Health Risks of Lesbian, Gay, Bisexual, and Transgender Youth

Related to Parental Response to Disclosure

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HEALTH RISKS FOR LESBIAN, GAY, BISEXUAL, AND TRANSGENDER YOUTH
RELATED TO PARENTAL RESPONSE TO DISCLOSURE

Abstract

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Lesbian, gay, bisexual, and transgender (LGBT) youth have increased risks to health compared to their heterosexual peers including depression, substance use and abuse, high risk sexual behaviors, violence, victimization, and suicidality. Strong parent-adolescent relationships can promote health for youth, but these relationships can be negatively impacted and even severed upon sexual minority status disclosure or discovery. This paper reviews literature on the subject of parental responses to adolescent disclosure of sexual minority status and the positive or negative consequences those responses have on adolescent health risks. Additionally, to provide the perspective of the parent, literature that examines parental experiences upon learning their child is a sexual minority is included. Bronfenbrenner’s bioecological model provides a theoretical framework explicating the ecological influences that shape the parental response to disclosure and ultimately, the health of the youth. Nursing implications include recognizing the potential disruption in parent-adolescent relationships and intervening to prevent family crises, minimize adolescent health risks, and promote health.
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Statement of the Problem

All who undergo the transition from childhood to young adulthood face cognitive, psychosocial, and personal identity challenges. Adolescence is a time of exploration and experimentation that helps establish a sense of individuality and uniqueness. Ironically, it is also a time when family belonging and fitting in with peers are of vital importance. The American maturation process focuses heavily on growing expectations for citizenship, leadership (Chapman & Werner-Wilson, 2008) and academic and occupational achievement (Zarrett & Eccles, 2006). Less attention is given to the achievement of a healthy sexual identity, although this critical milestone occurs during a period of high vulnerability and carries lifelong consequences for mental and physical health (Sullivan & Wodarski, 2002). The development of a sexual identity is thought to occur across the lifespan but it is during adolescence that humans experience biological and physiological changes and an increased awareness of the self as a sexual being (Chapman & Werner-Wilson, 2008). Sexual identity development is a solitary process for most adolescents with little guidance from adults in management and exploration of sexual desire, body image concerns, and intimate relationship skills (Chapman & Werner-Wilson, 2008). In a society of assumed heterosexuality, healthy sexual identity development becomes even more challenging for youth who identify as other than heterosexual or are questioning their sexual orientation (Sullivan & Wodarski, 2002).

Sexual minority youth, or those who identify as lesbian, gay, bisexual, or transgender (LGBT) often speak of feeling “different than heterosexual” during early to mid-childhood, but lack the understanding or words to explain their sexual orientation (Goldman, 2008). Children as young as 2 or 3 years old begin to develop an awareness of their own and other’s gender (Goldman, 2008). Savin-Williams (2001) stresses the similarities of developmental trajectories
for all adolescents while recognizing and respecting the unusual tasks of sexual minority youth based solely on their sexuality. For lesbian, gay, and bisexual youth, confusion most often accompanies the initial awareness of same-sex attraction until acknowledgment of homosexuality or bisexuality occurs, possibly followed by disclosure to peers and family and eventual recognition of a sense of sexual identity (Sullivan & Wodarski, 2002). Growing up in a society where heterosexuality is viewed as the superior and dominant norm demands a sexual minority youth to constantly find ways to balance being authentic and living up to the expectations of others (Savin-Williams, 2001). As this fragile sexual identity is developing, society is delivering the negative messages of shame, hatred, discrimination, rejection, and physical mistreatment (Sullivan & Wodarski, 2002). These unique stressors in the life of the LGBT adolescent contribute significantly to higher risk of negative health outcomes.

