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Sex, Race/Ethnicity, and Romantic Attractions: Multiple Minority Status Adolescents and Mental Health

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Abstract

This study examined the association between multiple minority statuses and reports of suicidal thoughts, depression, and self-esteem among adolescents. Data from the National Longitudinal Study of Adolescent Health were used to examine mental health outcomes across racial/ethnic groups for same-sex-attracted youths and female youths. Hispanic/Latino, African American, and White female adolescents reported more suicidal thoughts, higher depression, and lower self-esteem compared with male adolescents in their racial/ethnic group. Same-sex-attracted youths did not consistently demonstrate compromised mental health across racial/ethnic groups. Follow-up analyses show that White same-sex-attracted female adolescents reported the most compromised mental health compared with other White adolescents. However, similar trends were not found for racial/ethnic minority female youths with same-sex attractions.

Keywords

sexual minority youths; racial/ethnic minority youths; adolescents; multiple minority status; adolescent mental health

During adolescence, youths are confronted with the challenge of discriminating and potentially incorporating a whole host of characteristics into their self-identity (Harter, 1990). Identities based on race/ethnicity, gender, and sexual orientation are only a few of the characteristics of self that are shaped during this time, but incorporating such identities is challenging when these identities may be stigmatized. For ethnic minority adolescents, one of the primary goals during this time is the establishment of a positive racial/ethnic identity despite derogatory stereotypes attached to their race/ethnicity (Oyserman & Harrison, 1998; Phinney & Kohatsu, 1997). Adolescence is also a time of pubertal development, during which an increase in sexual and gender role behaviors occurs (Eccles & Bryan, 1994). Various external and perhaps internal forces may pressure the adolescent to conform to behaviors consistent with one's biological sex (Eccles & Bryan, 1994).

As gender identity develops, one's sexual identity emerges, which includes one's sexual orientation (Katchadourian, 1990; Koch, 1993; Rotheram-Borus & Fernandez, 1995). Many adolescents recognize whether or not their sexual orientation is heterosexual (Pilkington & D'Augelli, 1995) because of the increase in desires and attractions associated with pubertal development. However, the current cultural milieu discourages and inhibits sexual minority adolescents from expressing nonheterosexual orientations (D'Augelli, 1996). Rotheram-Borus and Fernandez (1995) noted that few resources are available to adolescents for the

validation of their lesbian, gay, or bisexual (LGB) identities. LGB adolescents face a dual task of exploring and developing an LGB identity while simultaneously coping with negative reactions to this identity. Whereas similar dual tasks are expected of adolescents developing an ethnic minority identity, LGB adolescents do not necessarily have the familial and peer support (Graber & Archibald, 2001) that ethnic minority adolescents may have.

However, with sexual identities, researchers are finding that adolescents who have same-sex attractions or who engage in same-sex behavior do not always identify as LGB (Diamond, 2000). These adolescents are rarely examined because many of the studies on LGB adolescents rely on self-identification or participation in LGB youth organizations (Savin-Williams, 2001a). In this study, we use data from a large nationally representative study of adolescents in the United States to examine the independent and joint effects of gender, race/ethnicity, and sexual minority statuses on mental health. We use the term *sexual minority* as an inclusive way to describe young people whose romantic, intimate, or sexual desires, behaviors, or identities are inconsistent with dominant expectations for heterosexuality (Diamond, 2003).

Research has well documented the association between mental health and the individual components of gender, race/ethnicity, and sexual minority identity among adolescents (e.g., Garofalo, Wolf, Wissow, Woods, & Goodman, 1999; Oyserman & Harrison, 1998; Pilkington & D'Augelli, 1995). While some researchers have examined the psychological impact of multiple minority identities on adults (Alquijay, 1997; Diaz, Ayala, Bein, Henne, & Marin, 2001; Greene, 1994; Walters, 1998), there has been little prior research on the mental health implications for adolescents. Moreover, less is known about sexual minority statuses because most researchers examining the mental health of sexual minority adolescents often rely on self-identification as LGB (for exceptions, see Diamond, 2000; Dubé & Savin-Williams, 2001; Russell & Consolacion, 2003; Savin-Williams & Ream, 2003). Sexual minority statuses may be related to one's sexual identity but may also be a different psychological construct (Diamond, 2003). This lack of research is due to historic limitations in the theoretical conceptualizations of sexual minorities and the availability of samples of a scale that allow for comparison of mental health indicators across multiple minority status groups.

