Mental Health Problems among Lesbian, Gay, and Bisexual Youths Ages 14 to 21[1]

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ABSTRACT

The mental health problems of lesbian, gay, and bisexual (lgb) youths were studied using a sample of 542 youths from community settings. Information about the development of sexual orientation, problems related to sexual orientation, parents' reactions, and victimization based on sexual orientation was related to mental health symptoms and suicidality. Lesbian, gay, and bisexual youths were found to demonstrate more symptoms than a comparison group of adolescents. Over one-third of the sample reported a past suicide attempt. More symptoms were related to parents not knowing about youths' sexual orientation or with both parents having negative reactions to youths' sexual orientation. More than three-quarters had been verbally abused because of their sexual orientation, and 15 percent reported physical attacks. More than one-third said they had lost friends because of their sexual orientation. Youths who had experienced more victimization and who had lost friends reported more mental health symptoms. Mental health professionals are urged to attend to the distinct problems of these youths, especially dealing with conflicts with families and peers.

KEYWORDS

adolescence, homosexuality, mental health, victimization

MUCH OF THE professional interest in lesbian, gay, and bisexual (lgb) youths results from evidence that they are at high risk for a range of health and mental health problems (D'Augelli & Hershberger, 1993; Fergusson, Horwood, & Beautrais, 1999; Lock & Steiner, 1999; Saewyc, Bearinger, Heinz, Blum, & Resnick, 1998; Safren & Heimberg, 1999). There is also evidence of alcohol and drug abuse among lgb youths (Jordan, 2000), as well as risky sexual behavior that increases their chance of HIV infection (Remafedi, 1994; Rosario, Meyer-Bahlburg, Hunter, & Gwadz, 1999; Rotheram-Borus, Marelich, & Srinivasan, 1999; Rotheram-Borus et al., 1994; Rotheram-Borus, Rosario, Van Rossem, Reid, & Gillis, 1995). Comprehensive reviews of these issues can be found in Anhalt and Morris (1999), Rotheram-Borus and Langabeer (2001), and Grossman (2001). Perhaps the most important – and contentious – finding related to lgb youth adjustment problems concerns suicidality (for a general review of research on suicidality and sexual orientation, see McDaniel, Purcell, & D'Augelli, 2001). Although no empirical evidence has

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found lgb youths to be over-represented among completed suicides, studies based on convenience samples have consistently found high suicide attempt rates among lgb youths (e.g. D'Augelli & Hershberger, 1993; D'Augelli, Hershberger, & Pilkington, 2001; Grossman & Kerner, 1998; Hammelman, 1993; Herdt & Boxer, 1993; Remafedi, 1987; Remafedi, Farrow, & Deisher, 1991; Rotheram-Borus, Hunter, & Rosario, 1994; Schneider, Farberow, & Kruks, 1989). In addition, results from representative samples have generally corroborated findings from earlier studies showing adjustment difficulties among lgb youths. Remafedi, French, Story, Resnick, and Blum (1998), comparing lgb youths and heterosexual youths in Minnesota public schools, confirmed an association of sexual orientation and suicide risk. Garofalo, Wolf, Kessel, Palfrey, and DuRant (1998) found similar results. DuRant, Krowchuk, and Sinal (1998) found a significant correlation between same-sex sexual activity and past suicide attempts among Vermont male high school students. The rates of suicide attempts for lgb youths found in these studies are considerably higher than estimates of suicide attempts among high school students in general (King, 1997; Lewinsohn, Rohde, & Seeley, 1996).

Many factors contribute to the mental health problems of lgb youths, although few studies have directly linked aspects of these youths' lives to the distress they experience. These youths experience the challenges of adolescence as do all youths, with the associated fluctuations of self-esteem. Adolescence is the transition from childhood to adulthood, and entails the negotiation of major developmental complexities related to the articulation of personal identity. Identity issues in adolescence occur during the course of biological changes, reorganization of peer social networks, and changes in family relationships (Graber & Archibald, 2001; McClintock & Herdt, 1996). In addition to the stressors associated with normative adolescent development, lgb youths face specific gay-related stressors, especially disclosing their sexual orientation to family and friends (Savin-Williams, 1998). Rosario, Rotheram-Borus, and Reid (1996) found that

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emotional distress in a sample of urban lgb youths was significantly related to the number of recent gay-related stressors experienced in the past three months. Having one's sexual orientation discovered, disclosing one's sexual orientation, and being ridiculed by others were associated with mental health problems and problem behavior. In an earlier analysis of the same sample, Rotheram-Borus et al. (1994) had found that gay-related stressors were more common among lgb youths who had made suicide attempts compared with youths who had not attempted suicide. Floyd, Stein, Harter, Allison, and Nye (1999) found a significant relationship between maternal attitudes towards youths' sexual orientation and youths' depressive symptoms. Safren and Heimberg (1999), however, found that mental health symptoms of lgb and heterosexual youths did not differ once levels of psychosocial predictors of distress were taken into account.

Victimization based on sexual orientation is another facet of many lgb youths' lives that can influence their mental health. Rivers and D'Augelli (2001) have noted that normative experiences involved in growing up as a lgb youth can be considered forms of victimization in that they can create considerable psychological conflict – being made to feel different, having to experience atypical family stressors solely because of sexual orientation, and, especially for gay and bisexual males, the psychosocial burdens of the HIV/AIDS epidemic. Verbal and physical attacks by others are also common among lgb youths. Research suggests that young lgb people are often the victims of such assaults. Dean, Wu, and Martin (1992) showed that young gay men aged 17–24 in New York were more frequently attacked than older men. Victimization was highest among women aged 17–24 in a large national sample of lesbians (Bradford, Ryan, & Rothblum, 1994). Nearly one-third of Pennsylvania adult lesbians and three-fifths of gay men surveyed reported harassment by junior or senior high school classmates or school employees (Gross, Aurand, & Addessa, 2000). In a study of New York City lgb youths, 41 percent had suffered from physical attacks; nearly half of these attacks were provoked by the youths' sexual orientation (Hunter, 1990). Lesbian, gay, and bisexual youths are more frequently the survivors of childhood physical or sexual abuse than heterosexual youths. In national surveys of victimization, between 19 and 41 percent of adult lesbians and gay males report family verbal abuse, and between 4 and 7 percent report family physical abuse (Berrill, 1990). Pilkington and D'Augelli (1995) found that over one-third of their lgb youth sample had been verbally abused by a family member. Of 1001 adult gay and bisexual males attending sexually transmitted disease clinics, Doll et al. (1992) found that 37 percent had been encouraged or forced to have sexual contact (mostly with older men) before age 19. Using the same sample, Bartholow et al. (1994) reported a significant association between earlier sexual abuse and current depression, suicidality, risky sexual behavior, and HIV-positive serostatus. Harry (1989) found that gay males were more likely to be physically abused during adolescence than heterosexual males, especially if they had a history of childhood femininity and poor relationships with their fathers.

