

49. Centers for Disease Control and Prevention. CDC Health Disparities and Inequalities Report—United States, 2011. *MMWR Surveill Summ*. 2011;60(suppl):1–113.
50. Kessler RC. Epidemiology of women and depression. *J Affect Disord*. 2003;74(1):5–13.
51. Seedat S, Scott KM, Angermeyer MC, et al. Cross-national associations between gender and mental disorders in the World Health Organization World Mental Health Surveys. *Arch Gen Psychiatry*. 2009;66(7):785–795.
52. Dunn EC, Gilman SE, Willett JB, Slopen NB, Molnar BE. The impact of exposure to interpersonal violence on gender differences in adolescent-onset major depression: results from the National Comorbidity Survey Replication (NCS-R). *Depress Anxiety*. 2012;29(5):392–399.
53. Nolen-Hoeksema S. Emotion regulation and psychopathology: the role of gender. *Annu Rev Clin Psychol*. 2012;8:161–187.
54. Li CE, DiGiuseppe R, Froh J. The roles of sex, gender, and coping in adolescent depression. *Adolescence*. 2006;41(163):409–415.
55. Collins D. Pretesting survey instruments: an overview of cognitive methods. *Qual Life Res*. 2003;12(3):229–238.
56. Sudman S, Bradburn NM, Schwartz N. *Thinking About Answers: The Application of Cognitive Processes to Survey Methodology*. San Francisco, CA: Jossey-Bass Publishers; 1996.
57. Warnecke RB, Johnson TP, Chavez N, et al. Improving question wording in surveys of culturally diverse populations. *Ann Epidemiol*. 1997;7(5):334–342.
58. Nunnally JC, Bernstein IH. *Psychometric Theory*. 3rd ed. New York, NY: McGraw-Hill; 1994.
59. Conron KJ, Scout, Austin SB. “Everyone has a right to, like, check their box”: findings on a measure of gender identity from a cognitive testing study with adolescents. *J LGBT Health Res*. 2008;4(1):1–9.
60. Clark MA, Armstrong G, Bonacore L. Measuring sexual orientation and gender expression among middle-aged and older women in a cancer screening study. *J Cancer Educ*. 2005;20(2):108–112.
61. Wylie SA, Corliss HL, Boulanger V, Prokop LA, Austin SB. Socially assigned gender nonconformity: a brief measure for use in surveillance and investigation of health disparities. *Sex Roles*. 2010;63(3–4):264–276.
62. Bem SL. The measurement of psychological androgyny. *J Consult Clin Psychol*. 1974;42(2):155–162.
63. Parent MC, Moradi B. An abbreviated tool for assessing conformity to masculine norms: psychometric properties of the Conformity to Masculine Norms Inventory-46. *Psychol Men Masc*. 2011;12(4):339–353.
64. Parent MC, Moradi B. An abbreviated tool for assessing feminine norm conformity: psychometric properties of the Conformity to Feminine Norms Inventory-45. *Psychol Assess*. 2011;23(4):958–969.
65. Blacker D, Endicott J. Psychometric properties: concepts of reliability and validity. In: Rush AJ, ed. *Handbook of Psychiatric Measures*. Washington, DC: American Psychiatric Association; 2000:7–14.
66. Conron KJ. *The Massachusetts Gender Measures Project. Final Report to the Massachusetts Department of Public Health*. Boston, MA: Institute on Urban Health Research, Northeastern University; 2011.
67. Tate CC, Ledbetter JN, Youssef CP. A two-question method for assessing gender categories in the social and medical sciences. *J Sex Res*. 2013;50(8):767–776.
68. Groves RM, Fultz NH, Martin E. Direct questioning about comprehension in a survey setting. In: Tanur JM, ed. *Questions About Questions: Inquiries Into the Cognitive Bases of Surveys*. New York, NY: Russell Sage Foundation; 1992:49–61.
69. Zucker KJ, Mitchell JN, Bradley SJ, Tkachuk J, Cantor JM, Allin SM. The Recalled Childhood Gender Identity/Gender Role Questionnaire: psychometric properties. *Sex Roles*. 2006;54(7–8):469–483.
70. SAS 9.2 [computer program]. Cary, NC: SAS Institute; 2008.
71. DeVellis RF. *Scale Development: Theory and Applications*. 2nd ed. Thousand Oaks, CA: Sage Publications; 2003.
72. Conron KJ. Considerations: collecting data on transgender status and gender nonconformity. In: Badgett L, Goldberg N, eds. *Best Practices for Asking Questions About Sexual Orientation on Surveys*. Los Angeles, CA: Sexual Minority Assessment Research Team, Williams Project, University of California, Los Angeles; 2009:33–37.
73. Massachusetts Dept of Public Health, Massachusetts Dept of Elementary and Secondary Education. *Massachusetts Youth Health Survey 2013*. Available at: <http://www.mass.gov/eohhs/docs/dph/behavioral-risk/yhs-hs2013.pdf> 2013. Accessed February 21, 2014.
74. Krieger N, Smith K, Naishadham D, Hartman C, Barbeau EM. Experiences of discrimination: validity and reliability of a self-report measure for population health research on racism and health. *Soc Sci Med*. 2005;61(7):1576–1596.
75. Jones CP, Truman BI, Elam-Evans LD, et al. Using “socially assigned race” to probe White advantages in health status. *Ethn Dis*. 2008;18(4):496–504.
76. Stock ML, Gibbons FX, Walsh LA, Gerrard M. Racial identification, racial discrimination, and substance use vulnerability among African American young adults. *Pers Soc Psychol Bull*. 2011;37(10):1349–1361.
77. *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*. Washington, DC: US Dept of Health and Human Services; 2011.