Homosexuality was removed from the American Psychiatric Association’s list of psychiatric disorders in 1973 (Ryan & Futterman, 1998). Though social and religious conservatives continue to contend that sexual reorientation is possible (Hein & Matthews, 2010), mental health professionals in pediatrics and adult care have asserted that there is no necessary treatment for homosexuality and that attempts to convert a person’s sexual orientation are unwarranted, damaging, and unsuccessful (Ryan & Futterman, 1998; Hein & Matthews, 2010). In May 2012, Dr. Robert Spitzer, the psychiatrist most known for promoting the success of reparative therapy for homosexuality recanted his position and issued a public apology to the gay community for any harm such unnecessary treatment may have caused since the flawed interpretation of his study results were released in 2003 (Spitzer, 2012). Despite 40 years of recognizing homosexuality as normal in the wide range of human sexuality, the stigma remains firmly attached. As recently as 2011, researchers have identified an abundance of health risks
pertinent to LGBT youth, many with long term or permanent consequences. The Centers for Disease Control and Prevention (CDC, 2011) reports that LGBT youth are much more likely than their heterosexual peers to have to cope with violence, victimization, depression, substance use, high-risk sexual behavior, homelessness, suicide attempts, and suicide completion. None of these risks is inherent to homosexuality; all are preventable.

Via the ongoing health initiative Healthy People 2020, the U. S. Department of Health and Human Services has published objectives for improving the health of adolescents by strengthening the relationship between parents (or guardian) and their child. Adolescent health is a new subject for Healthy People 2020 with a growing body of evidence supported by the CDC speaking to the importance of parental influence on health promotion of young people (Bouris et al., 2010). Due to the scarcity of research examining protective factors and resiliency of sexual minority youth, one might surmise that these positive parental influences do not apply to LGBT youth. Though several internet resources exist to provide hope, support, and reassurance to struggling LGBT adolescents, (It Gets Better Project, The Trevor Project, Born This Way Foundation, Trans Youth Family Allies) these electronic voices cannot replace the positive impact of a youth connection with at least one caring adult (Rutgers University, 2013).

Fortunately, Savin-Williams (2005) reminds interested readers that even though LGBT youth face a disproportionate level of adversity, the majority copes well with developing sexual identities and grows to become healthy, thriving adults.

Parenting an adolescent can be trying and complicated in the best of circumstances. Regardless of a young person’s sexual orientation, the parent-adolescent relationship necessitates role adjustments to allow for growing autonomy, mounting responsibilities, and ultimately identity formation as a young adult (Zarrett & Eccles, 2006). Historically, disclosure of sexual
orientation also referred to as “coming out,” to family members most often occurred when adult children were no longer living with parents. Though not universal, adolescents are now coming out to friends and families at earlier ages. The literature attributes this to political and social activism (Saltzburg, 2004), and to a greater acceptance of sexual minorities in popular culture (Jennings, 2003). Understandably, adolescents experience great fear of disclosing their sexual minority status to parents. Although little is known empirically, personal stories are replete with reports of rejection, alienation, and abuse at a time when youth remain emotionally, physically, and financially dependent on their parents (Savin-Williams, 2001). Even less empirical data exists to help explain the parental response to disclosure or discovery; however, the words crisis, shame, grief, and guilt recur throughout the literature.

**Statement of Purpose**

The purpose of this paper is to summarize the research on the phenomenon of parenting a sexual minority youth (lesbian, gay, bisexual, or transgender (LGBT) by conducting a critical review of the existing literature on the subject. Parental responses to adolescent sexual identity disclosure or discovery will be discussed as will an analysis of the consequential impact on the health risks of the adolescent. Gaps in research will be identified and finally, implications for nursing in the care of sexual minority youth, their parents, and families as a whole will be presented.
Search Strategies

A computer-based literature search was conducted to find peer-reviewed articles that examine the parental response to adolescent sexual orientation disclosure and the effects those responses have on youth health risks. The following databases were explored: PubMed, PsychInfo, CINAHL, and Google Scholar. Keywords used to search the databases were: gay, lesbian, bisexual, transgender, sexual orientation disclosure, sexual identity, youth, adolescent, parental experience, parental response, health risks, health risk behavior, resiliency, and protective factors. The initial search identified 64 articles that were further screened by abstract to exclude secondary sources and commentaries on the subject. Reference lists of selected research and journal articles were reviewed to identify additional sources of primary research studies. The literature was separated into two categories: parental experience and adolescent health. An attempt was made to include articles within the last ten years excluding studies prior to 2004. Due to the limited nature of primary research examining the parenting experience, one exception was made to include a qualitative study published in 2001. A total of twelve articles that encompass parental-adolescent relationships, adolescent sexual orientation and identity, and adolescent health were selected for review.
Theoretical Framework

