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Position on Reparative Therapy

AASECT

Position on Reparative Therapy

The American Association of Sexuality Educators, Counselors and Therapists (AASECT) takes the position that having a non-heterosexual sexual orientation, that being transgender and that being gender non-conforming, are not mental disorders. We oppose any "reparative" or conversion therapy that seeks to "change" or "fix" a person's sexual orientation, gender identity or gender expression. AASECT does not believe that non-heterosexual sexual orientation or being transgender or gender non-conforming is something that needs to be "fixed" or "changed."

The rationale behind this position is the following:

- Reparative therapy (for minors, in particular) is often forced or non-consensual.
- Reparative therapy has been proven harmful to minors.
- There is no scientific evidence supporting the success of these interventions.
- Reparative therapy is grounded in the idea that non-heterosexual orientation, transgender gender identity and gender non-conforming expressions are "disordered."
- Reparative therapy has been shown to be a negative predictor of psychotherapeutic benefit.

We define reparative or conversion therapy as:

- services or interventions purporting to "cure" any sexual orientation that is non-heterosexual or gender identity/expression that falls under a transgender umbrella.

- services that seek to change non-heterosexual orientation because of the assumption that homosexuality or bisexuality are mental disorders.

- services that seek to change transgender gender identities/expressions because of the assumption that being transgender is a mental disorder.

Our position is consistent with our professional colleagues, including but not limited to: the American Medical Association, the American Psychoanalytic Association, the National Association of Social Workers, the American Academy of Pediatrics, the American School Counselor Association, the American Mental Health Counselors Association, the American Bar Association, the American College of Physicians and the Canadian Psychological Association.

EXHIBIT 14

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AMERICAN SCHOOL COUNSELOR ASSOCIATION

The Professional School Counselor and LGBTQ Youth

(Adopted 1995, Revised 2000, 2005, 2007, 2013, 2014)

American School Counselor Association (ASCA) Position

Professional school counselors promote equal opportunity and respect for all individuals regardless of sexual orientation, gender identity or gender expression. Professional school counselors work to eliminate barriers that impede student development and achievement and are committed to the academic, personal/social and career development of all students.

The Rationale

Lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth often experience challenges to their academic and personal/social development related to a negative school climate. Students report feeling unsafe in school due to their sexual orientation, perceived orientation, gender identity or gender expression and report experiencing homophobic remarks, harassment and bullying (GLSEN, 2011). LGBTQ individuals often face multiple risk factors that may place them at greater risk for suicidal behavior (SPRC, 2008). Professional school counselors realize these issues impact healthy student development and psychological well-being.

The Professional School Counselor's Role

The professional school counselor works with all students through the stages of identity development and understands this may be more difficult for LGBTQ youth. It is not the role of the professional school counselor to attempt to change a student's sexual orientation or gender identity. Professional school counselors do not support efforts by licensed mental health professionals to change a student's sexual orientation or gender as these practices have been proven ineffective and harmful (APA, 2009). School counselors provide support to LGBTQ students to promote academic achievement and personal/social development. Professional school counselors are committed to the affirmation of all youth regardless of sexual orientation, gender identity and gender expression and work to create safe and affirming schools. School counselors:

- assist students with feelings about their sexual orientation and gender identity as well as the identity of others in an accepting and nonjudgmental manner
- advocate for equitable educational and extracurricular opportunities for all students regardless of sexual orientation, gender identity or gender expression
- promote policies that denounce the use of offensive language, harassment, and bullying that lead to a hostile school environment
- address absenteeism, lowered educational aspirations and academic achievement, and low psychological well-being as a result of victimization and feeling unsafe at school (GLSEN, 2012)
- provide a safe space for LGBTQ students and allies such as Gay and Straight Alliance Clubs
- promote sensitivity and acceptance of diversity among all students and staff to include LGBTQ students and diverse family systems
- advocate for the rights of families to access and participate in their student's education and school activities without discrimination (GLSEN, 2001)
- support an inclusive curriculum at all grade levels
- model language that is inclusive of sexual orientation and gender identity
- advocate for adoption of school policies that address discrimination and promote safe and supportive school environments (Robinson & Espelage, 2012)
- promote violence-prevention programs to create a safe school environment
- encourage staff training on inclusive practices, creating an affirming school environment, accurate information and risk factors for LGBTQ students (Russell, et.al. 2010)
- identify LGBTQ community resources for students and families

EXHIBIT 15

Summary

Professional school counselors promote affirmation, respect and equal opportunity for all individuals regardless of sexual orientation, gender identity, or gender expression. Professional school counselors promote awareness of and education on issues related to LGBTQ students and encourage a safe and affirming school environment. Professional school counselors work to eliminate barriers that impede student development and achievement and are committed to the academic, career and personal/social development of all students.

References

APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). *Report of the task force on appropriate therapeutic responses to sexual orientation.* Washington, DC: American Psychological Association.

Gay, Lesbian and Straight Education Network. (2012). *Playgrounds and prejudice: Elementary school climate in the United States.* New York, NY: GLESN and Harris Interactive, Inc.

Gay, Lesbian and Straight Education Network. (2001). *The GLESN public policy platform.* Retrieved from http://glsen.org/sites/default/files/GLSEN%20model%20district%20policy.pdf

Hatzenbuehler, M. L. (2011). The social environment and suicide attempts in lesbian, gay, and bisexual youth. *Pediatrics.* Published online April 18, 2011.

Kosciw, J. G., Greytak, E. A., Bartkiewicz, M. j., Boesen, M. J., & Palmer, N. A. (2012). *The 2011 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools.* New York, NY: GLSEN.

Movement Advancement Project. (2012). *An ally's guide to issues facing LGBT Americans.* Denver, CO: Author.

Robinson, J. P., & Espeiage, D. L. (2012). Bullying explains only part of LGBTQ heterosexual risk disparities: Implications for policy and practice. *Educational Researcher, 41*(8), 309-319.

Russel, S., Koslow, J., Horn, S., & Saewyc, E. (2010). Social policy report, safe schools policy for LGTBQ students. *Sharing Child and Youth Development Knowledge. 24*(4). Retrieved from http://srcd.org/sites/default/files/documents/spr_24_4_final.pdf

Suicide Prevention Resource Center. (2008). *Suicide risk and prevention for lesbian, gay, bisexual and transgender youth.* Newton, MA: Education Development Center.

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Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper From the American College of Physicians

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Abstract

In this position paper, the American College of Physicians examines the health disparities experienced by the lesbian, gay, bisexual, and transgender (LGBT) community and makes a series of recommendations to achieve equity for LGBT individuals in the health care system. These recommendations include enhancing physician understanding of how to provide culturally and clinically competent care for LGBT individuals, addressing environmental and social factors that can affect their mental and physical well-being, and supporting further research into understanding their unique health needs.

The lesbian, gay, bisexual, and transgender (LGBT) community is diverse, comprising persons from various races, ethnicities, and socioeconomic backgrounds; however, LGBT persons face a common set of challenges within the health care system. These challenges range from access to health care coverage and culturally competent care to state and federal policies that reinforce social stigma,

EXHIBIT 16

LGBT community and the challenges they face in accessing care. Although great strides have been taken in reducing health disparities in the LGBT community, much more needs to be done to achieve equity for LGBT persons in the health care system.

Although members of the LGBT community face similar health concerns as the general population, certain disparities are reported at a higher rate among LGBT persons than the heterosexual population (1). These disparities experienced by LGBT persons may be compounded if they are also part of a racial or ethnic minority (1). Of note, LGBT persons are more likely to identify themselves as being in poor health than heterosexual individuals, and different segments of the LGBT population have individual health risks and needs. For example, gay and bisexual men are at increased risk for certain sexually transmitted infections and account for more than half of all persons living with HIV or AIDS in the United States (1); lesbian women are less likely to have mammography or Papanicolaou test screening for cancer (2); lesbian and bisexual women are more likely to be overweight or obese (3); and lesbian, gay, and bisexual persons are more likely to become disabled at a younger age than heterosexual individuals (4).

Various state or federal laws may affect the quality of life of LGBT persons and can affect their physical and mental health. Same-sex marriage bans may cause psychological distress (5), prohibitive hospital visitation policies may prevent a same-sex parent from seeing a minor while the child is ill or participating in medical decision making for the child, and exclusions on transgender health care in private and public health plans may cause a transgender patient to seek treatment options through illegal channels (6). These laws and policies, along with others that reinforce marginalization, discrimination, social stigma, or rejection of LGBT persons by their families or communities or that simply keep LGBT persons from accessing health care, have been associated with increased rates of anxiety, suicide, and substance or alcohol abuse (7).

Addressing these disparities will require changes in the way LGBT persons and their families are regarded in society and by the health care system. Policies that are discriminatory toward the LGBT community, or are no longer supported by empirical research, continue to reinforce the environmental and social factors that can affect the mental and physical well-being of LGBT persons. The American College of Physicians (ACP) has a long-standing commitment to improving the health of all Americans and opposes any form of discrimination in the delivery of health care services. ACP is dedicated to eliminating disparities in the quality of or access to health care and is committed to working toward fully understanding the unique needs of the LGBT community and eliminating health disparities for LGBT persons.

This Executive Summary provides a synopsis of the full position paper, which is available in Appendix.

Methods

The ACP Health and Public Policy Committee, which is charged with addressing issues affecting the health care of the U.S. public and the practice of internal medicine and its subspecialties, developed these recommendations. The committee reviewed numerous studies, reports, and surveys on LGBT health care and related health policy. The committee also reviewed information on how state and federal policies may affect the physical and mental health of the LGBT population. Draft recommendations were reviewed by the ACP Board of Regents, Board of Governors, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, and Council of Subspecialty Societies. The position paper and recommendations were reviewed by the ACP Board of Regents and approved on 27 April 2015.

The following statements represent the official policy positions and recommendations of the ACP. The rationale for each is provided in the full position paper (Appendix).

A glossary of LGBT terminology used throughout this paper can be found at https://lgbt.ucsf.edu/glossary-terms.

1. The American College of Physicians recommends that gender identity, independent and fundamentally different from sexual orientation, be included as part of nondiscrimination and antiharassment policies. The College encourages medical schools, hospitals, physicians' offices, and other medical facilities to adopt gender identity as part of their nondiscrimination and antiharassment policies.

2. The American College of Physicians recommends that public and private health benefit plans include comprehensive transgender health care services and provide all covered services to transgender persons as they would all other beneficiaries.

3. The definition of "family" should be inclusive of those who maintain an ongoing emotional relationship with a person, regardless of their legal or biological relationship.

4. The American College of Physicians encourages all hospitals and medical facilities to allow all patients to determine who may visit and who may act on their behalf during their stay, regardless of their sexual orientation, gender identity, or marital status, and ensure visitation policies are consistent with the Centers for Medicare & Medicaid Services Conditions of Participation and The Joint Commission standards for Medicare-funded hospitals and critical-access hospitals.

5. The American College of Physicians supports civil marriage rights for same-sex couples. The denial of such rights can have a negative impact on the physical and mental health of

6. The American College of Physicians supports data collection and research into understanding the demographics of the LGBT population, potential causes of LGBT health disparities, and best practices in reducing these disparities.

7. Medical schools, residency programs, and continuing medical education programs should incorporate LGBT health issues into their curricula. The College supports programs that would help recruit LGBT persons into the practice of medicine and programs that offer support to LGBT medical students, residents, and practicing physicians.

8. The College opposes the use of "conversion," "reorientation," or "reparative" therapy for the treatment of LGBT persons.

9. The American College of Physicians supports continued reviews of blood donation deferral policies for men who have sex with men. The College supports evidence-based deferral policies that take into account a comprehensive assessment of the risk level of all individuals seeking to donate, which may result in varying deferral periods or a lengthened or permanent deferral on blood donation.

Conclusion

The ACP recognizes that reducing health disparities in the LGBT population will take concerted efforts not only by those in the medical community but also from society as a whole. Training future physicians to be culturally and clinically competent in LGBT health care, working with practicing physicians to increase their understanding of the LGBT population and their health needs, advocating for practical health policies supported by empirical research, and working to eliminate laws that discriminate against the LGBT community and their families are all important steps to reducing and ultimately eliminating the health disparities

Appendix: Lesbian, Gay, Bisexual, and Transgender Health Disparities: A Policy Position Paper From The American College of Physicians

Understanding the LGBT Community

The LGBT community is a highly diverse and multifaceted group of persons encompassing all cultures, ethnicities, and walks of life. Under the LGBT umbrella, each individual group faces unique cultural and health-related needs but shares common challenges, such as social stigma, discrimination, and disparities in health care, that unite them.

