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LGBT Youth and Family Acceptance

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Summary

In this article, we address theories of attachment and parental acceptance and rejection, and their implications for lesbian, gay, bisexual, and transgender (LGBT) youths' identity and health. We also provide two clinical cases to illustrate the process of family acceptance of a transgender youth and a gender nonconforming youth who was neither a sexual minority nor transgender. Clinical implications of family acceptance and rejection of LGBT youth are discussed.

Keywords

LGBT; youth; family; support; acceptance

Introduction

In this article, we discuss sexual minority, i.e., lesbian, gay, and bisexual (LGB) and transgender (LGBT) youth. Sexual orientation refers to the individual's object of sexual or romantic attraction or desire, whether of the same or other sex relative to the individual's sex,[1] with sexual minority individuals having a sexual orientation that is partly or exclusively focused on the same sex. Transgender refers to individuals for whom current gender identity and sex assigned at birth are not concordant, whereas cisgender refers to individuals for whom current gender identity is congruent with sex assigned at birth.[1,2] Sexual orientation and gender identity are distinct aspects of the self. Transgender individuals may or may not be sexual minorities, and vice versa. Little is known about

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transgender youth, although some of the psychosocial experiences of cisgender sexual minority youth may generalize to this population.

The Institute of Medicine recently concluded that LGBT youth are at elevated risk for poor mental and physical health compared with heterosexual and cisgender peers.[2] Indeed, representative samples of youth have found disparities by sexual orientation in health-related risk behaviors, symptomatology, and diagnoses, [3–8] with disparities persisting over time.[9–11] Furthermore, sexual orientation disparities exist regardless how sexual orientation is defined, whether by sexual or romantic attractions; sexual behaviors; self-identification as heterosexual, bisexual, lesbian/gay or other identities; or, any combination thereof. Disparities by gender identity have also been found, with transgender youth experiencing poorer mental health than cisgender youth.[12]

Attempts have been made to understand sexual orientation and gender identity-related health disparities among youth. It has been argued that sexual minority youth experience stress associated with society's stigmatization of homosexuality and of anyone perceived to be homosexual [see Ch. 5]. This "gay-related"[13] or "minority" stress[14] is experienced at the hands of others as victimization. It is also internalized, such that sexual minorities victimize the self by means, for example, of possessing negative attitudes toward homosexuality, known as internalized homonegativity or homophobia. In addition to interpersonal stigma and internalized stigma, the main focus of this article, structural stigma reflected in societal level norms, policies and laws also plays a significant role in sexual minority stress, and is discussed in Mark Hatzenbeuhler's article, "Clinical Implications of Stigma, Minority Stress, and Resilience as Predictors of Health and Mental Health Outcomes," in this issue. Meta-analytic reviews find that sexual minorities experience more stress relative to heterosexuals, as well as unique stressors.[6,15,16] Research also indicates that transgender individuals experience substantial amounts of prejudice, discrimination, and victimization[17] and are thought to experience a similar process of minority stress as experienced by sexual minorities,[18] although minority stress for transgender individuals is based on stigma related to gender identity rather than stigma related to having a minority sexual orientation. Stigma related to gender expression affects those with gender non-conforming behavior, a group that includes both transgender and cisgender individuals. This includes many cisgender youth growing up with LGB orientations.

Actual or anticipated family acceptance or rejection of LGBT youth is important in understanding the youth's experience of minority stress, how the youth is likely to cope with the stress, and consequently, the impact of minority stress on the youth's health.[19] This article addresses the role of family, in particular parental acceptance and rejection in LGBT youths' identity and health. Literature reviewed in this article focuses on the experiences of sexual minority cisgender youth due to a lack of research on transgender youth. However, we include findings and implications for transgender youth whenever possible.

Theories of Parental Acceptance and Rejection

The continued importance of parents in the lives of youth is indisputable: beginning at birth, extending through adolescence and even into emerging adulthood, affecting all relationships

beyond those with the parents, and determining the individual's own sense of self-worth. Attachment accounts for this vast reach and influence of parents.

According to Bowlby,[20–22] attachment to the primary caretaker guarantees survival because the attachment system is activated during stress and concerns the accessibility and responsiveness of the attachment figure to the child's distress and potential danger. The pattern or style of attachment that develops is based on repeated interactions or transactions with the primary caregiver during infancy and childhood. Those experiences, in interaction with constitutional factors like temperament, influence the internal working model (i.e., mental representations of emotion, behavior, and thought) of beliefs about and expectations concerning the accessibility and responsiveness of the attachment figure. In time, this internal working model influences perception of others, significantly influencing patterns in relationships over time and across settings. The beliefs and expectations concerning the attachment figure also affect the internal working model of the self, meaning the individual's sense of self-worth.

The three consistent patterns of attachment that arise in infancy and childhood are related to the internal working models of the self and other. The "secure" child has positive models of the self and other because the primary attachment figure has been accessible when needed and responsive in an attuned and sensitive manner to the child's needs and capabilities. Consequently, the securely attached child is able to regulate emotion, explore the environment, and become self-reliant in an age-appropriate manner. The "insecure" child has an inaccessible and unresponsive primary caregiver, who is intrusive, erratic or abusive. One of two insecure attachment patterns emerges. In the first pattern, the child dismisses or avoids the parent, becoming "compulsively"[21] self-reliant and regulating emotion even when contraindicated. This child with "avoidant/dismissive" attachment depends on the self, possessing a positive internal working model of the self but a negative one of the other. In the second insecure attachment pattern, the child is anxiously preoccupied with the caregiver but in a resistant (i.e., distressed or aroused) manner. The individual with "anxious/preoccupied/resistant/ambivalent" attachment has a negative working model of the self, but a positive model of the other.