## Promoting the Successful Development of Sexual and Gender Minority Youths

Because of societal discomfort with atypical expressions of sexual orientation and gender identity, lesbian, gay, bisexual and transgender (LGBT) youths have experienced enhanced developmental challenges compared with their heterosexual peers.

A recent special issue of the *American Journal of Public Health* delineated how social stigma affecting LGBT youths has resulted in a wide range of health disparities, ranging from increased prevalence of depression and sub-

stance use to downstream effects, such as an increased risk for cancer and cardiovascular disease when older.

We review the clinical significance of these findings for health care professionals, who need to become informed about these associations to provide better care for their sexual and gender minority youth patients, and to be able to educate their parents and other caregivers. (*Am J Public Health*. 2014;104:976–981. doi:10.2105/AJPH.2014.301876)

Kenneth H. Mayer, MD, Robert Garofalo, MD, MPH, and Harvey J. Makadon, MD

### HOMOSEXUAL AND GENDER

nonconforming behaviors have been variably expressed in different cultures since the beginning of recorded history. However, only in recent years has there been sufficient scholarship about sexual and gender minority youths to enable clinicians to learn more about the unique health needs of these populations.<sup>1</sup> For most of the 20th century and previous centuries, sexual and gender minority people were not recognized as

discrete populations that required specific, culturally responsive attention from health care professionals and public health programs. However, awareness increased after the emergence of the gay liberation movement in the late 1970s, and was exponentially enhanced as clinicians began to recognize an increasingly varied panoply of sexually transmitted infections, culminating with the AIDS epidemic. These observations were only the tip of the iceberg, because

many health issues faced by sexual and gender minorities were not exclusively related to their sexual behavior, but were often a response to the stigma and discrimination they experienced.<sup>2</sup> Societal understanding of these issues has been informed by the emerging awareness of health disparities that are not only prevalent among racial and ethnic minority populations, but are common among sexual and gender minority populations.<sup>3</sup> This emerging awareness has also led to the recognition that health systems must become responsive to the reality of a diverse array of minority health disparities, to enhance access to appropriate health care for disenfranchised populations.<sup>4</sup> An understanding of the reasons why specific populations may not fully engage in care is critical to creating more culturally responsive systems for health care, as well as the specific clinical conditions that may be more prevalent in subpopulations. It is also important that clinicians learn how to improve the ways that sexual and gender minority youths experience their clinical care, including evaluating how provider attitudes may affect physicians' ability to provide nonjudgmental care.

For sexual and gender minority populations, the recognition of the importance of addressing their unique health needs is a recent development.<sup>5</sup> Historically, many key professional documents, such as the early versions of the Diagnostic Management System (DSM) of the American Psychiatric Association, presumed that individuals who were homosexual or who displayed gender nonconformity were ipso facto experiencing a mental health illness. Only in recent decades have health professionals recognized that past dogma and professional bias caused much harm, and prevented development of ways for

providers to help their sexual and gender minority patients to optimize their resilience to lead confident, healthy, productive lives.<sup>6,7</sup> Health care professionals' understanding of sexual and gender minority subcultures is particularly important to ensure the successful growth and development of lesbian, gay, bisexual and transgender (LGBT) youths, given young people's developmental vulnerabilities, and the normative role that trusted health professionals can play. The February 2014 issue of the *American Journal of Public Health* has provided a wide array of studies based on recent data from the Youth Risk Behavioral Survey (YRBS) system, which provides data that can inform and improve the clinical care of sexual and gender minority youths.

Careful analyses of the life experiences of sexual and gender minority populations suggest that proximate causes of psychological distress and risk-taking behavior for some stem from early childhood experiences, including physical and emotional abuse by family or peers, as well as general societal stigma and discrimination (Institute of Medicine<sup>5</sup> [IOM]), resulting in dysfunctional behavior.<sup>8,9</sup> Similar health disparities (e.g., increased risk for HIV or sexually transmitted infection), depression, and substance use are now being recognized among sexual and gender minorities in developing countries.<sup>10</sup> These findings suggest that successful responses to the global HIV/AIDS epidemic will require the development of culturally sensitive programs that address concomitant clinical concerns and root causes, such as societal and institutional homophobia. Research is needed to understand how the majority of sexual and gender minority people lead resilient and productive lives in the

face of discrimination and to develop assets-based interventions that build on the community supports that they have created.

