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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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References

Bomar, P. J. (2004). *Promoting health in families: Applying family research and theory to nursing practice* (3rd ed.). Philadelphia: Saunders.

Cochran, S. D., Sullivan, J. G., & Mays, V. (2003). Prevalence of mental disorders, psychological distress and mental health services use among lesbian, gay and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology*, *71*, 53–61.

D'Augelli, A. R. (2002). Mental health problems among lesbian, gay, and bisexual youths ages 14 to 21. *Clinical Child Psychology and Psychiatry*, *7*, 433–456.

D'Augelli, A. R., & Hershberger, S. L. (1993). Lesbian, gay, and bisexual youth in community settings: Personal challenges and mental health problems. *American Journal of Community Psychology*, *21*, 421–448.

D'Augelli, A. R., Grossman, A. H., & Starks, M. T. (2005). Parent's awareness of lesbian, gay, and bisexual youth's sexual orientation. *Journal of Marriage and Family*, *67*, 474–482.

Diamond, L. M., & Lucas, S. (2004). Sexual-minority and heterosexual youths' peer relationships: Experiences, expectations, and implications for well-being. *Journal of Research on Adolescence*, *14*, 313–340.

Eisenberg, M. E., & Resnick, M. D. (2006). Suicidality among gay, lesbian and bisexual youth: The role of protective factors. *Journal of Adolescent Health*, *39*, 662–668.

Feeley, N., & Gottlieb, L. N. (2000). Nursing approaches for working with family strengths and resources. *Journal of Family Nursing*, *6*(1), 0–24.

Garofalo, R., Deleon, J., Osmer, E., Doll, M., & Harper, G. W. (2006). Overlooked, misunderstood and at-risk: Exploring the lives and HIV risk of ethnic minority male-to female transgender youth. *Journal of Adolescent Health*, *38*, 230–236.

Hanson, S. M. H., & Boyd, S. T. (1996). *Family health care nursing: Theory, practice and research*. Philadelphia: F. A. Davis Company.

Herdt, G., & Boxer, A. (1993). *Children of Horizons: How gay and lesbian teens are leading a new way out of the closet*. Boston: Beacon Press.

Lasser, J., & Tharinger, D. (2003). Visibility management in school and beyond: A qualitative study of gay, lesbian, bisexual youth. *Journal of Adolescence*, *26*, 233–244.

McClintock, M. K., & Herdt, G. (1996). Rethinking puberty: The development of sexual attraction. *Current Directions in Psychological Science*, *5*(6), 178–183.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*, 674–697.

Needham, B. L., & Austin, E. L. (2010). Sexual orientation, parental support, and health during the transition to young adulthood. *Journal of Youth and Adolescence*, *39*, 1189–1198.

Patterson, C. J. (2000). Family relationships of lesbians and gay men. *Journal of Marriage and the Family*, *62*, 1052–1069.

Perrin, E. C., Cohen, K., Gold, M., Ryan, C., Savin-Williams, R., & Schorzman, C. (2004). Gay and lesbian issues in pediatric health care. *Current Problems in Pediatric and Adolescent Health Care*, *34*(10), 355–398.

Radloff, L. S. (1977). The CES–D Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*, *1*, 385–401.

Resnick, M. D., Bearman, P. S., Blum, R. W., Bauman, K. E., Harris, K. M., Jones, J., . . . Udry, R. (1997).Protecting adolescents from harm. Findings from the national longitudinal study on adolescent health. *Journal of the American Medical Association*, *278*(10), 823–832.

Rosario, M., Meyer-Bahlburg, H. F. L., Hunter, J., Exner, T. M., Gwadz, M., & Keller, A. M. (1996). The psychosexual development of urban lesbian, gay, and bisexual youths. *Journal of Sex Research*, *33*(2), 113–126.

Rosario, M., Schrimshaw, E. W., & Hunter, J. (2009). Disclosure of sexual orientation and subsequent substance use and abuse among lesbian, gay, and bisexual youths: Critical role of disclosure reactions. *Psychology of Addictive Behaviors*, *23*(1), 175–184.

Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press.

Russell, S. T. (2003). Sexual minority youth and suicide risk. *American Behavioral Scientist*, *46*, 1241–1257.

Russell, S. T. (2005). Beyond risk: Resilience in the lives of sexual minority youth. *Journal of Gay and Lesbian Issues in Education*, *2*, 5–18.

Russell, S. T., & Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Journal of Public Health*, *91*, 1276–1281.

Russell, S. T., Seif, H., & Truong, N. L. (2001). School outcomes of sexual minority youth in the United States: Evidence from a national study. *Journal of Adolescence*, *24*, 111–127.

Ryan, C. (2009a). *Helping families support their lesbian, gay, bisexual, and transgender (LGBT) children*. Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development.

Ryan, C. (2009b). *Supportive families, healthy children: Helping families with lesbian, gay, bisexual & transgender children*. San Francisco: Family Acceptance Project, San Francisco State University.

Ryan, C., & Diaz, R. (2009). *FAPrisk Assessment Tool*. San Francisco: Family Acceptance Project, San Francisco State University.

Ryan, C., & Futterman, D. (1997). Lesbian and gay youth: Care and counseling. *Adolescent Medicine: State of the Art Reviews*, *8*(2), 207–374 [also published as Ryan, C., & Futterman, D. (1998). *Lesbian and gay youth: Care and counseling*. New York: Columbia University Press].

Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay and bisexual young adults. *Pediatrics*, *123*(1), 346–352.

Ryan, C., & Rivers, I. (2003). Lesbian, gay, bisexual, and transgender youth: Victimization and its correlates in the USA and UK. *Culture, Health, & Sexuality*, *5*, 103–119.

Savin-Williams, R. C. (1998a). Lesbian, gay, and bisexual youths' relationships with their parents. In C. J. Patterson & A. R. D. Augelli (Eds.), *Lesbian, gay, and bisexual identities in families: Psychological perspectives* (pp. 75–98). New York: Oxford University Press.

Savin-Williams, R. C. (1998b). The disclosure to families of same-sex attractions by lesbian, gay, and bisexual youths. *Journal of Research on Adolescence*, *8*, 49–68.

Savin-Williams, R. C. (2005). *The new gay teen*. Cambridge, MA: Harvard University Press.

Savin-Williams, R. C., & Dubé, E. M. (1998). Parental reactions to their child's disclosure of a gay/lesbian identity. *Family Relations*, *47*, 7–13.

Tharinger, D., & Wells, G. (2000). An attachment perspective on the developmental challenges of gay and lesbian adolescents: The need for continuity of caregiving from family and schools. *School Psychology Review*, *29*, 158–172.

Viswanathan, M., Ammerman, A., Eng, E., Gartlehner, G., Lohr, K. N., Griffith, D., . . . Whitener, L. (2004). *Community-based participatory research: Assessing the evidence*. Rockville, MD: Agency for Healthcare Research and Quality.AHRQ publication 04-E022-2.

van Wormer, K., & McKinney, R. (2003). What schools can do to help gay/lesbian/bisexual youth: A harm reduction approach. *Adolescence*, *38*, 409–420.

Wright, L. M., & Leahey, M. (2000). *Nurses and families: A guide to family assessment and interventions* (3rd ed.). Philadelphia: F. A. Davis Company.