An extensive amount of literature and research has focused on the topic of mental health risk among sexual minority adolescents. Rotheram-Borus and Langabeer (2001) and McDaniel, Purcell, and D'Augelli (2001) reviewed the literature on the mental health of sexual minorities and concluded that researchers generally found that sexual minority adolescents were at an increased risk of suicide, risk behaviors (e.g., drug use), and experiences of victimization. Studies using different sample types and methodologies have documented the increased psychological risk among LGB youths, both in large-scale population-based studies (Faulkner & Cranston, 1998; Garofalo et al., 1999; Russell & Joyner, 2001) and in community samples (Pilkington & D'Augelli, 1995). In a review of the literature examining the prevalence of mental disorders in LGB adult and adolescent populations, Meyer (2003) concluded that for the most part these populations do show higher levels of mental health disorders, but much of the research has methodological limitations owing to the difficulty of sampling hidden populations beyond community and clinical samples. Moreover, although better sampling strategies are incorporated in larger population research, these studies are often limited by the measures used (Meyer, 2003). Although research findings often find higher rates of mental health risk in both adolescent and adult sexual minority populations, the higher rates are most likely due to the current hostile milieu that often confronts sexual minorities in this culture rather than to sexual minorities themselves (Harper & Schneider, 2003).

Large-scale samples in particular have shown that the risks associated with LGB youths are numerous. For example, Faulkner and Cranston (1998) and Garofalo et al. (1999), using different waves of the Massachusetts Youth Risk Behavior Survey, found that sexual minority youths were more likely to be victimized, be involved in physical fights, use alcohol and drugs, participate in risky sexual behavior, and be suicidal. Examining data from the first wave of the National Longitudinal Study of Adolescent Health, Russell and Joyner (2001) also found that same-sex-attracted youths were more likely to report suicidal thoughts and attempts, higher levels of depression, and more alcohol consumption than other-sex-attracted youths. Russell, Franz, and Driscoll (2001) reported that youths who reported same- or both-sex romantic attractions were more likely to experience violence and to witness violence. Russell, Driscoll, and Truong (2002) also showed that both-sex-attracted youths were at a somewhat higher risk for substance use and abuse than were heterosexual youths. Thus, the negative impacts on both the physical and mental health of sexual minority youths warrant concern and careful investigation.

Only a handful of studies have used population-based samples to examine the interactions between race/ethnicity and sexual minority statuses (e.g., Diaz et al., 2001). While previous studies based on the data used in the present study demonstrate that females and those with same-sex attractions tend to have higher depression, lower self-esteem, and more suicidal thoughts (Russell & Consolacion, 2003; Russell & Joyner, 2001), trends of mental health have never been tested for different racial/ethnic groups. Thus, the purpose of this study is to examine the associations between minority statuses and mental health, measured by depression, self-esteem, and suicidal thoughts using data from the National Longitudinal Study of Adolescent Health ("Add Health").

Add Health is a large, school-based, representative sample of adolescents in the United States and is a comprehensive examination of issues pertaining to adolescent health. Although the main focus of this study is to examine the intersection of multiple minority statuses, White adolescents are included in our analyses. Between-racial/ethnic samples are not tested; rather, our study is about focusing on the within-group differences given the rare opportunity to do so with a representative sample. Although differences within each racial/ethnic group are important to explore, the similarities among the racial/ethnic minority groups and White adolescents are equally as important.

This study is exploratory because little empirical research exists regarding multiple minority statuses. However, on the bases of studies on female adolescents (Garafalo et al., 1999), studies of LGB-identified and sexual minority youths (Faulkner & Cranston, 1998; Pilkington & D'Augelli, 1995; Russell & Joyner, 2001), and the literature on multiple minority identities (Alquijay, 1997; Green, 1994; Walters, 1998), we tested three hypotheses:

- Hypothesis 1** Female adolescents will report more suicidal thoughts, higher depression, and lower self-esteem across racial/ethnic groups.
- Hypothesis 2** Same-sex-attracted youths will report more suicidal thoughts, higher depression, and lower self-esteem across racial/ethnic groups.
- Hypothesis 3** For racial/ethnic minorities, female youths with same-sex attractions will report more suicidal thoughts, higher depression, and lower self-esteem compared with other female youths or male youths of any attraction.

Method

Participants

Data from Add Health's in-home sample are used. The in-home sample is a subsample of adolescents from each of the schools who were asked to be interviewed in their home. Participation in the in-home interview was contingent upon receiving written consent from both the youth and parent (J. Tabor, personal communication, March 20, 2003). In Wave 1 of the study, 20,745 adolescents in Grades 7 through 12 were interviewed at home in 1994 and 1995; in the following year, 14,738 of the 7th- through 11th-grade participants from Wave 1 were reinterviewed for Wave 2 (Chantala & Tabor, 1999; for further information about the study design, see Chantala, 2003). Because mental health outcomes are measured at Wave 2, the sample is limited to adolescents who participated in both waves of the study. The final analytic sample included 13,205 (6,413 male and 6,792 female) adolescents.