### FACTORS INFLUENCING DEVELOPMENTAL CHALLENGES

Despite major advances in the extension of civil liberties for sexual and gender minority populations in many societies in recent years, bias and stigma remain a concern, particularly for young people, who often live in social environments that expose them to rejection and isolation, discrimination, and abuse.<sup>11</sup> Their introjection of societal disapproval may result in internalized homophobia, loss of self-esteem, depression, and other emotional distress.<sup>12,13</sup> Recent studies have found that sexual attraction begins with onset of puberty, if not sooner.<sup>14,15</sup> The usual processes of developing sexual and gender identities is particularly stressful for sexual minority youths because they are likely to experience identity confusion and lack of support for their emerging identities, resulting in high levels of stress as they realize they have a stigmatized identity.<sup>16</sup> They may feel shame, guilt, or denial.<sup>17</sup> Recent studies have suggested that heterosexual, as well as sexual and gender minority youths, are recognizing their sexual identities at earlier ages than in previous decades,<sup>18</sup> and for LGBT youths, this means that they are confronting social challenges when they may be less intellectually and socially mature, and may have fewer social supports than older adolescents and young adults.

The process of "coming out" may result in the loss of friends, verbal abuse, and other forms of rejection by parents, other key family members, trusted social

leaders, and other forms of discrimination or violence, ranging from physical abuse to emotional bullying.<sup>3</sup> Parents and guardians play pivotal roles as gatekeepers, who may create barriers to youths receiving care that is appropriate for their developmental stages and identities. This may be particularly problematic if the adult is unaware, nonsupportive, or hostile to the youth's expression of sexual orientation or gender-related behavior. Because adolescence is a critical period in identity formation, these adverse experiences may impair further psychosocial development, particularly in youths who grow up in dysfunctional families. These adolescents are at increased risk for impaired physical, social, and emotional health.<sup>19,20</sup> Clinicians will need to learn effective strategies to engage family support without compromising youths' privacy and confidentiality.

### HEALTH DISPARITIES

Although many earlier studies focused on male homosexual youths and their risks for HIV, more recent data indicate that sexual and gender minority adolescents are more likely than their heterosexual peers to experience a diverse array of health disparities, many of which may increase their vulnerability to sexually transmitted infections. Many of these conditions may be harmful in and of themselves (e.g., depression and substance use), preventing successful development.<sup>8,9,13</sup> The recent issue of the *American Journal of Public Health* presented robust new data from the YRBS for more than 20 000 youths surveyed between 2005 and 2007.<sup>21</sup> Although most participants in the study identified as heterosexual (93.2%), 3.4%

identified as bisexual, 1.1% as gay or lesbian, and 2.3% as unsure of their sexual orientation.<sup>22</sup> Because of the diversity of the subpopulations sampled, and the broad array of health behaviors surveyed, these data provide a unique opportunity to compare and contrast the health of sexual and gender minority youths with their heterosexual peers.

The data revealed some concerning trends among the sexual and gender minority youths compared with their heterosexual counterparts, across a variety of health domains, including increased rates of sexually transmitted infection risk behaviors,<sup>23</sup> problematic substance use,<sup>24</sup> alcohol use,<sup>25</sup> smoking,<sup>26</sup> abnormal weight,<sup>27</sup> and multiple cancer-related risk behaviors.<sup>28</sup> Furthermore, sexual and gender minority youths were more likely to report that they did not use seatbelts regularly compared with heterosexuals.<sup>29</sup>

The reasons for these health disparities are complex, but internalization of peer and social rejection appears to play a role. In the YRBS, sexual minorities reported more peer victimization than heterosexuals.<sup>30,31</sup> Peer victimization was related to disparities in cancer-related risk behaviors of substance use, sexual-risk behaviors, and purging. Sexual and gender minorities also reported more fighting, skipping school because they felt unsafe, and having property stolen or damaged at school.<sup>31</sup> The highest levels of victimization were reported by youths with bisexual identities or who reported both male and female sex partners.<sup>31</sup> These data suggest that peer victimization is important in understanding sexual orientation disparities regarding many adolescent health risk behaviors and the high prevalence of depression and related mental health conditions in

these populations.<sup>32</sup> Interventions are needed to reduce such victimization in schools, as a way to reduce sexual orientation disparities in cancer risk.

