and gender expression with health and mental health status in emerging adulthood.

Methods

Sampling and Procedures

This study used a participatory research approach that was advised at all stages by individuals who will use and apply the findings—LGBT adolescents, young adults, and families—as well as health and mental health providers, teachers, social workers, and advocates. Providers, youth, and family members provided guidance on all aspects of the research, including methods, recruitment, instrumentation, analysis, coding, materials development, and dissemination and application of findings. This type of participatory research has been shown to increase the representativeness and cultural competence of sampling and research strategies (Viswanathan et al., 2004).

We recruited a sample of 245 LGBT Latino and non-Latino white young adults from 249 LGBT venues within a 100-mile radius of our office. Half of the sites were community, social, and recreational agencies and organizations that serve LGBT young adults, and half were from clubs and bars serving this group. Bilingual recruiters (English and Spanish) conducted venue-based recruitment from bars and clubs and contacted program directors at each agency to access all young adults who use their services.

Preliminary screening procedures were used to select participants who matched the study criteria. Inclusion criteria were age (21–25), self-identified ethnicity (non-Latino white, Latino, or Latino mixed), self-identification as LGBT, homosexual, or nonheterosexual (e.g., queer) during adolescence, knowledge of their LGBT identity by at least one parent or guardian during adolescence, and having lived with at least one parent or guardian during adolescence at least part of the time. The survey was available in computer-assisted and pencil and paper formats. The study protocol was approved by the university's IRB.

Measures

Family Acceptance

The measure of family acceptance was developed based on individual in-depth interviews of 2–4 hr each with 53 socioeconomically diverse Latino and non-Latino white self-identified LGBT adolescents and their families in urban,

suburban, and rural communities across California. Interviews were conducted in English and Spanish, audio-taped, translated, and transcribed. Each participant provided narrative descriptions of family interaction and experiences related to gender identity and expression, sexual orientation, cultural and religious beliefs, family, school and community life, and sources of support and described instances or examples of times when parents, foster parents, caregivers, and guardians had shown acceptance and support of the adolescent's LGBT identity.

From these transcripts, a list of 55 positive family experiences (comments, behaviors, and interactions) was generated. We created 55 close-ended items that assessed the presence and frequency of each accepting parental or caregiver reaction to participants' sexual orientation and gender expression when they were teenagers (ages 13–19). At least three close-ended items were generated for each type of outwardly observable accepting reaction documented in the transcripts. Additional information on constructing and scoring the items is included in a previous article (Ryan et al., 2009).

Participants indicated the frequency with which they experienced each positive reaction using a 4-point scale (0 = never, 3 = many times). Reliability analyses indicate high consistency in participants' responses across items (Cronbach's $\alpha = 0.88$). Family acceptance scale scores were calculated as the sum of whether each event occurred (dichotomized as never versus ever). For example, survey items include:

- How often did any of your parents/caregivers talk openly about your sexual orientation?
- How often were your openly LGBT friends invited to join family activities?
- How often did any of your parents/caregivers bring you to an LGBT youth organization or event?
- How often did any of your parents/caregivers appreciate your clothing or hairstyle, even though it might not have been typical for your gender?

In addition to this scale, we calculated a categorical indicator of family acceptance, dividing the distribution into even thirds. The measure is used to illustrate differences between adolescents who reported low ($n = 81$, range = 0–15, mean = 7.13), moderate ($n = 83$, range = 16–30, mean = 22.60), or high ($n = 81$, range = 31–55, mean = 42.00) levels of family acceptance.

Demographic Measures

The measure of sexual identity includes categories for those who self-identified as gay/lesbian, bisexual, or other sexual identity (including "homosexual" or "other"). We also included measures of *immigrant status* (1 = born outside the United States, 0 = born in the United States), *childhood religious affiliation* (1 = any religious affiliation, 0 = no religious affiliation), and *childhood family religiosity* (How religious or spiritual was your family while you were growing up? 0 = not at all; 3 = extremely). *Parents' occupational status* was measured by coding written responses for the primary occupation of each parent or caregiver (1 = unskilled manual labor, 2 = semiskilled labor, 3 = skilled labor, 4 = professional) and multiplying the score for mothers and fathers (in the small number of cases with missing data, the mean maternal or paternal occupation code was used to calculate the total parental occupation status score).