Research into LGBT health has been expanding as the community has become more visible and outspoken about engaging the health care system in developing a knowledge base on the distinctive challenges and health disparities they face. However, gaps in the medical community's understanding of the overall makeup of the LGBT community and the environmental and social factors that may influence the needs of those persons present an obstacle to addressing challenges in a meaningful way. In 2011, the Institute of Medicine issued a report outlining a research agenda targeting several areas that could affect how the health care system approaches LGBT health, including demographics, social influences, disparities and inequalities, intervention that includes increasing access to care and addressing physical or mental conditions, and transgender-specific needs. The report also recommended the inclusion of the LGBT community in national health surveys and emphasized a need for scientific rigor and a respectful environment when gathering data (8).

One important obstacle to identifying health issues within the LGBT population is a lack of reliable data and the exclusion of sexual and gender minorities' identification on federal health surveys. Recent efforts have been made to gather population data on persons who identify as lesbian, gay, bisexual, or transgender and those who

couples that identified as being married. Before that, the 2000 U.S. Census changed the relationship status of same-sex partners identifying as being the spouse of the head of household to an "unmarried partner" because there were no states in which same-sex marriage was legal. In the 1990 U.S. Census, if a same-sex couple identified themselves as married, the sex of 1 of the respondents was automatically changed to the opposite sex and the couple was enumerated as an opposite-sex married couple (9). The Patient Protection and Affordable Care Act allows the Department of Health and Human Services (HHS) to collect "additional demographic data to further improve our understanding of health disparities," and in 2013, the National Health Interview Survey—an annual study of health care access, use, and behaviors—included sexual orientation as part of its data collection system (10). Recent estimates put the number of persons who identify as lesbian, gay, bisexual, or transgender at more than 9 million or approximately 3.4% of the U.S. population, which some analysts believe may be an underestimate (1). Individuals who may have same-sex attractions or experiences but do not self-identify as LGBT may still fall into the category of sexual minorities and face health disparities associated with LGBT persons.

Access to Care in the LGBT Population

The LGBT community has often been overlooked when discussing health care disparities and continues to face barriers to equitable care. Barriers to care are multidimensional and include stigma and discrimination, poverty, lack of education, racial or ethnic minority status, and other psychological health determinants (11). Studies show that persons who identify as LGBT have greater economic disadvantages and are more vulnerable to poverty than those who do not. Using available information from national surveys, the Williams Institute reports higher overall poverty rates for persons identifying under the LGBT umbrella than heterosexual persons and higher rates of poverty in same-sex couples than heterosexual couples (7.6% vs. 5.7%) (12).

Research shows that LGBT adults and their children are more likely to be uninsured by public or private insurance and that they and their family members continue to face difficulties in gaining access to care and face a higher risk for health disparities than the general population (2). Most Americans gain health insurance coverage through their employer; data are limited but suggest LGBT persons face higher unemployment rates than non-LGBT persons. A 2009 survey in California found a 14% unemployment rate among LGBT adult workers compared with 10% among non-LGBT adults (13).

The Affordable Care Act sought to increase access to care for low-income Americans by expanding Medicaid programs to all persons at or below 133% of the federal poverty level, providing financial subsidies to help those making between 100% and 400% of the federal poverty level purchase insurance on the federal and state marketplace exchanges, and including nondiscrimination protections in health plans sold on the exchanges. Although estimates suggested that the number of uninsured LGBT persons would be reduced as a result of Medicaid expansion, only about half of states have chosen to expand their Medicaid programs, which greatly diminishes its effect. This increases the number of LGBT persons who may fall into what has been dubbed the "coverage gap," in which persons may earn too much to qualify for their state's Medicaid program but too little to qualify for subsidies (14).

Transgender individuals face additional challenges in gaining access to care. Not only are they more likely to be uninsured than the general population, they are more likely to be uninsured than lesbian, gay, or bisexual persons (1). They also face high out-of-pocket costs for transgender-specific medical care if they lack insurance or their insurance coverage does not cover transgender health care. According to the American Congress of Obstetricians and Gynecologists, transgender youth who receive inadequate treatment are at an increased risk for engaging in self-mutilation or using illicit venues to obtain certain treatments; research shows more than 50% of

Mental and Physical Health Disparities

Existing research into the health of the LGBT population has found some health disparities that disproportionately affect the LGBT population. In 2000, the first federally funded research study on the health of LGBT persons assessed 5 major areas of concern for lesbian, gay, and bisexual persons (the report noted that transgender health concerns warranted an independent evaluation): cancer, family planning, HIV and AIDS, immunization and infectious diseases, and mental health (15). Research has shown that lesbian women are less likely to get preventive cancer screenings; lesbian and bisexual women are more likely to be overweight or obese (16); gay men are at higher risk for HIV and other sexually transmitted infections; and LGBT populations have the highest rates of tobacco, alcohol, and other drug use (17). Lesbian, gay, and bisexual persons are approximately 2.5 times more likely to have a mental health disorder than heterosexual men and women (18).

Transgender persons are also at a higher lifetime risk for suicide attempt and show higher incidence of social stressors, such as violence, discrimination, or childhood abuse, than nontransgender persons (19). A 2011 survey of transgender or gender-nonconforming persons found that 41% reported having attempted suicide, with the highest rates among those who faced job loss, harassment, poverty, and physical or sexual assault (20).

Positions

1. The American College of Physicians recommends that gender identity, independent and fundamentally different from sexual orientation, be included as part of nondiscrimination and antiharassment policies. The College encourages medical schools, hospitals, physicians' offices, and other medical facilities to adopt gender identity as part of their nondiscrimination and antiharassment policies.

Nondiscrimination policies are in place to prevent employment discrimination or

law (21). However, state law varies considerably on the inclusion of sexual orientation and gender identity in nondiscrimination policies and some policies based on sexual orientation alone may not include gender identity. Eighteen states have employment nondiscrimination or equal employment opportunity statutes that cover both gender identity and sexual orientation, and an additional 3 states have nondiscrimination statutes that cover sexual orientation only (22). The Human Rights Campaign, an LGBT rights organization, estimated that as a result of these assorted laws, 3 of 5 U.S. citizens live in an area that does not provide protection for gender identity or sexual orientation (23).

Sexual orientation and gender identity are inherently different and should be considered as such when assessing whether nondiscrimination or harassment policies provide protection to all members of the LGBT community. According to the Institute of Medicine, "sexual orientation" refers to a person's enduring pattern of or disposition to have sexual or romantic desires for, and relationships with, persons of the same sex or both sexes (8). "Gender identity" refers to a person's basic sense of being a man or boy, a woman or girl, or another gender. Gender identity may or may not correspond to a person's anatomical sex assigned at birth. The term "transgender" is now widely used to refer to a diverse group of persons who depart significantly from traditional gender norms (24). Persons who have a "marked difference" between their anatomical sex at birth and their expressed or experienced gender may be diagnosed with gender dysphoria, which is a diagnosis under the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (25).

Evidence shows that individuals with gender identity variants face increased discrimination, threats of violence, and stigma. The National Gay and Lesbian Task Force and the National Center for Transgender Equality conducted a national survey of transgender and gender-nonidentifying persons and found high rates of

workplace, and they experience double the rate of unemployment than the general population (20). Therefore, LGBT persons are more likely to lose their job or not be hired (26).

Employers have the option to include gender identity as part of their company's nondiscrimination or antiharassment policies even if their state does not, and many companies have chosen to include comprehensive protections policies. To reduce the potential for discrimination, harassment, and physical and emotional harm toward persons who are not covered by current protections, the medical community should include both sexual orientation and gender identity as part of any comprehensive nondiscrimination or antiharassment policy.

2. The American College of Physicians recommends that public and private health benefit plans include comprehensive transgender health care services and provide all covered services to transgender persons as they would all other beneficiaries.

The LGBT community is at increased risk for physical and emotional harm resulting from discrimination or harassment, and transgender persons may face greater inequalities in the health care system than the general population. Of note, 19% of transgender persons lack any type of health insurance (20). A handful of states have laws about insurance coverage for transgender health care, such as hormone replacement therapy or sexual reassignment surgery, which may be considered medically necessary as part of the patient's care. Eight states and the District of Columbia have prohibitions on insurance exclusion of treatments for sex reassignment surgery (27).

The World Professional Association for Transgender Health has developed health care standards for transgender persons who have been diagnosed with gender dysphoria. The standards emphasize treatments that will achieve "lasting personal

modification to a person's gender expression or how this individual appears or presents physically to others (28). Research shows that when transgender persons receive individual, medically appropriate care, they have improved mental health, reduction in suicide rates, and lower health care costs overall because of fewer mental health–related and substance abuse–related costs (29). However, not all health plans cover all services associated with transgender health or consider such services medically necessary; some plans may issue blanket exclusions on transgender health care, not cover certain services for a transgender person as they would for nontransgender persons, or only cover the cost of gender reassignment surgery if certain conditions are met. For example, an insurance company may cover posthysterectomy estrogenic hormone replacement therapy for biological women but will not cover a similar type of hormone therapy for a postoperative male-to-female transgender patient. Many professional medical organizations, including the American Medical Association, American Psychological Association, American Psychiatric Association, American Congress of Obstetricians and Gynecologists, and American Academy of Family Physicians, consider gender transition–related medical services medically necessary (30).

The decision to institute a hormone therapy regimen or pursue sexual reassignment surgery for transgender individuals is not taken lightly. Transgender patients and their health care team, which may include primary care physicians, endocrinologists, mental health professionals, and others, are in the best position to determine the most appropriate care plan unique to the patient's needs. Throughout the course of treatment, patients and their physicians or health care team should discuss available options and the evidence base for those treatments in which such evidence exists. It is especially important that transgender patients whose health care team has determined that treatment should include cross-sex hormone therapy or sexual reassignment surgery and postoperative hormone therapy be well-informed about the potential health risks associated with the long-term use of some hormonal

Without insurance coverage, the cost of treatment for persons with gender dysphoria may be prohibitively expensive. The most extensive and expensive sexual reassignment surgeries may cost tens of thousands of dollars; this does not include associated costs, such as counseling, hormone replacement therapy, copays, or aftercare. The high costs of treatment can result in persons who cannot access the type of care they need, which can increase their levels of stress and discomfort and lead to more serious health conditions. In 2014, the HHS lifted the blanket ban on Medicare coverage for gender reassignment surgery (31) and the federal government announced it would no longer prohibit health plans offered on the Federal Employees Health Benefits Program from offering gender reassignment as part of the plan (27). Transgender health advocates are hopeful this will result in wider coverage for transgender care in private health plans.

The cost of including transgender health care in employee health benefits plans is minimal and is unlikely to raise costs significantly, if at all. A survey of employers offering transition-related health care in their health benefit plans found that two thirds of employers that provided information on actual costs of employee utilization of transition-related coverage reported 0 costs (32). This is the result of a very small portion of the population identifying as transgender and a smaller portion of that group having the most expensive type of gender reassignment surgery as part of their treatment. An analysis of the utilization of transgender health services over 6 years after transgender discrimination was prohibited in one California health plan found a utilization rate of 0.062 per 1000 covered persons (33). The inclusion of transgender-related health care services within a health plan may also result in an overall reduction of health care costs over time because patients are less likely to engage in self-destructive behaviors, such alcohol or substance abuse.

3. The definition of "family" should be inclusive of those who maintain an ongoing emotional relationship with a person, regardless of their legal or biological relationship.

The term "family" as it is seen in society is changing and no longer means married heterosexual parents with children. An analysis shows only 22% of families fall into this category (34). Stepparents, single parents, grandparents, same-sex couples, or foster or adoptive parents all make up the changing face of U.S. families. Across the country, LGBT persons are raising children, and demographic data shows that 110 000 same-sex couples are raising as many as 170 000 biological, adopted, or foster children and 37% of LGBT adults have had a child (35). This modern concept of family is no longer dependent on parental status and does not only include adult heads of household with minor children. Same-sex couples and different-sex couples who do not have children may nevertheless have persons in their lives that they consider family.