Urie Bronfenbrenner’s bioecological model offers a theoretical framework for understanding how individuals are affected by their surrounding environmental factors. Organizing his theory into systems and creating a model depicting encircling levels around a child as the center point (see Figure 1 in Appendix), Bronfenbrenner (2005) explains how the immediate and distant settings and the interactions between them influence psychosocial development. Beyond child development, this model can be applied to families and their surrounding social context. This paper uses Bronfenbrenner’s model to examine the adolescent as the focal point. The model helps explain how and what environmental influences shape parental responses to learning their child is a sexual minority. With the adolescent in the circle center, the model directs attention to parental responses and their influence on the child.

Each system of the bioecological model necessitates a brief description. The level closest to the center focal point is called the microsystem. For an adolescent, this includes family, school, peer groups, and religious institutions. “Most young people live their lives in three arenas: home, school, and church. When you’re young and gay, any one of those can be a landmine” (I. Sullivan, Odyssey Youth Center Operations Manager, personal communication, March 21, 2012).

The next layer, the mesosystem, involves the interactions between two or more components of the microsystem. For example, do the parents and the religious institution share similar beliefs about raising children? Outside the mesosystem exists the exosystem encompassing environments that are physically removed from the center point but within which other family members interact and thus are indirectly connected. If the adolescent is at the center of the model, an example of an exosystem environment is the parental place of employment.
The outer layer of the circular model is called the macrosystem and includes the values, norms, laws, and customs of the culture. The chronosystem exists outside of the model and explains how all these systems and their relationships with one another can change over time. This applies specifically to topics involving LGBT issues as evolutions occur in societal and cultural attitudes and beliefs about homosexuality. For example, for the first time in history, the sitting U.S. President (Barack Obama) has publically supported marriage equality for same-sex couples (May 9, 2012, ABC News interview). Individual states are legalizing marriage for same-sex couples via court rulings. In the November 2012 election cycle, three states (Maine, Maryland, and Washington) supported marriage equality by popular vote and Minnesota voters chose not to add a ban of same-sex marriage to their state constitution.

These societal changes in the chronosystem are important because they demonstrate just how much difference a decade can make. One can speculate that this would be a very different paper were it written ten years ago or ten years in the future. As society becomes more accepting, fewer negative messages will filter down through the ecological systems to reach the developing youth in the center, thus theoretically reducing health risks.
Literature Review

The literature was divided into two sections: parental experience and response, and adolescent health. The parental experience was examined and analyzed with respect to Bronfenbrenner’s model. An understanding of the parental experience helps explicate the responses of acceptance or rejection of the youth. Following an examination of the literature concerning parents, the articles examining LGBT youth health risks related to parental acceptance or rejection were reviewed.

Parental Experiences and Responses

The decision to disclose sexual orientation (“come out”) to parents is a complex one for all lesbian, gay, and bisexual individuals. Coming out can be beneficial to self-esteem, psychological adjustment, and the development of a positive identity (Carnelley, Hepper, Hicks, & Turner, 2011). LaSala (2000) reported other benefits of disclosure include an increase in the closeness and honesty of the parent-child relationship and lack of need to conceal or avoid same-sex relationships. The decision to disclose to parents is especially challenging for adolescents. Because they are still dependent on parents in many ways, adolescents risk losing physical, emotional, and financial support, or worse, abuse or ejection from the home (D’Augelli, Grossman, & Starks, 2008).

