Discordance Between LGBTQ+ Youth Identities and Parental Acknowledgement or Knowledge of Identity as a Predictor of Mental Health Outcomes

Jordan Arntz, Andrea Wiglesworth, MA, Bonnie-Klimes Dougan, Ph.D,
University of Minnesota, Twin Cities

Introduction

- The purpose of this study is to determine if discordance between how a parent and child report the child's sexual and/or gender identity status is a predictor of mental health outcomes. In addition, it examines four different conditions of concordance or discordance both cross-sectionally and longitudinally to see various perspectives. It is also controlled for caregiver support longitudinally and cross-sectionally.
- In the United States, around 2-5% of individuals identify as gay, lesbian, or bisexual, which is an estimated amount of 16,595,000 people (UCLA, 2011). About 0.5% – 2% of the population identifies as transgender which is an estimated 6,638,000 people (UCLA, 2011). These estimates often only include adults, leaving us with less information on LGBTQ+ children.
- LGBTQ+ children are at higher risk for experiencing violence, bullying, harassment, and physical assault (CDC, 2015). They are also at higher risk for suicidal attempts and suicidal ideation (CDC, 2015) as well as anxiety, depression, and other clinical symptoms (Goodin et al., 2022).
- Minority stress is a theory that distinguishes excess stress that individuals in stigmatized social categories experience as a result of social position. It is cumulative to general stress, and unique to specific experiences of that group (Meyer, 2003).
- Contributions to minority stress include prejudice events, concealment, expectation of rejection or actual rejection, and internalized homophobia. Outness or concealment has recently been a topic explore in research, as it can be a predictor of life satisfaction, greater authenticity, increased awareness, and less internalized homophobia, which increases health outcomes (Meyer, 2003).
- Clark et al. (2020) analyzed data from the ABCD study on discordance and concordance as a predictor of psychiatric disorders. It was found that 7.9% of the dyads disagreed about the child's identity, and that discordant groups mostly had worsened mental health outcomes. To continue this work, the current study looks at the type of discordance relating to both internalizing and externalizing symptoms, and in addition to Clark et al., analyze any differences in suicidal ideation.

The Current Study

- *Aim 1:* Does concordance/discordance relate to child mental health (internalizing, externalizing, suicide ideation) concurrently or prospectively?
- *Aim 2:* Does the nature of the discrepancy in reporting on child identity matter regarding outcomes?
- *Aim 3:* Do family factors account for this impact on mental health above and beyond discrepancy?

Materials

Participant data was pulled from the Adolescent Brain and Cognitive Development Study (ABCD study) which is the largest long-term study of brain development and child health in the United States. Those included in the study identified as a sexual or gender minority (SGM) at any time point in the study (baseline to year 3). The Child Behavior Check List (CBCL) is completed by the parent and measured internalizing or externalizing symptoms. The Kiddie Schedule for Affective Disorders and Schizophrenia (KSADS) is completed by the child and measures suicidal ideation. The Children's Report of Parent Behavior Inventory (CRPBI) is completed by the child to measure perceived caregiver support. Year one data were used for cross-sectional-analyses and data across year one and year two were used for longitudinal analyses. Note that the "both no" group still includes youth that identify as SGM at some point up to year three.

Methodology

Aim 1:
A series of regressions were modeled with the primary predictor variable being discordant groups (parent yes, child no; parent no, child yes) compared to concordant groups (both yes; both no) reporting the child SGM identity. The models were run cross-sectionally and longitudinally for clinical outcomes of internalizing symptoms, externalizing symptoms, and suicidal ideation.

Aim 2:
Regression models were identical to Aim 1 other than the grouping of the conditions. Here, the four-groups were analyzed separated with reference to the both yes group. The four groups are: both parent and child identifying the child as having SGM status (BY – both yes), neither identifying SGM status (BN – both no), parent identifying but child no (PYCN), and parent not identifying but child does (PNCY).

Aim 3:
Aim 2 analyses were repeated with the addition of parental support as a primary predictor, which gives insight to the differences in clinical outcomes beyond the presence of parent influence.