The findings in the articles in this special issue highlight a range of health disparities for sexual and gender minority youths, but unfortunately are not the first to document the deleterious effects of violence and victimization on their development. Half of the students in one study who reported homophobic bullying reported they skipped school because of the experience.<sup>9</sup> School environments need to create climates where youths are comfortable in expressing their identities. Hatzenbuehler et al.<sup>33</sup> found, in this YRBS sample, that sexual and gender minority adolescents living in states and cities with more protective school climates were significantly less likely to report past-year suicidal thoughts than sexual minority adolescents living in states and cities with less protective climates. Schools that support sexual and gender minority students, and explicitly oppose homophobic bullying, create an environment in which all students feel safe and are able to learn.<sup>16</sup>

The challenges for youths may be particularly profound for those who are from racial and ethnic minority communities. In a longitudinal report of sexual minority Black and Latino youths, the participants reported involvement in fewer gay-related social activities and less comfort with others knowing their sexual identity compared with White youths.<sup>34</sup> This was possibly because they may have felt marginalized by their familial community, at a time when they experienced racism in the LGBT community. Thus, proactive support for the healthy

development of sexual and gender minority youths must incorporate awareness of the cultural norms of their natal communities and of their peers.

## FOCUSING ON RESILIENCE

Despite societal rejection, the majority of sexual and gender minority youths become adults who lead healthy and productive lives.<sup>35</sup> Lack of social or familial acceptance may lead to internalized self-rejection, and multiple studies have shown that they are more likely to report childhood sexual abuse,<sup>20</sup> substance abuse,<sup>36–38</sup> depression,<sup>13</sup> as well as domestic and homophobic violence than their heterosexual peers.<sup>16,17,39</sup> Several groups have noted that these health conditions are correlated and potentiate the risk for each other.<sup>40–42</sup> These syndemics synergistically interact to produce substantially worse health outcomes for sexual and gender minority youths, often compounded by internalized homophobia and cultural marginalization. The homophobic violence that sexual and gender minority youths experience may predispose them to greater psychosocial morbidity since they often do not have access to community support.

However, despite these challenges, the majority of LGBT youths are not unhealthy, suggesting that most are resilient in the face of societal rejection.<sup>35,43</sup> Recent developmental work suggested that many LGBT youths have developed strengths in the face of adversity, which may enable them to make a successful transition into adulthood.<sup>44</sup> A longitudinal multicenter study of adult men who have sex with men found that internalized homophobia tended to decrease as the men got older, and that those

individuals who had the least residual negative effects about their sexual orientation were the least likely to be depressed or to report other syndemic problems.<sup>45</sup> Further research is urgently needed to better understand why LGBT youths, who have been exposed to negative developmental experiences, continue to function well. Clinicians have an important role to play by helping sexual and gender minority youths understand the assets they possess, and to assist youths who are not optimally coping to find support systems that will enable them to develop their skills, to accept themselves, and to appreciate and utilize their innate strengths.

## WHAT CLINICIANS NEED TO KNOW

Although it is likely all clinicians care for sexual and gender minority youths, many may not know it, despite being in a unique position to provide them with vital health information. Adolescent health education in schools is often primarily focused on pregnancy prevention, and not how youths can accurately assess their risks for HIV and sexually transmitted infections, while having satisfying sex lives. Ironically, several studies have shown that many patients desire to discuss sexual orientation and gender identity with clinicians. As noted in a landmark report in 1997, the IOM commented, "Ironically, it may require greater intimacy to discuss sex than to engage in it."<sup>46</sup> Studies have shown that clinicians are far more likely to talk about adherence to HIV therapy than to discuss risk behavior to prevent HIV transmission.<sup>47</sup> With respect to speaking openly to LGBT youths, bias among clinicians toward sexual and gender minorities has

been identified as a cause of health disparities among these populations.<sup>6,7,48</sup> Although the etiology of professional bias has not been well studied, it can be assumed that it results from a combination of having learned the now disavowed medical dogma (the previously discussed DSM) and the lack of any significant programs to educate students, trainees, and practicing clinicians about unique health issues of concern among LGBT youths.<sup>45</sup> These findings suggest that clinical training needs to be improved, by providing new knowledge, and addressing clinician attitudes toward sexual and gender minority youths, to enhance open and nonjudgmental discussions in clinical settings, to facilitate patients' health and resilience.

A primary issue for clinicians is to recognize the importance of, and become comfortable with, talking openly with their patients and clients about their sexual orientation and gender identity. When dealing with youths, it will be important to recognize that these may be issues about which there may be considerable fluidity, and for many, reluctance to openly discuss their sexuality with anyone without first establishing a trusting relationship. Obviously, the urgency and directness of such discussions must reflect the context of the clinical encounter. Early exploration of sexual risk will be more important when examining a patient with an acute sexually transmitted infection or potential acute HIV syndrome; however, repeated encounters may be needed to establish trust in other settings.