Attachment patterns in childhood are partly related to character traits in adulthood, and have implications for emotion regulation from the perspective of coping with stress, as detailed elsewhere.[23,24] Based on positive working models of the self and other, the securely attached individual approaches a stressful situation in an adaptive manner that allows for a realistic appraisal of the situation and a selection of coping strategies most likely to reduce or eliminate the stressor or, at minimum, render the stressor tolerable. By comparison, insecurely attached individuals may distort reality because they may be more likely to appraise a situation as stressful even when it is not. They may also be maladaptive in their management of stress and use emotion-focused coping strategies, such as substance use, to improve mood and tolerate stress. These patterns of coping influenced by attachment are present by and common in adolescence.[25] Coping is critical because sexual orientation and gender development are potentially stressful experiences for all youth, but especially for sexual and gender minorities, given the frequent stigmatization of homosexuality, gender non-conforming behavior, and gender-variant identities.[19]

Implications for Parent-Child Attachment

The vast majority of sexual minority youth are born to heterosexual parents. Those parents may not uncommonly possess implicit or explicit negative attitudes toward homosexuality and expect their children to be heterosexual. Parents may not only be surprised that their child may be or is a sexual minority, but they may also respond negatively to the child. Similarly, the vast majority of transgender and/or gender nonconforming youth are born to cisgender and/or gender conforming parents, who often possess negative attitudes toward those who violate societal expectations for gender identity, expression, and roles, and expect their children to be cisgender and gender conforming. Negative responses from parents to LGBT youth may range from anxious concerns about the child's well-being and future to abuse and even banishment of the child from the home.

The range of possible parental responses to the child's sexual orientation, gender-related behavior or identity when these deviate from parental expectation is linked to the child's attachment.[24] The securely attached youth has parents who have encouraged age-appropriate exploration and value the child as a unique individual. Such parents may be surprised and concerned by the child's sexual minority orientation, gender non-conformity, or transgender identity, but they are likely to work through their negative attitudes over time and continue to be accessible and responsive to their child. Thus, the attachment of the securely attached youth may be shaken when parents learn of these, but it is unlikely to be undone. This does not apply to insecurely attached youth, given their a priori inaccessible, unresponsive, and potentially abusive parents. Knowledge of these deviations from expectation, coupled with negative attitudes, may lead such parents to be less supportive of their child, or reject them. The latter may manifest in parental abuse of the youth, running away by the youth to escape maltreatment, or eviction of the youth from the home.

Representative samples of youth find that relative to heterosexual peers, sexual minorities report lower levels of parental closeness[26] and elevated rates of parental abuse[6,27] and homelessness.[28–32] Transgender youth also report elevated rates of child abuse[13] compared to cisgender peers. More specifically, sexual minority youth relative to heterosexual peers and siblings report less secure attachment to their mothers and their mothers report less affection for them.[33] It has also been found that maternal attachment mediates sexual orientation disparities in depressive symptomatology and substance use.[33,34] These disparities in sexual and gender minority youth from their and gender normative peers and siblings involving the degree of attachment underscore the importance of parental attitudes toward non-heterosexual orientations, gender non-conforming behavior, and gender identity variance for secure attachment in youth. Pediatric clinicians should assess these and the quality of the parent-child attachment.

These attachment implications and findings take on added meaning when considered along with youth's neurocognitive development and coping capabilities. It is known that development of the prefrontal cortex lags behind that of limbic regions during adolescence,[35] ensuring less impulse control and greater risk taking.[36] The findings extend to emotion regulation. Human imaging studies demonstrate that youth have a difficult time down-regulating amygdala activation.[37] Therefore, coping in youth is circumscribed by

limited ability to rationally or logically plan, execute, evaluate, and readjust a problem-focused strategy to eliminate or reduce stress, while simultaneously controlling emotional reactivity.

Consequently, youth greatly depend on adults, especially parents, both to assist them with meeting developmental demands and to guide their personal experiences in various domains (e.g., interpersonal, romantic) and settings (e.g., school, work). LGBT youth with insecure attachment may have a difficult time navigating and coping with such challenges if their parents are inaccessible and unresponsive.

Nevertheless, attachment may change over time.[38] This may happen if the attachment figure becomes more or less accessible and responsive, or if one attachment figure (e.g., the mother) buffers the negative impact of another attachment figure (e.g., the father). A non-parental individual may provide support, but whether she or he could provide the deep sense of security and the safe haven of an attachment figure is uncertain, particularly if social structures and cultural traditions do not foster these.

Parental Reactions to Gender Nonconformity

Gender nonconformity, defined as having a gender expression that is perceived to be inconsistent with gender norms expected for an individual's sex,[39] is not uncommon in children. A study of gender atypical behavior (one aspect of gender nonconformity) among elementary school children found that approximately 23% of boys and 39% of girls displayed multiple gender atypical behaviors.[40] Gender nonconformity exists on a spectrum, with some children displaying less and some children displaying more gender nonconformity. This spectrum has implications for victimization, such that youth who are more gender nonconforming are at increased risk for abuse by caregivers,[41] as well as peer victimization and bullying (see Mark Hatzenbeuhler's article, "Clinical Implications of Stigma, Minority Stress, and Resilience as Predictors of Health and Mental Health Outcomes," in this issue) and an increased risk of depressive symptoms.[42] Although a link exists between childhood gender nonconformity and later sexual minority orientation[43] and/or transgender identity,[44] not all children who are gender nonconforming are LGB or transgender in later adolescence or adulthood.[44]

As with stigma attached to sexual minorities and transgender individuals, gender nonconformity is also stigmatized in and of itself, particularly among boys. Connell's theory of hegemonic masculinity sheds light on this stigma, as it suggests that one form of masculinity, with features such as aggression, limited emotionality, and heterosexuality, is culturally exalted above others.[45,46] For this reason, variation from this level of masculinity among boys can be stigmatized. Similar to stigma related to sexual minorities and transgender individuals, stigma related to gender nonconformity is often enacted through prejudice, discrimination, and victimization. A study of early adolescents found that gender nonconformity was associated with increased victimization by peers.[47] Youth who are sexual minorities may be bullied for gender nonconformity before they are aware of their sexual orientation. A recent study found that sexual minority youth were bullied as early as fifth grade, which is before the majority of sexual minority youth are aware of their sexual

orientation or disclose it to others.[48] Although the study did not assess the reason for bullying, it is possible that these youth were bullied based on gender nonconformity.