In comparison with the rates found in these samples, the prevalence estimates for victimization of different kinds directed at adolescents in general survey findings are considerably lower (Finkelhor & Dziuba-Leatherman, 1994). Recent population-based studies of lgb youths show evidence of high levels of victimization of such youths. Faulkner and Cranston (1998), using a representative sample of Massachusetts high school students, compared youths with same-sex sexual contact with those reporting heterosexual contact only. Youths with same-sex experience reported having been threatened or injured with a weapon at school twice as often as heterosexual students, had property stolen or damaged twice as often, and avoided school more due to feeling unsafe. In a similar study using a later sample, Garofolo, Wolf, Kessel, Palfrey, and

DuRant (1998) found that one-third of the lgb youths had been threatened with a weapon at school, compared with 7 percent of the other youths. More lgb youths reported property damage. In a Vermont survey of high school students, DuRant et al. (1998) found that the number of male-sexual partners (used as a proxy for same sex sexual orientation) was significantly related to different kinds of victimization. Compared with males with female partners, males with male sexual partners were more likely to be in fights in school, to require medical attention following school fights, and to be threatened more often. Studies have also documented victimization directed to lgb students at colleges and universities (Evans, 2001).

This report presents data on factors associated with mental health among lgb youths by using a large sample of youths attending social and recreational groups in community settings. It has an advantage over other lgb youth studies in that it utilizes a sample taken from many communities, not from a single agency, community, or geographical region. It also includes information about sexual orientation development, which has not been linked to mental health outcomes in other research. Length of time youths have been open about their sexual orientation, their current openness, and their identifiability by others were considered to determine whether earlier disclosure of sexual orientation (and therefore stresses handled at younger ages) would be associated with greater mental health problems. Relationships with parents, especially parents' knowledge of and reactions to youths' sexual orientation, were examined, with the expectation that greater parental awareness and more positive reactions would be associated with better mental health. Associations between victimization experiences and mental health were also tested.

Method

Participants

Two datasets were combined for the analyses presented here. The first data were gathered from 1987 to 1989, and the second from 1995 to 1997. Similar data-collection procedures were used both times, with the primary goal being the generation of the most diverse national sample possible given resource limitations. Several strategies were employed to generate the samples. First, listings of social and recreational groups for lgb youths were identified. These groups varied considerably in nature, ranging from very small groups of several youths meeting in the homes of local adult human services professionals to larger groups meeting in community buildings, such as churches and recreational centers. In some groups group discussion of personal concerns occurred, whereas in others youths simply met to socialize. In all cases, however, adults from the community with counseling or human services experience were present. These adults served as group coordinators, and they also facilitated the referral of youths to professional counseling or other services if needed. None of these groups were formal counseling groups.

Letters were sent to group coordinators across the United States of America and Canada, requesting that they consult with their group members about participation in this project. Groups interested in involvement were asked to notify the researchers. In addition, for the second data-collection effort, a description of the project was posted on several Internet sites. This posting elicited responses from several groups, including a youth group in New Zealand, which was included in analyses. An adult contact person was identified in each group who served as liaison to the project; this person would administer the instrument and assure that all human subjects requirements were met. Details about procedures can be found in D'Augelli and Hershberger (1993) and D'Augelli et al. (2001).

This process yielded a final sample of 542 youths, 336 (62%) males and 206 (38%) females. Youths reported their current sexual orientation in one of three categories: gay or lesbian; bisexual, but mostly gay or lesbian; or, bisexual, equally gay or lesbian and heterosexual. Youths acknowledging other sexual orientations or youths said they were unsure were excluded. Three-quarters (74%) self-identified as gay or lesbian (male: 79%; female: 66%); 20 percent said they were bisexual, but mostly gay or lesbian (male: 19%; female: 21%); and, 6 percent said they were bisexual, but equally gay/lesbian and heterosexual (male: 2%; female: 13%). Significantly more females identified as bisexual, $\chi^2(2, N = 542) = 28.57$, $p < .001$. Their ages ranged from 14 to 21, with one-third from 14 to 18, and two-thirds from 19 to 21. Average age was 19.08 (SD = 1.5); males were significantly older, $t(540) = 2.49$, $p < .01$. A two-factor ANOVA with gender and the study (first or second data-collection) as factors revealed a significant interaction effect, $F(1,538) = 12.99$, $p < .01$; inspection of the four means found that females in the first study were the anomalous group, being about one year younger than the others, on average. Over three-quarters of the sample was White; 8 percent were African American, 4 percent were of Hispanic origin, 1 percent were Native American or Canadian, and the rest came from a variety of other backgrounds. Geographical diversity was reasonably represented: 38 percent lived in major metropolitan areas, 19 percent in small cities, 28 percent in medium-sized towns or in the suburbs, 10 percent in small towns, and 5 percent in rural areas. Because of the small representation of youths of color in any particular category, comparisons between youths of different racial and ethnic backgrounds were not attempted.

Instrument

Sexual orientation development The following information about crucial ages at which different milestones related to sexual orientation occurred was obtained: age of first awareness of same-sex attraction; age of first self-labeling as lesbian, gay, or bisexual; age of first disclosure of same-sex sexual orientation; and, age of first disclosure to a parent. Additional descriptors of early sexual orientation experience were calculated. Years of awareness of lgb orientation was computed by subtracting youths' age at first awareness from their age; years before self-labeling was age of awareness subtracted from age of self-labeling; and, years before first disclosure was the subtraction of age at self-labeling from age of first disclosure. These scores reflect the duration of the crucial phases of sexual orientation development. The percentage of youths' lives during which they were aware of same-sex feelings was calculated by dividing the age at which youths reported their first awareness by their chronological age. To approximate the percentage of their lives youths knew of their sexual orientation but had not told anyone, the difference between the age of self-labeling and the age of first disclosure was divided by youths' age. Finally, as an indicator of the percentage of youths' lives spent self-identified as lgb but non-disclosed (perhaps the best indicator of time 'in the closet'), age of self-labeling was subtracted from age of first disclosure, and then divided by youths' age.

Youths were asked how open they were in general about their sexual orientation. They responded using a seven-point scale with 1 = *Lgb identity hidden*, to 7 = *Complete openness and honesty about lgb identity*. They were also asked about their identifiability by others. The question was, 'How likely do you think that other people who *don't* know you could identify you as lesbian, gay, or bisexual?' This question was answered with 1 = *Not likely*, 2 = *Likely*, and 3 = *Very likely*.

Mental health problems The primary mental health measure was the Brief Symptom Inventory (BSI; Derogatis, 1993). The BSI is a standardized measure consisting of ratings

of the severity of 53 symptoms over a two-week period. The BSI yields nine subscales: Somatization (a focus on bodily dysfunctions), Obsessive-Compulsiveness, Interpersonal Sensitivity (sensitivity to others' reactions), Depression, Anxiety, Hostility, Phobic Anxiety (an avoidance of particular places), Paranoid Ideation (a distrust of others), and Psychoticism (alienation from others). An overall measure of symptoms called the Global Severity Index (GSI) is also calculated by averaging the endorsement ratings of all symptoms. The BSI is an efficient indicator of mental health symptoms, and its reliability and validity are well-established. In the first data-set, Cronbach's alphas for the subscales ranged from .72 to .89, and was .97 for the GSI score. Similar reliabilities were found for the BSI in the other data-set. Correlations between BSI subscales ranged from .52 to .80. Although these correlations were all statistically significant, as would be expected, their magnitude suggested that the subscales were distinct, though interrelated.