At the time of the first interview, the average age of the sample was roughly 15 years ($M = 15.31$, $SD = 1.60$). In terms of romantic attractions, 6% reported having no attractions, 85% reported only other-sex attractions, and 9% reported same- or both-sex attractions. The racial/ethnic backgrounds of the respondents included 55% White, 21% African American, 17% Hispanic/ Latino, and 7% Asian/Pacific Islander (see Table 1 for frequencies of romantic attractions by race for each sex).¹ In addition, 8% of the sample reported being born outside of the United States, and slightly over half of the sample (53%) reported living with both biological parents. The adolescent's parent who completed the most education averaged about 14 years ($M = 13.87$, $SD = 2.79$) of school.

Measures

Romantic Attraction—The measure of romantic attraction is composed of data from Waves 1 and 2. In an effort to examine the dynamic nature of sexual attraction, our measure of romantic attraction utilizes both waves of data to incorporate sexual attraction across time, which is not captured in studies that measure sexual attraction at a single point in time. At each wave, romantic attraction was measured with two questions. Adolescents were asked whether they had been romantically attracted to a male and whether they had been romantically attracted to a female. The adolescents were given the response choices of either *yes* or *no* for both questions that were used to categorize them into one of three groups: *no attractions*, *other-sex attractions*, or *same-sex attractions*. We categorized the youths as having *no attractions* if they reported no attractions to either sex in both surveys. If adolescents reported attractions discordant with their biological sex, then they were considered to have *other-sex attractions*. If adolescents reported either an attraction to the same sex or to both sexes at either wave, then the adolescent was considered to have *same-sex attractions*.²

Race/Ethnicity—Using data from Wave 1, we categorized respondents into four racial/ethnic groups: White, African American, Hispanic/Latino, or Asian/Pacific Islander. Too

¹Higher percentages of Hispanic/Latino adolescents identified as having same-sex attractions (11%) compared with any other racial/ethnic group (8% for Whites, 9% for African Americans, and 7% Asian/Pacific Islanders). Russell and Truong (2001) made this observation about Hispanic/Latino adolescents in Add Health and found that this racial/ethnic group does have significantly higher same-sex-attracted youths than any other racial/ethnic group. One possible interpretation of this finding is that there may be cultural differences in what a "romantic" attraction involves. However, further research on this topic is needed to illuminate the source of this difference.

²Previous research often combine bisexual and same-sex-attracted individuals into a single group (see Pilkington & D'Augelli, 1995). However, other researchers have found significant differences on outcomes between bisexual and same-sex-attracted youths, suggesting that separate analyses for these two groups may be more appropriate (Russell & Seif, 2002). Because the main focus of this study is to focus on differences within racial/ethnic groups rather than between racial/ethnic groups, separate analyses of same- and both-sex attracted youths were not possible because of small cell sizes.

few respondents identified themselves as Native American to be included in the statistical analyses presented below. Participants could choose a single racial/ethnic background or multiple ones. Only 5% of the analytic sample ($n = 618$) selected multiple racial backgrounds. If respondents chose multiple racial/ethnic backgrounds, they were asked in a follow-up question to choose a category that “best” described their racial/ethnic background. On this second question, respondents did have the option not to choose a single racial background (e.g., *refuse* or *other*). Individuals who acknowledged a multiracial background but who later chose a single “best” category were included in the analyses.³ Inclusion of multiracial individuals did not change the significance levels of the models or the effects of the independent variables in the main analyses.⁴ Thus, the following results reported include multiracial individuals.

Suicidal Thoughts—The outcome measure of suicidal thoughts was drawn from data in Wave 2. Suicidal thoughts were measured with a single item that asked, “During the past 12 months, did you ever seriously think about committing suicide?” (0 = *no*, 1 = *yes*).

Depression—The outcome measure of depression was drawn from data in Wave 2. Depression was measured by averaging responses on 20 items. Examples of these items included: “You were bothered by things that usually don’t bother you,” “You felt that you could not shake off the blues, even with help from your family and your friends,” and “You had trouble keeping your mind on what you were doing.” Responses were on a 4-point scale ranging from 0 (*never or rarely*) to 3 (*most of the time or all of the time*). The 20 items are similar to items on Radloff’s (1977) Center for Epidemiological Studies—Depression Scale (Crockett, Randall, Shen, Russell, & Driscoll, 2004; Udry, 2001). On 18 of the items, participants were asked how true each item was during the past week. On 2 items referring to frequency of crying and of sleep difficulties, participants were asked how often they experienced these conditions in the past year.⁵ Increases on the depression scale reflect higher levels of depression. The Cronbach’s alpha was .88.