Young Adult Adjustment and Health

We report on three indicators of positive adjustment and health, and five negative indicators. The indicators of positive adjustment include the 10-item Rosenberg (1965) *self-esteem* scale. *Social support* was based on the average of 12 items, including: "There is a special person who is around when I am in need," "I get the emotional help and support I need from my family," "My friends really try to help me" (1 = strongly disagree, 5 = strongly agree; Cronbach's $\alpha = 0.89$). General health is assessed with one item: "How is your health in general?" (1 = poor; 5 = excellent).

We assessed negative health outcomes with five measures. For *depression* we used the 20-item Center for Epidemiological Studies Depression scale, originally developed to measure somatic and affective symptoms of depression in community samples of adults (Radloff, 1977). *Substance abuse* was measured as the sum of four items that asked about substance use problems: "[I]n the past five years": " . . . have you had problems with the law because of your alcohol or drug use?" " . . . have you lost a job because of your alcohol or drug use?" " . . . have you passed out or lost consciousness because of your alcohol or drug use?" " . . . have you had conflicts with family, lovers, or friends because of your alcohol or drug use?" (0 = no; 1 = somewhat yes/yes). *Sexual behavior risk* was defined as reporting any unprotected anal or vaginal intercourse within the past 6 months with a casual partner or a steady partner who was nonmonogamous or serodiscordant for HIV (0 = no; 1 = yes). *Suicidal thoughts or behaviors* were measured as follows: "During the past six months did you have any thoughts of ending your life?" (0 = no; 1 = yes); "Have you ever, at any point in your life, attempted to take your own life?" (0 = no; 1 = yes).

Analysis

We first examined the associations between our measure of family acceptance and the background characteristics of study participants. For the health outcome measures we present average scores for the three categories of family acceptance (to test for statistical differences across groups using one-way ANOVA); for categorical measures we present

proportions of the sample in each of the family acceptance categories (differences tested with chi-square). Finally, we use ordinary least squares and logistic regression analyses to test the degree to which family acceptance predicts young adult health outcomes, controlling for background characteristics.

Results

Scores on family acceptance range from lowest to highest possible: 0–55. The average score is 23.9, with a standard deviation of 15.2. The distribution is remarkably flat (the skewness is 0.25 and Kurtosis is –0.98): The participants in this study included a wide range of family accepting experiences during adolescence.

The sample included roughly equal numbers of young adults who self-identified as male and female; 9% of the sample identified as transgender. Seventy percent identified as gay or lesbian (42% gay; 28% lesbian), 13% identified as bisexual, and 17% reported an alternative sexual identity (among these, 35 participants wrote in "queer"). There were no statistical differences in the average levels of family acceptance based on sexual identity (gay/lesbian, bisexual, versus other sexual orientation), gender (male versus female), or transgender identity.

The sample was evenly divided between Latino and non-Latino white participants; 19% were born outside the United States. Whites reported higher average levels of family acceptance. Immigrant status was strongly associated with family acceptance: Those born in the United States reported higher family acceptance compared with immigrants. Childhood religious affiliation was linked to family acceptance; participants who reported a childhood religious affiliation reported lower family acceptance compared with those with no religious affiliation in childhood. Childhood family religiosity was also linked to family acceptance; highly accepting families reported low religiosity compared with the high religiosity among low accepting families. Finally, we find evidence of a link between social class and family acceptance such that highly accepting families had higher parental occupational status compared with those that scored low on acceptance (statistical analyses available from authors on request).

Associations between young adult health and the three levels of family acceptance are presented in Table 1. There are clear links between family acceptance in adolescence and health status in young adulthood. Young adults who reported high levels of family acceptance scored higher on all three measures of positive adjustment and health: self-esteem, social support, and general health. For the measures of negative health outcomes, young adults who reported low levels of family acceptance had scores that were significantly worse for depression, substance abuse, and suicidal ideation and attempts. Half as many participants from highly accepting families reported suicidal thoughts in the past 6 months compared with those who reported low acceptance (18.5% versus 38.3%). Similarly, the prevalence of suicide attempts among participants who reported high levels of family acceptance was nearly half (30.9% versus 56.8%) the rate of those who reported family acceptance. Sexual risk behavior was the only young adult health indicator for which there was no strong association with family acceptance in adolescence; this outcome was not examined in subsequent analyses.