Table 2. Aim 1 Results

	Internalizing Symptoms		Externalizing Symptoms		Suicide Ideation	
	B	*b (se b)*	*B*	*b (se b)*	*Exp(B)*	*b (se b)*
Year 1 Cross-Sectional Analysis						
Sex(Ref = Male)	-0.01	-0.07 (0.43)	-0.10***	-1.43 (0.40)	0.84	-0.09 (0.16)
SGM Reporting (REF = Concordant)						
Discordant	0.02	0.30 (0.39)	0.05	0.67 (0.36)	0.91	-1.41 (0.15)
Year 1 Prospective Analysis						
Sex(Ref = Male)	-0.065	-0.88 (1.15)	-0.14	-1.67 (0.97)	0.92	-0.09 (0.17)
SGM Reporting (REF = Concordant)						
Discordant	-0.04	-0.42 (0.98)	0.06	0.61 (0.83)	0.88	-0.12 (0.16)

REF = Describes the SGM identity reporting profile used as the reference group for the analysis
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Aim 1 Results:

- There are no significant differences between the groups at year one or over time (year one to year two).

Aim 2 Result Highlights:

- Clinical symptoms: At year one, all other groups were less likely to report internalizing and externalizing symptoms compared to BY. Over time (from year one to year two), there were no significant differences.
- Suicidal Ideation: At year one, BN group was 65% less likely, PY/CN were 80% less likely, and PN/CY were 40% less likely to report suicidal ideation compared to BY group. Over time, BN group was 50% less likely, PY/CN group was 80% less likely, and PN/CY was not significantly differing compared to BY group.

Table 3. Aim 2 Results

	Internalizing Symptoms		Externalizing Symptoms		Suicide Ideation	
	B	*b (se b)*	*B*	*b (se b)*	*Exp(B)*	*b (se b)*
Year 1 Cross-Sectional Analysis						
Sex (Ref = Male)	-0.01	-0.14 (0.41)	-0.09***	-1.36 (0.38)	0.80	-0.23 (0.17)
SGM Reporting (REF = Both Yes)						
Both No	-0.16***	-2.23 (0.42)	-0.10***	-1.31 (0.39)	0.36***	-1.04 (0.20)
Parent Yes, Child No	-0.07*	-1.73 (0.69)	-0.04	-0.96 (0.65)	0.17***	-1.75 (0.34)
Parent No, Child Yes	-0.18***	-2.75 (0.44)	-0.10***	-1.37 (0.42)	0.59*	-0.53 (0.23)
Year 1 Prospective Analysis						
Sex (Ref = Male)	-0.06	-0.78 (1.12)	-0.130	-1.51 (0.95)	0.88	-0.13 (0.17)
SGM Reporting (REF = Both Yes)						
Both No	-0.14	-2.37 (1.46)	-0.11	-1.61 (1.24)	0.51***	-0.67 (0.20)
Parent Yes, Child No	-0.083	-1.20 (1.21)	0.04	0.53 (1.02)	0.22***	-1.52 (0.35)
Parent No, Child Yes	-0.004	-0.12 (2.14)	-0.001	-0.013 (1.81)	0.74	-0.30 (0.23)

REF = Describes the SGM identity reporting profile used as the reference group for the analysis
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 4. Aim 3 Results