Self-Esteem—Self-esteem items were drawn from Wave 2 data. Self-esteem was measured by averaging the responses to six statements. Adolescents were asked what their level of agreement was to each statement on a 5-point scale ranging from 1 (*strongly agree*) to 5 (*strongly disagree*). Examples of items included “You have a lot of good qualities,” “You have a lot to be proud of,” and “You like yourself just the way you are.” Four items are similar to ones on the Rosenberg Self-Esteem Scale (Rosenberg, 1989), and the other two items are similar to those on the Self-Attitude Inventory (Lorr & Wunderlich, 1986). Items were reverse coded to show that increases on the scale reflected higher levels of self-esteem. The Cronbach’s alpha was .86. Self-esteem and depression showed a strong negative correlation, $r(13,205) = -.49, p < .001$.

³Inclusion of multiracial individuals within a single racial category is controversial. We recognize that there is a great amount of diversity within racial categories. To include one group of individuals from one ethnic background (e.g., Filipino) who may potentially be multiracial (e.g., some Filipinos can claim Spanish ancestry) into a single racial category (e.g., Asian/Pacific Islander) but exclude others who acknowledge multiple racial backgrounds but claim membership in a single racial group does not seem justified.

⁴All models were computed twice (with and without multiracial individuals), and only two differences were found. When multiracial people were removed, the control variable, birthplace, was no longer significant for the main effects model predicting suicidal thoughts for White adolescents. A second difference was found in a follow-up comparison for an interaction between race/ethnicity and romantic attraction for African Americans. With multiracial individuals *excluded*, African American same-sex-attracted male youths reported higher levels of depression when compared with African American male youths with no romantic attractions. This difference is not found when multiracial individuals are included in the analyses. Because African American same-sex-attracted male youths report higher levels of depression than African American other-sex-attracted male youths regardless of whether multiracial youths are included, we did not feel this difference added any more information.

⁵Crockett et al. (2004) addressed the concern regarding the two different time frames for this measure of depression. They conducted factor analyses on the items and found that the factor loadings for the 2 items with the year time frame did not differ from the other 18 items.

Procedure

To examine romantic attraction group differences on emotional health, we computed survey logistic regressions to predict suicidal thoughts, and we calculated survey linear regressions for depression and self-esteem. SAS and SUDAAN programs were used to control for the clustered sample design and sample weights (Chantala & Tabor, 1999). First, the models were run with romantic attraction and sex as predictor variables on all the outcome variables for each race/ethnicity to examine whether sex and romantic attraction predicted mental health out-comes similarly across racial/ethnic groups. Next, models were computed with romantic attraction, sex, and the interaction between the predictor variables on all of the outcomes. The interaction was added to the model to test whether multiple minority statuses (i.e., same-sex-attracted females) significantly predicted the outcome variables beyond the effects of romantic attraction and sex alone. In all models, we controlled for two parents present in the household, age of the adolescent, birthplace, and years of education of the parent with the highest level of education. All control variables were created with items from Wave 1. These factors are controlled for in the models because at least one of the independent variables and at least two of the three outcome variables were significantly associated with the control variable.

Results

To test whether romantic attraction and sex predicted emotional health for different racial/ethnic adolescents, we calculated survey logistic regressions for suicidal thoughts and survey regression models for depression and self-esteem for each race/ethnicity.⁶ Nearly all models were significant with the exception of the one model predicting suicidal thoughts for Asian/Pacific Islander adolescents. Moreover, in analyses in which romantic attraction is significant, only the significant outcomes for adolescents with no attractions are reported.

Suicidal Thoughts

The interaction between romantic attraction and sex was not significant for predicting suicidal thoughts for either African American or Hispanic/Latino adolescents. The main effects of both romantic attraction and sex were significant predictors for African American adolescents, $\chi^2(1.99, N = 2,797) = 15.09, p < .001$; $\chi^2(1, N = 2,797) = 17.38, p < .001$, respectively, but only sex was significant for Hispanic/Latino adolescents, $\chi^2(1, N = 2,260) = 7.08, p < .01$ (see Hispanic/Latino and African American models, Table 2). As shown in Table 2, African American and Hispanic/Latina female youths were about two times more likely to report suicidal thoughts than male youths in their racial group. For Hispanic/Latino youths, same-sex-attracted youths did not differ from other-sex-attracted youths. However, this was not the case for African American same-sex-attracted adolescents who were more than two times as likely to report suicidal thoughts compared with African American other-sex-attracted adolescents (odds ratio [OR] = 2.39, 95% confidence interval [CI] = 1.49, 3.83).

For White adolescents, the interaction between romantic attraction and sex was significant, $\chi^2(1.91, N = 7,253) = 9.92, p < .01$ (see White Model 2, Table 2). Follow-up comparisons show that same-sex-attracted young women showed the greatest risk for suicidal thoughts. They were 3.77 (95% CI = 2.40, 5.92) times more likely than their same-sex-attracted male peers, 3.31 (95% CI = 2.38, 4.60) times more likely than other-sex-attracted female peers, and 6.39 (95% CI = 3.05, 13.35) times more likely than female peers with no attractions to report suicidal thoughts. Same-sex-attracted young men were 1.54 times (95% CI = 1.05,

⁶Satterthwaite-adjusted *F* and Satterthwaite-adjusted chi-square were computed to test the survey regression models and survey logistic models, respectively. However, "Satterthwaite-adjusted" has been omitted to facilitate the flow of the text.