Despite research that shows a growing trend toward acceptance of LGBT individuals and families (36), there is no widely used standard definition of family inclusive of the diverse nature of the family structure and definitions vary widely: They can differ from state to state, within the Internal Revenue Service for tax purposes, by employers to determine eligibility for health plans, and by hospitals for the purposes of visitation or medical decision making. If LGBT spouses or partners are not legally considered a family member, they are at risk for reduced access to health care and restrictions on caregiving and decision making; further, they are at increased risk for health disparities, and their children may not be eligible for health coverage (34). Therefore, LGBT persons and families may already be at a financial disadvantage, with single LGBT parents 3 times more likely to live near the poverty line than their non-LGBT counterparts and LGBT families twice as likely to live near the poverty threshold (35). These financial disadvantages can translate into lack of access to medical care and poorer health outcomes similar to those experienced by non-LGBT persons and their families who are uninsured or underinsured, in addition to the health disparities that are already reported among the LGBT community.

married couples and families and is an example of a broad, comprehensive definition of family that includes a person's biological, legal, and chosen family:

> Family means any person(s) who plays a significant role in an individual's life. This may include a person(s) not legally related to the individual. Members of "family" include spouses, domestic partners, and both different-sex and same-sex significant others. "Family" includes a minor patient's parents, regardless of the gender of either parent. (37)

A definition of family inclusive of all types of families, including the LGBT population, is not only fundamental to reducing the disparities and inequalities that exist within the health care system, but also important for the equal treatment of LGBT patients and their visitors in the hospital setting. Countless accounts show loved ones being denied the right to visit; assist in the medical decision-making process for their partner, minor, or child; or be updated on the condition of a patient because hospital visitation policy broadly prohibits those who are not recognized family members from access to the patient. These policies are discriminatory against LGBT patients, their visitors, and the millions of others who are considered family, such as friends, neighbors, or nonrelative caregivers who can offer support to the patient.

4. The American College of Physicians encourages all hospitals and medical facilities to allow all patients to determine who may visit and who may to act on their behalf during their stay, regardless of their sexual orientation, gender identity, or marital status, and ensure visitation policies are consistent with the Centers for Medicare & Medicaid Services Conditions of Participation and The Joint Commission standards for Medicare-funded hospitals and critical-access hospitals.

When persons or their loved ones need emergency care or extended inpatient stays in

rights as patients or visitors. Hospital visitation policies are not always clear or consistent about who can visit or make medical decisions for a patient if they become incapacitated or cannot do so themselves. The absence or limited access of loved ones can cause uncertainty and anxiety for the patient. In contrast, the involvement of family and outside support systems can improve health outcomes, such as management of chronic illness and continuity of care (38).

A highly publicized incident of LGBT families facing discrimination and being denied hospital visitation occurred in Florida in 2007. A woman on vacation with her family had an aneurysm and was taken to the hospital. Her same-sex partner and their children were denied the right to see her or receive updates on her condition, and she eventually slipped into a coma and died (39). In response to this incident, President Obama issued a presidential memorandum recommending that the HHS review and update hospital visitation policies for hospitals participating in Medicare or Medicaid and critical-access hospitals to prohibit discrimination based on such factors as sexual orientation or gender identity (40).

Throughout the rulemaking process, the HHS revised the Medicare Conditions of Participation to require that all hospitals explain to all patients their right to choose who may visit during an inpatient stay, including same-sex spouses, domestic partners, and other visitors, and the patients' right to choose a person to act on their behalf. The Joint Commission, the nation's largest organization for hospital accreditation, also updated its standards to include equal visitation for LGBT patients and visitors (41). As a result of these updated policies, most hospitals and long-term care facilities are required to allow equal visitation for LGBT persons and their families.

The presidential memorandum also recommended that the HHS instruct hospitals to disclose to their patients that patients have a right to designate a representative to

"should give deference to patients' wishes about their representatives, whether expressed in writing, orally, or through other evidence, unless prohibited by state law" (42). With piecemeal regulations and policies governing the legal rights of LGBT persons and their families, some same-sex spouses or domestic partners choose to prepare advance directives, such as durable powers of attorney and health care proxies, in an effort to ensure their access to family members and their ability to exert their right to medical decision making if necessary.

5. The American College of Physicians supports civil marriage rights for same-sex couples. The denial of such rights can have a negative impact on the physical and mental health of these persons and contribute to ongoing stigma and discrimination for LGBT persons and their families.

The health and financial benefits of marriage for different-sex couples are widely reported, and contemporary research supports similar benefits in same-sex marriage. On the other hand, denial of marriage rights for LGBT persons may lead to mental and physical health problems. Health benefits associated with same-sex marriage result from improved psychological health and a reinforced social environment with community support (43). Research suggests that being in a legally recognized same-sex marriage diminishes mental health differentials between LGBT and heterosexual persons (5). A comparison study on the utilization of public health services by gay and bisexual men before and after Massachusetts legalized same-sex marriage found a reduction in the number of visits for health problems and mental health services. The study noted a 13% reduction in visits overall after the legalization of same-sex marriage (44).

In contrast, denial of such rights can result in ongoing physical and psychological health issues. Thus, LGBT persons encountering negative societal attitudes and discrimination often internalize stressors and have poor health unseen to those

increases in general anxiety, mood disorders, and alcohol abuse (45). The denial of marriage rights to LGBT persons has also been found to reinforce stigmas of the LGBT population that may undermine health and social factors, which can affect young adults (46). The American Medical Association's broad policy supporting civil rights for LGBT persons acknowledges that denial of civil marriage rights can be harmful to LGBT persons and their families and contribute to ongoing health disparities (47).

Since 2003, the overall support for marriage equality has increased. The shift in attitudes toward acceptance of same-sex marriage has broad positive implications for the future of U.S. civil marriage rights. A 2013 survey by the Pew Research Center revealed that nearly half of U.S. adults expressed support for same-sex marriage. Of note, millennials (those born after 1980) showed the highest rate of support for same-sex marriage rights at 70%. Not only has overall opinion changed, but individually, 1 in 7 respondents reported they had changed their minds from opposing to supporting same-sex marriage. The Pew survey found that 32% of respondents changed their mind because they knew someone who identified as lesbian or gay (36).

The legal landscape is also shifting in favor of inclusive civil marriage rights for same-sex couples. The American Bar Association has adopted a resolution recognizing "that lesbian, gay, bisexual and transgender (LGBT) persons have a human right to be free from discrimination, threats and violence based on their LGBT status and condemns all laws, regulations and rules or practices that discriminate on the basis that an individual is [an] LGBT person" (48). In June 2013, the U.S. Supreme Court struck down a provision of the Defense of Marriage Act that defined marriage as a "union between a man and a woman." The decision allowed legally married same-sex couples to have the same federal benefits offered to heterosexual couples (49). Currently more than half of the states and the District of Columbia allow same-

arguments in a case involving same-sex marriage bans in Michigan, Ohio, Kentucky, and Tennessee; this will ultimately determine the constitutionality of same-sex marriage bans, including whether states would be required to recognize same-sex marriages performed legally out of state (51).

6. The American College of Physicians supports data collection and research into understanding the demographics of the LGBT population, potential causes of LGBT health disparities, and best practices in reducing these disparities.

Previous efforts to understand the LGBT population by including sexual orientation or gender identity in health surveys and data collection are a good first step, but there is a long way to go to understand the unique health needs of all members of the LGBT community. Understanding the demographics of the persons who make up this community is a key first step to understanding how environmental and social determinants may contribute to the health disparities they face. Overwhelming evidence shows that racial and ethnic minorities experience greater health disparities than the general population. In 2010, ACP published an updated position paper on racial and ethnic disparities in health care, which identified various statistics on health disparities in racial and ethnic minority groups, such as higher levels of uninsured Hispanics than white persons (34% vs. 13%) and lower rates of medication adherence in minority Medicare beneficiaries diagnosed with dementia (52). Persons who are part of both the LGBT community and a racial or ethnic minority group may face the highest levels of disparities. For example, data show that 30% of African American adults who identify as lesbian, gay, or bisexual are likely to delay getting a prescription compared with 19% of African American heterosexual adults (26).

Transgender persons may also face certain increased risk factors that can affect their health that are not included when discussing the LGBT population as a whole, which creates research gaps with the LGBT community. A survey study of transgender

education, employment, housing, and public accommodations than other sexual, racial, or ethnic minority groups. The lack of and unfamiliarity with research focused on the physical health issues of transgender persons, such as hormone replacement therapy and cancer risk, limit the understanding or development of best practices that could reduce the disparities felt by this population. The dearth of such research is detrimental to physicians' understanding of issues unique to transgender patients and reduces their ability to care for these patients.

Data that have been gathered in the relatively short time since the inclusion of sexual orientation, gender identity, and same-sex marital status have revealed information that can be used to create tailored plans to decrease health disparities in in the LGBT community. For example, in 2009 the California Health Interview Survey collected information on certain health indicators and included sexual orientation along with racial and minority status. The survey found a higher rate of uninsured lesbian, gay, or bisexual Latino adults in the state than their African American counterparts (36% vs. 14%) (20).

In addition to obtaining information from population surveys, including gender identity and sexual orientation as a component of a patient's medical record (paper or electronic) may help a physician to better understand an LGBT patient's needs and provide more comprehensive care. This can be particularly useful in the care of transgender persons, whose gender identity and gender expression may differ from their sex assigned at birth and are not in line with the standard sex template on many forms. Including this information—especially in electronic health records that can standardize information, such as anatomy present and the preferred name/pronoun—can create a more comfortable experience for the patient and keep the physician up to date on the patient's transition history, if applicable (53). If a physician uses paper medical records, the patient's chart should be flagged using an indicator, such as a sticker, to alert staff to use the preferred name and pronoun of the patient (54).

7. Medical schools, residency programs, and continuing medical education programs should incorporate LGBT health issues into their curricula. The College supports programs that would help recruit LGBT persons into the practice of medicine and programs that offer support to LGBT medical students, residents, and practicing physicians.

Establishing understanding, trust, and communication between a physician and a patient is key to an ongoing and beneficial physician–patient relationship. However, reported instances of physician bias or denial of care to LGBT patients may influence patients to withhold information on their sexual orientation, gender identity, or medical conditions that could help the physician have a better understanding of the potential health needs of their patients. Physicians can play an integral role in helping an LGBT patient navigate through the medical system by providing respectful, culturally, and clinically competent care that underscores the overall health of the patient. In an article published in *The New England Journal of Medicine,* Makadon noted how physicians can create a welcoming and inclusive environment to LGBT patients:

> [G]uidelines for clinical practice can be very simple: ask the appropriate questions and be open and nonjudgmental about the answers. Few patients expect their providers to be experts on all aspects of gay and lesbian life. But it is important that providers inquire about life situations, be concerned about family and other important relationships, understand support systems, and make appropriate referrals for counseling and support when necessary. (55)

Providing clinically and culturally competent care for transgender persons in the primary care setting may present a challenge to physicians who are not knowledgeable about transgender health. Transgender persons have reported encounters with physicians who are unaware of how to approach treatment of a transgender person, and half of transgender patients reported having to "teach"

transgender status (20). Resources for physicians on how to approach the treatment of transgender patients should emphasize respecting the patient's gender identity while providing prevention, treatment, and screening to the anatomy that is present (56).

To better understand the unique health needs of the LGBT community, physicians and medical professionals must develop a knowledge base in cultural and clinical competency and understand the factors that affect LGBT health; this should begin in the medical school setting and continue during practice. Assessment of LGBT-related content at medical schools found a median of 5 hours spent on LGBT-related issues over the course of the curriculum (57). Exposure to members of the LGBT population in medical school has been shown to increase the likelihood that a physician will take a more comprehensive patient history, have a better understanding of LGBT health issues, and have a more positive attitude toward LGBT patients (58). Studies show that undergraduate students pursuing a career in medicine are receptive to incorporating LGBT-related issues into their education and agree that it applies to their future work (59). The College recognizes the importance of incorporating LGBT health into the medical school curriculum and publishes a comprehensive medical textbook on LGBT health, *The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health, 2nd Edition* (60).

In November 2014, the Association of American Medical Colleges Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development released a comprehensive report recommending strategies on how to implement changes in academic medical institutions to better address the needs of LGBT patients; further, the committee identified challenges and barriers to carrying out these changes. The report recognizes 3 methods of integrating LGBT health into the medical school curricula: full curriculum revision, the addition of a required class, or LGBT health study as a part of elective materials. The report also identifies barriers to curricular

institutional time that would permit teachers to participate in continuing education on the topic (61).