Negative societal views may include adverse parental reactions to a child's gender nonconformity. A qualitative study found that parents welcomed gender nonconformity among their daughters, but had mixed reactions to their sons' gender nonconformity; they accepted some level of nonconformity in their sons (e.g., interest in cooking), but had negative reactions to higher levels of nonconformity (e.g., wearing dresses).[49] In addition to increased risk for bullying victimization from peers, previous research has found that gender nonconforming children have a high prevalence of childhood sexual abuse, physical abuse, and psychological abuse by caregivers,[41,50] which may be indicative of negative parental reactions to their child's gender nonconformity. Parents' initial reactions to gender nonconformity in their children may extend to reactions to youth's sexual orientation disclosure.

Parental Reactions to Youths' LGBT Disclosure

Disclosure of sexual orientation to family members is common among sexual minority youth. One study found that 79% of sexual minority youth had disclosed their sexual orientation to at least one parent, and two-thirds of youth had disclosed their orientation to at least one sibling and one extended family member.[51] Another study of sexual minority emerging adults found that 46% of men and 44% of women had disclosed their sexual orientation to their parents.[52] In this study, participants were more likely to disclose their sexual orientation to their mothers than to their fathers, and disclosures typically occurred around age 19 years in a face-to-face encounter.

A number of theories have been proposed to conceptualize the reactions of parents to their children's disclosure of sexual minority orientation,[53] including mourning/loss paradigms based on Kubler-Ross's stage model of grief[54] and family stress theory.[55,56] Willoughby et al. applied family stress theory to parental reactions to their children's sexual orientation disclosure, proposing that reactions may depend on the availability of family-level resources (e.g., relational competencies)[57,58] to manage stress, meanings that parents attributed to the stressful event (e.g., believing that sexual orientation is a choice), and co-occurring stressors (e.g., divorce, major illness).[59] Although these theories are useful for understanding parents' reactions to their child's sexual orientation disclosure, some researchers have proposed that these models are limited in that they may not describe the reaction of all parents, account for developmental change in reactions over time, or consider the experiences of the child.[53]

Parents may experience a number of different responses when faced with a disclosure of sexual minority orientation from their child, ranging from accepting to rejecting. Research in this area has yielded mixed results regarding the positivity and negativity of parental reactions. One study found that sexual minority youth who had disclosed their sexual orientation to family members reported more verbal and physical abuse by family members and more suicidality compared to youth who had not disclosed their orientation.[60] However, this study was published in 1998 and much has changed since then regarding societal acceptance of sexual minorities. Another study found that among sexual minority youth who

had disclosed their sexual orientation to their mother or father, the majority (89–97%) received a positive reaction.[61] However, these findings may be misleading, given they do not consider how many youth have not disclosed to parents due to fear of negative reactions or rejection.

A review of the sexual minority literature finds that one-third of youth experience parental acceptance, another third experience parental rejection, and the remaining third do not disclose their sexual orientation even by their late teenage years and early twenties.[19] The review also finds that regardless of initial reactions, parents generally become more accepting of their child over time. For instance, one study found that compared to sexual minority youth who had not disclosed their sexual orientation to parents, sexual minority youth who had disclosed their orientation reported more past sexual orientation-based verbal victimization from parents, but more current family support and less fear of future parental victimization,[62] indicating greater acceptance over time. Whether such findings generalize to transgender youth is unknown. Our first case vignette at the end of this article illustrates areas needing more empirical research regarding transgender youth's disclosure of gender identity to parents.

The process of sexual orientation disclosure in families may be shaped by the values of the family system.[63] In one study investigating traditional values and family acceptance of sexual minorities, families with a strong emphasis on traditional values (e.g., importance of religion, emphasis on marriage, emphasis on having children) were perceived as less accepting of sexual minority orientation than less traditional families.[64] Parental responses to youth's disclosure of sexual minority orientation may also differ based on race/ethnicity or cultural levels of acceptance of sexual minority individuals (see Ch. 11, "Sociocultural Factors and LGBT Youth's Health-related behavior: The role of race/ethnicity, socioeconomic status, religion and culture"). However, only one study, as far as we know, has examined parental responses to youths' sexual orientation disclosure by race/ethnicity among young adult gay males of African-American, European-American, Mexican-American, and Vietnamese-American backgrounds. It found family responses to be similar across the four groups.[63]

Additional research on levels of family support and rejection of sexual minority youth has found group differences by sexual orientation, race/ethnicity, and gender identity. A study of sexual orientation group differences in parental support of young adults found that lesbian and bisexual women reported lower levels of parental support than heterosexual women, and that gay men reported lower levels of parental support than bisexual or heterosexual men.[65] These group differences may be related to general attitudes toward different sexual orientation groups, indicating that attitudes toward sexual minority individuals are more negative than attitudes toward heterosexual individuals.[66] Some race/ethnicity differences in level of family support have also been found. In a study of White and Latino sexual minority young adults, Latino men reported the highest number of negative family reactions to their sexual orientation in adolescence.[67] However, another study found similar levels of parental support among White and racial/ethnic minority LGBT youth.[68] More research is needed to obtain a clearer picture of how race/ethnicity may be related to parental responses to sexual orientation disclosure among youth, as well as parental support and rejection of LGBT youth

(see Ch. 11 for more information). Although there is little research on family support and rejection of transgender youth, some research has indicated that these youth report more rejection than cisgender youth.[69] Further empirical research is needed on family support and rejection among transgender youth, particularly compared to cisgender sexual minority youth.