2.26) more likely than other-sex-attracted male peers and 4.51 times (95% CI = 1.83, 11.11) more likely than male peers with no attractions to report suicidal thoughts. Lastly, compared with other-sex-attracted males, other-sex-attracted females were 1.75 (95% CI = 1.44, 2.13) times more likely to report suicidal thoughts, whereas males with no attractions were 0.34 (95% CI = .14, .84) times less likely to report suicidal thoughts.

Depression

Sex and romantic attraction significantly predicted depression for Hispanic/Latino adolescents, $F(1, 128) = 29.19, p < .001$ and $F(1.98, 128) = 6.61, p < .01$, respectively (see Hispanic/Latino model, Table 3). Higher levels of depression were reported by Hispanic/Latina female adolescents ($M = .76, SE = .03$) in comparison with male adolescents ($M = .63, SE = .02$) and by same-sex-attracted adolescents ($M = .77, SE = .03$) in comparison with other-sex-attracted adolescents ($M = .70, SE = .02$). However, the interaction between sex and romantic attraction was not significant for Hispanic/Latino adolescents. Only sex significantly predicted depression among Asian/Pacific Islander adolescents, $F(1, 128) = 9.70, p < .01$ (see Asian/Pacific Islander model, Table 3). Females ($M = .75, SE = .03$) reported higher levels of depression than males ($M = .61, SE = .03$). Neither romantic attraction nor the interaction between sex and romantic attraction was significant for Asian/Pacific Islander adolescents.

For both African American and White adolescents, the interaction between romantic attraction and sex was significant, $F(1.99, 128) = 3.49, p < .05$ and $F(1.70, 128) = 4.53, p < .05$, respectively (see African American and White Models 2, Table 3). Follow-up comparisons show that compared with African American other-sex-attracted male youths ($M = .58, SE = .02$), African American same-sex-attracted males ($M = .75, SE = .04$) and African American other-sex-attracted females ($M = .72, SE = .02$) reported significantly higher levels of depression, $t(128) = 3.98$ and 5.64 , respectively ($ps < .001$, two-tailed). For White adolescents, same-sex-attracted females ($M = .83, SE = .04$) reported higher levels of depression in comparison with same-sex-attracted males ($M = .62, SE = .03$), other-sex-attracted females ($M = .64, SE = .01$), and females with no attractions ($M = .50, SE = .03$), $t(128) = 4.85, 5.15$, and 6.42 , respectively ($ps < .001$, two-tailed). White same-sex-attracted males ($M = .62, SE = .03$) reported higher levels than other-sex-attracted males ($M = .50, SE = .01$) and males with no attractions ($M = .48, SE = .03$), $t(128) = 3.91$ and 3.26 , respectively ($ps < .01$, two-tailed). Other-sex-attracted females ($M = .64, SE = .01$) reported higher levels of depression when compared with other-sex-attracted males ($M = .50, SE = .01$) and females with no attractions ($M = .50, SE = .03$), $t(128) = 12.81$ and 3.79 , respectively ($ps < .001$, two-tailed).

Self-Esteem

Although the overall model predicting self-esteem for Asian/Pacific Islanders was significant, $F(5.21, 128) = 3.93, p < .01$, only the control variables, age and birthplace, significantly predicted self-esteem (see Asian/Pacific Islander model, Table 4). Neither sex nor romantic attraction was significant for Asian/Pacific Islander adolescents. Sex predicted self-esteem for Hispanic/Latino adolescents, $F(1, 128) = 14.52, p < .001$, but not romantic attraction (see Hispanic/Latino model, Table 4). Hispanic/Latina female adolescents ($M = 3.99, SE = .03$) reported lower levels of self-esteem compared with Hispanic/Latino male adolescents ($M = 4.16, SE = .03$). For African American adolescents both sex and romantic attraction predicted self-esteem, $F(1, 128) = 5.52, p < .05$ and $F(1.93, 128) = 6.68, p < .01$, respectively, but the interaction between the two predictors was not significant (see African American model, Table 4). Lower levels of self-esteem were reported by females ($M = 4.27, SE = .02$) compared with males ($M = 4.32, SE = .02$) and by same-sex-attracted youths ($M = 4.13, SE = .04$) compared with other-sex-attracted youths ($M = 4.31, SE = .02$).