Quantitative studies with descriptive statistics examine various characteristics of parents and give insight into patterns of positive and negative responses. D’Augelli, Grossman, and Starks (2008) examined the relationship of various family constellations on parental knowledge of and response to their child’s sexual orientation. They found that more youth in single-parent homes are “out” (70%) than in two-parent homes (50%). In single-parent households where the parent was aware of their child’s sexual orientation, half of the responses were positive and half
were negative. In homes where these single parents were unaware of the child’s sexual orientation, the LGB youth perceived that two-thirds of those parents would have a negative reaction if they found out. Similarly, in two-parent homes where only one parent was aware, approximately half of the responses were positive and half were negative. Mothers were more likely to know than fathers in two-parent homes, but reactions did not differ by parental gender. If both parents were aware, the response was approximately one-third positive, one-third negative, and one-third mixed. If neither parent was aware, 58% of the LGB youth expected a negative response should they be discovered (D’Augelli, Grossman, & Starks, 2008).

In their study to determine psychological characteristics that predict resiliency, Grossman, D’Augelli, and Frank (2011) examined the perceived social support of 55 transgender youth, age 15-21 years. As with most research involving transgender individuals, convenience sampling and small sample size limited the generalization ability of results. Still, results included descriptive statistics revealing of the youth’s experience of parental response. Transgender youth reported “feeling different” at approximately age 7.5 years. By age 9 or 10, most of these youth were told by their parents to stop acting outside of gender norms. For example, two-thirds of female-to-male youth were told to stop being a “tomboy” and three-fourths of male-to-female youth were told to stop being a “sissy.” Parental verbal and physical abuses were reportedly worse for more gender non-conforming youth. The mean age of disclosure for transgender youth was 15 years; however parents urged mental health counseling 2 to 3 years prior, suggesting parental suspicion and concern. In contrast to parental response to learning a child is lesbian, gay, or bisexual, parents of transgender youth are more likely to react negatively and there is a difference between mothers and fathers. Mothers responded negatively in 54% whereas fathers responded negatively in 62.9% of these cases.
Though these quantitative studies are helpful to provide an account of numbers of positive or negative parental responses, they can also be misleading. In the qualitative literature that elucidates the parental experience of learning their adolescent child is gay or lesbian, there is no evidence of any parent having an initial positive reaction. Rather, a positive response occurs as a process and may require months or years to manifest.

Saltzburg (2004, 2009) conducted two important phenomenological studies to examine the parental experience of adolescent disclosure of lesbian or gay sexual orientation. As is the nature of phenomenological studies, sample sizes were small. Both studies were further limited by lack of parental diversity in race, socioeconomic status, and age. The parents were all white, middle-class and in middle-adulthood ranging from mid-40’s to early 50’s. Nevertheless, both studies provide rich insight into the circumstances behind the parental response. In her first study, the author’s intent was to learn how parents assign meaning to the discovery of their child’s sexual orientation. Through in-depth interviews of five mothers and two fathers of adolescents (age 15-18 years) the author identified several themes. Some parents had an awareness of cross-gender differences in their adolescent that were recognized since early childhood but uneasiness prompted avoidance of the issue. Three parents privately wavered between apprehension and denial of sexual minority status of their child for years before sexual orientation was confirmed. When suspicion turned into reality upon disclosure, parental emotional responses included panic, deep loss, aloneness, shame, disappointment, sadness, and despair. All parents in this study felt an emotional detachment from their child. Influenced by extended family members and religious institutions, these parents held beliefs about homosexuality as immoral or deviant and struggled to reconcile such negativity with ongoing love for their child. Feelings of parental failure emerged as these parents attempted to continue
an active parenting role for their adolescent even as they withdrew from routine social activities and responsibilities (Saltzburg, 2004).

In her second phenomenological study, Saltzburg (2009) explored how eight parents’ experiences of their own social support influenced their abilities to adapt to the news of disclosure. Rejection or denial of a lesbian, gay, or bisexual adolescent were parental responses that attempted to preserve social acceptance and avoid social consequences. Hearing the shaming messages from societal influences in the exosystem of Bronfenbrenner’s model precipitated a personal crisis. Fearing judgment, criticism, and rejection from traditional sources of support within their own microsystem—family members, religious institutions, friends, neighbors, and colleagues—these parents withdrew, isolated, and consequently found themselves utterly alone in their fear, grief, and emotional pain (Saltzburg, 2009).

