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**Commentaries**

**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 substance 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)
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.2 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.3 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.4 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.5 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.6,7 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 Medicine5 [IOM]), resulting in dysfunctional behavior.6,8 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.10 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.11 Their introspection of societal disapproval may result in internalized homophobia, loss of self-esteem, depression, and other emotional distress.12,13 Recent studies have found that sexual attraction begins with onset of puberty, if not sooner.14,15 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.16 They may feel shame, guilt, or denial.17 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,18 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.19 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.19,20 Clinicians will need to learn effective strategies to engage family support without compromising youths’ privacy and confidentiality.

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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.8,9,13 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 2007.21 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 trans of their sexual orientation. 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, problematic substance use, alcohol use, smoking, abnormal weight, and multiple cancer-related risk behaviors. Furthermore, sexual and gender minority youths were more likely to report that they did not use seatbelts regularly compared with heterosexuals.

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. 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. The highest levels of victimization were reported by youths with bisexual identities or who reported both male and female sex partners. 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. 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. School environments need to create climates where youths are comfortable in expressing their identities. 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.

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. 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.

FOCUSDING ON RESILIENCE

Despite societal rejection, the majority of sexual and gender minority youths become adults who lead healthy and productive lives. 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, substance abuse, depression, as well as domestic and homophobic violence than their heterosexual peers. Several groups have noted that these health conditions are correlated and potentiate the risk for each other. 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. 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. 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. 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." 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. 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.\textsuperscript{3,7,48} 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.\textsuperscript{45} 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 nondjudgmental 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.

The National LGBT Health Education Center (NLHEC) 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 health 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 fearful 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...
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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." 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 patients, 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. 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.

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This article was accepted December 29, 2013.

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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.

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