Implications for LGBT Youth Identity and Health

Levels of family acceptance and rejection may have implications for sexual minority youth's identity development. A study of sexual minority adolescents and young adults examined associations between parental acceptance and identity profiles that were affirmed as opposed to being characterized by struggle.[70] Results indicated that less parental rejection was associated with a greater likelihood of having an affirmed identity than struggling with one's identity,[70] suggesting that the level of parental rejection may affect youths' ability to accept their own sexual minority identity. Similarly, youth whose parents knew about their sexual orientation reported less "internalized homophobia" (or self-stigma – see Ch. 5, "Clinical Implications of Stigma, Minority Stress, and Resilience as Predictors of Health and Mental Health Outcomes") compared both to youth whose parents did not know about their sexual orientation and youth who newly disclosed their orientation to their parents over the course of the study.[71]

Pediatric care providers should be aware that family rejection may have serious consequences for LGBT youth's physical and mental health.[72,73] Studies have found that parental rejection is associated with health risk behaviors and poor mental and physical health outcomes among LGBT individuals. Sexual minority emerging adults with higher levels of family rejection were more likely to report attempted suicide, high levels of depression, and illegal drug use, and engagement in unprotected sexual intercourse.[67] Parental rejection negatively affects health among both transgender and cisgender adolescents. In the Thai study referenced earlier, family rejection predicted adolescents' level of depression, suicidal thinking, and sexual risk behaviors among both transgender and cisgender youth.[69]

Conversely, family acceptance may be protective for LGBT youth's health. Among sexual minority youth, adolescents whose mothers responded positively to their sexual orientation disclosure were less likely to use substances compared to those who had not disclosed their orientation to their parents or whose mothers and fathers did not react positively.[61] In addition, family support and acceptance is associated with greater self-esteem, social support, general health status, less depression, less substance abuse, and less suicidal ideation and behaviors among LGBT youth.[74] Family support is also associated with less substance use among LGBT youth.[74–76] Among transgender youth specifically, parental support is protective against depression[77] and associated with having a higher quality of life.[78]

Clinical Implications

The preceding information underscores why it is important for providers of pediatric care to know the effects of family non-acceptance and rejection on youth; to understand specific threats to family acceptance affecting LGBT youth like parental stigma against LGB orientation, gender non-conforming behavior and/or gender variant identities; to assess these in youth and families; and to intervene appropriately in case of family non-acceptance or risk for it. The following case vignettes illustrate these principles in clinical practice.

Case 1 (Box 1) illustrates several complexities of coming out as transgender during the later adolescent period. The burden of unshared personal information and associated shame and fears of rejection, especially by one's closest supports, combined with the mental effort required to maintain an external identity at odds with the internal sense of true self all contributed significantly to this patient's depression. Improvement in depression was observed with disclosure to the mother, but depression recurred following subsequent negative or ambivalent parental responses. Acceptance was achieved within a broader social network, but peer and other community support could not replace the desired parental reaction. Without the support of the parents, the patient regressed and acquiesced to the sex assigned at birth, followed by depression that required pharmacological treatment. Although the pediatrician and psychotherapist were not able to effect parental acceptance, treatment was used to clarify its importance as a way to set the stage for further family work or adaptive separation, individuation, and coping with ongoing family non-acceptance.

Box 1

Case 1

A 16 year-old natal male presented to the physician with his mother and father with a chief complaint of depression. He reported feelings of worthlessness, failure, unhappiness, becoming easily overwhelmed and emotionally numb when stressed. During that first meeting he made a point of reporting that he had grown to feel more distant from his mother and father.

A referral was made for individual psychotherapy. During subsequent follow-up appointments the depression symptoms remained unchanged. There was ongoing resistance to therapy but during the course of care a positive alliance was developed with the physician. It was noted later in the treatment that the physician's neutral, inquisitive style, appearance of non-judgment and of agency for the patient, signaling of a primary alliance with the patient rather than the parents (while maintaining respect for the parents' interests) all helped to establish a good clinical alliance with the patient.

Seven months into the treatment relationship, an appointment was scheduled with the physician at the patient's request. The stated goal for the meeting was to inform the physician, "I'm a girl. I don't feel like I'm a girl, I *am* a girl." The patient reported constant preoccupation with thoughts related to their current gender identity, efforts to cope with already developed secondary sex characteristics and how to achieve gender affirmation. The patient indicated a preference for the use of feminine gender pronouns. The patient also chose to come out to her mother in the office with the physician present.

Her mother was able to express an interest in understanding what was being explained to her but anticipated a slow process. The patient left the office indicating that the mother's response was consistent with her expectations.

The next scheduled appointment occurred two weeks later. By that time the patient had told her father who did not attend the visit. Her father's response was experienced as reserved and without clear acceptance or rejection. The drive to come out seemed to have been amplified since the initial experience with her mother. Beginning with a trusted faculty counselor at school and then with teachers and finally peers, she had informed members of her school and social community about her gender identity. The patient experienced their responses as supportive. There were no reports of explicit or implicit mistreatment. Her parents remained avoidant, however.

The patient felt an urgent drive to take action in the period after gender identity disclosure. After informing her broader social community, the patient sought to formally change her name and remained focused on gender affirmation. The family rejected the psychotherapist's suggestion to consult with a gender management service, saying they would not agree to this "until [he's] 18."

The patient's symptoms of depression continued, despite apparent relief and transient mood improvement immediately following the initial gender identity disclosure. As depression returned following her mother's and then father's avoidant responses, the patient appeared driven to repeat the disclosure to an expanding set of her social community. Each supportive encounter resulted in another transient improvement in mood, but these were always followed by recurrence of depression. Observing and discussing that process with the patient led to a calming of the fervent drive to act, but the depression remained. The patient eventually abandoned efforts to obtain a supportive and accepting response from the parents, and elected to defer pursuing further gender affirmation until able to do so independently, including suspending social transition such as requesting to be addressed by feminine name and pronoun. The depression was ultimately treated with antidepressant medication.