Fields (2001) conducted a qualitative study as a participant-observer within a group for parents of lesbian and gay children. Metro Parents and Allies for Gay Empowerment (Metro PAGE) was a local chapter of a national organization with a threefold mission: support to cope with a critical society; education of the public about lesbian and gay issues; and advocacy to end discrimination. Only one of the 16 parents in this study still had a child living at home. The others were parents of lesbian and gay young adults in their 20’s. All 16 parents considered homosexuality to be a deviancy from the norm of appropriate sexuality. Extensive field notes and interview data revealed that most parents felt a profound loss upon disclosure, as if their child had died. They came to Metro PAGE meetings as a step towards recovery from that loss. Many parents had difficulty believing that other parents were struggling with the same challenges. For some, the disclosure had a physical impact; one parent passed out and another likened it to a crisis such as a car accident or cancer. All of these parents reported feeling
vulnerable to outside societal judgment and feared being perceived as responsible for their child’s sexual orientation due to an abnormal parent-child relationship or poor gender role modeling. Fields found that much of the work being done at these meetings revolved around newer members re-establishing their identity as good parents despite having raised lesbian or gay children. Longer term members were less likely to be concerned with theoretical causes of homosexuality, suggesting that over time, parents become less influenced by negative societal messages and more able to accept their child (Fields, 2001).

The bioecological model, as described in the theoretical framework section, provides a clear pictorial illustrating how the customs, beliefs, and values of the broad macrosystem filter down through the levels and influence the individual. The closer the level to the center of the circle, the more powerful the messages are on the receiver. The articles in this section provide insight into how parents, too, are shaped by their surrounding environments. Faced with their own struggles during what is perceived as a family crisis, even parents who eventually become accepting may not be initially emotionally available to help their child cope with the challenges of being a sexual minority teen.

The parental descriptions of their experiences of learning a child is a sexual minority demonstrate the likelihood that families facing these circumstances need counsel and guidance. Despite suspicions and suppositions, parents often deny and avoid addressing the question with their child, fearing that discussing the issue will make it a reality. From the youth’s perspective, silence from the parent equates to probable disapproval and possible rejection. The expectation of a negative response prevents youth from turning to parents for needed support during a confusing and vulnerable time.
Adolescent Health Risks and Behaviors

Identifying LGBT youth as a vulnerable population has led to an increase in research with a public health focus over the past two decades. However, researchers face significant challenges designing flawless studies given the hidden nature of this population. Sample sizes are small and usually gathered by convenience, often from LGBT youth centers and community organizations. These participants have already taken at least one small step toward seeking support or camaraderie and may not be representative of the general LGBT youth population. Many studies are cross-sectional or retrospective with young adult participants reflecting back and self-reporting their interpretation of events during adolescence. Despite limitations, research is moving forward and improving our understanding of this important subject.

Despite overwhelming evidence that sexual minority youth have higher health risks than their heterosexual peers, health disparities cannot be explained by sexual orientation or identity alone. Bronfenbrenner’s bioecological model reveals the influence of the greater society and close social systems such as family or religious institutions on physical, social, and emotional health. The articles in this section are included because each reviews or empirically examines the parental influence on health of LGBT youth as related to the coming out process. The studies focus on various health risks or behaviors experienced by LGBT youth; however, collectively they address violence and victimization (Grossman & D’Augelli, 2006; Poteat, Mereish, DiGiovanni, & Koenig, 2011), substance use and abuse (Needham & Austin, 2010; Padilla, Crisp, & Rew, 2010; Rosario, Schrimshaw, & Hunter, 2009; Ryan, Huebner, Diaz, & Sanchez, 2009; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010) mental health and depression (Needham & Austin, 2010; Ryan et al., 2009; Ryan, et al., 2010), suicidality (Needham & Austin, 2010;
Ryan, Huebner, Diaz, and Sanchez (2009) conducted a study to uncover a clear connection between parental rejection of their sexual minority adolescent and poor health outcomes. These researchers designed a Family Rejection Scale and administered the survey to a sample of 224 White, Latino, or mixed race, LGB young adults age 21-25 years. The survey required recall and was reflective of the participants’ adolescent experiences of parental rejection. Family rejection scores divided the sample into three subgroups including low, moderate, and high rejection. Health risks examined included nine specific areas under three main outcome variables: mental health (suicide thoughts, depression), substance use, and sexual risk behaviors. The results of this study revealed large statistically significant differences for poor health outcomes when participants with high rejection scores were compared with those with low rejection scores. Latino gay and bisexual males had the highest rejection scores and the poorest outcomes in mental health and sexual risk behaviors (Ryan et al., 2009), suggesting cultural differences in parental response and the impact of those responses.

