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

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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

SINCE STUDIES WERE first published on homosexual youth in the 1970s and 1980s,1,2 serious health disparities3–8 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,12,13 symptoms of depression and mental health problems,12,13 and sexual health risks, including risk for sexually transmitted infections, HIV,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 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.27–30 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.31 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 α = .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, and lifetime
suicide attempts. Level of current depression was assessed through the Center for Epidemiologic Studies Depression Scale (CES-D). We used the recommended cut-off point for adolescents and young adults (H11022 >H11616 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 1: Demographics

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

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

* 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, regressing each health outcome 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 2 Health-Related Problems According to Gender and Ethnicity

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

GxE indicates gender-by-ethnicity interaction.

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

b P < .05.

c P < .001.

### TABLE 3 Family Rejection

<table>
<thead>
<tr>
<th>Gender</th>
<th>White Mean (SD)</th>
<th>Latino Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>24.10 (17.03)</td>
<td>24.52 (17.12)</td>
</tr>
<tr>
<td>Female</td>
<td>17.65 (13.83)</td>
<td>19.94 (14.60)</td>
</tr>
</tbody>
</table>

Range of scale: 0 [en]51. Ethnicity: F:1220 = 1.58, not significant; gender: F:1220 = 4.06, P < .05; gender by ethnicity: F:229 = 1, not significant.
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 pediatricians36 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 over-represented 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...
Unfortunately, there appears to be an error in the document, as the text does not display properly. It seems to be a corrupted or incomplete page. Could you please provide the correct page or a different document to assist you with the information you're seeking?
21. Cochran SD, Mays VM. Lifetime prevalence of suicidal symp-

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
29. GLSEN. *From Teasing to Torment: School Climate in America, A Survey of Students and Teachers.* New York, NY: GLSEN; 2005
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