The interaction between sex and romantic attraction was significant for White adolescents, $F(1.89, 128) = 7.73, p < .001$ (see White Model 2, Table 4). Follow-up analyses show that White same-sex-attracted female youths ($M = 3.87, SE = .05$) reported the lowest level of self-esteem in comparison with same-sex-attracted males ($M = 4.21, SE = .04$), other-sex-attracted females ($M = 4.12, SE = .01$), and females with no attractions ($M = 4.31, SE = .05$), $t(128) = -6.06, -5.19$, and -5.44 , respectively ($ps < .001$, two-tailed). Other-sex-attracted female adolescents ($M = 4.12, SE = .01$) reported lower levels of self-esteem compared with other-sex-attracted males ($M = 4.26, SE = .01$) and females with no attractions ($M = 4.31, SE = .05$), $t(128) = -8.03$ and -3.30 , respectively ($ps < .01$, two-tailed).

Discussion

In sum, the pattern of mental health risk for female adolescents was fairly consistent for all racial/ethnic backgrounds. Hispanic/Latina, African American, and White young women were more likely to report suicidal thoughts. Female adolescents of all racial/ethnic backgrounds reported higher levels of depression. In addition, Hispanic/Latina, African American, and White young women reported lower levels of self-esteem. Only Asian/Pacific Islander young women did not differ in self-esteem from young men. These findings mostly support our first hypothesis that adolescent females report more suicidal thoughts, higher depression, and lower self-esteem across racial/ethnic groups and are consistent with other literature on the mental health of female adolescents (e.g., Garofalo et al., 1999).

However, a much less consistent pattern emerges for same-sex-attracted youths across racial groups. African American and White same-sex-attracted youths reported more suicidal thoughts, but not Hispanic/Latino or Asian/Pacific Islander same-sex-attracted youths. Hispanic/Latino, African American, and White same-sex-attracted youths reported higher levels of depression, but this is not found for Asian/Pacific Islander same-sex-attracted youths. Furthermore, only African American and White same-sex-attracted youths reported lower self-esteem; no difference was found for Asian/Pacific Islander and Hispanic/Latino same-sex-attracted youths. These findings only partially support our second hypothesis and are somewhat consistent with the literature on LGB-identified youths and sexual minorities (e.g., Faulkner & Cranston, 1998; Pilkington & D'Augelli, 1995; Russell & Joyner, 2001). Although some same-sex-attracted youths reported lower levels of mental health, this was not true across all racial/ethnic minority groups, which is somewhat contrary to the findings on ethnic and sexual minority identities by some authors (e.g., Alquijay, 1997; Greene, 1994; Walters, 1998) who propose that LGBs of color are at risk for higher levels of compromised health. Although these results do not find consistent risk for sexual minority statuses within racial/ethnic groups, these results do not necessarily mean that individuals with multiple minority identities are not distressed because of experiences of rejection from their racial/ethnic community and from the LGB community. However, the findings in this study seem to be somewhat consistent with research from Dubé and Savin-Williams (1999), who found that ethnic sexual minority youths in their sample did not show increased levels of internalized homophobia.

Perhaps the inconsistencies of risk associated with sexual minorities reflect an ability of some of these individuals to readjust themselves to statuses or identities that may be adaptive (Pittinsky, Shih, & Ambady, 1999). In Pittinsky et al.'s (1999) study, participants with multiple identities were able to reorient themselves to identities that were more adaptive to a situation, and they also did not disidentify with the identity that was not adaptive. Thus, although one's status or identity may be disparaged in some contexts, one may have other statuses or identities that may be adaptive. Perhaps only those who do not have adaptive statuses or identities show an increase in mental health risk. Therefore, the

ability to be adaptive with one's identities may then be a potential internal resource of resiliency for racial/ethnic and sexual minority individuals.

Perhaps even more interesting is the significant interactions between sex and romantic attraction. For racial/ethnic minorities, the only significant interaction was for African American adolescents on the measure of depression. African American same-sex-attracted young men reported higher levels of depression compared with other-sex-attracted youths. This finding was not paralleled for African American same-sex-attracted young women. However, African American other-sex-attracted female adolescents did report higher depression than other-sex-attracted male adolescents. For White adolescents, same-sex-attracted young women consistently reported lower levels of mental health on all measures when compared with same-sex-attracted young men, with other-sex-attracted young women, and with young women with no attractions. These findings do not support our third hypothesis that multiple minority statuses (sex, race/ethnicity, and sexual minority status) result in poorer mental health outcomes. Contrary to expectations, our findings show that the risk associated with multiple minority statuses (i.e., same-sex-attracted female youths) appears consistent among White adolescents.