Similar findings of low parental support contributing to increased health risks were found in a sample of LGB youth transitioning from adolescence into young adulthood. Needham and Austin (2010) analyzed data from wave 3 of the Add Health study, a broad, school-based study of adolescents, grades 7-12, where respondents had subsequently aged to a mean of 21.8 years. Fewer LGB young adults remained living with parents at this age compared with heterosexual peers, suggesting higher rates of strained family connections with this group. LGB respondents reported lower levels of parental support. Lesbian and bisexual females were the most affected in the areas of depression, suicidal thoughts, and marijuana and hard drug use. Higher rates of
depression and suicidal thoughts were found in gay and bisexual males compared with heterosexual peers; however, this study found no significant differences between gay and heterosexual males in their risk for substance abuse (Needham & Austin, 2010).

Research findings are mixed regarding whether or not it is beneficial for adolescents to disclose their sexual orientation. Attempting to maintain secrecy from friends and family is as stressful as disclosing and risking rejection. The stress from either action has been shown to put youth at higher risk of substance use. In a longitudinal study investigating family and friend reactions to disclosure and substance use, Rosario, Schrimshaw, and Hunter (2009) hypothesized that the reaction (accepting or rejecting) would be more predictive of substance use than the act of disclosing alone. They also predicted that accepting reactions would offset negative reactions and thus youth experiencing more acceptance would be less likely to use substances. Though parents are only a part of this study, the results demonstrate that reaction to disclosure matters. LGB youth with more rejecting reactions from people they considered close to them were more likely to be using alcohol, tobacco, and marijuana. Accepting reactions were found to offer some protection against the abuse of alcohol (Rosario, Schrimshaw, & Hunter, 2009).

Another study relative to LGB youth substance abuse was conducted to determine whether family supportive responses toward disclosure and access to social networks in the gay community buffered life stress enough to lower substance use (Padilla, Crisp, & Rew, 2010). LGBT youth use substances for coping with stigma, verbal and physical violence, and sometimes to deal with internal homophobia (Savin-Williams, 2001). The authors used a social ecological conceptual model and hypothesized that those offering support who are closest to the child, namely parents and community networks, serve as a protective mechanism against substance use. The dependent variable in this study was a dichotomous variable for illegal drug use including
marijuana, cocaine, ecstasy, or crystal methamphetamine. Three independent variables included: (a) youth stress levels, (b) measures of family support under varying conditions (out to parents, not out to parents, parental religious beliefs), and (c) access to gay community support such as a youth group. Respondents include 1,906 youth, age 12 to 17 years, from various locations around the United States. Results revealed the critical role that parental acceptance of adolescent sexual orientation plays in creating strong family ties. The most significant measure of family support in this study was the mother’s reaction to disclosure. Youth whose mothers had a positive response were 39% less likely to use substances than youth who had not disclosed, or youth who had a mother or father react negatively. A father’s positive response to disclosure also decreased the risk of substance use, but not to the level of significance (Padilla, Crisp, & Rew, 2010).

Homophobic victimization in schools is associated with safety issues for students in a perceived hostile environment. In a study seeking to determine if parental support could buffer the effects of school victimization against suicidality and poor school performance, Poteat, Mereish, DiGiovanni and Koenig (2011) found differences among youth based on sexual orientation and race and ethnicity. Participants in this study were from 45 public schools in Wisconsin, ranging in age from 10 to 18 years. Heterosexual youth (94.2%) were compared with sexual minority youth who self-identified as lesbian, gay, bisexual, transgender or questioning (LGBTQ). Race differences were dichotomously separated by White (76.4%) and “youth of color.” These authors predicted that homophobic victimization would predict higher suicidality and a feeling of poor school belonging among all groups and that parental support would buffer these effects. Results showed that homophobic victimization predicted suicidality for LGBTQ and White, heterosexual youth but not for youth of color. This finding is explained by research
suggesting that racial and ethnic minorities have more resiliency in managing minority stress due to prior experience persevering through discrimination. Another interesting result is that parenting support did not moderate the effect of homophobic victimization on suicidality for LGBTQ youth, but it did for heterosexual youth. This finding suggests that LGBTQ youth facing fear of rejection from parents do not seek their support for school homophobic victimization and thus are at higher risk for alienation at school and suicidality (Poteat, Mereish, DiGiovanni, & Koenig, 2011).