	Internalizing Symptoms		Externalizing Symptoms		Suicide Ideation	
	B	*b (se b)*	*B*	*b (se b)*	*Exp(B)*	*b (se b)*
Year 1 Cross-Sectional Analysis						
Sex (Ref = Male)	-0.009	-0.15 (0.40)	-0.09***	-1.36 (0.38)	0.79	-0.24 (0.17)
SGM Reporting (REF = Both Yes)						
Both No	-0.15***	-2.16 (0.42)	-0.09**	-1.26 (0.39)	0.36***	-1.03 (0.20)
Parent Yes, Child No	-0.065*	-1.64 (0.69)	-0.03	-0.86 (0.64)	0.19***	-1.69 (0.35)
Parent No, Child Yes	-0.18***	-2.73 (0.44)	-0.098***	-1.40 (0.41)	0.54**	-0.61 (0.23)
Caregiver Support	-0.10***	-2.10 (0.53)	-0.14***	-2.69 (0.50)	0.31***	-1.17 (0.21)
Year 1 Prospective Analysis						
Sex(Ref = Male)	-0.054	-3.54 (5.36)	-0.13	-1.496 (0.94)	0.87	-0.14 (0.17)
SGM Reporting (REF = Both Yes)						
Both No	-0.16*	-2.85 (1.47)	-0.14	-2.04 (1.24)	0.52***	-0.66 (0.20)
Parent Yes, Child No	-0.083	-1.20 (1.20)	0.04	0.54 (1.008)	0.23***	-1.46 (0.35)
Parent No, Child Yes	-0.009	-0.24 (2.13)	-0.005	-0.12 (1.79)	0.71	-0.34 (0.23)
Caregiver Support	0.18*	3.82 (1.18)	0.19*	3.46 (1.50)	0.50***	-0.69 (0.21)

REF = Describes the SGM identity reporting profile used as the reference group for the analysis
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Aim 3 Result Highlights:

- Clinical symptoms: At year one, all groups compared to BY were less likely to report internalizing and externalizing symptoms. Only BN were less likely to report internalizing symptoms over time (from year one to year two).
- Suicidal Ideation: At year one, BN group was 65% less likely, PY/CN were 80% less likely, and PN/CY were 50% less likely to report suicidal ideation compared to BY group. Over time, BN group was 50% less likely, PY/CN group was 80% less likely, and PN/CY was not significantly differing compared to BY group. These results are controlled for parental support.

Conclusion

Previous literature emphasizes the importance of familial support and expresses that LGBTQ+ children experience worsened health outcomes. There are gaps in research examining the experiences of children aged 9-10 years-old who identify as SGM. There were no differences found in Aim 1 but there were differences found when dividing the groups further in Aim 2 and Aim 3. These significant differences can be observed above. It's important to note that causality cannot be assumed and information surrounding outness, concealment, or other personal situations were not gathered. When children did not identify as SGM, it could be because they have not disclosed their identity, which is associated with risk factors. However, youth who identified as SGM are showing worsened suicidal ideation. There are also similarities in some results between the "both yes" and "parent no, child yes" group. In the PN/CY group, a child could be out but not acknowledged by parents, or a child could not be out to their family but still recognizes their own identity. Looking at results, children who identified no were less likely to experience suicidal ideation than children identifying as SGM. The results for suicidal ideation did not change much when controlling for caregiver support. This could mean that caregiver support might not be as significant a protective factor as previously thought.
To build upon this current study, an additional analysis on context for concordance or discordance relating to identify could give more specific evidence. It's important that future directions explore other protective factors for LGBTQ+ youth as well as gain more insight into the specific experiences that contribute to minority stress or worsened health outcomes.

References

Centers for Disease Control and Prevention (CDC). (N.D.). LGBTQ+Youth. Lesbian, Gay, Bisexual, and Transgender Health. https://www.cdc.gov/lgbthealth/youth.htm

Clark, K., Mennies, R., Olino, T., Dougherty, L., & Pachankis, J. (2020). Parent versus child report of children's sexual orientation: Associations with psychiatric morbidity in the Adolescent Brain Cognitive Development study. Annals of Epidemiology, 45, 1-4.

Gates, G.J. (2011, April). *How many people are lesbian, gay, bisexual, and transgender?* UCLA School of Law Williams Institute.

Goodin, A., Fallin-Bennett, K., Anderson-Hoagland, E., & Fallin-Bennett, A. (2022). Tobacco use and mental health disparities in LGB youth. *Public Health Nursing (Boston, Mass.), 39*(3), 659-663.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674-697.

Acknowledgements

Special thanks to my honors thesis committee: Bonnie Klimes-Dougan, Andrea Wiglesworth, Kathryn Cullen, and Marti Gonzales. Recognition of the Research on Adolescent Depression (RAD) Lab in the Department of Psychology is also necessary, for the guidance I received throughout the project.