Information was obtained about youths' past suicidal thoughts and past suicide attempts. Youths were first asked, 'Have you *ever* seriously thought of taking your own life?' which was answered on a four-point scale ranging from 1 = *Never*, to 4 = *Often*. They were asked whether they had ever tried to kill themselves, and as Yes or No. Youths in the second study were asked more questions about suicidality, results of which are presented elsewhere (D'Augelli et al., 2001).

Finally, youths were asked if they are currently receiving help from a professional counselor for personal problems, and if they had ever received such help.

Problems related to sexual orientation

Youths were asked to evaluate five problem areas that typically cause stress for lgb youths. The problems were: 'telling my family that I'm lgb', 'dissatisfaction with my sex life', 'telling straight friends about my sexuality', 'my religious beliefs and my sexuality', and 'worry about AIDS'. For each, the respondent used a 4-point scale, with 1 = *Extremely troubling*, 2 = *Very troubling*, 3 = *Somewhat troubling*, and 4 = *No problem for me*. Although other problems were listed on the instruments used in the two datasets, these were the only problems that the two instruments had in common.

Parents' reactions to sexual orientation

Parental reactions to youths' sexual orientation were examined using two questions from Savin-Williams (1990). First, mothers' and fathers' knowledge of youths' sexual orientation was determined by having youths categorize each parent's knowledge using a 4-point scale. Response options were: 1 = *Definitely knows, and we have talked about it*, 2 = *Definitely knows, but we have never talked about it*, 3 = *Probably knows or suspects*, and 4 = *Does not know or suspect*. Youths then were asked, 'How has each of these people reacted (or how do you think they would react) to the fact that you are lgb?' Again, responses were on a 4-point scale, as follows: 1 = *Accepting (or it would not matter)*, 2 = *Tolerant (but not accepting)*, 3 = *Intolerant (but not rejecting)*, and 4 = *Rejecting*.

Youths were asked about their relationships with their parents in general. The question was, 'How do you get along with your parents now?' Youths responded separately for mothers and for fathers using a 5-point scale, from 1 = *Excellent*, 2 = *Very well*, 3 = *Well*, 4 = *Not well*, and 5 = *Poorly*.

Victimization based on sexual orientation

Information was sought about victimization related to youths' sexual orientation using items commonly used in research on this form of victimization. Data about lifetime

occurrences of six types of victimization were available in both datasets: verbal abuse, threats of physical attack, objects being thrown, assaults (being punched, kicked, or beaten), threats with weapons, and sexual assaults. Respondents noted how often each type of victimization occurred using these categories: never, once, twice, or three or more times. A total victimization score was computed by summing the scores for the six types of victimization.

Youths were also asked if they had lost friends as a result of their sexual orientation. Although not direct victimization, losses of friends for lgb youths can create considerable distress, especially if these friends disclose youths' sexual orientation to others.

Fears related to sexual orientation

Youths were asked whether their openness about their sexual orientation was influenced by fear of untoward consequences. They were asked if they experienced the following fears: fear of loss of friends, fear of verbal abuse at school, fear of physical attack at school, fear of verbal abuse at home, and fear of physical attack at home. Youths simply noted whether they had each fear.

Results

Sexual orientation characteristics and mental health

Information about developmental milestones of youths' sexual orientation is shown in Table 1. Youths in the sample reported their first awareness of their same-sex feelings at about age 10, with males noting the awareness earlier. Self-labeling occurred about five years after the initial awareness, with males once again reaching the milestone sooner. Disclosure of sexual orientation for the first time occurred at about 17, although youths reported this occurring as young as 10 years of age and as old as 21. Fourteen percent disclosed between the ages of 10 and 14; 69 percent between 15 and 18; and, 17 percent disclosed between the ages of 19 and 21. First disclosure to a parent, most often mothers, occurred at about the same time, at 17. Analyses were conducted on these sexual orientation milestones to determine if there had been changes between data-collection periods. Two-factor ANOVAs were conducted with the different ages and the studies as factors. Only one significant finding occurred, with females in the second study self-labeling as lesbian or bisexual at older ages (at about 16) than the other three groups (who, generally, self-labeled at about age 15), $F(1,517) = 7.01$, $p < .01$. Other analyses of these data show that parents are seldom the first person to whom youths disclose their orientation. Youths were aware of their same-sex feelings for eight to nine years, about half of their lives. Youths spent about five years between the age at which they first became aware of their same-sex sexual feelings to the age of self-labeling. Males spent over one-third (35%) of their lives being aware but non-disclosed, or 'closeted;' females spent 30 percent of their lives without disclosure. On average, youths spent about half of their lives aware of their same-sex feelings (age of awareness/age), although there was considerable range on this score, from 5 percent of their lifetimes to nearly all of their lives.

Males spent more years aware of their same-sex feelings than females. Females spent a greater percentage of their lives aware of these feelings. Youths spent about one-third of their lives aware of same-sex feelings but not revealing these feelings to others. There was wide variability in the time youths spent 'in the closet', ranging from zero (disclosure occurred in the same year as awareness) to over 80 percent of their lives. Males spent significantly more of their lives aware, but not disclosed, than females. If one uses age of self-labeling as the marker against which to compare age of first disclosure, youths were found to have spent about 7 percent of their lives self-labeled yet non-disclosed.

Table 1. Sexual orientation milestones of lesbian, gay, and bisexual youths

	Males (N = *336)*			*Females* (N = *206)*			t
Milestones	n	M	*SD*	n	M	*SD*	*M vs. F*
First awareness	331	9.93	3.57	205	11.10	4.07	3.51***
First self-labeling	328	14.89	2.86	193	15.69	2.51	3.22***
First disclosure	328	16.67	2.09	194	16.64	1.90	0.14
First disclosure to a parent	226	17.39	1.96	151	17.26	2.11	0.63
Years of awareness[a]	331	9.29	3.79	205	7.78	4.23	4.29***
Years before self-labeling[b]	324	5.01	3.50	192	4.68	3.88	1.00
Years before disclosure[c]	325	1.77	2.34	192	0.96	1.78	4.15***
Percent of life aware[d]	331	0.52	0.19	205	0.59	0.22	4.05***
Percent of life aware but non-disclosed[e]	324	0.35	0.18	193	0.30	0.21	2.99***
Percent of life self-identified but non-disclosed[f]	325	0.09	0.12	192	0.05	0.09	4.06***

*$p < .05$; **$p < .01$; ***$p < .001$.
[a]Age – Year of First Awareness; [b]Age at Self-Labeling – Age of Awareness; [c]Age of First Disclosure – Age of Self-Labeling; [d]Age of First Awareness/Age; [e](Age of First Disclosure – Age at First Awareness)/Age; [f](Age of First Disclosure – Age at Self-Labeling)/Age.

Correlations between the various sexual orientation milestones and BSI scores revealed few significant relationships. Youths who self-identified as lgb, disclosed to someone, and disclosed to a parent earlier had higher Somatization scores, *r*s = –.10, –.10, and –.13, all $p < .05$. These correlations explain relatively little variance, and may have occurred by chance, given the number of correlations calculated (40). Two significant relationships emerged between openness about sexual orientation and mental health symptoms. Youths who were less open were more likely to have higher Interpersonal Sensitivity scores, $r(505) = –.15$, $p < .001$, higher Depression scores, $r(505) = –.09$, $p < .05$, and higher Psychoticism scores, $r(509) = –.14$, $p < .01$. As to identifiability as lgb by others, greater identifiability was modestly related to higher Somatization scores, $r(492) = .11$, $p < .01$, and higher Anxiety scores, $r\ (492) = .12$, $p < .01$.