Transgender youth are often excluded from research examining the issues of sexual minority youth because the population is small and gender identity experiences differ from the sexual orientation concerns of LGB youth. Due to lack of representation of transgender youth in several studies of this review, a study specifically about the health of transgender adolescents and access to supportive resources is included here. Gender non-conformity is highly unacceptable in most Western cultures and thus transgender youth are often at higher risk for poor health outcomes than other sexual minority youth. Grossman and D’Augelli, (2006) conducted focus group sessions with transgender youth (mean age 16.5 years) to learn about their experiences and identify health concerns. Stigma and shame begins earlier with transgender youth because they often behave like the opposite gender before they understand that it will be perceived as inappropriate. Nearly all focus group members reported negative reactions to gender atypical behavior ranging from physical abuse to harassment by family members and social circles. Rejection and victimization at home and school left these youth feeling an utter lack of a safe environment. Half of these youth were ejected from home, with some of them reporting turning to prostitution as a survival strategy and thus being at higher risk for sexually transmitted infections. Self-harm or suicidal thoughts were ways to cope with
parental and religious community pressures to conform. Additionally, some youth considered suicide as a way to protect their parents, whom they loved deeply, from the shame of having a transgendered child. Importantly, the transgender youth in these focus groups perceived their mental and physical health needs to be poorly understood by the medical community and therefore felt abandoned by yet another potential source of support (Grossman & D’Augelli, 2006).

The studies in this review tend to focus on negative parental responses as a mediator of increased health risks for their LGBT youth. Despite extensive general research explaining the links between family connectedness and healthy children, there remains a scarcity of research investigating positive parental support of LGBT youth as a protective factor against these risks. Only one study acknowledges relatively recent societal changes in attitudes about LGBT people in general, allowing for an increase in the number of parents who not only support, but also affirm their child’s sexual orientation. Ryan, Russell, Huebner, Diaz, and Sanchez (2010) conducted a study of 245 LGBT Latino and White young adults to determine if parental acceptance of LGBT identity during adolescence impacted young adult health status. The authors identified a clear link between high levels of parental acceptance and high scores on measures of general health. Additionally, higher acceptance levels contributed to lower risks in the areas of suicidal thoughts, suicide attempts, depression, and substance abuse. These findings suggest that the experience of an accepting and supportive family during adolescence can have lasting positive effects on the health of an LGBT youth (Ryan, et al., 2010).

There is no dispute in the literature that LGBT youth face higher risks to their current and future health than their heterosexual peers. Importantly, the literature reviewed in this section explicitly asserts that health risks of LGBT youth are not inherent to sexual orientation or gender
identity alone, but rather related to family characteristics and responses to disclosure. A glimpse into the parental experience helps provide a deeper understanding of reasons behind disruptions to the parent-adolescent relationship and subsequent health risks for LGBT youth. Equipped with this understanding, professional nurses are called to play an active role in minimizing social barriers to health for this vulnerable population.

**Significance, Implications, and Recommendations**

Given that adolescence is a particularly healthy time in a lifespan, we can often attribute poor health in this population to a social or public health problem rather than a disease process (U.S. Department of Health and Social Services, 2012). The studies in this review provide evidence that LGBT youth are vulnerable to health risks based solely on their developing sexual orientations and identities and their surrounding environments. We know from Bronfenbrenner’s bioecological theory that children are shaped by biology, genetics, their immediate environment, and the greater society in which they live (Kaakinen & Harmon Hanson, 2010).