Although most medical schools now teach students to ask patients who are sexually active if they have sex with men, women, or both,<sup>48</sup> these questions focus on sexual risk, and do not recognize the complexity of sexual orientation,

which includes gaining an understanding of sexual identity (gay, straight, or bisexual), behavior, or desire. It is just as important to explore issues of sexual concern, risk, and health for those who have not been sexually active as it is for those who have had sexual experiences. Helping an adolescent, who is thinking about coming out, to get the appropriate supports in place in advance of discussing their situation widely may be of enormous benefit. Dealing with youths who are questioning their gender identity can be complex, but can play a critical role in helping them have a positive early experience as they explore their feelings and options. Some youths may be very clear with respect to having a transgender identity or identifying with the gender consistent with their birth sex, while others may consider themselves as neither male nor female and consider themselves as having a no specific gender, or may describe themselves as "gender queer."

After establishing a level of comfort with patients' sexual orientation and gender identity, it is then important to consider related issues rooted in the disparities we know to be more prevalent among sexual and gender minorities, and to engage in care that will lead to overcoming barriers to having a healthy life. For example, sexually active adolescents will require routine sexually transmitted infection and HIV services. Providers who do not have these resources need to become familiar with local outreach agencies, hotlines, and media that can connect adolescents with positive role models and social opportunities. Because of their higher risk, youths should be questioned specifically about anxiety, depression, and mental resilience. Lack of acceptance by families is felt to be

one of the reasons for the high rates of homelessness among LGBT youths. Clinicians must be aware of this as a potential outcome, and work with families and youths to optimize family acceptance.

Unfortunately, clinical training to enhance understanding of sexual and gender minority youths has been woefully lacking. Until recently, there has been little opportunity for practicing clinicians to learn more about how to improve their knowledge and reflect upon biases they have, which might interfere with their providing sensitive, nonjudgmental, and well-informed health care. Professional organizations such as the American Medical Association and the American Association of Medical Colleges have taken strong positions about the need for clinicians and institutions to consider how to provide equitable, quality care for LGBT people. The American College of Obstetrics and Gynecology has stated its opposition to gender identity discrimination and has lent its support for health insurance coverage for care of transgender people. The Joint Commission for the Accreditation of Hospitals has published a *Field Guide*<sup>49</sup> that sets out principles to be followed by organizations to insure access to quality care for LGBT people.

There are now several programs around the country that focus on providing resources for clinicians to train them to provide competent care for LGBT patients. The National LGBT Health Education Center at the Fenway Institute in Boston is funded by a national collaborative agreement with Health Resources and Services Administration to provide training to clinicians in community health centers nationwide. The center holds webinars at least monthly on topics for clinicians on

LGBT health that are available for free and provides continuing education credits. The resources of the Education Center can be accessed through its Web site at <http://www.lgbthealtheducation.org>. The Human Rights Campaign administers the health equity index for health care organizations seeking to demonstrate their leadership in providing quality care for LGBT people.

### THE DEVELOPMENT OF CULTURALLY TAILORED SERVICES

Despite the increased awareness of the risks faced by LGBT youths, finding culturally appropriate and sensitive health care services can too often be an elusive goal. Barriers created by societal stigma, secrecy surrounding their sexual orientation or gender identity, and a general lack of knowledge as to where to find LGBT-friendly providers continue to challenge access to care for this vulnerable population. Further complicating the matter, LGBT adolescents may be unwilling or fear using their health insurance to access needed services out of concerns that their sexual identities may be disclosed to parents or peers. LGBT youths may therefore seek services in public health clinics or other settings where they may more easily ensure their anonymity, but where the full range of medical, social, and preventive health care services may not be readily available.

However, in the past decade, the increased recognition of the complex risk, social, and societal environments in which LGBT youths attempt to access culturally sensitive health care has resulted in the development of specialized programs or centers designed to specifically offer services tailored

to the unique needs of LGBT youths. Largely in urban settings, centers such as the Sidney Borum Health Center in Boston, Massachusetts; the Broadway Youth Center in Chicago, Illinois; the Ali Forney Center in New York City; and the youth services programs of the Los Angeles Gay and Lesbian Center in Los Angeles, California, have established themselves as “barrier-free” care programs. These programs offer a variety of medical and social services designed to meet the complex needs of LGBT youths, including the homeless, transgender individuals, and youths affected by HIV/AIDS. These specialized centers typically employ a one-stop shop model within a safe, welcoming, nonjudgmental environment. They offer a range of services from basic necessities (e.g., meals, shower) to medical care, testing, and counseling for HIV and other sexually transmitted infections, case management, mental health counseling, and in some settings, vocational and educational training. Importantly, as these centers have become firmly established, they have often partnered with other community-based organizations to creatively round out comprehensive service provision. They have partnered with academic health centers and health services to train future generations of physicians and other health care providers on the specialized models of care LGBT youths may require. To date, thousands of LGBT youths have received care and services at these specialized centers. Their importance in improving the health care delivery of LGBT adolescent health care services, particularly those who are the most marginalized, was emphasized in the 2009 IOM report, “Adolescent Health Services: Missing Opportunities.”<sup>50</sup> However, despite the development of specialized centers that have