The results in this study are extremely exploratory but nevertheless highly intriguing. The findings show that sexual minority status does not necessarily predict compromised mental health and that various patterns on mental health measures emerge when different racial/ethnic groups are examined separately. Thus, studies examining sexual minorities may need to be cautious when generalizing from samples with only a few racial/ethnic minorities included. When separate analyses of racial/ethnic minorities are not possible because of sample size, the overall finding of the sample may not be an accurate representation of racial/ethnic sexual minorities included. Moreover, the inconsistent findings in this study may potentially demonstrate that sexual minority statuses are similar and related to LGB identities, but they may also be distinct phenomena as proposed by Diamond (2003).

Although the results do show increased mental health risk among some populations of sexual minorities, differences are found between racial/ethnic groups. The differences show that sexual minority youths of different racial/ethnic backgrounds are not equally at risk. Thus, service providers should be cautious in assuming that multiple minority statuses and identities are indicators for increased risk. Instead, service providers should focus on the issues that are relevant to specific racial/ethnic groups. Moreover, the results in this study suggest that services that are designed for predominantly White sexual minorities may not be relevant for racial/ethnic sexual minorities. Programs designed for predominantly White sexual minorities are not likely to match the issues needing to be addressed for racial/ethnic sexual minorities.

A major limitation in this study is that the numbers of respondents in some of the subgroup categories become quite small when examining multiple minority statuses. Although the sample was drawn to represent a national sample of youths, with reduced cell sizes, the generalizability to the larger population of adolescents is compromised. This study also is limited because the sample was school-based. When examining a special subpopulation such as sexual minority or racial/ethnic minority adolescents, there may be a bias toward sampling individuals who have social support or ones with high resiliency—those who are most likely to remain within the school system. The adolescents who are most at risk may potentially drop out of school (McDaniel et al., 2001) or may not be attending school on a regular basis.

Lastly, as with many secondary analyses of large datasets, this study is limited by its measures. For example, suicidal thoughts in this study are measured by a single item with a

dichotomous response. Researchers have critiqued the use of determining suicidality with a single item because this measure does not incorporate variability of the meaning of an affirmative response (Savin-Williams, 2001b). Therefore, it becomes difficult to determine by a single affirmative answer how frequently adolescents thought about suicide and under what circumstances these thoughts had occurred. Similarly, although our measure of sexual minorities used romantic attractions rather than asking adolescents to self-label, which may also be problematic, our study relied on a single measure of sexual minority status. Although Add Health does have data on the sexual behavior of adolescents, these data were not included in the present measure of sexual minority status. In the past, we have examined the intersection of sexual attraction and sexual behavior (Russell & Consolacion, 2003), but because this study focuses on racial/ ethnic minorities with same-sex attractions, analyzing the additional factor of sexual behavior is not possible because of small cell sizes. Ideally, multiple measures would be used to examine different aspects of sexuality to better understand the relationships among attractions, behavior, and identity. However, Add Health was the first large-scale study to measure adolescent romantic attraction. In addition, the measure used here is considered developmentally appropriate (Diamond, 2003) and has been shown to be linked to behavioral and emotional risk factors in ways that are similar to past studies of adolescent sexual identity (Russell et al., 2002; Russell et al., 2001; Russell & Joyner, 2001).

Much still needs to be explored regarding sexual and racial/ethnic minorities. Although this study focuses on the intersection of different minority statuses, future research needs to address the relationship between one's minority status and one's identity especially in adolescent populations. In addition, studies on mental health of sexual minority populations should incorporate the contexts of sexual minorities, differentiate between varying sources of stress affecting sexual minorities, and account for the effects of sexual minority identities as a potential beneficial resource or as a factor that may potentially heighten the stress (Meyer, 2003). Future research on individuals with multiple stigmatized statuses or identities should focus on contexts and the cognitive adaptiveness of individuals as a potential source for resiliency. Furthermore, although this study did not analyze multiracial/ ethnic individuals separately because too few reported same-sex attractions, research on the mental health outcomes of multiracial/ethnic adolescents is needed and is possible with Add Health.

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TABLE 1

Frequency of Romantic Attractions per Race/Ethnicity for Each Sex

Variable	Romantic attraction					
	No attraction		Other-sex attraction		Same-sex attraction	
	Males	Females	Males	Females	Males	Females
Race/ethnicity						
White	211	147	2,999	3,295	323	278
African American	104	105	1,031	1,302	147	108
Hispanic/Latino	66	56	934	937	125	142
Asian/Pacific Islander	45	36	392	357	36	29
Total	426	344	5,356	5,891	631	557
						13,205