The final analyses examined the degree to which associations between family acceptance and young adult well-being were independent of the background characteristics of study participants. Regression results are presented in Table 2. For all health outcomes, the link between family acceptance and young adult health is present regardless of background characteristics. Table 2 shows that, consistent with prior research on gay and lesbian youth and young adults, and in contrast to studies of heterosexual women and men, females reported higher self-esteem and social support and lower

Table 1. Family Acceptance as Predictors of Health Outcomes

Outcome variable	Family acceptance categories			Between-group difference
	Low acceptance	Moderate acceptance	High acceptance	$F/\chi 2$ (df = 2)
Self-esteem	2.62	2.83	2.95	$F = 17.10^{***}$
Social support	3.26	3.78	4.10	$F = 19.90^{***}$
General health	3.35	3.55	3.96	$F = 8.96^{**}$
Depression (CES-D)	20.10	16.48	10.37	$F = 15.93^{***}$
Substance abuse (past 5 years)	1.46	1.10	.85	$F = 4.81^{**}$
Sexual behavior risk (past 6 months)	35.8%	37.4%	28.4%	$\chi 2 = 1.67$
Suicidal thoughts (past 6 mos.)	38.3%	22.9%	18.5%	$\chi 2 = 8.96^{*}$
Suicide attempts (lifetime)	56.8%	36.1%	30.9%	$\chi 2 = 12.57^{**}$

$^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$.

Table 2. Family Acceptance and Health Outcomes Controlling for Background Characteristics. OLS Regression, Standardized Estimates

	Self-esteem	Social support	General health	Depression	Substance abuse
Family acceptance	0.33***	0.44***	0.21***	–0.29***	–0.19**
Background characteristics:					
Bisexual	–0.07	0.11	0.11+	–0.10+	0.04
Other sexual identity (reference group: gay/lesbian)	–0.06	0.08	–0.10	–0.01	0.10
Female	0.17**	0.06*	0.02	–0.10	–0.19**
Transgender (reference group: male)	0.05	–0.13+	–0.22**	0.08	–0.04
White (reference group: Latino	–0.17*	–0.08	0.01	0.10	–0.01
Immigrant (reference group: U.S. born)	–0.07	–0.06	–0.04	0.10	–0.07
Parents' occupation status	0.08	0.20**	0.17**	–0.11+	–0.07
Childhood religious affiliation (reference group: no affiliation)	–0.03	0.15	–0.08	0.00	–0.04
Childhood family religiosity	–0.08	–0.09*	0.05	0.04	0.08
Adjusted R^2	0.16	0.30	0.17	0.14	0.06

+$p < .10$; *$p < .05$; **$p < .01$; ***$p < .001$.

Table 3. Family Acceptance and Young Adult Health Outcomes Controlling for Background Characteristics. Logistic Regression, Odds Ratios (95% Confidence Interval)

	Suicidal ideation (past 6 months)	Suicide attempts (ever)
Family acceptance	0.98 (0.95–0.99)*	0.97 (0.95–0.98)**
Background characteristics:		
Bisexual	1.12 (.44–2.81)	0.74 (0.31–1.78)
Other sexual identity (reference group: gay/lesbian)	1.06 (.42–2.63)	2.36 (0.99–5.58)+
Female	0.60 (0.32–1.10)+	0.52 (0.29–0.92)*
Transgender (reference group: male)	1.42 (0.48–4.22)	0.73 (0.25–2.14)
White (reference group: Latino)	1.25 (0.61–2.54)	1.39 (0.73–2.67)
Immigrant (reference group: U.S. born)	1.52 (0.69–3.33)	1.01 (1.01–2.19)
Parents' occupation status	0.97 (0.90–1.04)	0.91 (0.85–0.97)**
Childhood religious affiliation (reference group: no affiliation)	0.91 (0.38–2.14)	0.81 (0.37–1.77)
Childhood family religiosity	1.18 (0.83–1.70)	1.17 (0.83–1.66)

+$p < .10$; *$p < .05$; **$p < .01$; ***$p < .001$.

substance abuse. Transgender respondents reported lower social support and general health; however, there were no differences in their reports of self-esteem, depression, and substance abuse. Bisexuals reported slightly better general health and less depression. White respondents reported lower self-esteem than Latinos. Family socioeconomic status was associated with general health scores; it was also associated with higher social support and less depression.