For some LGBT persons interested in pursuing careers in medicine, there continues to be an underlying concern that their sexual orientation or gender identity may affect their selection into a medical school or residency program and acceptance by their peers. In 2012, Dr. Mark Schuster published his personal story about being gay in medicine starting in the 1980s when he entered medical school, through residency, and into practice. In his article, he spoke of a former attending physician he worked under who acted as an advisor and had indicated he would offer him a recommendation for residency, only to find this physician later renege on that offer after Dr. Schuster shared that he was gay (62). Little research has been done on the recruitment of LGBT physicians into the practice of medicine or how disclosing sexual orientation may affect training. One survey measuring the perceptions and attitudes toward sexual orientation during training found that 30% of respondents did not reveal their sexual orientation when applying for residency positions for fear of rejection (63).

Academic medical institutions can make efforts to create a welcoming and inclusive environment for students and faculty. The University of California, San Francisco, LGBT Resource Center developed a checklist for medical schools to assess LGBT curriculum, admissions, and the working environment within their institution. The checklist includes inclusive application procedures, measurement of retention of LGBT students, and efforts and resources dedicated to student well-being (64). In a 2013 white paper, the Gay and Lesbian Medical Association made several recommendations to support an LGBT-inclusive climate at health professional schools in such areas as institutional equality, transgender services and support, diversity initiatives, admissions, staff and faculty recruitment and retention, staff and faculty training, and other areas that underscore simple yet thoughtful ways to

8. The College opposes the use of "conversion," "reorientation," or "reparative" therapy for the treatment of LGBT persons.

Since 1973, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* has not considered homosexuality an illness (66). All major medical and mental health organizations do not consider homosexuality as an illness but as a variation of human sexuality, and they denounce the practice of reparative therapy for treatment of LGBT persons (67). The core basis for "conversion," "reorientation," or "reparative" therapy, which is generally defined as therapy aiming at changing the sexual orientation of lesbian women and gay men, is mostly based on religious or moral objections to homosexuality or the belief that a homosexual person can be "cured" of their presumed illness.

In 2007, the American Psychological Association conducted a literature review of 83 studies on the efficacy of efforts to change sexual orientation. It found serious flaws in the research methods of most of the studies and identified only 1 study that met research standards for establishing safety or efficacy of conversion therapy and also compared persons who received a treatment with those who did not. In that study, intervention had no effect on the rates of same-sex behavior, so it is widely believed that there is no scientific evidence to support the use of reparative therapy (68). The Pan American Health Organization, the regional office for the Americas of the larger World Health Organization, also supports the position that there is no medical basis for reparative therapy and that the practice may pose a threat to the overall health and well-being of an individual (69). Dr. Robert Spitzer, the author of a 2003 research study often cited by supporters of the reparative therapy movement to purport that persons may choose to change their sexual orientation, has denounced the research as flawed and apologized to the LGBT community in a letter for misinterpretations or misrepresentations that arose from the study (70).

actually cause emotional or physical harm to LGBT individuals, particularly adolescents or young persons. Research done at San Francisco State University on the effect of familial attitudes and acceptance found that LGBT youth who were rejected by their families because of their identity were more likely than their LGBT peers who were not rejected or only mildly rejected by their families to attempt suicide, report high levels of depression, use illegal drugs, or be at risk for HIV and sexually transmitted illnesses (71). The American Psychological Association literature review found that reparative therapy is associated with the loss of sexual feeling, depression, anxiety, and suicidality (68).

States have delved into the debate over the use of reparative therapy for minor children given the potential for harm. California; New Jersey; and Washington, DC, have enacted laws banning the practice. Several other state legislatures, such as those in Washington state, Massachusetts, New York, and Oregon, have introduced or passed legislation through one chamber but failed to pass the bill into law (72). The New Jersey law was challenged on the grounds that the ban limited the free speech of mental health professionals, but the law was upheld by the Third U.S. Circuit Court of Appeals (73). In May 2015, the U.S. Supreme Court declined to hear a challenge to the law (74).

9. The American College of Physicians supports continued reviews of blood donation deferral policies for men who have sex with men. The College supports evidence-based deferral policies that take into account a comprehensive assessment of the risk level of all individuals seeking to donate, which may result in varying deferral periods or a lengthened or permanent deferral on blood donation.

Persons who are considered at increased or possible risk for certain infectious diseases, such as intravenous drug users, recipients of animal organs or tissues, and those who have traveled or lived abroad in certain countries, are prohibited by the U.S

deferral of blood donation for MSM was instituted during a time when the incidence of HIV and AIDS increased to epidemic levels in the United States, and the disease and how it was transmitted were largely misunderstood by the scientific community. In the following years, concerted efforts by the medical community, patient advocates, and government officials and agencies resulted in advancements in blood screening technology and treatments for the virus. However, during that time of uncertainty, policies were implemented to balance the risk for contaminating the blood supply with what was known about the transmissibility of the disease.

Several medical organizations support deferral policy reform based on available scientific evidence and testing capabilities. The American Medical Association policy on blood donor criteria supports, "the use of rational, scientifically based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their level of risk" (76). The American Association of Blood Banks, America's Blood Centers, and the American Red Cross have long advocated for a modification to deferral criteria to be "made comparable with criteria for other groups at increased risk for sexual transmission of transfusion-transmitted infections" and recommend a 12-month deferral for men who have had sex with another man since 1977, which is in line with deferral criteria for others who have exhibited high-risk behavior (77). The eligibility standards and policies on the donation of tissues or tissue products (5-year deferral since last sexual contact) (78) and vascular organs (risk assessed individually, disclosed to transplant team, and consent required) (79) by MSM also reflect a measured assessment of disease transmission risk to donor recipients.

Many countries, including the United Kingdom, Canada, Finland, Australia, and New Zealand, have successfully instituted deferral periods ranging from 12 months to 5 years in lieu of a lifetime ban on blood donation by MSM without measurable increased risk to the blood supply. A study of the risk of blood donations from MSM

transfusion-transmitted HIV (80). Australia changed the deferral policy for MSM from 5 years to 12 months over 1996 to 2000. A study that compared the prevalence of HIV among blood donors from the 5-year deferral period compared with the 12-month deferral period found no evidence that the 12-month period increased risk for HIV in recipients (81).

In late 2014, the HHS Advisory Committee on Blood and Tissue Safety and Availability voted in favor of recommending a 1-year deferral policy for MSM and increased surveillance of the blood supply. The U.S Food and Drug Administration announced it would be updating its policy on blood donation from MSM after considering recommendations made by the HHS, reviews of available scientific evidence, and recommendations from its own Blood Products Advisory Committee. The policy about indefinite deferral on blood donation from MSM is being updated to a 1-year deferral period from the last sexual contact, and the U.S. Food and Drug Administration will issue draft guidance on the policy change in 2015. In addition, the agency announced it has already taken steps to implement a national blood surveillance system to monitor what, if any, effects the new policy has on the nation's blood supply (82). Lifting the lifetime ban on blood donation by MSM is an important first step toward creating equity among those wishing to donate blood. The U.S Food and Drug Administration should continue to monitor the effects of a 1-year deferral and update its policy as information and data are gathered through surveillance to make further strides toward policies that assess donor eligibility on the basis of scientific data and individual risk factors, such as the length of time since a high-risk behavior has occurred, type of sex that occurred, number of partners during a period of time, or a combination of factors (83).

References

1 **Ranji U, Beamesderfer A, Kates J, Salganicoff A.** Health and access to care and coverage for lesbian, gay, bisexual, and transgender individuals in the U.S. Menlo Park, CA: Kaiser Family Foundation; 2014. Accessed at http://kff.org/report-section/health-and-access-to-care-and-coverage-for-lgbt-individuals-in-the-u-s-health-challengeson 10 December 2014.

2 **Buchmueller T, Carpenter CS.** Disparities in health insurance coverage, access, and outcomes for individuals in same-sex versus different-sex relationships, 2000-2007. Am J Public Health. 2010;100:489-95.
CrossRef PubMed

3 **Ard KL, Makadon HJ.** Improving the health care of lesbian, gay, bisexual and transgender people: understanding and eliminating health disparities. Boston: The Fenway Institute; 2012. Accessed at www.lgbthealtheducation.org/wp-content/uploads/12-054_LGBTHealtharticle_v3_07-09-12.pdf on 11 February 2015.

4 **Fredriksen-Goldsen KI, Kim HJ, Barkan SE.** Disability among lesbian, gay, and bisexual adults: disparities in prevalence and risk. Am J Public Health. 2012;102:e16-21.
CrossRef PubMed

5 **Wight RG, Leblanc AJ, LeeBadgett MV.** Same-sex legal marriage and psychological well-being: findings from the California Health Interview Survey. Am J Public Health. 2013;103:339-46.
CrossRef PubMed

6 **Committee on Health Care for Underserved Women.** Committee Opinion no. 512: health care for transgender individuals. Obstet Gynecol. 2011;118:1454-8.
CrossRef PubMed

7 **U.S. Department of Health and Human Services.** Healthy people 2020: lesbian, gay, bisexual, and transgender health. Accessed at www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health on 10 December 2014.

for Better Understanding. Washington, DC: National Academies Pr; 2011.

9 **U.S. Census Bureau, Fertility and Family Statistics Branch.** Frequently asked questions about same-sex households. Accessed at www.census.gov/hhes/samesex/files/SScplfactsheet-final.pdf on 10 December 2014.

10 **Ward BW, Dahlhamer JM, Galinsky AM, Joestl SS.** Sexual orientation and health among U.S. adults: national health interview survey, 2013. Natl Health Stat Report. 2014:1-10.

11 **Dilley JA, Simmons KW, Boysun MJ, Pizacani BA, Stark MJ.** Demonstrating the importance and feasibility of including sexual orientation in public health surveys: health disparities in the Pacific Northwest. Am J Public Health. 2010;100:460-7. CrossRef PubMed

12 **Lee Badgett MV, Durso LE, Schneebaum A.** New patterns of poverty in the lesbian, gay, and bisexual community. Los Angeles: The Williams Institute; 2013. Accessed at http://williamsinstitute.law.ucla.edu/wp-content/uploads/LGB-Poverty-Update-Jun-2013.pdf on 10 December 2014.

13 A broken bargain: discrimination, fewer benefits and more taxes for LGBT workers: condensed version. Denver: Movement Advancement Project; 2013. Accessed at www.lgbtmap.org/file/a-broken-bargain-condensed-version.pdf on 10 December 2014.

14 **Kates J, Ranji U.** Health care access and coverage for the lesbian, gay, bisexual, and transgender (LGBT) community in the United States: opportunities and challenges in a new era. Oakland, CA: Kaiser Family Foundation; 2014. Accessed at http://kff.org/disparities-policy/perspective/health-care-access-and-coverage-for-the-lesbian-gay-bisexual-and-transgender-lgbt-community-in-the-united-states-opportunities-and-challenges-in-a-new-era on 10 December 2014.

15 **Dean L, Meyer IH, Robinson K, Sell RL, Sember R, Silenzio VMB, et al.** Lesbian, gay, bisexual, and transgender health: findings and concerns. Journal of the Gay and Lesbian Medical Association. 2000;4:101-51. Accessed at www.felgtb.org/rs/334/d112d6ad-54ec-438b-9358-4483f9e98868/91f/filename/2000-dean-l-lgbt-health-findings-and-concerns.pdf

16 **Brown JP, Tracy JK.** Lesbians and cancer: an overlooked health disparity. Cancer Causes Control. 2008;19:1009-20.
CrossRef PubMed

17 **U.S. Department of Health and Human Services.** Healthy people 2020: lesbian, gay, bisexual, and transgender health: understanding LGBT health. Accessed at www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25#eleven on 10 December 2014.

18 **National Alliance on Mental Illness.** Mental health issues among gay, lesbian, bisexual, and transgender (GLBT) people. Arlington, VA: National Alliance on Mental Illness Multicultural Action Center; 2007. Accessed at www.nami.org/Content/ContentGroups/Multicultural_Support1/Fact_Sheets1/GLBT_Mental_Health_07.pdf on 10 December 2014.

19 **Reisner SL, White JM, Bradford JB, Mimiaga MJ.** Transgender health disparities: comparing full cohort and nested matched-pair study designs in a community health center. LGBT Health. 2014;1:177-184.
PubMed

20 **Grant JM, Mottet LA, Tanis J, Harrison J, Herman JL, Keisling M.** Injustice at every turn: a report of the national transgender discrimination survey. Accessed at www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf on 10 December 2014.