Mental health problems

A multivariate analysis of variance (MANOVA) comparing males and females on BSI scores yielded a significant finding for gender, Wilks' $\lambda = .96$, $F(9,497) = 2.45$, $p < .01$. Follow-up *t*-tests found females showing more symptoms than males on the three subscales on which there were significant differences, Somatization ($t(507) = 1.93$, $p < .05$), Obsessive-Compulsiveness ($t(208) = 1.97$, $p < .05$), and Anxiety ($t(508) = 2.33$, $p < .05$). However, a comparison of GSI scores by gender was not significant, $t(505) = 1.25$, *ns*. Females may differ from males on some mental health symptoms, but not on overall symptomatology. A comparison of the two datasets with regard to youths' GSI scores was non-significant, $t(505) = 1.82$.

Youths' responses to the BSI were compared to norms for the BSI based on the

responses of 2408 adolescent non-patients (Derogatis, 1993, p. 36). Results are shown in Table 2. Lesbian, gay, and bisexual youths as a group reported significantly more symptoms than the comparison group on six of the nine BSI scales, Obsessive-Compulsiveness, Interpersonal Sensitivity, Depression, Anxiety, Hostility, and Psychoticism. GSI scores between the two groups did not differ. Gay and bisexual males were found to have significantly higher Obsessive-Compulsiveness, Depression, and Psychoticism scores than the comparison males, whereas their Somatization and Hostility scores were significantly lower. Males' overall symptom scores (GSI) were not different from the comparison group's scores. Lesbian and bisexual females were significantly higher on all BSI subscales except Hostility and Paranoid Ideation. And, lesbian and bisexual females' GSI scores were also significantly higher than the comparison group's scores. Although the normative sample Derogatis used for his adolescent non-patient group was younger (13–19; $M = 15.8$) than the sample of youths in the current study, inspection of BSI norms for adults shows that BSI scores consistently decrease from adolescence to adulthood. This provides greater confidence for the conclusion that lgb youths demonstrated more symptomatology on the BSI than comparable youths' scores.

There was considerable evidence of past and current suicidality. When asked about ever having serious thoughts about suicide, 8 percent of the males and 15 percent of the females said they often had such thoughts; an additional 27 percent of the males and 27 percent of the females sometimes had suicidal thoughts. Females more frequently had past thoughts of suicide than males, $\chi^2(3, N = 537) = 7.87$, $p < .05$. Suicide attempts were reported by 36 percent of the males and by 39 percent of the females, or 37 percent of the entire sample. (In the first study, 42% acknowledged a suicide attempt, compared with 34% in the second study, a difference that approached statistical significance, $\chi^2(2, N = 528)$, $p = .08$). Youths who reported a past suicide attempt were compared with youths who had not made an attempt on their BSI scores. A MANOVA comparing suicide attempters with non-attempters on BSI scores was significant, Wilks' $\lambda = .90$, $F(9,487) = 5.72$, $p < .001$. Follow-up *t*-tests are shown in Table 3 (on p. 443). Suicide attempters demonstrated significantly more symptomatology on all BSI subscales and on the GSI.

One-quarter (24%) of the sample were seeing a professional counselor for personal problems when they participated in the study, and 63 percent said they had received professional help at some point in their lives. More females were currently receiving professional care, $\chi^2(1, N = 441) = 5.22$, $p < .05$, and had received help in the past, $\chi^2(1, N = 519) = 4.44$, $p < .05$. More youths who had made suicide attempts than non-attempters had received professional help in the past (74 vs 56%), $\chi^2(1, N = 507) = 16.61$, $p < .001$. More suicide attempters (30%) than non-attempters (21%) were also currently receiving professional help, $\chi^2(1, N = 433)$, $p < .001$.

To determine if there were community differences related to youths' mental health problems, analyses were conducted comparing youths who resided in metropolitan areas ($N = 458$, or 85% of the entire sample) with those who lived in rural areas or small towns ($N = 85$, or 15%). No differences were found on GSI scores or on suicide attempt rates.

Problems related to sexual orientation and mental health

Telling families about sexual orientation was seen as extremely troubling by 23 percent of the youths, very troubling by 19 percent, somewhat troubling by 28 percent, and no problem by only 29 percent. Nearly one-quarter (24%) said difficulties with their sex lives were extremely troubling, 19 percent said very troubling, 38 percent said somewhat troubling, and 28 percent said no problem. Telling friends about one's sexual orientation was extremely troubling for 22 percent of the sample, very troubling for 19 percent,

Table 2. Brief Symptom Inventory scores of lesbian, gay, and bisexual youths and adolescent comparison groups

	Total					*Males*					*Females*				
	Total sample (N = *542*)		*Comparison sample* (N = *2408*)			*GB males* (N = *336*)		*Comparison males* (N = *1601*)			*LB females* (N = *206*)		*Comparison females* (N = *807*)		
Subscale	M	*SD*	M	*SD*	t	M	*SD*	M	*SD*	t	M	*SD*	M	*SD*	t
Somatization	.63	.76	.63	.64	.12	.58	.74	.67	.67	2.25*	.72	.79	.56	.57	2.57*
Obsessive-compulsiveness	1.17	.96	.94	.75	4.75**	1.11	.96	.75	.76	2.76**	1.28	.95	.92	.71	4.71**
Interpersonal sensitivity	1.29	1.08	.99	.84	6.17**	1.26	1.10	1.00	.83	.39	1.33	1.04	.97	.86	4.37**
Depression	1.22	.82	.82	.79	8.62**	1.23	1.00	.82	.80	6.75**	1.22	1.01	.80	.79	5.58**
Anxiety	.97	.90	.78	.68	4.52**	.90	.86	.79	.69	1.47	1.09	.94	.75	.66	4.55**
Hostility	.93	.87	1.02	.86	2.00*	.88	.84	1.06	.89	3.37**	1.02	.92	.93	.80	1.23
Phobic anxiety	.58	.76	.54	.64	1.21	.57	.72	.58	.66	.30	.92	.85	.48	.59	6.58**
Paranoid ideation	1.08	.90	1.13	.82	1.01	1.08	.90	1.17	.84	1.46	1.08	.89	1.06	.77	.31
Psychoticism	.93	.85	.73	.73	5.05**	.93	.85	.74	.73	3.84**	.92	.85	.71	.72	2.97**
General Severity Index	.89	.69	.83	.59	1.85	.86	.68	.86	.61	.02	.94	.70	.79	.55	2.22*

*$p < .05$; **$p < .01$.