In Case 2 (Box 2), the child benefited from the protective effects of supportive parents to whom she appeared to have a secure attachment. Her masculine gender expression provoked mistreatment from peers. The stress of her exclusion began to affect her psychological health, but was modified by her ability to share her feelings and experiences at school with her parents and to rely on their ability to provide support and take appropriate protective action. A good relationship with the pediatrician extended the foundation of support. Together they were able to care for the child through an environmental action that may have prevented the need for mental health care. This case also underscores that gender nonconforming behavior may, but does not necessarily, mean that the youth will have a LGB orientation or be transgender later in adolescence or adulthood.

Box 2

Case 2

The pediatrician had provided primary care for a girl since her birth. She experienced an unremarkable early development and had remained medically healthy. She was clearly “a tomboy” as her mom would note, but this garnered no concern as it might if instead of a masculine girl she were a feminine boy. There was no interest in dolls or princesses, no comfort in wearing a dress, and no affinity for pink or purple. She wore jeans and T-shirts, played football with the boys at recess, and was comfortable getting dirty.

During her fourth grade year, a Monday office visit was scheduled after an episode of emesis at school. Her mother explained that the previous week, her daughter had been complaining of stomachaches and headaches in the morning. She had stayed home from school on Friday, but seemed better by that afternoon and over the weekend. On Monday morning she had again complained of feeling sick. Her examination was unremarkable. Physically she was well. Reassurance was given along with written authorization to return to school the next day.

School avoidance continued. Given the doctor’s findings, she was not kept home. She began to pick at her skin and appeared unhappy. Her parents had always been caring and attentive though not intrusive. They asked what had been happening at school. Their daughter explained that a bully had called her “gay” and said she was “a lesbian”. In the absence of effective intervention for bullying by her school, her persistent masculine gender expression elicited name-calling by a bully, which led to a group dynamic of teasing by other children at school. This led to widespread peer rejection and shunning. Her parents listened and supported her. A meeting was arranged at the school where the teacher acknowledged awareness of recent shifts in friendships. Although he and school administration acknowledged the problem, they did not implement standard anti-bullying interventions (see Ch. 6, “LGBT Youth and Bullying”), expressing confidence that the peer ostracism would pass quickly without school intervention.

However, peer perceptions of her sexual orientation and associated social ostracism did not change. With her parents’ support and encouragement, she was able to attend school. Her skin picking resolved, but she remained unhappy. After speaking with their daughter, the parents requested a school district transfer, but were opposed by school administration.

Parents sought help from the pediatrician, asking for a letter of medical necessity. The pediatrician readily provided one that included information about negative health effects of bullying, social isolation and alienation resulting from gender nonconformity and perceived sexual minority status. She included information about increased risk of depression and suicide. After receiving the letter, the school district approved a transfer.

Adjustment to the new school, which had an antibullying policy and curriculum that included non-tolerance of bullying on the basis of sexual orientation and gender, was positive. The patient’s mood improved quickly after the transfer. She found friends who introduced her to a new hobby of freestyle skateboarding. Now a teenager, she has

become quite accomplished. Both she and her current boyfriend participate in the same competitive skateboard circuit.

Summary

In this article, we have discussed theories of attachment, parental acceptance and rejection, and implications of each for LGBT youths' identity and health. We have provided two clinical cases to illustrate the impact of family acceptance and rejection of a transgender youth and a gender nonconforming youth who was neither a sexual minority nor transgender. It is clear from existing research that family acceptance and rejection is crucial to the health and well-being of LGBT youth. However, the majority of research conducted in this area has focused on sexual minority cisgender youth. More research is needed to understand how family acceptance and rejection affects the health of transgender youth. Health care providers working with LGBT youth should address issues of family acceptance and rejection during clinical visits to ensure that youth develop a healthy sense of self in terms of their sexual orientation and gender identity.

References

1. Rosario, M.; Schrimshaw, EW. Theories and etiologies of sexual orientation. In: Tolman, DL.; Diamond, LM., editors. APA Handbook of Sexuality and Psychology. Washington, DC: American Psychological Association; 2014. p. 555-596.
2. Institute of Medicine. The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding. 2011.
3. Austin SB, Nelson LA, Birkett MA, Calzo JP, Everett B. Eating disorder symptoms and obesity at the intersections of gender, ethnicity, and sexual orientation in US high school students. Am J Public Heal. 2013; 103(2):e16–e22.
4. Fergusson DM, Horwood LJ, Beautrais AL. Is sexual orientation related to mental health problems and suicidality in young people? Arch Gen Psychiatry. 1999; 56(10):876–880. [Accessed October 10, 2015] http://www.ncbi.nlm.nih.gov/pubmed/10530626. [PubMed: 10530626]
5. Marshal MP, Friedman MS, Stall R, et al. Sexual orientation and adolescent substance use: a meta-analysis and methodological review. Addiction. 2008; 103(4):546–556. DOI: 10.1111/j.1360-0443.2008.02149.x [PubMed: 18339100]
6. Friedman MS, Marshal MP, Guadamuz TE, et al. A meta-analysis of disparities in childhood sexual abuse, parental physical abuse, and peer victimization among sexual minority and sexual nonminority individuals. Am J Public Health. 2011; 101(8):1481–1494. DOI: 10.2105/AJPH.2009.190009 [PubMed: 21680921]
7. Rosario M, Corliss HL, Everett BG, et al. Sexual orientation disparities in cancer-related risk behaviors of tobacco, alcohol, sexual behaviors, and diet and physical activity: pooled Youth Risk Behavior Surveys. Am J Public Health. 2014; 104(2):245–254. DOI: 10.2105/AJPH.2013.301506 [PubMed: 24328632]
8. Wichstrøm L. Sexual orientation as a risk factor for bulimic symptoms. Int J Eat Disord. 2006; 39(6):448–453. DOI: 10.1002/eat.20286 [PubMed: 16634052]
9. Marshal MP, Friedman MS, Stall R, Thompson AL. Individual trajectories of substance use in lesbian, gay and bisexual youth and heterosexual youth. Addiction. 2009; 104(6):974–981. DOI: 10.1111/j.1360-0443.2009.02531.x [PubMed: 19344440]
10. Needham BL. Sexual attraction and trajectories of mental health and substance use during the transition from adolescence to adulthood. J Youth Adolesc. 2012; 41(2):179–190. DOI: 10.1007/s10964-011-9729-4 [PubMed: 22076077]