21 **U.S. Equal Employment Opportunity Commission.** What you should know about EEOC and the enforcement protections for LGBT workers. Washington, DC: U.S. Equal Employment Opportunity Commission; 2014. Accessed at www.eeoc.gov/eeoc/newsroom/wysk/enforcement_protections_lgbt_workers.cfm on 10 December 2014.

22 **American Civil Liberties Union.** Non-discrimination laws: state by state information —map. New York: American Civil Liberties Union; 2014. Accessed at www.aclu.org/maps/non-discrimination-laws-state-state-information-map on 10 December 2014.

23 **Human Rights Campaign.** Resources: workplace discrimination laws and policies.

24 **Bockting WO**. From construction to context: gender through the eyes of the transgendered. SIECUS Report 28:3-7.

25 **American Psychiatric Association.** Gender dysphoria. Arlington, VA: American Psychiatric Publishing; 2013. Accessed at www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf on 10 December 2014.

26 **Krehely J.** How to close the LGBT health disparities gap: disparities by race and ethnicity. Washington, DC: Center for American Progress; 2009. Accessed at http://cancer-network.org/media/pdf/lgbt_health_disparities_gap_race.pdf on 11 February 2015.

27 **Millman J.** One health insurer just took the feds' offer to end transgender discrimination. Who else will follow? The Washington Post. 31 October 2014. Accessed at www.washingtonpost.com/blogs/wonkblog/wp/2014/10/31/one-health-insurer-just-took-the-feds-offer-to-end-transgender-discrimination-who-else-will-follow on 10 December 2014.

28 **Coleman E, Bockting W, Botzer M, Cohen-Kettenis P, DeCuypere G, Feldman J, et al.** Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. International Journal of Transgenderism. 2011;13:165-232. Accessed at www.wpath.org/uploaded_files/140/files/IJT%20SOC,%20V7.pdf on 11 February 2015.

29 **National Center for Transgender Equality, National Gay and Lesbian Task Force.** National transgender discrimination survey report on health and health care. Washington, DC: National Center for Transgender Equality; 2010. Accessed at www.thetaskforce.org/static_html/downloads/reports/reports/ntds_report_on_health.pdf on 1 May 2015.

30 **Cray A, Baker K.** FAQ: health insurance needs for transgender Americans. Washington, DC: Center for American Progress; 2012. Accessed at http://cdn.americanprogress.org/wp-content/uploads/2012/10/TransgenderHealth.pdf on 10 December 2014.

surgery/2014/05/30/28bcd122-e818-11e3-a86b-362fd5443d19_story.html on 10 December 2014.

32 **Herman JL.** Costs and benefits of providing transition-related health care coverage in employee health benefits plans: findings from a survey of employers. Los Angeles: The Williams Institute; 2013. Accessed at https://escholarship.org/uc/item/5z38157s on 11 February 2015.

33 **State of California Department of Insurance.** Economic impact assessment: gender nondiscrimination in health insurance. Los Angeles: California Department of Insurance; 2012. Accessed at http://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf on 10 December 2014.

34 **Movement Advancement Project, Family Equality Council, Center for American Progress.** All children matter: how legal and social inequalities hurt LGBT families: condensed version. Denver: Movement Advancement Project; 2011. Accessed at www.lgbtmap.org/file/all-children-matter-condensed-report.pdf on 11 February 2015.

35 **Gates GJ.** LGBT parenting in the United States. Los Angeles: The Williams Institute; 2013. Accessed at http://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Parenting.pdf on 10 December 2014.

36 **Pew Research Center.** Growing support for gay marriage: changed minds and changing demographics. Washington, DC: Pew Research Center; 2013.Accessed at www.people-press.org/2013/03/20/growing-support-for-gay-marriage-changed-minds-and-changing-demographics on 10 December 2014.

37 **The Human Rights Campaign.** LGBT-inclusive definitions of family. Washington, DC: Human Rights Campaign; 2014. Accessed at www.hrc.org/resources/entry/lgbt-inclusive-definitions-of-family on 10 December 2014.

38 **Institute for Patient and Family-Centered Care.** Changing hospital "visiting" policies and practices: supporting family presence and participation. Bethesda, MD: Institute for Patient and Family-Centered Care; 2010. Accessed at www.ipfcc.org/visiting.pdf on 10 December 2014.

www.americanprogress.org/issues/lgbt/news/2014/04/15/88015/hospital-visitation-and-medical-decision-making-for-same-sex-couples on 10 December 2014.

40 **Obama B.** Presidential memorandum: Hospital visitation. 15 April 2010. Accessed at www.whitehouse.gov/the-press-office/presidential-memorandum-hospital-visitation on 10 December 2014.

41 **The Joint Commission.** New and Revised Hospital EPs to Improve Patient-Provider Communication. Approved: New and revised hospital EPs to improve patient-provider communication. Jt Comm Perspect. 2010;30:5-6.

42 **Centers for Medicare & Medicaid Services.** Medicare steps up enforcement of equal visitation and representation rights in hospitals. 8 September 2011. Accessed at www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2011-Press-releases-items/2011-09-08.html on 10 December 2014.

43 **Buffie WC.** Public health implications of same-sex marriage. Am J Public Health. 2011;101:986-90.
CrossRef PubMed

44 **Hatzenbuehler ML, O'Cleirigh C, Grasso C, Mayer K, Safren S, Bradford J.** Effect of same-sex marriage laws on health care use and expenditures in sexual minority men: a quasi-natural experiment. Am J Public Health. 2012;102:285-91.
CrossRef PubMed

45 **Hatzenbuehler ML, McLaughlin KA, Keyes KM, Hasin DS.** The impact of institutional discrimination on psychiatric disorders in lesbian, gay, and bisexual populations: a prospective study. Am J Public Health. 2010;100:452-9.
CrossRef PubMed

46 **Herdt G, Kertzner R.** I do, but I can't: the impact of marriage denial on the mental health and sexual citizenship of lesbian and gay men in the United States. Sex Res Soc Pol. 2006;3:33-49.
CrossRef

American Medical Association. AMA policies on LGBT issues: general policies

48 **American Bar Association.** Resolution 114B. Accessed at www.americanbar.org/content/dam/aba/images/abanews/2014am_hodres/114b.pdf on 10 December 2014.

49 **Schwartz J.** United States v. Windsor: between the lines of the defense of marriage act opinion. The New York Times. 26 June 2013. Accessed at www.nytimes.com/interactive/2013/06/26/us/annotated-supreme-court-decision-on-doma.html?_r=0 on 10 December 2014.

50 **Freedom to Marry.** States. Accessed at www.freedomtomarry.org/states on 10 December 2014.

51 **The Supreme Court.** Certiorari granted. 16 January 2015. Accessed at www.supremecourt.gov/orders/courtorders/011615zr_f2q3.pdf on 23 January 2015.

52 **American College of Physicians.** Racial and ethnic disparities in health care, updated 2010. Philadelphia: American College of Physicians; 2010. Accessed at www.acponline.org/advocacy/current_policy_papers/assets/racial_disparities.pdf on 11 February 2015.

53 **Deutsch MB, Green J, Keatley J, Mayer G, Hastings J, Hall AM. World Professional Association for Transgender Health EMR Working Group.** Electronic medical records and the transgender patient: recommendations from the World Professional Association for Transgender Health EMR Working Group. J Am Med Inform Assoc. 2013;20:700-3.
CrossRef PubMed

54 **National LGBT Health Education Center.** Affirmative care for transgender and gender non-conforming people: best practices for front-line health care staff. Accessed at www.lgbthealtheducation.org/wp-content/uploads/13-017_TransBestPracticesforFrontlineStaff_v6_02-19-13_FINAL.pdf on 10 December 2014.

55 **Makadon HJ.** Improving health care for the lesbian and gay communities. N Engl J Med. 2006;354:895-7.
CrossRef PubMed

57 **Obedin-Maliver J, Goldsmith ES, Stewart L, White W, Tran E, Brenman S, et al.** Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. JAMA. 2011;306:971-7.
CrossRef PubMed

58 **Sanchez NF, Rabatin J, Sanchez JP, Hubbard S, Kalet A.** Medical students' ability to care for lesbian, gay, bisexual, and transgendered patients. Fam Med. 2006;38:21-7.
PubMed

59 **Sequeira GM, Chakraborti C, Panunti BA.** Integrating lesbian, gay, bisexual, and transgender (LGBT) content into undergraduate medical school curricula: a qualitative study. Ochsner J. 2012;12:379-82.
PubMed

60 **Makadon HJ, Mayer KH, Potter J, Goldhammer H.** The Fenway Guide to LGBT Health. 2nd ed. Philadelphia: American College of Physicians; 2015. Accessed at www.acponline.org/newsroom/fenway_guide_book.htm on 5 May 2015.

61 **Association of American Medical Colleges.** Implementing curricular and institutional climate changes to improve health care for individuals who are LGBT, gender nonconforming, or born with DSD. Washington, DC: Association of American Medical Colleges; 2014. Accessed at http://lgbt.ucsf.edu/sites/lgbt.ucsf.edu/files/wysiwyg/AAMC_LGBT-DSD%20Report%202014.pdf on 11 February 2015.

62 **Schuster MA.** On being gay in medicine. Acad Pediatr. 2012;12:75-8.
CrossRef PubMed

63 **Lee KP, Kelz RR, Dubé B, Morris JB.** Attitude and perceptions of the other underrepresented minority in surgery. J Surg Educ. 2014;71:47-52.
CrossRef

64 **University of San Francisco LGBT Center.** LGBT concerns in medical education: a tool for institutional self-assessment. Accessed at http://geiselmed.dartmouth.edu/students/diversity/qmd/medical_education.pdf on

65 **Snowdon S.** Recommendations for enhancing the climate for LGBT students and employees in health professional schools: a GLMA white paper. Accessed at http://gme.wustl.edu/About_the_GME_Consortium/Educational%20Resources/Recommendations%20for%20Enhancing%20LGBT%20Climate%20in%20Health%20Professional%20Schools.pdf on 11 February 2015.

66 **American Psychiatric Association.** LGBT-sexual orientation. Accessed at www.psychiatry.org/lgbt-sexual-orientation on 10 December 2014.

67 **American Psychological Association.** Just the facts about sexual orientation & youth: a primer for principals, educators, & school personnel: efforts to change sexual orientation through therapy. Accessed at www.apa.org/pi/lgbt/resources/just-the-facts.aspx on 10 December 2014.

68 **American Psychological Association Task Force.** Report of the American Psychological Association Task Force on appropriate therapeutic responses to sexual orientation. Washington, DC: American Psychological Association; 2009. Accessed at www.apa.org/pi/lgbt/resources/therapeutic-response.pdf on 11 February 2015.

69 **Pan American Health Organization.** "Cures" for an illness that does not exist. Accessed at www.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=17703 on 10 December 2014.

70 **Spitzer RL.** Spitzer reassesses his 2003 study of reparative therapy of homosexuality [Letter]. Arch Sex Behav. 2012;41:757
CrossRef PubMed

71 **Ryan C.** Supportive families, healthy children: helping families with lesbian, gay, bisexual & transgender children. San Francisco: Family Acceptance Project, San Francisco State Univ; 2009. Accessed at http://cchealth.org/topics/lgbtq/pdf/supportive_families.pdf on 10 December 2014.

72 **Hartmann, M.** Where the states stand in the fight to bangay conversion therapy. Accessed at http://nymag.com/daily/intelligencer/2015/04/where-the-states-stand-on-gay-conversion-therapy.html on 5 May 2015.

73 **United States Court of Appeals for the Third Circuit.** No. 13-4429. Accessed at

74 **Hurley L.** U.S. top court rejects challenge to New Jersey "gay conversion therapy" ban. Accessed at www.reuters.com/article/2015/05/04/us-usa-court-gays-idUSKBN0NP17L20150504 on 5 May 2015.

75 **U.S. Food and Drug Administration.** Blood donations from men who have sex with other men questions and answers. Accessed at www.fda.gov/biologicsbloodvaccines/bloodbloodproducts/questionsaboutblood/ucm108186.htm on 10 December 2014.

76 **American Medical Association.** Policy H-50.973: blood donor referral criteria. In: AMA policies on LGBT issues. Accessed at www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbt-advisory-committee/ama-policy-regarding-sexual-orientation.page on 10 December 2014.

77 **American Association of Blood Banks.** Joint statement before ACBSA on donor deferral for men who have had sex with another man (MSM). 15 June 2010. Accessed at www.aabb.org/advocacy/statements/Pages/statement061510.aspx on 10 December 2014.