The holistic health of families is a primary concern for nursing professionals. Nurses must be aware of their own biases and be able to communicate the consensus of the American Academy of Pediatrics, the American Psychological Association and other major medical and mental health professions that heterosexuality and homosexuality are both normal expressions of human sexuality (Just the Facts Coalition, 2008). Prepared with an understanding of the health promoting importance of the parent-adolescent relationship, nurses must recognize the significance of their role in assessment, education, and support to LGBT youth and their families. Addressing the needs of parents for LGBT information and connections to supportive coping resources can avert a crisis or lessen its severity. Saltzburg (2009) calls for overall anticipatory outreach to include the possibility of parenting a LGBT youth in everyday
information about parenting. Nurses in school settings using a strength-based approach can identify parents, caregivers, and guardians of sexual minority youth and provide education on the supportive behaviors that offer their children protection from poor health outcomes such as depression, substance abuse, or suicide. Some examples of these parental supportive behaviors are: connecting the youth with a LGBT adult role model, bringing the youth to LGBT organizations or events, and requiring that other family members are respectful of the youth, if not accepting (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010).

Working with sexual minority youth requires development of trusting relationships and safe spaces. Nurses in various settings such as schools or clinics can increase the comfort level of youth by providing lists of community and national LGBT resources in waiting rooms or offices. Posted expressions of nondiscrimination to include sexual orientation and gender identity should be clearly visible. Nurses should advocate in their workplaces for changes in paperwork that allow all patients to self-identify gender and sexual identity. Assumptions of sexual orientation should be avoided based on appearance or behaviors. As adolescence is the time when most sexual minority youth are sorting out their sexuality, even a pregnant teen should not be assumed heterosexual (Moon, O’Briant, & Friedland, 2002). Once an environment of safety and confidentiality has been established, nurses should directly ask about sexual identities and behaviors. Youth can be assured that this information helps nurses to address specific health care needs. Directly asking alleviates the youth’s insecurities about whether or not to disclose and demonstrates respect for the youth by not making assumptions.

Of particular importance in a health care encounter with sexual minority youth is an assessment of personal safety at home, school, and other environments where youth spend time. Nurses should be forthright with youth about mandatory reporting of violence and abuse that
may otherwise be perceived as a breach of trust (Moon, O’Briant, & Friedland, 2002). Assessing the health of LGBT youth within the context of home and family provides an even more holistic picture and allows a clinician to address the psychosocial issues that we know influence health. Application of bioecological theory is critical for nurse clinicians such that improved health outcomes will result from interventions that foster connections between vulnerable youth and their immediate and distant surroundings (Difulvio, 2011).

**Recommendations for Future Research**

Nurse researchers interested in learning more about the adolescent LGBT population can expand the body of literature by focusing on two main areas. First, it is difficult to find studies that examine personal characteristics and environmental influences of healthy and thriving sexual minority youth, though we know they exist (Savin-Williams, 2005). Research in this area would be beneficial for youth in providing potential role models for wellness and resiliency and for parents by expanding optimism and possibilities for bright futures. Secondly, there is controversy, yet no empirical research examining the benefits and risks of sexual orientation disclosure to family during adolescence. Research in this area would help nurses and other youth advocates provide guidance to young LGBT individuals as they struggle to make this complicated decision.

Sexual minority youth face unconventional tasks in development of a healthy sexual identity in a heteronormative society with little adult guidance. With an awareness of the parental influence on adolescent health and a recognition of the parents’ experience upon sexual minority disclosure, nurses can intervene to help families avoid risks and promote a healthy adolescent transition to young adulthood.
References


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Appendix

Figure 1. Bronfenbrenner’s bioecological model depicting the surrounding influences on the adolescent in the center. Family, church, and school are pictorial examples of the microsystem—the closest level with the strongest effects. Relationships between components of the microsystem comprise the mesosystem. The adolescent may have little direct contact with components of the exosystem, yet still be influenced by them. The macrosystem includes laws, policies, customs, and beliefs that influence the adolescent from the surrounding society. Outside the concentric circles exists the chronosystem represented by a clock and calendar to show how all components of the systems change over time (Bronfenbrenner, 2005).