11. Rosario M, Li F, Wypij D, et al. Disparities by Sexual Orientation in Frequent Engagement in Cancer-Related Risk Behaviors: A 12-Year Follow-Up. Am J Public Health. 2016; 106(4):698–706. DOI: 10.2105/AJPH.2015.302977 [PubMed: 26794176]
12. Reisner SL, Vetters R, Leclerc M, et al. Mental Health of Transgender Youth in Care at an Adolescent Urban Community Health Center: A Matched Retrospective Cohort Study. J Adolesc Heal. 2015 Jan.:4–9.
13. Rosario M, Schrimshaw EW, Hunter J, Gwadz M. Gay-related stress and emotional distress among gay, lesbian, and bisexual youths: A longitudinal examination. J Consult Clin Psychol. 2002; 70(4):967–975. [PubMed: 12182280]
14. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. Psychol Bull. 2003; 129(5):674–697. DOI: 10.1037/0033-2909.129.5.674 [PubMed: 12956539]
15. Katz-Wise SL, Hyde JS. Victimization experiences of lesbian, gay, and bisexual individuals: a meta-analysis. J Sex Res. 2012; 49(2–3):142–167. DOI: 10.1080/00224499.2011.637247 [PubMed: 22380586]
16. Newcomb ME, Mustanski B. Internalized homophobia and internalizing mental health problems: a meta-analytic review. Clin Psychol Rev. 2010; 30(8):1019–1029. DOI: 10.1016/j.cpr.2010.07.003 [PubMed: 20708315]
17. Grant, JM.; Mottet, LA.; Tanis, J.; Harrison, J.; Herman, JL.; Keisling, M. Injustice at Every Turn: A Report of the National Transgender Discrimination Survey. 2011.
18. Hendricks ML, Testa RJ. A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. Prof Psychol Res Pract. 2012; 43(5):460–467. DOI: 10.1037/a0029597
19. Rosario M, Schrimshaw EW. The sexual identity development and health of lesbian, gay, and bisexual adolescents: An ecological perspective. Handb Psychol Sex Orientat. 2013; :87–101. DOI: 10.1093/acprof:oso/9780199765218.003.0007.
20. Bowlby, J. Attachment and Loss: Volume I. Attachment. 2. New York, NY: Basic Books; 1969.
21. Bowlby, J. Attachment and Loss: Volume II. Separation: Anxiety and Anger. New York, NY: Basic Books; 1973.
22. Bowlby, J. Attachment and Loss: Volume III: Loss: Sadness and Depression. New York, NY: Basic Books; 1980.
23. Mikulincer, M.; Shaver, PR. Attachment in Adulthood: Structure, Dynamics, and Change. New York, NY: Guilford Press; 2007.
24. Rosario M. Implications of childhood experiences for the health and adaptation of lesbian, gay, and bisexual individuals: Sensitivity to developmental process in future research. Psychol Sex Orientat Gend Divers. 2015; 2(3):214–224. [PubMed: 26900586]
25. Seiffge-Krenke I. Coping with relationship stressors: The impact of different working models of attachment and links to adaptation. J Youth Adolesc. 2006; 35:25–39.
26. Pearson J, Wilkinson L. Family relationships and adolescent well-being: are families equally protective for same-sex attracted youth? J Youth Adolesc. 2013; 42(3):376–393. DOI: 10.1007/s10964-012-9865-5 [PubMed: 23196375]
27. Corliss HL, Cochran SD, Mays VM. Reports of parental maltreatment during childhood in a United States population-based survey of homosexual, bisexual, and heterosexual adults. Child Abuse Negl. 2002; 26:1165–1178. [PubMed: 12398854]
28. Corliss HL, Goodenow CS, Nichols L, Bryn Austin S. High burden of homelessness among sexual-minority adolescents: Findings from a representative massachusetts high school sample. Am J Public Health. 2011; 101(9):1683–1689. DOI: 10.2105/AJPH.2011.300155 [PubMed: 21778481]
29. McLaughlin, Ka; Hatzenbuehler, ML.; Xuan, Z.; Conron, KJ. Disproportionate exposure to early-life adversity and sexual orientation disparities in psychiatric morbidity. Child Abuse Negl. 2012; 36(9):645–655. DOI: 10.1016/j.chiabu.2012.07.004. [PubMed: 22964371]
30. Rice E, Barman-Adhikari A, Rhoades H, et al. Homelessness experiences, sexual orientation, and sexual risk taking among high school students in Los Angeles. J Adolesc Health. 2013; 52(6):773–778. DOI: 10.1016/j.jadohealth.2012.11.011 [PubMed: 23360897]
31. Minkler & Wallerstein, Ch 16 - Analyzing & interpreting data with communities.pdf.