Table 3. Brief Symptom Inventory scores of suicide attempters among lesbian, gay, and bisexual youths

	Suicide attempters (N = 189)		*Non-attempters (N = 317)*		
Subscale	M	*SD*	M	*SD*	t
Somatization	.80	.85	.54	.70	3.82***
Obsessive-compulsiveness	1.37	1.05	1.06	.88	3.57***
Interpersonal sensitivity	1.55	1.17	1.14	.99	4.19***
Depression	1.59	1.13	1.02	.85	6.32***
Anxiety	1.21	1.03	.84	.78	4.57***
Hostility	1.19	1.01	.80	.75	4.93***
Phobic anxiety	.82	.93	.44	.60	5.46***
Paranoid ideation	1.35	1.05	.93	.76	5.07***
Psychoticism	1.19	.96	.77	.74	5.47***
General Severity Index	1.19	.80	.76	.58	7.74***

***$p < .001$.

somewhat troubling for 25 percent, and no problem for 34 percent. Reconciling religious beliefs with one's sexual orientation was extremely troubling for 17 percent of youths, very troubling for 22 percent, somewhat troubling for 26 percent, and no problem for about one-third (34%). Females were significantly more troubled about their religious beliefs than males, $\chi^2(3, N = 522) = 11.36$, $p < .01$. About 40 percent of the males saw religious beliefs as posing no problem for them compared with 25 percent of the females. In contrast, males were significantly more worried about HIV than females, $\chi^2(3, N = 532) = 44.28$, $p < .001$. For example, 35 percent of the males were extremely troubled by AIDS compared with 17 percent of the females; and, only 10 percent of the males considered AIDS to be no problem compared with 28 percent of the females.

Youths' evaluations of the five problems related to sexual orientation were correlated with BSI scores. Results are shown in Table 4. Telling families was unrelated to mental health symptoms, although many youths found this a troubling event, as noted earlier. Dissatisfaction with one's sex life, however, was significantly correlated with all of BSI subscales and with the GSI, such that more symptoms were associated with more dissatisfaction. Telling friends about one's sexual orientation was significantly related to higher Interpersonal Sensitivity, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism scores, and the General Severity Index. Dealing with religious issues was associated with higher Somatization and Obsessive-Compulsive scores. Correlations between AIDS concerns and BSI scores were calculated by gender. There were no associations between BSI scores and AIDS concerns for females. For males, concerns about AIDS were significantly related to higher Anxiety and Phobic Anxiety scores.

Parents' reactions to sexual orientation and mental health

Overall, youths evaluated their current relationships with their parents similarly for mothers and for fathers. About one-quarter (26%) said their relationships with mothers were excellent, 20 percent said good, 28 percent said they got along well, 10 percent said not well, and 18 percent said relationships were poor. For fathers, 26 percent said excellent, 11 percent said very well, 34 percent said well, 10 percent said not well, and 18 percent said poorly. No differences were found between male and female youths' views of their relationships with either parent. Thus, over one-quarter of the sample said they

Table 4. Correlations between lesbian, gay, and bisexual youths' problems related to sexual orientation and Brief Symptom Inventory scores

Subscale	*Telling family*	*Dissatisfaction with sex life*	*Telling straight friends*	*Religious beliefs*	*Worry about AIDS/males*	*Worry about AIDS/females*
Somatization	.01	–.08	–.03	–.11*	–.08	–.00
Obsessive–compulsiveness	.05	–.20***	–.02	–.10*	–.06	–.04
Interpersonal sensitivity	.03	–.25***	–.14***	–.00	–.07	–.02
Depression	.06	–.27***	–.08	–.01	–.07	–.00
Anxiety	.02	–.17***	–.04	–.07	–.12**	.06
Hostility	.04	–.17***	–.11*	–.01	–.09	.02
Phobic anxiety	.04	–.15***	–.11*	.00	–.12**	.04
Paranoid ideation	.06	–.22***	–.13**	.00	–.03	–.04
Psychoticism	.01	–.27***	–.15***	–.04	–.07	–.03
General Severity Index	.05	–.23***	–.10*	–.05	–.09	–.02

* $p < .05$; ** $p < .01$; *** $p < .001$.

Table 5. Parents' knowledge of and reactions to lesbian, gay, and bisexual youths' sexual orientation

Parent	*Knowledge*								*Reaction*							
	Knows, Have Talked		*Knows, No Talk*		*Suspects*		*Doesn't Know*		*Accepting*		*Tolerant*		*Intolerant*		*Rejecting*	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	*n*	%
Mother	343	69	41	8	71	14	43	9	230	48	133	28	49	10	65	14
Father	223	48	08	15	81	17	90	19	150	34	119	28	77	18	81	19

did not interact well or interacted poorly with their parents. When evaluations of relationships with parents were correlated with mental health symptoms, significant relationships were found for all BSI subscales and the GSI for mothers. All but two of the correlations were significant at $p < .05$; Somatization and Obsessive-Compulsiveness approached significance ($p < .10$). The same pattern held for relationships with fathers. All of the correlations were in the same direction, with fewer mental health problems associated with better relationships with parents. For mothers, correlations ranged from $r = .13$ (Phobic Anxiety) to .19 (for Depression); for fathers, from $r = .10$ (Obsessive-Compulsiveness) to .16 (for Psychoticism).

Many parents knew of their offspring's sexual orientation, as can be seen in Table 5. Over-three quarters (77%) of the youths reported that their mothers were aware, and of these most have discussed the topic. Nearly one-quarter of the mothers suspect or do not know. Fewer fathers (63%) were aware of their children's sexual orientation. Thus, 23 percent of mothers and 36 percent of fathers were unaware. Even though some fathers knew, fewer fathers (48%) than mothers (69%) had actually discussed the topic. Mothers were significantly more aware than fathers, $t(470) = 8.46$, $p < .001$. As to reactions to youths' sexual orientation (or expected reactions if youths had not disclosed), nearly half of the mothers (48%) and one-third (33%) of the fathers were deemed accepting, the most positive rating on the scale. Nearly one-quarter (24%) of the mothers, however, were intolerant or rejecting, and over one-third (37%) of the fathers were intolerant or rejecting. Mothers' attitudes were significantly more positive than fathers', $t(435) = 4.83$, $p < .001$.

Youths' current overall relationships with their parents were related to parents' knowledge of and reactions to youths' sexual orientation. More positive relationships with parents were associated with more positive reactions to youths' sexual orientation by mothers, $r(447) = .38$, $p < .001$, and by fathers, $r(402) = .35$, $p < .001$. Youths with better relationships with their fathers had fathers who were more aware of their sexual orientation, $r(432) = .11$, $p < .05$.

Several approaches were taken to examining the relationship between parents' knowledge and reactions and youths' mental health. First, parental knowledge and reaction scores were correlated with BSI scales. Partial correlations were used, controlling for the quality of youths' relationships with parents. Results are shown in Table 6. Clearly, parents' reactions are more associated with youths' symptoms than is parents'

Table 6. Correlations between families' knowledge of and reactions to lesbian, gay, and bisexual youths' sexual orientation and Brief Symptom Inventory scores

Subscale	*Mother's knowledge*	*Mother's reaction*	*Father's knowledge*	*Father's reaction*
Somatization	.03	.13**	.03	.09
Obsessive-compulsiveness	.10*	.15**	–.03	.00
Interpersonal sensitivity	.12**	.10	.08	.09
Depression	.10*	.11*	.03	.05
Anxiety	.08	.14**	.01	.05
Hostility	.09	.05	.06	.07
Phobic anxiety	.06	.12**	.02	.13**
Paranoid ideation	.08	.13**	.06	.14**
Psychoticism	.17***	.15**	.06	.03
General Severity Index	.12**	.15**	.04	.08

* $p < .05$; ** $p < .01$.