been instrumental in reaching and delivering health care services to marginalized LGBT youth populations, it must be emphasized that the majority of LGBT youths, particularly those in suburban or rural environments, seek care in traditional health care settings, such as school-based health centers, private practices, and unspecialized community-based health centers. This underscores the importance of ensuring that training in culturally sensitive care for LGBT youths occurs broadly and is not limited to urban centers or the previously mentioned specialized LGBT centers. The development of services tailored to the special health care needs of LGBT youths begins with creating a welcoming office or clinic environment. This can include the display of posters, flyers, or other materials that include LGBT people or that demonstrate a clear willingness to provide care for a diverse array of young people. Office policies can develop regarding confidentiality and help establish a safe clinical space. Guidelines can be posted prominently in waiting areas and patient examination rooms. Confidentiality can be addressed proactively by educating parents, guardians, youth, and staff on the parameters and importance of confidential care, including visibly posted office policies. Staff training is critically important—not just for medical or nursing staff, but for front desk and office staff as well because they are often the first individuals a young LGBT person may come into contact within a clinical setting.

The patient interview is another prime opportunity to set a comfortable tone for the LGBT adolescent patient, allowing a young person to seek information, help, support, and medical treatment as needed. Many LGBT youths will not be comfortable sharing their identity with a clinician, especially

if they are still in the process of exploring this identity. Therefore, it is not necessarily important to know which youths are LGBT and which are not, as long as a safe space is created for the young person to discuss issues related to gender and sexuality, and their needs and concerns are met. Culturally tailored care for LGBT youths means that sensitive topics, such as school and home safety, sexual activity, and substance use must be carefully and comprehensively addressed with specific probing questions, but without falling routinely into traditional stereotypes (e.g., all young gay men are at risk for HIV). The physical examination and diagnostic evaluation of LGBT youths should be guided more by a young person’s behavior than stated identity and should typically follow the general recommendations for all adolescent health care, such as those detailed in the American Medical Association’s Guidelines for Adolescent Preventive Services.<sup>51</sup> Of the utmost importance is the recognition that with proper training and education, the delivery of LGBT sensitive care and services for youths is both important and attainable for the majority of clinical providers and clinical systems of care.

## CONCLUSIONS

In summary, these articles examining YRBS data provide new insights regarding the prevalence and etiology of health disparities for sexual and gender minority youths. It is clear from these data that many of the root causes are related to familial and societal rejection, creating a cycle of alienation, depression, and decreased self-efficacy, which impair the ability of sexual and gender minority youths to make successful

adjustments in their maturation process. The data suggest that structural interventions are needed, ranging from education of parents regarding how important their acceptance can be, to training health care professionals to be knowledgeable about the provision of culturally sensitive care for their sexual and gender minority patients. The progress in the achievement of civil rights for LGBT people over the past few decades has been rapid, so now is the time for the public health and clinical communities to facilitate improved health for sexual and gender minority people through enhancing the understanding of the reasons for persistent disparities and the dissemination of best practices. ■

## About the Authors

*Kenneth H. Mayer and Harvey J. Makadon are with The Fenway Institute, Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, MA. Robert Garofalo is with the Northwestern University Feinberg Medical School, Lurie Children’s Memorial Hospital, Chicago, IL.*

*Correspondence should be sent to Kenneth H. Mayer, MD Fenway Health, The Fenway Institute, 1340 Boylston Street, Boston, MA 02445 (e-mail: kmayer@fenwayhealth.org). Reprints can be ordered at <http://www.ajph.org> by clicking the “Reprints” link.*

*This article was accepted December 29, 2013.*

## Contributors

The article concept was developed by K. H. Mayer and reviewed and revised by R. Garofalo and H. K. Makadon. All authors wrote sections of the article, found appropriate references, and edited the final version of the article.

## Acknowledgments

We wish to acknowledge Andrea Karis for assistance in preparation of the article. The writing was supported through intramural funds of The Fenway Institute.

## References

1. Mayer KH, Bradford JB, Makadon HJ, et al. Sexual and gender minority health: what we know and what needs to be done. *Am J Public Health*. 2008;98(6):989–995.
2. Stall R, Mills TC, Williamson J, et al. Association of co-occurring psychosocial health problems and increased vulnerability