32. Waller MW, Sanchez RP. The association between same-sex romantic attractions and relationships and running away among a nationally representative sample of adolescents. Child Adolesc Soc Work J. 2011; 28:475–493.
33. Rosario M, Reisner SL, Corliss HL, Wypij D, Frazier AL, Austin SB. Disparities in depressive distress by sexual orientation in emerging adults: the roles of attachment and stress paradigms. Arch Sex Behav. 2014; 43(5):901–916. DOI: 10.1007/s10508-013-0129-6 [PubMed: 23780518]
34. Rosario M, Reisner SL, Corliss HL, Wypij D, Calzo J, Austin SB. Sexual-orientation disparities in substance use in emerging adults: a function of stress and attachment paradigms. Psychol Addict Behav. 2014; 28(3):790–804. DOI: 10.1037/a0035499 [PubMed: 25134050]
35. Casey BJ, Getz S, Galvan A. The adolescent brain. Dev Rev. 2008; 28(1):62–77. DOI: 10.1016/j.dr.2007.08.003 [PubMed: 18688292]
36. Galvan A, Hare TA, Parra CE, et al. Earlier development of the accumbens relative to orbitofrontal cortex might underlie risk-taking behavior in adolescents. J Neurosci. 2006; 26(25):6885–6892. DOI: 10.1523/JNEUROSCI.1062-06.2006 [PubMed: 16793895]
37. Hare TA, Tottenham N, Galvan A, Voss HU, Glover GH, Casey BJ. Biological substrates of emotional reactivity and regulation in adolescence during an emotional go-nogo task. Biol Psychiatry. 2008; 63(10):927–934. DOI: 10.1016/j.biopsych.2008.03.015 [PubMed: 18452757]
38. Booth-LaForce C, Groh AM, Burchinal MR, Roisman GI, Owen MT, Cox MJV. Caregiving and contextual sources of continuity and change in attachment security from infancy to late adolescence. Monogr Soc Res Child Dev. 2014; 79(3):67–84. DOI: 10.1111/mono.12114 [PubMed: 25100090]
39. Green, E.; Maurer, L. The Teaching Transgender Toolkit: A Facilitator's Guide to Increasing Knowledge, Decreasing Prejudice and Building Skills. Ithaca, NY: Planned Parenthood of the Southern Finger Lakes; 2015.
40. Sandberg DE, Meyer-Bahlburg HF, Ehrhardt AA, Yager TJ. The prevalence of gender-atypical behavior in elementary school children. J Am Acad Child Adolesc Psychiatry. 1993; 32(2):306–314. DOI: 10.1097/00004583-199303000-00010 [PubMed: 8444758]
41. Roberts AL, Rosario M, Corliss HL, Koenen KC, Austin SB. Childhood gender nonconformity: a risk indicator for childhood abuse and posttraumatic stress in youth. Pediatrics. 2012; 129(3):410–417. DOI: 10.1542/peds.2011-1804 [PubMed: 22351893]
42. Roberts AL, Rosario M, Slopen N, Calzo JP, Austin SB. Childhood gender nonconformity, bullying victimization, and depressive symptoms across adolescence and early adulthood: an 11-year longitudinal study. J Am Acad Child Adolesc Psychiatry. 2013; 52(2):143–152. DOI: 10.1016/j.jaac.2012.11.006 [PubMed: 23357441]
43. Rieger G, Linsenmeier JAW, Gygax L, Bailey JM. Sexual orientation and childhood gender nonconformity: Evidence from home videos. Dev Psychol. 2008; 44(1):46–58. DOI: 10.1037/0012-1649.44.1.46 [PubMed: 18194004]
44. Wallien MSC, Cohen-Kettenis PT. Psychosexual outcome of gender-dysphoric children. J Am Acad Child Adolesc Psychiatry. 2008; 47(12):1413–1423. [PubMed: 18981931]
45. Connell, RW. Gender and Power. Stanford, CA: Stanford University Press; 1987.
46. Connell, RW. Masculinities. Berkeley, CA: University of California Press; 1995.
47. Aspenlieder L, Buchanan CM, McDougall P, Sippola LK. Gender nonconformity and peer victimization in pre- and early adolescence. Eur J Dev Sci. 2009; 3(1):3–16. http://ezp-prod1.hul.harvard.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2010-11950-002&site=ehost-live&scope=site.
48. Schuster, MA.; Bogart, LM.; Elliott, MN. [Accessed February 29, 2016] A longitudinal study of bullying of sexual-minority youth. The New England Journal of Medicine. http://www.nejm.org.ezp-prod1.hul.harvard.edu/doi/full/10.1056/NEJMc1413064. Published 2015
49. Kane EW. "No Way My Boys Are Going to Be Like That!": Parents' Responses to Children's Gender Nonconformity. Gend Soc. 2006; 20(2):149–176. DOI: 10.1177/0891243205284276
50. Roberts AL, Rosario M, Corliss HL, Koenen KC, Austin SB. Elevated risk of posttraumatic stress in sexual minority youths: mediation by childhood abuse and gender nonconformity. Am J Public Heal. 2012; 102(8):1587–1593. DOI: 10.2105/ajph.2011.300530