Table 7. Parental knowledge and reactions and mean Brief Symptom Inventory scores

	Parents' knowledge				*Parents' reactions*[a]			
	Both know	*Neither knows*	*One knows*	F	*Both accepting*	*Both rejecting*	*One accepting, One rejecting*	F
Somatization	.61	.62	.64	.07	.56	.89	.57	6.52**
Obsessive-compulsiveness	1.16	1.25	1.03	1.27	1.08	1.42	1.13	4.09*
Interpersonal sensitivity	1.19	1.49	1.32	3.24*	1.15	1.59	1.37	5.92**
Depression	1.17	1.33	1.18	1.05	1.15	1.45	1.18	2.98*
Anxiety	.93	1.02	.96	.41	.87	1.26	.95	6.52**
Hostility	.86	1.01	.99	1.56	.86	1.13	.89	3.32*
Phobic anxiety	.53	.61	.58	.49	.49	.85	.52	7.94***
Paranoid ideation	.99	1.15	1.14	1.71	.94	1.37	1.13	8.07***
Psychoticism	.85	1.10	.88	3.57*	.86	1.16	.85	4.82**
General Severity Index	.84	.97	.88	1.50	.80	1.13	.86	7.48***

[a]All BSI scores of youths with rejecting parents are significantly higher than scores for youths with accepting parents. Youths with rejecting parents also had significantly higher scores on Somatization, Anxiety, Phobic Anxiety, and the General Severity Index than youths whose parents disagreed.
* $p < .05$; ** $p < .01$; *** $p < .001$.

Table 8. Prevalence of lifetime victimization of lesbian, gay, and bisexual youths based on sexual orientation

	Never		*Once*		*Twice*		*3+ Times*	
Type	n	%	n	%	n	%	n	%
Verbal abuse	97	19	73	15	58	12	271	54
Threat of violence	302	62	64	13	55	11	69	14
Objects thrown	384	78	55	11	22	4	32	6
Assault	419	85	19	4	19	4	35	7
Threatened with weapon	470	94	7	1	13	3	8	2
Sexual assault	419	84	48	10	17	3	12	2

knowledge. There was no relationship between fathers' knowledge and their children's symptoms, whereas there were several significant correlations between mothers' knowledge and youths' symptoms. A much more pronounced pattern is seen in parental reactions. For mothers, seven BSI subscales and the GSI are significantly correlated with maternal reactions, with negative reactions from mothers associated with more symptoms. Only two BSI subscales (Phobic Anxiety and Paranoid Ideation) showed significant correlations with fathers' reactions, but the findings were all in the same direction.

Next, youths were categorized into one of three groups based on their parents' knowledge of their sexual orientation: (i) both parents knew (if there was only one parent, that parent knew), (ii) neither parent knew (if there was one parent, that parent did *not* know), and (iii) one parent knew and the other did not know. In 62 percent of the cases ($N = 315$), both parents (or the sole parent) knew; in 20 percent ($N = 103$), neither parent knew or the sole parent did not know, and in 18 percent ($N = 97$) one parent was aware and the other was not. Similarly, youths were placed into three categories based on parental reactions. In over half the youths (57%, $N = 276$), both parents (or a sole parent) were accepting; in 17 percent ($N = 84$) both (or the sole parent) were rejecting, and in about one-quarter of the families (26%, $N = 124$), one parent was accepting and one was rejecting. In only 11 percent ($N = 35$) of the cases in which parents differed were mothers more rejecting than fathers.

The groups were compared on BSI scores. Analyses of variance were used to compare scores of the three types of parental knowledge and the three types of parental reactions. Significant *F*-tests were followed up with Tukey tests (with $p < .05$). Table 7 presents the means for parents' scores. The three parent knowledge groups differed only on youths' Interpersonal Sensitivity and Psychoticism scores. In both cases, follow-up tests found that the significant difference among the three was the greater symptoms expressed by youths whose parents were both unaware of their sexual orientation. The same pattern occurred, but was more pronounced when youths' views of parental reactions were considered. For these scores, all BSI subscales and the GSI significantly differed among the groups of parents. Follow-up tests found that, for every analysis, youths with rejecting parents showed significantly higher symptoms than youths with accepting parents. For several BSI subscales – Somatization, Anxiety, Phobic Anxiety – as well as for the GSI, youths with rejecting parents showed higher symptoms scores than youths with parents whose reactions were different from one another. The presence of one rejecting parent in a family is associated with greater mental health symptoms in these youths.

Victimization experiences

As can be seen in Table 8, 81 percent of the youths reported having been verbally abused based on their sexual orientation over the course of their lives, 38 percent have been threatened with physical attack, 22 percent have had objects thrown at them, 15 percent have been physically assaulted, 6 percent have been assaulted with a weapon, and 16 percent have been sexually assaulted. Importantly, more than half of the sample (54%) had been subjected to three or more incidents of verbal abuse. Fourteen percent had been threatened with violence three or more times. Only one gender difference was found: males were more often threatened with violence than females, $\chi^2(3, N = 496) = 10.36$, $p < .05$. In several other categories (verbal abuse, objects thrown, sexual assault), however, males' scores approached statistically significant differences from females' scores ($p < .10$). Males' lifetime overall victimization scores were significantly higher than females' scores, $t(462) = 2.92$, $p < .01$. No differences in victimization

Table 9. Correlations of lesbian, gay, and bisexual youths' victimization experiences with Brief Symptom Inventory scores

Subscale	*Verbal abuse*	*Threat of attack*	*Objects thrown*	*Assault*	*Threatened with a weapon*	*Sexual assault*	*Overall victimization*
Somatization	.22***	.18***	.18***	.18***	.21**	.15**	.25***
Obsessive-compulsiveness	.16**	.09	.05	.12**	.04	.10	.12*
Interpersonal sensitivity	.16**	.11*	.12**	.14**	.02	.09	.16**
Depression	.15**	.12**	.06	.12**	.02	.14**	.13**
Anxiety	.25***	.19***	.18***	.20**	.14**	.22***	.27***
Hostility	.15**	.15**	.15**	.15**	.09	.13**	.19***
Phobic anxiety	.18***	.19***	.15**	.20***	.06	.13**	.21***
Paranoid ideation	.20***	.21***	.16**	.20***	.08	.16***	.24***
Psychoticism	.12**	.09*	.07	.15**	.03	.12*	.12**
General Severity Index	.22***	.18***	.15**	.19***	.10*	.17***	.23***

N = 450–485.
* $p < .05$; ** $p < .01$; *** $p < .001$.

