PEDIATRICS®
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

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

Caitlin Ryan, David Huebner, Rafael M. Diaz and Jorge Sanchez

Pediatrics 2009;123;346-352
DOI: 10.1542/peds.2007-3524

ARTICLE

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

Caitlin Ryan, PhD, ACSW[a], David Huebner, PhD, MPH[b], Rafael M. Diaz, PhD[a], Jorge Sanchez, BA[a]

[a]César E. Chávez Institute, San Francisco State University, San Francisco, California; [b]Department of Psychology, University of Utah, Salt Lake City, Utah

The authors have indicated they have no financial relationships relevant to this article to disclose.

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

www.pediatrics.org/cgi/doi/10.1542/peds.2007-3524

doi:10.1542/peds.2007-3524

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

Accepted for publication Jul 31, 2008

Address correspondence to Caitlin Ryan, PhD, ACSW, Adolescent Health Initiatives, César E. Chávez Institute, College of Ethnic Studies, San Francisco State University, 3004 16th St, 301, San Francisco, CA 94103. E-mail: caitlin@sfsu.edu

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

ACKNOWLEDGMENTS

This work was funded by a grant from The California Endowment awarded to Drs Ryan and Diaz.

We gratefully acknowledge the support of our funder and the contribution of our community advisory groups and the many adolescents, families and young adults who shared their lives and experiences with us. We also thank The California Endowment, the reviewers, and our colleagues for their assistance and insightful comments: Elizabeth Saewyc, PhD, RN, PHN; Stephen Russell, PhD; Janet Shalwitz, MD; and Donna Futterman, MD.

REFERENCES

1. Roesler T, Deisher R. Youthful male homosexuality. *JAMA.* 1972;219(8):1018–1023
2. Remafedi G. Adolescent homosexuality: Psychosocial and medical implications. *Pediatrics.* 1987;79(3):331–337
3. Garofalo R, Wolf C, Kessel S, Palfrey J, DuRant RH. The association between risk behaviors and sexual orientation among a school-based sample of adolescents. *Pediatrics.* 1998;101(5):895–902
4. DuRant RH, Krowchuk DP, Sinai SH. Victimization, use of violence, and drug use at school among male adolescents who engage in same-sex sexual behavior. *J Pediatr.* 1998;133:113–118
5. Remafedi G. Predictors of unprotected intercourse among gay and bisexual youth: Knowledge, beliefs, and behavior. *Pediatrics.* 1994;94(2 pt 1):163–168