78 **U.S. Food and Drug Administration.** Guidance for industry: eligibility determination for donors of human cells, tissues, and cellular and tissue-based products: IV. donor screening (§ 1271.75). Accessed at www.fda.gov/BiologicsBloodVaccines/GuidanceComplianceRegulatoryInformation/Guidances/Tissue/ucm073964.htm#DONORSCREENING1271.75 on 5 May 2015.

79 **Cray A.** Discriminatory donor policies substitute stereotypes for science. Washington, DC: Center for American Progress; 2012. Accessed at www.americanprogress.org/issues/lgbt/news/2012/09/11/37294/discriminatory-donor-policies-substitute-stereotypes-for-science on 10 December 2014.

80 **Davison KL, Conti S, Brailsford SR.** The risk of transfusion-transmitted HIV from blood donations of men who have sex with men, 12 months after last sex with a man: 2005-2007 estimates from England and Wales. Vox Sang. 2013;105:85-8.
CrossRef PubMed

81 **Seed CR, Kiely P, Law M, Keller AJ.** No evidence of a significantly increased risk of transfusion-transmitted human immunodeficiency virus infection in Australia

82 **Hamburg MA.** FDA Commissioner Margaret A. Hamburg's statement on FDA's blood donor deferral policy for men who have sex with men. 23 December 2014. Accessed at www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm427843.htm on 19 January 2015.

83 **Flanagan P.** How should we assess risk behaviour when determining donor deferral? Reflections on the MSM deferral. Biologicals. 2012;40:173-5.
CrossRef PubMed

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ARTICLE

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

Caitlin Ryan, PhD, ACSW[a], David Huebner, PhD, MPH[b], Rafael M. Diaz, PhD[a], Jorge Sanchez, BA[a]

[a]César E. Chávez Institute, San Francisco State University, San Francisco, California; [b]Department of Psychology, University of Utah, Salt Lake City, Utah

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What's Known on This Subject

To our knowledge, no other study has examined the relationship between family rejection of LGB adolescents with health and mental health problems in emerging adulthood.

What This Study Adds

This study expands our understanding of predictors of negative health outcomes for LGB adolescents and provides new directions for assessing risk and preventing health and mental health problems in LGB adolescents.

ABSTRACT

OBJECTIVE. We examined specific family rejecting reactions to sexual orientation and gender expression during adolescence as predictors of current health problems in a sample of lesbian, gay, and bisexual young adults.

METHODS. On the basis of previously collected in-depth interviews, we developed quantitative scales to assess retrospectively in young adults the frequency of parental and caregiver reactions to a lesbian, gay, or bisexual sexual orientation during adolescence. Our survey instrument also included measures of 9 negative health indicators, including mental health, substance abuse, and sexual risk. The survey was administered to a sample of 224 white and Latino self-identified lesbian, gay, and bisexual young adults, aged 21 to 25, recruited through diverse venues and organizations. Participants completed self-report questionnaires by using either computer-assisted or pencil-and-paper surveys.

RESULTS. Higher rates of family rejection were significantly associated with poorer health outcomes. On the basis of odds ratios, lesbian, gay, and bisexual young adults who reported higher levels of family rejection during adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse compared with peers from families that reported no or low levels of family rejection. Latino men reported the highest number of negative family reactions to their sexual orientation in adolescence.

CONCLUSIONS. This study establishes a clear link between specific parental and caregiver rejecting behaviors and negative health problems in young lesbian, gay, and bisexual adults. Providers who serve this population should assess and help educate families about the impact of rejecting behaviors. Counseling families, providing anticipatory guidance, and referring families for counseling and support can help make a critical difference in helping decrease risk and increasing well-being for lesbian, gay, and bisexual youth. *Pediatrics* 2009;123:346–352

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Key Words
LGB adolescents, risk factors, sexual orientation, gay youth, homosexuality

Abbreviations
LGB—lesbian, gay, and bisexual
FAP—Family Acceptance Project
CES-D—Center for Epidemiologic Studies Depression Scale
STD—sexually transmitted disease
OR— odds ratio

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Address correspondence to Caitlin Ryan, PhD, ACSW, Adolescent Health Initiatives, César E. Chávez Institute, College of Ethnic Studies, San Francisco State University, 3004 16th St, 301, San Francisco, CA 94103. E-mail: caitlin@sfsu.edu

SINCE STUDIES WERE first published on homosexual youth in the 1970s and 1980s,[1,2] serious health disparities[3–8] have been documented among lesbian, gay, and bisexual (LGB) adolescents compared with their heterosexual peers. Population-based and community studies have documented higher levels of suicide attempts,[9–11] substance use,[3,4,6] symptoms of depression and mental health problems,[12,13]and sexual health risks, including risk for sexually transmitted infections, HIV,[3,14,15] and adolescent pregnancy.[16–18] Similarly, population-based studies have reported high levels of negative health outcomes for LGB adults compared with heterosexuals.[19–22]

Both practitioners and researchers have noted that risks to physical, emotional, and social health for sexual minority adolescents are primarily related to social stigma and negative societal responses,[23–26] particularly in schools[3,25–29] In addition, several studies have linked minority stress (experiencing and internalizing negative life events and victimization in the social environment) with negative health outcomes in LGB adults, including depressive symptoms, substance use, and suicidal ideation.[30,31]

Pediatric providers are trained to work closely with families and to recognize that families have "a central and enduring influence" on a child's life.[32] Because parents and key caregivers are perceived to play a vital role in an

EXHIBIT 17

adolescent's health and well-being,[33] it is surprising that so little attention has focused on parents and caregivers' influence on their LGB children and adolescents' health and well-being.

This article presents findings related to family rejection from the Family Acceptance Project (FAP), a research and intervention initiative to study the influence of family reactions on the health and mental health of lesbian, gay, and bisexual adolescents and young adults. To our knowledge, no other study has previously examined this relationship. The current study was designed to link specific family reactions to their children's sexual orientation and gender expression with health and mental health problems in emerging adulthood.

METHODS

Sampling and Recruitment

The FAP uses a participatory research approach advised at all stages by the population of interest (LGB adolescents, young adults, and family members), as well as health care providers, teachers, and advocates. Participatory research increases both the representativeness and the cultural competence of sampling and research strategies.[34] Providers, youth, and family members met regularly with the research team to provide guidance on all aspects of the research, including methods, recruitment, instrumentation, analysis, coding, materials development, and dissemination and application of findings.

We recruited a sample of 245 LGB young non-Latino white and Latino adults, ages 21 to 25 years, who were open about their sexual orientation to at least 1 parent or primary caregiver (including guardians) during adolescence. Twenty-one participants self-identified as transgender. Because of the small number of transgender participants, we only report here on outcomes from 224 LGB respondents. Participants were recruited conveniently from 249 LGB venues within 100 miles from our office. Half of the sites were community and social organizations that serve LGB young adults, and half were from clubs and bars serving this group. Bilingual recruiters conducted venue-based recruitment from bars and clubs and contacted each agency to access all young adults who use their services.

Study Procedures

Young adults who expressed interest in the study were screened for eligibility, and those meeting inclusion criteria were enrolled. Criteria included: age 21 to 25 years; ethnicity (non-Latino white, Latino, or Latino mixed); self-identification as LGB, homosexual, or queer/non-heterosexual during adolescence; knowledge of their LGB sexual orientation by at least 1 parent or guardian during adolescence; and having lived with at least 1 parent or guardian during adolescence at least part-time. LGB young adults, ages 21 to 25 years, were studied to assess the impact of family reactions to their LGB identity at an age when most young people have achieved greater independence and are more likely to be living on their own with fewer immediate parental buffers or behavioral restrictions.

The family rejection measures in the survey were developed based on a previous in-depth qualitative study conducted in English and Spanish among 53 socioeconomically and geographically diverse Latino and non-Latino white LGB adolescents and 49 completed families throughout California from 2002 to 2004. These in-depth individual interviews of 2 to 4 hours each generated 106 specific behaviors that families and caregivers used to express acceptance or rejection of their LGB children; 51 of these family reactions were rejecting (such as excluding their LGB child from family activities or events).

Measures

Family Rejection

On the basis of transcripts of in-depth interviews, we created 51 close-ended items that assessed the presence and frequency of each rejecting parental or caregiver reaction to participants' sexual identity and gender expression when they were teenagers, creating at least 3 close-ended items for each type of outwardly observable rejecting reaction documented in transcripts. For example, "Between ages 13–19, how often did your parents/caregivers blame you for any anti-gay mistreatment that you experienced?"

For each survey item, participants indicated whether their parents or caregivers reacted in the way specified by the item "many times," "a few times," "once or twice," or "never." For the current analysis, however, we dichotomized responses to each item into never (0) or ever (1). We dichotomized item responses because, at this point in the research program, it is unclear whether the frequencies of different rejecting reactions are equivalent with respect to potential health impact. For example, are multiple acts of exclusion from family activities equivalent to multiple disparaging comments made by the family about LGB persons? We plan to address these questions in subsequent analyses. In addition, the dichotomous scoring of items facilitated comparison of the mean number of different types of family rejecting reactions for different gender and ethnic subgroups. Dichotomized scores were then added to create a family rejection score, with values ranging from 0 to 51 (mean: 20.91; SD: 15.84). Reliability analyses indicate that the FAP Family Rejection Scale has high internal consistency (Cronbach's $\alpha = .98$).

To facilitate use of the findings by pediatric providers, we also divided the sample equally into 3 subgroups based on the tertile in which their family rejection score fell: low rejection scores ($n = 76$; scores ranging from 0–11.00 [mean: 4.86]), moderate rejection scores ($n = 74$; scores ranging from 11.09 to 25.50 [mean: 17.48]), and high rejection scores ($n = 74$; scores ranging from 26.56 to 51.00 [mean: 40.83]).

Mental Health

We assessed 3 mental health outcomes: current depression, suicidal ideation in the last 6 months, and lifetime

TABLE 1 **Demographics**

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

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

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

[b] $P < .05$.

[c] $P < .001$.

suicide attempts. Level of current depression was assessed through the Center for Epidemiologic Studies Depression Scale (CES-D). We used the recommended cutoff point for adolescents and young adults[35] (>16 indicates probable depression). Suicidal ideation and suicide attempts were measured by single items that were scored dichotomously yes (1) or no (0).

Substance Use and Abuse

We assessed substance use and abuse in 3 ways: heavy alcohol drinking in the past 6 months, use of illicit drugs in the past 6 months, and substance use–related problems in the last 5 years. Heavy drinking was defined by drinking 1 to 2 times per week or more with 3 or more drinks on a typical day. Illicit drug use was assessed by a single item answered dichotomously about use in the past 6 months. Four items assessed the potential negative consequences of alcohol and/or drug use: problems with the law, loss of employment, loss of consciousness, and conflicts with family, lovers, or friends. Measure of substance use–related problems was scored dichotomously (≥1 substance use–related problems [1] versus none [0]).

Sexual Risk Behavior

We assessed sexual behavior in the last 6 months by asking about number, gender, and type of sexual partners, type of sexual activity, and whether condoms were used when activity involved anal or vaginal penetration. Based on these responses, we created 2 measures of sexual risk: Any unprotected anal and/or vaginal sex with a casual, nonmonogamous, or HIV-serodiscordant partner (1) at last intercourse, and (2) any time in the past 6 months. Because young lesbian and bisexual women experience their greatest risks for HIV infection through sexual behaviors with men, sex between 2 women was not categorized as "risky" for HIV infection. Significant percentages of young women reported unprotected vaginal sex with casual male partners. Finally, we asked whether participants had ever in their lives been diagnosed by a health care professional as having an STD. The 3 measures were scored dichotomously as yes (1) or no (0).

RESULTS

Demographic Profile of the Sample

Table 1 includes the demographic profile of the sample. The mean age was 22.82 years, with no significant age differences by gender or ethnicity. Forty-eight percent were non-Latino whites and 52% were Latino; 51% identified as male, 49% as female. Contrary to what would be expected for non-LGB populations, non-Latino white men were the least likely to be employed (61.5%) and were less likely to be in school (40%). The findings on sexual identity development indicate that, on average, men were aware of same-sex attraction 2 years earlier than women and self-identified as LGB ~1 year earlier than the women. No gender differences were found for disclosure of sexual orientation to family and others.