51. Rosario M, Schrimshaw EW, Hunter J. Disclosure of sexual orientation and subsequent substance use and abuse among lesbian, gay, and bisexual youths: Critical role of disclosure reactions. Psychol Addict Behav. 2009; 23(1):175–184. DOI: 10.1037/a0014284.Disclosure [PubMed: 19290704]
52. Savin-Williams RC, Ream GL. Sex variations in the disclosure to parents of same-sex attractions. J Fam Psychol. 2003; 17(3):429–438. DOI: 10.1037/0893-3200.17.3.429 [PubMed: 14562466]
53. Savin-Williams RC, Dube EM. Parental Reactions to Their Child's Disclosure of a Gay / Lesbian Identity *. Fam Relat. 1998; 47(1):7–13. DOI: 10.2307/584845
54. Kubler-Ross, E. On Death and Dying. New York, NY: MacMillan; 1969.
55. Hill, R. Families under Stress. Westport, CT: Greenwood; 1949.
56. McCubbin HI, Patterson JM. The family stress process: The double ABCX model of adjustment and adaptation. Marriage Fam Rev. 1983; 6:7–37.
57. McCubbin, HI.; Thompson, AI.; McCubbin, MA. Family Assessment: Resiliency, Coping and Adaptation: Inventories for Research and Practice. Madison, WI: University of Wisconsin Publishers; 1996.
58. Patterson JM. Families experiencing stress. Fam Syst Med. 1988; 6:202–237.
59. Willoughby BLB, Doty ND, Malik NM. Parental Reactions to Their Child's Sexual Orientation Disclosure: A Family Stress Perspective. Parenting. 2008; 8(1):70–91. DOI: 10.1080/15295190701830680
60. D'Augelli AR, Hershberger SL, Pilkington NW. Lesbian, gay, and bisexual youth and their families: disclosure of sexual orientation and its consequences. Am J Orthopsychiatry. 1998; 68(3):361–371. discussion 372–375. [PubMed: 9686289]
61. Padilla YC, Crisp C, Rew DL. Parental acceptance and illegal drug use among gay, lesbian, and bisexual adolescents: Results from a national survey. Soc Work. 2014; 55(3):265–275.
62. D'Augelli AR, Grossman AH, Starks MT. Parents' Awareness of Lesbian, Gay, and Bisexual Youths' Sexual Orientation. J Marriage Fam. 2005; 67(2):474–482.
63. Merighi JR, Grimes MD. Coming out to families in a multicultural context. Fam Soc. 2000; 81(1): 32.doi: 10.1606/1044-3894.1090
64. Newman BS, Muzzonigro PG. The effects of traditional family values on the coming out process of gay male adolescents. Adolescence. 1993:109.
65. Needham BL, Austin EL. Sexual orientation, parental support, and health during the transition to young adulthood. J Youth Adolesc. 2010; 39(10):1189–1198. DOI: 10.1007/s10964-010-9533-6 [PubMed: 20383570]
66. Horn, SS. Handbook of Psychology and Sexual Orientation. New York, NY: Oxford University Press; 2013. Attitudes about sexual orientation; p. 239-251.
67. Ryan C, Huebner D, Diaz RM, Sanchez J. Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. Pediatrics. 2009; 123(1): 346–352. DOI: 10.1542/peds.2007-3524 [PubMed: 19117902]
68. Poteat VP, Mereish EH, DiGiovanni CD, Koenig BW. The effects of general and homophobic victimization on adolescents' psychosocial and educational concerns: The importance of intersecting identities and parent support. J Couns Psychol. 2011; 58(4):597–609. [PubMed: 21859187]
69. Yadegarfard M, Meinhold-Bergmann ME, Ho R. Family Rejection, Social Isolation, and Loneliness as Predictors of Negative Health Outcomes (Depression, Suicidal Ideation, and Sexual Risk Behavior) Among Thai Male-to-Female Transgender Adolescents. J LGBT Youth. 2014; 11(4):347–363. DOI: 10.1080/19361653.2014.910483
70. Bregman HR, Malik NM, Page MJL, Makynen E, Lindahl KM. Identity Profiles in Lesbian, Gay, and Bisexual Youth: The Role of Family Influences. J Youth Adolesc. 2013; 42(3):417–430. DOI: 10.1007/s10964-012-9798-z [PubMed: 22847752]
71. D'Augelli AR, Grossman AH, Starks MT, Sinclair KO. Factors associated with parents' knowledge of gay, lesbian, and bisexual youths' sexual orientation. J GLBT Fam Stud. 2010; 6(2):178–198.
72. Ryan C, Huebner D, Diaz RM, Sanchez J. Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. Pediatrics. 2009; 123(1): 346–352. DOI: 10.1542/peds.2007-3524 [PubMed: 19117902]

73. Ryan C, Russell ST, Huebner D, Diaz R, Sanchez J. Family acceptance in adolescence and the health of LGBT young adults. J Child Adolesc Psychiatr Nurs. 2010; 23(4):205–213. DOI: 10.1111/j.1744-6171.2010.00246.x [PubMed: 21073595]

74. Ryan C, Russell ST, Huebner D, Diaz R, Sanchez J. Family acceptance in adolescence and the health of LGBT young adults. J Child Adolesc Psychiatr Nurs. 2010; 23(4):205–213. DOI: 10.1111/j.1744-6171.2010.00246.x [PubMed: 21073595]

75. Newcomb ME, Heinz AJ, Birkett M, Mustanski B. A longitudinal examination of risk and protective factors for cigarette smoking among lesbian, gay, bisexual and transgender youth. J Adolesc Heal. 2014; 54(5):558–564. DOI: 10.1016/j.biotechadv.2011.08.021.Secreted

76. Newcomb ME, Heinz AJ, Mustanski B. Examining risk and protective factors for alcohol use in lesbian, gay, bisexual, and transgender youth: a longitudinal multilevel analysis. J Stud Alcohol Drugs. 2012; 73(5):783–793. http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3410946&tool=pmcentrez&rendertype=abstract. [PubMed: 22846242]

77. Simons L, Schrager SM, Clark LF, Belzer M, Olson J. Parental support and mental health among transgender adolescents. J Adolesc Heal. 2013; 53(6):791–793. DOI: 10.1016/j.jadohealth.2013.07.019

78. Simons L, Schrager SM, Clark LF, Belzer M, Olson J. Parental support and mental health among transgender adolescents. J Adolesc Health. 2013; 53(6):791–793. DOI: 10.1016/j.jadohealth.2013.07.019 [PubMed: 24012067]

Key Points

- Parent-child attachment has implications for developing healthy relationships later in life.
- LGBT youth may experience a disruption in parent-child attachment if they are rejected based on their sexual orientation or gender identity.
- Parental rejection of LGBT youth negatively affects youths' identity and health.
- Parental acceptance of LGBT youth is crucial to ensure that youth develop a healthy sense of self.