It is noteworthy that family religious affiliation, although linked to lower family acceptance, was positively associated with young adult social support. Follow-up analyses showed that the association between childhood religious affiliation and social support was not significant; thus, childhood religious affiliation is positively linked to social support in young adulthood after accounting for family acceptance. Religious affiliation in adolescence is known to be a factor that promotes well-being; these results indicate that this association is consistent for LGBT young adults only after differences between low and high family acceptance are taken into account.

Logistic regression results for the two dichotomous health outcomes (suicidal ideation and attempts) are presented in Table 3; results are interpreted as odds ratios, for which a number greater than one is interpreted as higher odds of the risk outcome, and a number lower than one represents lower odds. Table 3 shows that family acceptance is associated with reduced odds of suicidal ideation and attempts. The odds

ratios are deceptively small (suicidal thoughts: 0.98; suicide attempts: 0.97) given the 50-point range of the measure of family acceptance. To illustrate this point, we calculated the odds ratios for suicidal ideation and attempts for those who report low or no family acceptance compared with medium or high. Participants who had low family acceptance as adolescents were more than three times as likely to report both suicidal ideation and suicide attempts compared with those who reported high levels of family acceptance. Consistent with the results for depression, females are less likely than males to report suicidal ideation or attempts. Finally, for suicide attempts, family socioeconomic status was protective, but identifying as "queer" rather than as lesbian, gay, or bisexual was a strong risk factor.

Discussion

Until now, most thinking about LGBT adolescents and families has focused on negative parent–adolescent relationships or family rejection; our study is unique in pointing out the lasting, dramatically protective influence of specific family accepting behaviors related to an adolescent's LGBT identity on the health of LGBT young adults. These results show clear associations even after accounting for individual and background characteristics.

First, based on a sample of self-identified LGBT young adults, our results indicate that family acceptance did not vary based on gender, sexual identity, or transgender identity. Specifically, it does not appear that families are more accepting of female than male LGBT adolescents, of bisexual than gay/lesbian adolescents, or of transgender compared with nontransgender adolescents. However, Latino, immigrant, religious, and low-socioeconomic status families appear to be less accepting, on average, of LGBT adolescents. It appears that it is not the sexual orientation or gender identity of the adolescents themselves but the characteristics of their families (their ethnicity, immigration and occupation status, and religious affiliation) that seem to make a difference in distinguishing between those that score high versus low on acceptance of their LGBT children. This stands in contrast to family rejection, which has been shown to be higher among males and Latinos (Ryan et al., 2009).

Second, we find that family acceptance in adolescence is associated with young adult positive health outcomes (self-esteem, social support, and general health) and is protective for negative health outcomes (depression, substance abuse, and suicidal ideation and attempts). The only exception to the pattern was for sexual risk behavior during the past 6 months, for which family acceptance had no clear association. A prior study has shown a link between family LGBT rejection and sexual risk behaviors with this sample (Ryan et al., 2009), with parental rejection of their LGBT adolescent being associated with greater sexual health risk in young adulthood. The lasting influence of accepting family comments, attitudes, behaviors, and interactions related to the adolescent's LGBT identity clearly applies to personal emotional and physical states. It may be that intimate and sexual relationships are more strongly influenced by proximal interpersonal factors such as peer relations or characteristics of intimate relationships. These findings deserve further exploration in future research.

Third, our results show that the influence of family acceptance persists, even after control for background characteristics. Further, we find associations between background characteristics and young adult mental health and physical health that warrant further investigation. Independent of levels of family acceptance, transgender young adults reported lower social support and general health. While these specific findings have not been previously reported to our knowledge, they are consistent with the limited existing research that identifies transgender adolescents as a group at high risk for compromised health (Garofalo, Deleon, Osmer, Doll, & Harper, 2006). Young adults who did not ascribe to "gay," "lesbian," or "bisexual" identities (those who self-identified as "queer") were more than twice as likely to report lifetime suicide attempts but not recent suicidal thoughts. Our results indicate that although they were not at risk in young adulthood, they reported higher rates of earlier suicide attempts. These may be adolescents who most struggle to find an authentic, personal sexual identity or who do not identify with "gay" and "lesbian" stereotypes, perceptions, or expectations. A lack of fit or identification with the LGB community may be an important factor in their earlier suicide attempts. We know of no existing research that examines the implications for mental health of alternative identities among sexual minority adolescents.