Negative Health Outcomes According to Gender and Ethnicity

Table 2 reports the prevalence of negative health problems for the sample according to gender and ethnicity. Rates are high for depression, suicidal ideation and at-

TABLE 2 **Health-Related Problems According to Gender and Ethnicity**

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

GxE indicates gender-by-ethnicity interaction.

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

[b] $P < .05$.

[c] $P < .001$.

tempts, substance use, and sexual health risks. More than half (54.7%) reported at least 1 substance use–related problem, and 40.6% reported at least 1 lifetime suicide attempt. Taken together, the data indicate that about half of this sample of young LGB adults show considerable mental health and substance use problems. Sexual risk behavior appears somewhat less frequently but still at a relatively high incidence.

To determine whether health outcomes differed according to gender and ethnicity, a series of logistic regression analyses were conducted, regressing each outcome onto gender (G: male, female), ethnicity (E: non-Latino white, Latino), and their interaction. Results of these analyses are presented in Table 2. For 2 of the 3 mental health outcomes, significant gender-by-ethnicity interactions were observed, with Latino men showing higher rates of depression and suicidal ideation. Latino men also showed higher levels of HIV risk behavior.

Family Rejection According to Gender and Ethnicity

Table 3 reports means and SDs for the FAP Family Rejection Scale according to gender and ethnicity. Because scale items were scored dichotomously (ever [1] versus never [0]), scale means reflect the mean number of different negative parental/caregiver reactions experienced during adolescence within each subgroup. Non-Latino white women reported the least (mean: 17.65), whereas Latino men reported the highest number (mean: 24.52) of negative family reactions to their sexual orientation in adolescence. To determine whether levels of family rejection differed by gender and ethnicity, a 2 (gender) × 2 (ethnicity) analysis of variance was conducted on the number of reported rejecting experiences (see Table 3). Statistically significant main effects were observed only for gender, indicating that men reported more rejecting reactions than women.

Family Rejection as Predictor of Negative Health Outcomes

The relationships between experiences of family rejection and the 9 negative health outcomes were analyzed in 2 different ways. First, we analyzed the relationship between continuous scale scores and health outcomes in logistic regressions where continuous scores were the independent variable controlling for gender and ethnicity. For this analysis, continuous scores were rescaled so that 1 unit equaled 1 SD. Resulting odds ratios (ORs) can be interpreted as the increased risk for an outcome, given a 1-SD increase in family rejection. A second series of logistic regression analyses were conducted in which each health outcome was regressed onto the trichotomized rejection score, also controlling for gender and ethnicity. These results are reported in Table 4, including the proportion of participants within each family rejection subgroup (low, moderate, and high) who experienced the given negative health outcome.

Greater experiences of family rejection were associated with poorer health outcomes. This was true for all but 2 of the 9 outcomes (heavy drinking in the past 6 months and lifetime history of STD diagnosis). In general, large statistically significant differences in health outcomes were observed when participants scoring in the upper tertile of family rejection were compared with those in the lower tertile. Fewer differences were observed when moderate levels of rejection were compared with low rejection. As Table 4 shows, LGB young adults who reported higher levels of family rejection during adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to report illegal drug use, and 3.4 times more likely to report having engaged in unpro-

TABLE 3 **Family Rejection**

Gender	White	Latino
Male	21.30 (17.03)	24.52 (17.12)
Female	17.65 (13.83)	19.74 (14.60)

Range of scale: 0 [en]51. Ethnicity: $F_{1220} = 1.58$, not significant; gender: $F_{1220} = 4.06$, $P < .05$; gender by ethnicity: $F_{2239} < 1$, not significant.

TABLE 4 **Family Rejection as Predictors of Negative Health Outcomes**

Outcome Variable	Rejection Scale Score, OR (95% Confidence Interval)[a]	Percentage of Participants Experiencing Outcome			Moderate Rejection, OR (95% Confidence Interval)[b]	High Rejection, OR (95% Confidence Interval)[b]
		Low Rejection Scores	Moderate Rejection Scores	High Rejection Scores		
Mental health						
Suicidal ideation	2.13 (1.53–2.95)[c]	11.8	21.6	43.2	2.12 (0.86–5.18)	5.64 (2.42–13.14)[c]
Suicide attempts	3.09 (2.18–4.37)[c]	19.7	35.1	67.6	2.29 (1.08–4.83)[d]	8.35 (3.90–17.85)[c]
Depression (CES-D >16)	2.21 (1.62–3.01)[c]	22.4	44.6	63.5	2.92 (1.42–6.00)[e]	5.94 (2.86–12.34)[c]
Substance use/abuse						
Heavy drinking (past 6 mo)	0.84 (0.63–1.12)	40.8	47.3	36.5	1.34 (0.69–2.63)	0.71 (0.36–1.42)
Illicit substance use (past 6 mo)	1.83 (1.35–2.49)[c]	42.1	50.0	71.6	1.42 (0.74–2.72)	3.38 (1.69–6.77)[e]
Substance-related problems (any, ever)	1.60 (1.19–2.14)[e]	48.0	47.3	68.9	0.98 (0.51–1.88)	2.28 (1.16–4.50)[d]
Sexual risk behavior						
Unprotected sex with a casual partner (past 6 mo)	1.73 (1.25–2.40)[e]	23.7	12.2	45.9	0.41 (0.16–1.04)	2.50 (1.17–5.34)[d]
Unprotected sex with a casual partner (last intercourse)	1.72 (1.23–2.42)[e]	13.2	13.9	35.1	1.04 (0.41–2.69)	3.36 (1.47–7.67)[e]
STD diagnosis (any, ever)	1.32 (0.95–1.85)	24.0	27.1	32.8	1.25 (0.58–2.69)	1.49 (0.68–3.27)

All effects were adjusted for gender (female, male) and ethnicity (Latino, white).

[a] Continuous scale score, rescaled such that 1 unit = 1 SD; ORs can be interpreted as the change in odds of the outcome for a 1-SD change in rejection.

[b] Low rejection is the reference group.

[c] $P < .001$.

[d] $P < .01$.

[e] $P < .05$.

tected sexual intercourse, compared with peers from families with no or low levels of family rejection.

DISCUSSION

The results of this study show that negative family reactions to an adolescent's sexual orientation are associated with negative health problems in LGB young adults. As such, this study provides empirical evidence to begin addressing long-standing questions about the precursors of high levels of risk consistently documented in studies of LGB youth and young adults. Because families play such a critical role in child and adolescent development, it is not surprising that adverse, punitive, and traumatic reactions from parents and caregivers in response to their children's LGB identity would have such a negative influence on their risk behaviors and health status as young adults. This study begins to help us understand the important role that parents and caregivers of lesbian, gay, and bisexual youth play in contributing to health problems in their LGB children. Given that higher levels of family rejection and higher rates of negative mental health and HIV risk outcomes were found among Latino gay and bisexual men, our study suggests that this subgroup is particularly affected.

Our findings also underscore a key recommendation of the American Academy of Pediatrics Task Force on the Family: to expand practice to encompass assessment of family relationships and behaviors.[36] Although the current study does not determine causality, it establishes a link between specific parental and caregiver rejecting behaviors and negative health problems in LGB young adults. LGB young people from families with no or low levels of rejection are at significantly lower risk than those from highly rejecting families related to depression, suicidality, illicit substance use, and risky sexual behavior. So helping families identify and reduce specific rejecting behaviors is integral to helping prevent health and mental health problems for LGB young people.

Parents consider pediatricians[36] and other health providers to be important sources of guidance in childrearing. By asking LGB adolescents about their relationships with their families and experiences with family rejection, providers can obtain important information in determining the adolescent's risk profile. Anticipatory guidance offers a direct opportunity to advise parents of LGB youth on how to support their child's health and development.[23]

The current study also has important implications for identifying youth at risk for family violence and for being ejected from their homes or placed in custodial care because of their LGB identity. LGB youth are overrepresented in foster care, juvenile detention, and among homeless youth. Moreover, conflict related to the adolescent's sexual and gender identity is a primary cause of ejection or removal from the home. Early intervention to help educate families about the impact of rejecting behaviors is important to help maintain these youth in their homes.

There are several limitations to the study. This is a retrospective study that measures young adults' reported experiences that occurred several years earlier, which may introduce some potential for, recall bias. To minimize this concern, we created measures that asked whether a specific family event related to their LGB identity actually occurred (eg, verbal abuse), rather than asking generally about "how rejecting" parents were. Although we went to great lengths to recruit a diverse sample drawing from multiple venues, our sample is

technically one of convenience, and thus shares the limitations inherent in all convenience samples.[37] Thus, these data might not represent all subpopulations of LGB young adults, as well as individuals who are neither white nor Latino. The study focused on LGB non-Latino white and Latino young adults to permit more in-depth assessment of cultural issues and experiences related to sexual orientation and gender expression, so it did not include all other groups and drew from 1 urban geographic area. Subsequent research should include greater ethnic diversity to assess potential differences in family reactions. Lastly, given the cross-sectional nature of this study, we caution against making cause–effect interpretations from these findings.

RECOMMENDATIONS FOR PRACTICE

Pediatric providers can help decrease family rejection and increase support for LGB young people in several ways:

1. Ask LGB adolescents about family reactions to their sexual orientation and gender expression and refer to LGB community support programs and for supportive counseling as needed.
2. Identify LGB support programs in the community and online resources to educate parents about how to help their LGB children. Parents need access to positive parental role models to help decrease rejection and increase family support for their LGB children.
3. Advise parents that negative reactions to their adolescent's LGB identity may negatively influence their child's health and mental health.
4. Recommend that parents and caregivers modify highly rejecting behaviors that have the most negative influence on health concerns, such as suicidality.
5. Expand anticipatory guidance to include information on the need for support and the link between family rejection and negative health problems in LGB young people.

Unlike children and adolescents, in general, who receive services and care in the context of their families, LGB adolescents are typically served as adults as if they have no families, across a wide range of settings. These findings indicate that providers serving LGB young people must begin to assess family dynamics and consider the role of families when assessing an LGB adolescent's risk and making decisions about their care. Counseling families, providing anticipatory guidance, and referring families for counseling and support can help make a critical difference in decreasing risk and increasing well-being for many LGB youth who have limited support. Our preliminary work with families who are ambivalent and conflicted about their children's LGB identity indicates that they are receptive and interested to learn about how their words, actions and behaviors affect their children's health. Additional work is needed to demonstrate how to help families increase support for their LGB children by building on family strengths and the love they have for their LGB children.

APPENDIX: RESOURCES FOR FAMILIES WITH LGB CHILDREN

PFLAG

Education, information, and support for parents and families with LGB family members; referrals to LGB community resources and services: www.pflag.org

PFLAG for Families of Color & Allies (New York City)

Education, information, and support for families of color with LGB family members, including information, resources, and support in Spanish: www.pflagfamiliesofcolor.org

API Family Pride

Education, information, and support for Asian and Pacific Islander (API) families with LGB family members: www.apifamilypride.org

Family Acceptance Project

Research-based education and services for ethnically diverse families with LGB children in English, Spanish, and Chinese; currently developing provider assessment tools and interventions to help increase family support for ethnically diverse LGB children and youth: http://familyproject.sfsu.edu

Gender Spectrum Education & Training

Family information, support, and annual conference for families with gender-variant children; training on gender identity and expression for schools and providers for helping gender nonconforming and transgender children and youth: www.genderspectrum.org

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REFERENCES

1. Roesler T, Deisher R. Youthful male homosexuality. *JAMA.* 1972;219(8):1018–1023
2. Remafedi G. Adolescent homosexuality: Psychosocial and medical implications. *Pediatrics.* 1987;79(3):331–337
3. Garofalo R, Wolf C, Kessel S, Palfrey J, DuRant RH. The association between risk behaviors and sexual orientation among a school-based sample of adolescents. *Pediatrics.* 1998;101(5):895–902
4. DuRant RH, Krowchuk DP, Sinai SH. Victimization, use of violence, and drug use at school among male adolescents who engage in same-sex sexual behavior. *J Pediatr.* 1998;133:113–118
5. Remafedi G. Predictors of unprotected intercourse among gay and bisexual youth: Knowledge, beliefs, and behavior. *Pediatrics.* 1994;94(2 pt 1):163–168