TABLE 2

Odds Ratios Predicting Suicidal Thoughts for Each Race/Ethnicity at Wave 2

Variable	White							
	Hispanic/Latino		African American		Model 1		Model 2	
	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
Sex ^a								
Female	1.80 **	1.16, 2.79	2.09 ***	1.47, 2.96	1.98 ***	1.63, 2.41	1.75 ***	1.44, 2.13
Romantic attraction ^b								
No attraction	—	—	—	—	.44 **	.25, .75	.34 *	.14, .84
Same-sex	—	—	2.39 ***	1.49, 3.83	2.40 ***	1.83, 3.15	1.54 *	1.05, 2.26
Birthplace ^c								
Foreign-born	.39 ***	.23, .65	—	—	.34 *	.11, .99	—	—
Parents in household ^d								
Two parents	—	—	—	—	.76 **	.62, .93	.76 **	.62, .93
Sex × Romantic Attraction								
Female, no attraction	—	—	—	—	—	—	—	—
Female, same-sex	—	—	—	—	—	—	2.15 ***	1.40, 3.32
N	2,260		2,797				7,253	

Note. Age of participant and education of parent were not significant in these models and were omitted from this table. Variables entered simultaneously. OR = odds ratio; CI = confidence interval. Model 1 is the main effects model. Model 2 adds the interaction between sex and romantic attraction. Dashes represent nonsignificance.

^aReference category is male.

^bReference category is other-sex attraction.

^cReference category is U.S.-born.

^dReference category is other family structure.

* $p < .05$.

** $p < .01$.

*** $p < .001$.

TABLE 3

Regression Models Predicting Depression for Each Race/Ethnicity at Wave 2

	Asian/Pacific Islander			Hispanic/Latino			African American			White		
	Model 1			Model 1			Model 1			Model 1		
	B (SE)	β		B (SE)	β		B (SE)	β		B (SE)	β	
Sex ^a												
Female	.12 (.04) **	.16		.13 (.03) ***	.16		.12 (.02) ***	.15		.14 (.03) ***	.18	
Romantic attraction ^b												
No attraction	—	—		-.12 (.04) **	-.08		—	—		-.05 (.02) *	-.03	
Same-sex	—	—		.07 (.03) *	.06		—	—		.14 (.02) ***	.10	
Birthplace ^c												
Foreign-born	—	—		-.10 (.03) **	-.10		—	—		—	—	
Parents in household ^d												
Two parents	—	—		—	—		-.07 (.02) ***	-.08		-.07 (.01) ***	-.09	
Age	.03 (.01) **	.13		—	—		.03 (.01) ***	.13		.02 (.00) ***	.09	
Parent education	—	—		-.02 (.00) ***	-.14		-.02 (.00) ***	-.10		-.02 (.00) ***	-.11	
Sex $\times$ Romantic Attraction												
Female, no attraction												
Female, same-sex										-.16 (.06) *	-.08	
R ²	.08			.07			.06			.08		

Note. Variables in regression models entered simultaneously. Model 1 is the main effects model. Model 2 adds the interaction between sex and romantic attraction. Dashes represent nonsignificance.

^aReference category is male.

^bReference category is other-sex attraction.

^cReference category is U.S.-born.

^dReference category is other family structure.

* $p < .05$.

.100* > *p*
***
.10 < *p*
***

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TABLE 4

Regression Models Predicting Self-Esteem for Each Race/Ethnicity at Wave 2

Variable	White									
	Asian/Pacific Islander		Hispanic/Latino		African American		Model 1		Model 2	
	B (SE)	β	B (SE)	β	B (SE)	β	B (SE)	β	B (SE)	β
Sex ^a										
Female	—	—	-.17 (.04) ***	-.14	-.07 (.03) *	-.06	-.16 (.02) ***	-.14	-.15 (.02) ***	-.13
Romantic attraction ^b										
No attraction	—	—	—	—	—	—	.10 (.04) **	.04	—	—
Same-sex	—	—	—	—	-.18 (.05) ***	-.10	-.13 (.03) ***	-.06	—	—
Birthplace ^c										
Foreign-born	-.11 (.05) *	-.09	—	—	—	—	—	—	—	—
Parents in household ^d										
Two parents	—	—	—	—	.08 (.04) *	.07	.08 (.02) ***	.07	.08 (.02) ***	.07
Age	-.05 (.01) ***	-.16	—	—	-.03 (.01) **	-.08	-.02 (.01) ***	-.06	-.02 (.01) ***	-.06
Parent education	—	—	—	—	—	—	.01 (.00) **	.04	.01 (.00) **	.04
Sex × Romantic Attraction										
Female, no attraction	—	—	—	—	—	—	—	—	—	—
Female, same-sex	—	—	—	—	—	—	—	—	-.20 (.06) **	-.07
R ²	.06		.03		.03		.04		.04	

Note. Variables in regression models entered simultaneously. Model 1 is the main effects model. Model 2 adds the interaction between sex and romantic attraction. Dashes represent nonsignificance.

^aReference category is male.

^bReference category is other-sex attraction.

^cReference category is U.S.-born.

^dReference category is other family structure.

* $p < .05$.

.100* > *p*
***
***
***
p < .01
***