In the context of these novel findings, there are several limitations to our study. LGBT individuals are a hidden population; thus, we cannot claim that this sample is representative of the general population of LGBT individuals. However, in order to maximize the broadest inclusion in our sample, we mapped the universe of social, recreational and service organizations, bars, and clubs that serve LGBT young adults within 100 miles of our office. We contacted each community organization to notify each member or participant so all would have an equal chance of participating in our study; and we conducted venue-based recruitment at bars and clubs within our recruitment area. In addition, the study focused on LGBT non-Latino white and Latino young adults, the two largest ethnic groups in California. The study did not include persons from other ethnic groups because of funding constraints. Subsequent research should include greater ethnic diversity to assess potential cultural differences in family reactions to their children's LGBT identity. Finally, the study is retrospective; young adults provided information about experiences that happened during their teenage years which

allows the potential for recall bias in describing specific family reactions to their LGBT identity. To minimize this concern, we created measures that asked as objectively as possible whether or not a specific family behavior or response related to their LGBT identity actually occurred (e.g., did your parent or caregiver connect you with an LGBT adult role model?).

Others have argued for the need for studies that identify risk and protective factors that are unique to LGBT individuals (Russell, 2003). Given that positive parent–adolescent relationships are known to be a foundation for optimal development, it is ironic that attention to LGBT adolescent–parent relationships has almost exclusively focused on negativity. Our approach to directly measuring LGBT-specific behaviors that express family and caregiver acceptance during adolescence is an important step toward better understanding LGBT health, and offers the opportunity for focused prevention and intervention with diverse families that have LGBT children. Practice approaches and programs that specifically support families of LGBT children and adolescents may have great potential for preventing the well-documented LGBT health disparities.

Implications for Nursing Practice and Research

Nurses are uniquely positioned to provide assessment, education, and support to LGBT youth and families and to discuss the impact of family acceptance on their children's health and well-being. Family-oriented care is a cornerstone of nursing practice (e.g., Bomar, 2004; Hanson & Boyd, 1996; Wright & Leahey, 2000) and guides nursing intervention and research in multiple care settings.

Although the focus of the research and relationships between LGB youth (little has been published, to date, on transgender youth) and families has been on disruption, conflict, and negative interactions, family support and connectedness are protective factors for adolescents, in general, and have been shown to protect against suicidality in LGB youth (Eisenberg & Resnick, 2006), in particular. Nurses can incorporate this emerging empirical understanding of the impact of family response on LGBT children's well-being into individual practice and interactions with youth and their families in several ways:

Assessment

Nurses should routinely ask adolescents about their sexual orientation and gender identity to provide appropriate assessment and care. A clinical protocol sponsored by the Health Resources and Services Administration and developed by clinical care and practice experts on sexual minority youth has been published on mental health assessment and primary care (see Ryan & Futterman, 1997, 1998). (Download from http://familyproject.sfsu.edu)

Table 4. Supportive Behaviors That Help Families Promote Their LGBT Child's Well-Being

Talk with your child or foster child about their LGBT identity
Express affection when your child tells you or when you learn that your child is LGBT
Support your child's LGBT identity even though you may feel uncomfortable
Advocate for your child when he or she is mistreated because of their LGBT identity
Require that other family members respect your LGBT child
Bring your child to LGBT organizations or events
Connect your child with an LGBT adult role model to show them options for the future
Work to make your faith community supportive of LGBT members or find a supportive faith community that welcomes your family and LGBT child
Welcome your child's LGBT friends and partner to your home and to family events and activities
Support your child's gender expression
Believe your child can have a happy future as an LGBT adult

LGBT, lesbian, gay, bisexual, and transgender.
From: Supportive Families, Healthy Children: Helping Families with Lesbian, Gay, Bisexual & Transgender Children by Caitlin Ryan, 2009, Family Acceptance Project, San Francisco State University. Copyright 2009 by Caitlin Ryan. Reprinted with permission.