6. Rosario M, Hunter J, Gwadza M. Exploration of substance use among lesbian, gay, and bisexual youth: Prevalence and correlates. *J Adolesc Res.* 1997;12:454–476
7. Rosario M, Meyer-Bahlburg HFL, Hunter J, Gwadz M. Sexual risk behaviors of gay, lesbian and bisexual youths in New York City: Prevalence and correlates. *AIDS Educ Prev.* 1999;11(6): 476–496
8. Remafedi G. Health disparities for homosexual youth: The children left behind. In: Wolitski RJ, Stall R, Valdiserri RO, editors. *Unequal Opportunity: Health Disparities Affecting Gay and Bisexual Men in the United States*. New York, NY: Oxford University Press; 2007:275–300
9. Remafedi G, French S, Story M, Resnick MD, Blum R. The relationship between suicide risk and sexual orientation: results of a population-based study. *Am J Public Health.* 1998; 88(1):57–60
10. Garofalo R, Wolf C, Wissow LS, Woods ER, Goodman E. Sexual orientation and risk of suicide attempts among a representative sample of youth. *Arch Pediatr Adolesc Med.* 1999;153(5): 487–493
11. D'Augelli AR, Hershberger SL, Pilkington NW. Suicidality patterns and sexual orientation-related factors among lesbian, gay, and bisexual youths. *Suicide Life Threat Behav.* 2001;31(3): 250–264
12. D'Augelli AR, Hershberger SL. Lesbian, gay, and bisexual youth in community settings: Personal challenges and mental health problems. *Am J Community Psychol.* 1993;21(4):421–448
13. D'Augelli AR. Mental health problems among lesbian, gay, and bisexual youths ages 14 to 21. *Clin Child Psychol Psychiatry.* 2002;7(4):433–456
14. Harper GW. Sex isn't that simple: culture and context in HIV prevention interventions for gay and bisexual male adolescents. *Am Psychol.* 2007;62(8):803–819
15. Saewyc EM, Skay CL, Pettingell SP, et al. Hazards of stigma: The sexual and physical abuse of gay, lesbian, and bisexual adolescents in the United States and Canada. *Child Welfare.* 2006;85(2):195–213
16. Saewyc EM, Bearinger LH, Blum RW, Resnick MD. Sexual intercourse, abuse and pregnancy among adolescent women: Does sexual orientation make a difference? *Fam Plann Perspect.* 1998;31:127–131
17. Saewyc E, Pettingell S, Skay C. Teen pregnancy among sexual minority youth during the 1990s: countertrends in a population at risk. *J Adolesc Health.* 2004;34(2):125–126
18. Forrest R, Saewyc E. Sexual minority teen parents: demographics of an unexpected population. *J Adolesc Health.* 2004; 34(2):122
19. Cochran SD, Sullivan JG, Mays V. Prevalence of mental disorders, psychological distress and mental health services use among lesbian, gay and bisexual adults in the United States. *J Consult Clin Psychol.* 2003;71(1):53–61
20. Gilman SE, Cochran SD, Mays VM, Hughes M, Ostrow D, Kessler RC. Prevalences of DSM-III-R disorders among individuals reporting same-gender sexual partners in the National Co-morbidity Survey. *Am J Public Health.* 2001;91(6):933–939
21. Cochran SD, Mays VM. Lifetime prevalence of suicidal symptoms and affective disorders among men reporting same-sex sexual partners: results from the NHANES III. *Am J Public Health.* 2000;90(4):573–578
22. Herrell R, Goldberg J, True WR, Ramakrishman V, Lyons M, Eisen S, Tsuang MT. Sexual orientation and suicide: a co-twin control study in adult men. *Arch Gen Psychiatry.* 1999;56(10): 867–874
23. Ryan C, Futterman D. Lesbian and gay youth: Care and counseling. *J Adolesc Med.* 1997;8(2):207–374
24. Perrin EC. *Sexual Orientation in Child and Adolescent Health Care*. New York, NY: Kluwer Academic/Plenum Publishers; 2002
25. Bontempo D,. D'Augelli AR. Effects of at-school victimization and sexual orientation on lesbian, gay, or bisexual youths' health risk behavior. *J Adolesc Health.* 2002;30(5):364–374
26. Goodenow C, Szalacha L, Westheimer K. School support groups, other school factors, and the safety of sexual minority adolescents. *Psychol Schools.* 2006;43(5):573–589
27. California Safe Schools Coalition and 4-H Center for Youth Development, University of California, Davis. *Safe Place to Learn: Consequences of Harassment Based on Actual or Perceived Sexual Orientation and Gender Non-conformity and Steps for Making Schools Safer*. San Francisco, CA: California Safe Schools Coalition; 2004
28. Reis B. *They Don't Even Know Me: Understanding Anti-Gay Harassment and Violence in Schools*. Safe Schools Coalition: Seattle, WA; 1999
29. GLSEN. *From Teasing to Torment: School Climate in America, A Survey of Students and Teachers*. New York, NY: GLSEN; 2005
30. Diaz RM, Ayala G, Bein E, Jenne J, Marin BV. The impact of homophobia, poverty, and racism on the mental health of Latino gay men. *Am J Public Health.* 2001;91(6):927–932
31. Meyer IH. Minority stress and mental health in gay men. *J Health Soc Behav.* 1995;36(1):38–56
32. American Academy of Pediatrics, Task Force on the Family. Preface to the report of the Task Force on the Family. *Pediatrics.* 2003;111(6 pt 2):1539
33. Steinberg L, Duncan P. Work Group IV: Increasing the capacity of parents, families, and adults living with adolescents to improve adolescent health outcomes. *J Adolesc Health.* 2002;31(6 suppl):261–263
34. Viswanathan M, Ammerman A, Eng E, et al. *Community-Based Participatory Research: Assessing the Evidence.* Rockville, MD: Agency for Healthcare Research and Quality; 2004. AHRQ publication 04-E022-2
35. Radloff LS. The use of the Center for Epidemiologic Studies depression scale in adolescents and young adults. *J Youth Adolesc.* 1991;20(2):149–166
36. Schor EL; American Academy of Pediatrics, Task Force on the Family. Family pediatrics: report of the task force on the family. *Pediatrics.* 2003;111(6 pt 2):1539–1571
37. Binson D, Blair J, Huebner DM, Woods WJ. Sampling in surveys of lesbian, gay, and bisexual people. In: Meyer IH, Northridge ME, eds. *The Health of Sexual Minorities: Public Health Perspectives on Lesbian, Gay, Bisexual, and Transgender Populations*. New York, NY: Springer; 2007:375–418

INTERNAL REVENUE SERVICE
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CINCINNATI, OH 45201

DEPARTMENT OF THE TREASURY

MAR 30 2016

Date:

Employer Identification Number:
81-0742851
DLN:
17053358354025
Contact Person:
ROGER W VANCE ID# 31173
Contact Telephone Number:
(877) 829-5500
Accounting Period Ending:
December 31
Public Charity Status:
509(a)(2)
Form 990/990-EZ/990-N Required:
Yes
Effective Date of Exemption:
December 7, 2015
Contribution Deductibility:
Yes
Addendum Applies:
No

INSTITUTE FOR HEALTHY FAMILIES
C/O CHRISTOPHER J DOYLE
10620 CRESTWOOD DRIVE SUITE C
MANASSAS, VA 20109-7918

Dear Applicant:

We're pleased to tell you we determined you're exempt from federal income tax under Internal Revenue Code (IRC) Section 501(c)(3). Donors can deduct contributions they make to you under IRC Section 170. You're also qualified to receive tax deductible bequests, devises, transfers or gifts under Section 2055, 2106, or 2522. This letter could help resolve questions on your exempt status. Please keep it for your records.

Organizations exempt under IRC Section 501(c)(3) are further classified as either public charities or private foundations. We determined you're a public charity under the IRC Section listed at the top of this letter.

If we indicated at the top of this letter that you're required to file Form 990/990-EZ/990-N, our records show you're required to file an annual information return (Form 990 or Form 990-EZ) or electronic notice (Form 990-N, the e-Postcard). If you don't file a required return or notice for three consecutive years, your exempt status will be automatically revoked.

If we indicated at the top of this letter that an addendum applies, the enclosed addendum is an integral part of this letter.

For important information about your responsibilities as a tax-exempt organization, go to www.irs.gov/charities. Enter "4221-PC" in the search bar to view Publication 4221-PC, Compliance Guide for 501(c)(3) Public Charities, which describes your recordkeeping, reporting, and disclosure requirements.

Letter 947

Exhibit 18

NPIdb (/)

NPI Lookup from the NPI Registry — National Provider Identifier Database

Home (https://npidb.org/) / Doctors (https://npidb.org/doctors/)
/ Behavioral Health and Social Service Providers (https://npidb.org/doctors/behavioral_health/)
/ Counselor (https://npidb.org/doctors/behavioral_health/counselor_101y00000x/)
/ CHRISTOPHER DOYLE (https://npidb.org/doctors/behavioral_health/counselor_101y00000x/1598126435.aspx)

CHRISTOPHER DOYLE
Counselor

Profile for **CHRISTOPHER DOYLE** in MANASSAS, VA.

A provider who is trained and educated in the performance of behavior health services through interpersonal communications and analysis. Training and education at the specialty level usually requires a master?s degree and clinical experience and supervision for licensure or certification.

Share | Tweet (https://twitter.com/intent/tweet?text=&url=&via=npidb) | Reviews

Contact Information — Edit my contact information (/correction/)

CHRISTOPHER DOYLE
10620 CRESTWOOD DR STE C
MANASSAS, VA 20109-4403

Phone: 703-367-0894
Fax:
Website:

Specialty	Taxonomy Code
★ Counselor (/doctors/behavioral_health/counselor_101y00000x/va/)	101Y00000X (/taxonomy/101Y00C

★ Indicates primary specialty

Edit contact information (/correction/)

NPI Profile & details for CHRISTOPHER DOYLE · (Male)

NPI Number 1598126435

Exhibit 19

Credentials	
Entity	Individual
Enumeration date	03/18/2016
Last updated	03/18/2016 - About 3 years ago
Sole proprietor [1]	No
Identifiers	VA License # 0701006315
Hospital affiliation(s)	n/a

[1] A sole proprietor/sole proprietorship is an individual, and as such, is eligible for a single NPI number. The sole proprietor must apply for the NPI number using his or her own Social Security Number (SSN), not an Employer Identification Number (EIN) even if he/she has an EIN.

Reviews for CHRISTOPHER DOYLE

+ Submit Review

There are currently no reviews for CHRISTOPHER DOYLE
Be the first to post a comment or review.

Read our reviews / comments about this provider to help you decide if they are right for you. Share your experience by posting a comment or review about this provider to help others decide which is right for them.

Nearby Counselor

LORRIE BEYERL, LPC, NCC
(/doctors/behavioral_health/professional_101yp2500x/1003951443.a
7450 HERITAGE VILLAGE PLAZA
GAINESVILLE, VA

OPEN **MARY L WELSH, LPC LMFT** (/doctors/behavioral_health/marriage-family-therapist_106h00000x/1154401271.aspx)
7404 GALLERHER RD
GAINESVILLE, VA

MELINDA C BURGIN, LPC
(/doctors/behavioral_health/counselor_101y00000x/1144234741.asp
14107 NEWBROOK DR
CHANTILLY, VA

MICHELLE R WARD, LPC, LMFT
(/doctors/behavioral_health/professional_101yp2500x/1033260906.a
10339 DEMOCRACY LANE
FAIRFAX, VA

RUTHANN E LONG FARIAS, LPC
(/doctors/behavioral_health/counselor_101y00000x/1164694600.asp
3615 CHAIN BRIDGE ROAD
FAIRFAX, VA

CREATIVE THERAPY ASSOCIATES, LLC
(/organizations/behavioral_health/marriage-family-therapist_106h00000x/1275676967.aspx)
10339 DEMOCRACY LN
FAIRFAX, VA

KAREN A CARRARO, LCSW (/doctors/behavioral_health/mental-health_101ym0800x/1003901224.aspx)
3221 WEST OX ROAD
HERNDON, VA

CYNTHIA L PASCAL, MS (/doctors/behavioral_health/mental-health_101ym0800x/1093193567.aspx)
9801 JOYCE STREET
FAIRFAX, VA

PATRICE B GARVER, PHD (/doctors/behavioral_health/mental-health_101ym0800x/1083138309.aspx)
2915 HUNTER MILL RD
OAKTON, VA

ELLEN GOLD, MPS, BCDMT, LPC
(/doctors/behavioral_health/professional_101yp2500x/1194078568.a
11726 LARIAT LANEE
OAKTON, VA

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