- to HIV/AIDS among urban men who have sex with men. *Am J Public Health*. 2003;93(6):939–942.
3. Stall R, Friedman M, Catania J. Interacting epidemics and gay men's health: a theory of syndemic production among urban gay men. In: Wolitski RJ, Stall R, Valdiserri RO, eds. *Unequal Opportunity: Health Disparities Among Gay and Bisexual Men in the United States*. New York, NY: Oxford University Press; 2008:25–274.
  4. Makadon H, Mayer KH, Potter J, Goldhammer H. *The Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health*. Philadelphia, PA: American College of Physicians Press; 2008:1–526.
  5. Institute of Medicine. *The Health of Lesbian, Gay, Bisexual, Transgender People: Building a Foundation for Better Care*. Washington, DC: National Academy of Science Press; 2011.
  6. Arnold LM. Promoting culturally competent care for the lesbian, gay, bisexual, and transgender population. *Am J Public Health*. 2001;91(11):1731.
  7. Gonsler PA. Culturally competent care for members of sexual minorities. *J Cult Divers*. 2000;7(3):72–75.
  8. Safren SA, Heimberg RG. Depression, hopelessness, suicidality, and related factors in sexual minority and heterosexual adolescents. *J Consult Clin Psychol*. 1999;67(6):859–866.
  9. Almeida J, Johnson RM, Corliss HL, et al. Emotional distress among LGBT youth: the influence of perceived discrimination based on sexual orientation. *J Youth Adolesc*. 2009;38(7):1001–1014.
  10. Beyrer C. Hidden yet happening: the epidemics of sexually transmitted infections and HIV among men who have sex with men in developing countries. *Sex Transm Infect*. 2008;84(6):410–412.
  11. Newman BS, Muzzonigro PG. The effects of traditional family values on the coming out process of gay male adolescents. *Adolescence*. 1993;28(109):213–226.
  12. Harrison TW. Adolescent homosexuality and concerns regarding disclosure. *J Sch Health*. 2003;73(3):107–112.
  13. D'Augelli AR. Mental health problems among lesbian, gay and bisexual youth ages 14 to 21. *Clin Child Psychol Psychiatry*. 2002;7(3):433–456.
  14. McClintock MK, Herdt G. Rethinking puberty: the development of sexual attraction. *Dev Psychol Sci*. 1996;5(6):178–183.
  15. Grov C, Bimbi DS, Nanin JE, et al. Race, ethnicity, gender, and generational factors associated with the coming-out process among lesbian, and bisexual individuals. *J Sex Res*. 2006;43(2):115–121.
  16. Murdock TB, Bolch MB. Risk and protective factors for poor school adjustment in lesbian, gay, and bisexual (LGB) high school youth: variable and person-centered analyses. *Psychol Sch*. 2005;42(2):159–172.
  17. Butler AH, Astbury G. The use of defence mechanisms as precursors to coming out in post-apartheid South Africa: a gay and lesbian youth perspective. *J Homosex*. 2008;55(2):223–244.
  18. Drasin H, Beals KP, Elliott MN, et al. Age cohort differences in the developmental milestones of gay men. *J Homosex*. 2008;54(4):381–399.
  19. Bostwick WB, Boyd CJ, Hughes TL, et al. Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States. *Am J Public Health*. 2010;100(3):468–475.
  20. Paul JP, Catania J, Pollack L, et al. Understanding childhood sexual abuse as a predictor of sexual risk-taking among men who have sex with men: The Urban Men's Health Study. *Child Abuse Negl*. 2001;25(4):557–584.
  21. Mustanski B, Van Wagenen A, Birkett W, et al. Identifying sexual orientation health disparities in adolescents: analysis of pooled data from the Youth Risk Behavior Survey. *Am J Public Health*. 2014;104(2):211–217.
  22. Mustanski B, Birkett M, Greene GJ, Rosario M, Bostwick W, Everett BG. The association between sexual orientation identity and behavior across race/ethnicity, sex, and age in a probability sample of high school students. *Am J Public Health*. 2014;104(2):237–244.
  23. Everett BG, Schnarrs PW, Rosario M, Garofalo R, Mustanski B. Sexual orientation disparities in STI risk behaviors and risk determinants among sexually active adolescent males: results from a school-based sample. *Am J Public Health*. 2014;104(6):1107–1112.
  24. Newcomb M, Birkett M, Corliss H, Mustanski B. Sexual orientation, gender, and racial differences in illicit drug use in a sample of US high school students. *Am J Public Health*. 2014;104(2):304–310.
  25. Talley A, Hughes T, Marshal M, et al. Exploring alcohol-use behaviors among heterosexuals and sexual minority adolescents: intersections with sex, age, and race/ethnicity. *Am J Public Health*. 2014;104(2):295–303.
  26. Corliss HL, Rosario M, Newcomb MA, Newcomb ME, Buchting FO, Matthews AK. Sexual orientation disparities in adolescent cigarette smoking: intersections with race/ethnicity, gender, and age. *Am J Public Health*. 2014;104(6):1137–1147.
  27. Austin SB, Nelson LA, Birkett MA, et al. Eating disorder symptoms and obesity at the intersections of gender, ethnicity and sexual orientation in US high school students. *Am J Public Health*. 2013;103(2):e16–e22.