- Ask LGBT adolescents and youth who are questioning their sexual orientation or gender identity about how their family, caregivers, or foster family reacts to their identity.
- Provide supportive counseling, as needed, and connect youth with LGBT community resources and programs.

Parent/Family Education

Nurses should identify parents and caregivers, including foster parents and guardians, in need of education and guidance to help support their LGBT children.

- With the youth's consent, help families identify supportive behaviors that help protect against risk and help promote their LGBT child's well-being. Table 4 includes a list of some family behaviors included in this study that help promote well-being for LGBT youth.
- For LGBT youth who report negative family reactions, use the *FAP*risk assessment screener[1] (Ryan & Diaz, 2009) to identify the level of family rejection and related health risks in LGBT youth. Discuss findings from the Family

[1] (Download from http://familyproject.sfsu.edu/publications)

Acceptance Project (see Ryan, 2009b; Ryan et al., 2009) on how educating families of LGBT youth can help them understand the serious negative health impact of family rejection on the adolescent's health and mental health (including depression, suicide, illegal drug use, and risk for HIV). With the youth's consent and participation, contact the family to provide education, family counseling, and support.

Support for Youth and Family

Some adolescents can use the support of their health professional to come out to parents and caregivers. Nurses can offer to help the youth disclose their sexual orientation or gender identity to the parent/caregiver. This includes providing education on sexual orientation and gender identity, guidance to help parents and foster parents understand how to support their LGBT child, and counseling to help families reconcile values and beliefs that homosexuality is wrong with their love for their LGBT child. While it is important to offer this support, it is essential to respect the youth's preferences and decisions about where, how, and when they choose to disclose their LGBT identity to parents, caregivers, and other family members. For LGBT youth who report family rejection and are fearful of family involvement, individual counseling can help the adolescent deal with rejection, and referral to LGBT youth programs, including school diversity clubs, can provide access to peer support and positive LGBT adult role models.

Advocacy and Professional Education

Nurses can advocate in their agencies and institutions for the importance of providing family-related care for LGBT adolescents. This includes serving LGBT youth in the *context* of their family (typically LGBT adolescents are served alone, as if they were adults, and few providers routinely ask about family reactions to the youth's LGBT identity, gender expression, and behavior).

Early Intervention

Nurses (particularly in school settings) can identify children and adolescents in need of support, including those who are gender variant, who may be perceived to be gay and are harassed by peers, and who come out at younger ages and may be more vulnerable to negative reactions from family and peers. Researchers have observed that the average age of sexual attraction is about age 10 for heterosexual and homosexually identified youth (McClintock & Herdt, 1996), and this finding has been reported in subsequent studies of LGB adolescents (D'Augelli & Hershberger, 1993; Herdt & Boxer, 1993; Rosario et al., 1996).

Parents and many providers have limited information about sexual orientation and gender identity development in children and adolescents. Many parents see identifying as gay during childhood and adolescence as a "phase" or a reaction to outside influences. Others may see gender nonconforming behavior, especially in boys, as willful and disobedient. Their children experience parental denial and minimization of their identity as rejection that can negatively impact their relationship. Nurses can help parents and caregivers understand that sexual orientation and gender identity development are normative aspects of child development. They can work with young people and families to provide counseling, family therapy, and access to family peer support to help decrease family conflict and educate families about rejecting behaviors that are associated with significantly elevated risk for their LGBT children.

Strengths-Based Approach

The increased focus on strengths in nursing (e.g., Feeley & Gottlieb, 2000) provides an important framework for reinforcing supportive responses among families who seek to affirm their LGBT children and helping other families who see their children's LGBT identity as deficit based. A strengths-based approach helps families more readily identify with their competencies, skills, and resources—all of which can help motivate and empower parents, caregivers, and other family members to adopt supportive behaviors identified in this research that can help decrease their LGBT children's risk and promote their well-being.

Nursing has helped define the field of family-oriented care, and nurses work with families in all settings. However, surprisingly little literature in nursing journals has focused on care related to families of LGBT patients. These findings on the critical role of parents and caregivers in promoting the well-being and decreasing risk of their LGBT children warrant further investigation, intervention research, and specific training in nursing education, particularly for psychiatric nurses who work with patients whose families are struggling to adjust to their child's LGBT identity.

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