Table 10. Lesbian, gay, and bisexual youths' fears related to sexual orientation and Brief Symptom Inventory scores

	Loss of friend			*Fear of verbal abuse at school*			*Fear of physical abuse at school*			*Fear of verbal abuse at home*			*Fear of physical abuse at home*		
Subscale	*Yes*	*No*	t	*Yes*	*No*	t	*Yes*	*No*	t	*Yes*	*No*	t	*Yes*	*No*	t
Somatization	.80	.53	3.92***	.73	.57	2.23*	.81	.56	3.42***	.84	.54	4.23***	.97	.58	3.96***
Obsessive-compulsiveness	1.48	1.00	5.56***	1.39	1.03	4.11***	1.42	1.07	3.80***	1.55	1.00	6.02***	1.53	1.11	3.38***
Interpersonal sensitivity	1.62	1.10	5.28***	1.49	1.16	3.36***	1.94	1.53	3.16**	1.62	1.09	4.71***	1.74	1.22	3.71***
Depression	1.46	1.01	4.09**	1.37	1.13	2.62***	1.42	1.14	2.87**	1.58	1.07	5.43***	1.70	1.14	4.31***
Anxiety	1.17	.85	3.82***	1.08	.90	2.15*	1.13	.90	2.60**	1.21	.86	4.13***	1.32	1.10	3.54***
Hostility	1.03	.87	2.01*	.96	.92	.55	.99	.91	.97	1.09	.86	2.80***	1.12	.90	1.94*
Phobic anxiety	.76	.47	4.27***	.71	.49	3.08***	.81	.48	4.43***	.81	.47	4.73***	1.04	.50	5.60***
Paranoid ideation	1.29	.93	4.03***	1.20	1.01	2.40***	1.27	1.00	3.04***	1.33	.97	4.22***	1.50	1.01	4.20***
Psychoticism	1.11	.82	3.74***	1.02	.87	2.00*	1.06	.87	2.20*	1.17	.82	4.19***	1.29	.87	3.75***
General Severity Index	1.08	.78	4.75***	1.00	.82	2.89**	1.06	.82	3.54***	1.13	.78	5.25***	1.24	.83	4.46***

* $p < .05$; ** $p < .01$; *** $p < .001$.

incidence were found when youths from metropolitan areas were compared with rural youths.

Table 9 presents correlations between youths' victimization experiences and BSI scores. Clearly, greater lifetime victimization based on sexual orientation was consistently associated with more current mental health symptoms.

More than one-third (39%) of the sample said they had lost friends because of their sexual orientation. More females (44%) than males (36%) lost friends, $\chi^2(1, N = 504) = 2.96$, $p = .08$. Youths who had lost friends were compared with those who had not on BSI scores. On all subscales and on the GSI, youths who had lost friends because of their sexual orientation reported significantly more mental health symptoms. In addition, a significant relationship was found between the loss of friends and suicide attempts, $\chi^2(1, N = 494) = 20.25$, $p < .001$. Half of the youths (52%) who had made a suicide attempt had lost friends, compared with one-third (32%) of the youths who had not made a suicide attempt.

Fears related to sexual orientation and mental health problems

Over one-third (36%) said that fear of losing friends influenced their openness about their sexual orientation, with significantly more females (46%) than males (30%) having this fear, $\chi^2(1, N = 512) = 12.88$. Over one-third (38%) were less open because of fear of verbal abuse at school, and 28 percent because of fear of physical abuse. About 30 percent feared verbal abuse at home, with more females (35%) than males (26%) having such a fear, $\chi^2(1, N = 4.55, p < .05)$. As to fear of physical abuse at home, 13 percent reported that this inhibited their discussion of their sexual orientation. Table 10 shows the relationship between BSI scores and the five fears related to youths' sexual orientation. Youths who fear losing friends have significantly more symptoms than youths without such fears. The same general finding is similar for the remaining fears. Having fears related to verbal and physical abuse at school and at home were significantly associated with higher mental health symptoms. To compare the impact of these fears with other factors found to be associated with variability in GSI scores, a multiple regression analysis was performed. The variables included in the analysis were mother's reaction to sexual orientation, father's reaction to sexual orientation, overall victimization, fear of losing friends, fear of verbal abuse at school, fear of physical abuse at school, fear of verbal abuse at home, and fear of physical abuse at home. The overall result was significant, $F(8,355) = 9.20$, $p < .01$, and the adjusted $R^2 = .15$. Table 11 shows that the significant predictors of overall mental health symptoms among this group of variables were fear of losing friends, fear of verbal abuse at home, and overall victimization based on sexual orientation.

Table 11. Predictors of General Severity Index scores of lesbian, gay, and bisexual youths

Variable	*β*	*SE*	t
Mother's reaction to sexual orientation	.08	.04	.15
Father's reaction to sexual orientation	.02	.03	.67
Overall victimization based on sexual orientation	.26	.01	5.17**
Fear of losing friends	.24	.09	3.82**
Fear of verbal abuse at school	–.03	.11	–.39
Fear of physical abuse at school	–.03	.11	.73
Fear of verbal abuse at home	.16	.09	2.50**
Fear of physical abuse at home	.01	.12	.86

**$p < .01$.

Discussion

The results of this study provide evidence of mental health problems in a large sample of lgb youths drawn from community groups in diverse geographical areas. Lesbian, gay, and bisexual youths had significantly more symptoms than a comparison group of adolescents on six of the nine subscales of the BSI, a standardized indicator of mental health difficulties. Overall, the lgb youths had higher Somatization, Obsessive-Compulsiveness, Interpersonal Sensitivity, Depression, and Psychoticism scores than the normative comparison group of adolescents, although the total symptom score (the General Severity Index) between the two groups did not differ. Lesbian and bisexual youths had more symptoms on seven of the nine BSI scales than comparison females, whereas gay and bisexual male youths showed more symptoms on only three BSI subscales compared with the male comparison group. Whereas the male youths in this study did not have significantly different overall symptom scores than the comparison males, the females had significantly more symptoms than the comparison females. Indeed, the gay and bisexual males had lower Somatization and Hostility scores than the comparison group of males.

Over one-third (37%) of the sample reported that they had made a suicide attempt, and attempters manifested more symptoms than non-attempters. Related to these problems is the high involvement by these youths with professional counselling – more than half had seen a counselor at some point in their lives, and about one-quarter were receiving counseling at the time they participated in the study. Youths' involvement with professional helping is partly a function of the sites from which they were recruited. Although the groups were not counseling agencies, the adults associated with the groups were often mental health or counseling professionals, and they typically assisted troubled youths by arranging counseling or making referrals to supportive counseling groups. The findings of elevated mental health problems are consistent with other studies of lgb youths showing an increased rate of problem behavior as well as studies documenting a higher suicide attempt rate than is found among adolescents in general. The results are also consistent with recent population-based studies showing some elevated symptomatology among lesbian and gay adults (e.g. Cochran & Mays, 2000; Herrell et al., 1999). The findings study suggest that mental health professionals need to devote attention to the concerns of lgb youths, and that particular areas of their lives are likely to be associated with increased distress.

Contrary to expectations, few aspects of youths' sexual orientation development were related to their mental health. Many youths had been aware of their same-sex feelings for many years, nearly half of their lives. Several more years evolved before self-labeling, when the feelings became clearer. Their first disclosures tended to be near the end of their high school years, and disclosures to parents occurred later. The ages at which they reached sexual orientation milestones occurred did not correlate with mental health as measured by the BSI. Some modest evidence was found for a positive relationship between openness about sexual orientation and fewer mental health symptoms; greater identifiability by others was also found to be associated with increased symptomatology. The earlier milestones occurred many years prior to data collection, so their mental health impact may have long dissipated, especially in the light of more current stressors. It should be remembered that the BSI seeks information about symptoms in the past two weeks, so that assessment of mental health symptoms at a time more proximate to the events themselves might have revealed associations. In any event, for youths who are open enough about themselves to attend lgb groups, the ages at which they came to terms with their sexual orientation are not linked to current symptoms.