6. Rosario M, Hunter J, Gwadza M. Exploration of substance use among lesbian, gay, and bisexual youth: Prevalence and correlates. *J Adolesc Res.* 1997;12:454–476
7. Rosario M, Meyer-Bahlburg HFL, Hunter J, Gwadz M. Sexual risk behaviors of gay, lesbian and bisexual youths in New York City: Prevalence and correlates. *AIDS Educ Prev.* 1999;11(6):476–496
8. Remafedi G. Health disparities for homosexual youth: The children left behind. In: Wolitski RJ, Stall R, Valdiserri RO, editors. *Unequal Opportunity: Health Disparities Affecting Gay and Bisexual Men in the United States*. New York, NY: Oxford University Press; 2007:275–300
9. Remafedi G, French S, Story M, Resnick MD, Blum R. The relationship between suicide risk and sexual orientation: results of a population-based study. *Am J Public Health.* 1998;88(1):57–60
10. Garofalo R, Wolf C, Wissow LS, Woods ER, Goodman E. Sexual orientation and risk of suicide attempts among a representative sample of youth. *Arch Pediatr Adolesc Med.* 1999;153(5):487–493
11. D'Augelli AR, Hershberger SL, Pilkington NW. Suicidality patterns and sexual orientation-related factors among lesbian, gay, and bisexual youths. *Suicide Life Threat Behav.* 2001;31(3):250–264
12. D'Augelli AR, Hershberger SL. Lesbian, gay, and bisexual youth in community settings: Personal challenges and mental health problems. *Am J Community Psychol.* 1993;21(4):421–448
13. D'Augelli AR. Mental health problems among lesbian, gay, and bisexual youths ages 14 to 21. *Clin Child Psychol Psychiatry.* 2002;7(4):433–456
14. Harper GW. Sex isn't that simple: culture and context in HIV prevention interventions for gay and bisexual male adolescents. *Am Psychol.* 2007;62(8):803–819
15. Saewyc EM, Skay CL, Pettingell SP, et al. Hazards of stigma: The sexual and physical abuse of gay, lesbian, and bisexual adolescents in the United States and Canada. *Child Welfare.* 2006;85(2):195–213
16. Saewyc EM, Bearinger LH, Blum RW, Resnick MD. Sexual intercourse, abuse and pregnancy among adolescent women: Does sexual orientation make a difference? *Fam Plann Perspect.* 1998;31:127–131
17. Saewyc E, Pettingell S, Skay C. Teen pregnancy among sexual minority youth during the 1990s: countertrends in a population at risk. *J Adolesc Health.* 2004;34(2):125–126
18. Forrest R, Saewyc E. Sexual minority teen parents: demographics of an unexpected population. *J Adolesc Health.* 2004;34(2):122
19. Cochran SD, Sullivan JG, Mays V. Prevalence of mental disorders, psychological distress and mental health services use among lesbian, gay and bisexual adults in the United States. *J Consult Clin Psychol.* 2003;71(1):53–61
20. Gilman SE, Cochran SD, Mays VM, Hughes M, Ostrow D, Kessler RC. Prevalences of DSM-III-R disorders among individuals reporting same-gender sexual partners in the National Co-morbidity Survey. *Am J Public Health.* 2001;91(6):933–939
21. Cochran SD, Mays VM. Lifetime prevalence of suicidal symptoms and affective disorders among men reporting same-sex sexual partners: results from the NHANES III. *Am J Public Health.* 2000;90(4):573–578
22. Herrell R, Goldberg J, True WR, Ramakrishman V, Lyons M, Eisen S, Tsuang MT. Sexual orientation and suicide: a co-twin control study in adult men. *Arch Gen Psychiatry.* 1999;56(10):867–874
23. Ryan C, Futterman D. Lesbian and gay youth: Care and counseling. *J Adolesc Med.* 1997;8(2):207–374
24. Perrin EC. *Sexual Orientation in Child and Adolescent Health Care*. New York, NY: Kluwer Academic/Plenum Publishers; 2002
25. Bontempo D,. D'Augelli AR. Effects of at-school victimization and sexual orientation on lesbian, gay, or bisexual youths' health risk behavior. *J Adolesc Health.* 2002;30(5):364–374
26. Goodenow C, Szalacha L, Westheimer K. School support groups, other school factors, and the safety of sexual minority adolescents. *Psychol Schools.* 2006;43(5):573–589
27. California Safe Schools Coalition and 4-H Center for Youth Development, University of California, Davis. *Safe Place to Learn: Consequences of Harassment Based on Actual or Perceived Sexual Orientation and Gender Non-conformity and Steps for Making Schools Safer*. San Francisco, CA: California Safe Schools Coalition; 2004
28. Reis B. *They Don't Even Know Me: Understanding Anti-Gay Harassment and Violence in Schools*. Safe Schools Coalition: Seattle, WA; 1999
29. GLSEN. *From Teasing to Torment: School Climate in America, A Survey of Students and Teachers*. New York, NY: GLSEN; 2005
30. Diaz RM, Ayala G, Bein E, Jenne J, Marin BV. The impact of homophobia, poverty, and racism on the mental health of Latino gay men. *Am J Public Health.* 2001;91(6):927–932
31. Meyer IH. Minority stress and mental health in gay men. *J Health Soc Behav.* 1995;36(1):38–56
32. American Academy of Pediatrics, Task Force on the Family. Preface to the report of the Task Force on the Family. *Pediatrics.* 2003;111(6 pt 2):1539
33. Steinberg L, Duncan P. Work Group IV: Increasing the capacity of parents, families, and adults living with adolescents to improve adolescent health outcomes. *J Adolesc Health.* 2002;31(6 suppl):261–263
34. Viswanathan M, Ammerman A, Eng E, et al. *Community-Based Participatory Research: Assessing the Evidence.* Rockville, MD: Agency for Healthcare Research and Quality; 2004. AHRQ publication 04-E022-2
35. Radloff LS. The use of the Center for Epidemiologic Studies depression scale in adolescents and young adults. *J Youth Adolesc.* 1991;20(2):149–166
36. Schor EL; American Academy of Pediatrics, Task Force on the Family. Family pediatrics: report of the task force on the family. *Pediatrics.* 2003;111(6 pt 2):1539–1571
37. Binson D, Blair J, Huebner DM, Woods WJ. Sampling in surveys of lesbian, gay, and bisexual people. In: Meyer IH, Northridge ME, eds. *The Health of Sexual Minorities: Public Health Perspectives on Lesbian, Gay, Bisexual, and Transgender Populations*. New York, NY: Springer; 2007:375–418

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

Caitlin Ryan, David Huebner, Rafael M. Diaz and Jorge Sanchez

Pediatrics 2009;123;346-352
DOI: 10.1542/peds.2007-3524