  28. Rosario M, Corliss HL, Everett BG, Russell ST, Buchting FO, Birkett MA. Mediation by peer violence victimization of sexual orientation disparities in cancer-related risk behaviors of tobacco, alcohol, sexual risk, and diet and physical activity: Youth Risk Behavior Survey. *Am J Public Health*. 2014;104(6):1113–1123.
  29. Reisner SL, Van Wagenen A, Gordon A, Calzo JP. Disparities in safety belt use by sexual orientation identity among US high school students. *Am J Public Health*. 2014;104(2):311–318.
  30. Rosario M, Corliss H, Everett B, et al. Sexual orientation disparities in cancer-related risk behaviors of tobacco, alcohol, sexual behaviors, and diet and physical activity: pooled Youth Risk Behavior Surveys. *Am J Public Health*. 2014;104(2):245–254.
  31. Russell ST, Everett BG, Rosario M, Birkett M. Indicators of victimization and sexual orientation among adolescents: analyses from Youth Risk Behavior Surveys. *Am J Public Health*. 2014;104(2):255–261.
  32. Bostwick WB, Meyer I, Aranda F, et al. Mental health and suicidality among racially/ethnically diverse sexual minority youths. *Am J Public Health*. 2014;104(6):1129–1136.
  33. Hatzenbuehler ML, Birkett M, Van Wagenen A, Meyer IH. Protective school climates and reduced risk for suicide ideation in sexual minority youths. *Am J Public Health*. 2014;104(2):279–286.
  34. Rosario M, Scrimshaw EW, Hunter J. Ethnic/racial differences in the coming-out process of lesbian, gay, and bisexual youths: a comparison of sexual identity development over time. *Cult Divers Ethnic Minor Psychol*. 2004;10(3):215–228.
  35. Herrick AL, Stall R, Chmiel JS, et al. It gets better: resolution of internalized homophobia over time and associations with positive health outcomes among MSM. *AIDS Behav*. 2013;17(4):1423–1430.
  36. Mansergh G, Flores S, Koblin B, et al. Alcohol and drug use in the context of anal sex and other factors associated with sexually transmitted infections: results from a multi-city study of high-risk men who have sex with men in the USA. *Sex Transm Infect*. 2008;84(6):509–511.
  37. Hughes TL. Alcohol use and alcohol-related problems among lesbians and gay men. *Annu Rev Nurs Res*. 2005;23:283–325.
  38. Greenwood GL, White EW, Page-Shafer K, et al. Correlates of heavy substance use among young gay and bisexual men: the San Francisco Young Men's Health Study. *Drug Alcohol Depend*. 2001;61(2):105–112.
  39. Greenwood GL, Relf MV, Huang B, et al. Battering victimization among a probability-based sample of men who have sex with men. *Am J Public Health*. 2002;92(12):1964–1969.
  40. Stall R, Purcell DW. Intertwining epidemics: a review of research on substance use among men who have sex with men and its connection to the AIDS epidemic. *AIDS Behav*. 2000;4(2):181–192.
  41. Mustanski B, Garofalo R, Herrick A, Donenberg G. Psychosocial health problems increase risk for HIV among urban young men who have sex with men: preliminary evidence of a syndemic in need of attention. *Ann Behav Med*. 2007;34(1):37–45.
  42. McCarthy KS, Wimsone W, Guadamuz TE, et al. Syndemic analysis of co-occurring psychosocial health conditions and HIV infection in a cohort of men who have sex with men (MSM) in Bangkok, Thailand. *XVIII Int AIDS Conf*. 2010.
  43. Fergus S, Zimmerman MA. Adolescent resilience: a framework for understanding healthy development in the face of risk. *Annu Rev Public Health*. 2005;26:399–419.
  44. Herrick AL, Lim SH, Wei C, et al. Resilience as an untapped resource in behavioral intervention design for gay men. *AIDS Behav*. 2011;15(suppl 1):S25–S29.
  45. Steward WT, Charlebois ED, Johnson MO, et al. Receipt of prevention services among HIV-infected men who have sex with men. *Am J Public Health*. 2008;98(6):1011–1014.
  46. Institute of Medicine. *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*. Washington, DC: National Academy of Science Press; 1997.
  47. Gooren LJ. Clinical practice. Care of transsexual persons. *N Engl J Med*. 2011;364(13):1251–1257.
  48. Obedin-Maliver J, Goldsmith ES, Stewart L, et al. Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. *JAMA*. 2011;306(9):971–977.
  49. The Joint Commission on the Accreditation of Hospitals. *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide*. Oak Brook, IL: The Joint Commission on the Accreditation of Hospitals; 2011.
  50. Institute of Medicine. *Adolescent Health Services: Missing Opportunities*. Washington, DC: National Academy of Science Press; 2007.
  51. Elster A. The American Medical Association guidelines for adolescent preventive services. *Arch Pediatr Adolesc Med*. 1997;151(9):958–959.

Copyright of American Journal of Public Health is the property of American Public Health Association and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.