In contrast, other aspects of these youths' lives were more strongly linked to their mental health. Of the problems related to their sexual orientation that youths had to confront, issues with their sex lives and telling heterosexual friends about their sexual orientation were particularly important correlates of distress. Significantly more symptoms were reported by youths who were unhappy with their sex lives. Given the general nature of the question, it is difficult to know exactly what youths were responding to, and it may well be that they interpreted the question as referring to their sexual activities or their sexual orientation. Both sets of issues are worth exploring in more detail in future research. Telling their friends about their sexual orientation was associated with several BSI subscales that focus on relationships with others. The actual loss of friends as a result of their sexual orientation was a powerful factor in the lives of these youths. More than one-third reported that they had lost friends because of their sexual orientation. Those who had lost friends reported more mental health symptoms and more past suicide attempts than those who did not lose friends. And, peer relationships remained sources of conflict, with loss of friends a strong influence on how open many youths were about their sexual orientation. Indeed, youths who acknowledged that they feared losing friends reported more symptoms. The loss of friends as a result of others' knowledge of youths' sexual orientation creates a double risk: the negative consequences of the loss of friends' support, and the probability that friends will reveal youths' sexual orientation to others, leading to a widening circle of potential rejections and increased chances of peer victimization.

Although peers (and especially their loss) are important to lgb youths' adjustment, relationships with parents were considerably more strongly linked to their mental health. Most had discussed their sexual orientation with their mothers, and many had also told their fathers. The more positive the relationship was between youths and parents, the more positive parents were about youths' sexual orientation. Surely youths are more likely to divulge such sensitive personal matters more so to parents they feel closer to; it is also possible that the disclosure of sexual orientation increases closeness between youths and their parents. Parents' reactions to youths' sexual orientation were significantly related to youths' mental health, and there were clear differences in youths' mental health associated with whether their parents agreed or disagreed among themselves in their acceptance of their children. Youths both of whose parents were rejecting were significantly more likely to demonstrate mental health problems than when parents were accepting or when one parent was accepting. Living with rejecting parents was associated with considerable distress. In such situations, there is little support available at home, and youths cannot share concerns with their families as their identity develops. Other analyses of the first data-set used in this report (D'Augelli, Hershberger, & Pilkington, 1998) showed that youths living at home who had not disclosed to parents expected negative reactions, and that those who did disclose experienced more victimization from families than non-disclosed youths. Being fearful of parents finding out can be very distressing if youths presume (rightly or wrongly) that one or both parents will be rejecting, will resort to verbal or physical attacks, or will force the youth from the home.

Parents' negative reactions (or the fear of them) are thus a powerful form of victimization that many of these youths experience. Verbal and physical attacks from others are other forms of victimization that impact mental health. More mental health problems were reported by youths who had been victimized frequently, reflecting the stress that such experiences can induce. Verbal insults were experienced by most of the youths, with over half noting three or more such experiences. These experiences were associated with higher symptom scores, and the correlations were not appreciably different to those

found with physical attacks. Youths who feared victimization – whether at home or in school, whether verbal or physical – also demonstrated higher symptoms. Because this was a cross-sectional study, causality cannot be established, however. It is possible, for example, that youths with mental health problems are especially vulnerable to victimization by others. Although it seems more likely that repetitive victimization from others would impact upon mental health, only longitudinal research can prove causal connections.

There are other limitations of the study. The data analyzed here do not provide information about the nature of the attacks or the locations in which victimization occurred. Other analyses from the second dataset used showed that over half of the youths reported verbal abuse in high school, and 11 percent said they had been physically assaulted in school (D'Augelli, Pilkington, & Hershberger, 2002). Youths who were more open in high school about their sexual orientation were victimized more, and male youths were targeted significantly more often than females. This helps explain why over one-third feared verbal abuse in school and over one-quarter feared physical attacks in school. These fears appear to be well-founded, based on these results and those found in population-based studies of high school youths (e.g. DuRant et al., 1998). Because of the importance of the family and the centrality of school in the lives of adolescents, chronic tensions at home and anxieties associated with school can have far-reaching consequences for developmental difficulties (Tharinger & Wells, 2000). As increasing numbers of adolescents self-identify at earlier ages, families and schools become increasingly important in insuring a successful transition to adulthood.

Clinical implications for working with lesbian, gay, and bisexual youths

There are several implications of these findings for professionals working with adolescents. Most generally, professionals must acknowledge the existence of lgb youths, and must understand that the development of non-heterosexual sexual orientation accelerates around puberty. Many adolescents who come to self-identify as lgb have known about their feelings for many years before they tell anyone, and these years of secrecy may well be very difficult ones. These years of silence and hiding may be times of considerable worry and fear, social withdrawal, academic performance problems, and school avoidance. Clinicians working with adolescents should be aware that some of their clients are lesbian, gay, or bisexual, at various stages of the developmental processes associated with the emergence of their sexual orientation. Most of these youths are not likely to disclose their situation to clinicians, unless the presenting problem directly relates to their sexual orientation. This situation is especially true for younger adolescents who may not yet self-identify as lgb, but who experience same-sex sexual and emotional attractions. Youths who do disclose their sexual orientation during adolescence (and we do not know what percentage of all such youths disclose during these years) should be considered at some risk for stress that can eventuate in mental health problems, and support should be available for them.

Another important issue for professionals is lgb youths' relationships with their families. Unacknowledged youths may be experiencing conflicts with parents and siblings that are the result of their conflicts about their sexual identity, and reflect fears that family members will find out, and will be hostile. Such youths will be most reluctant to reveal their sexual orientation in counseling sessions with their parents, even though such counseling could provide support and constructive guidance to the parents. Youths who have already told parents and other members of their families also need special attention. The processes of families adapting to youths' newly revealed sexual orientation are generally difficult at first; younger lgb adolescents who tell their families (or

are found out) have many years at home to deal with potentially stressful situations, especially if one of their parents is rejecting. Counseling families about current research on sexual orientation is crucial, and connecting parents to support groups for parents has been found to be extremely helpful as well. It is important to remember that the process of adjustment to one's child's lgb identity can take considerable time for some parents. Because of these issues, it is imperative that counselors carry out a careful assessment of youths' families in terms of likely reactions to their children's sexual orientation. Unless counselors are assured that at least one parent – and preferably both – is accepting, advice to youths to disclose to families should not be given, as this may put the youth at risk for verbal and physical harm that can extend for several years (D'Augelli et al., 1998).

Support from parents and peers may mitigate the development of mental health problems of lgb youths, but other, non-familial victimization experiences also put youths in jeopardy. Policies should be in place in school settings that prohibit victimization based on sexual orientation, and supportive programs should be developed (Nichols, 1999). Counselors should be knowledgeable about lgb youths and how to help them (Hershberger & D'Augelli, 1999; Ryan & Futterman, 1998). Of particular importance in this context is an appreciation of the psychological consequences of stigmatization and victimization on youths (Rivers, 2000). Indeed, professionals should routinely inquire about past victimization experiences of lgb youths, and assist youths in recovering from mental health problems related to this history. Access to social and community groups for lgb youths is also of considerable importance, especially in the face of familial or peer rejection. Lesbian, gay, and bisexual youths must have support, and their development needs to be normalized. Openness about their sexual orientation during adolescence puts youths at risk, but it also provides them with the opportunity to obtain the social resources required to integrate sexual orientation into other aspects of their lives at an age-appropriate time.

Note

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