ISSN 2382-1019

# SEXUAL MINORITY (LGBTQ) YOUTH AND ROLE OF HEALTH CARE PROVIDER

Mandakini Sadhir, MD; Stephanie J Stockburger, MD; and Hatim A Omar, MD
Division of Adolescent Medicine, Department of Pediatrics, University of Kentucky, Lexington, Kentucky, United States

***Correspondence:*** Professor Hatim, e-mail: haomar2@uky.edu
Received: 29/1/2016; Revised: 28/2/2016; Accepted: 1/3/2016

Adolescence is a time period of physical, psychological and cognitive changes. It is an important phase for an individual to discover who they really are (self-identity), how they are perceived (social identity) and how they fit into the environment they live in.[1] One of the major tasks of adolescence is sexual maturation and sexual and /or gender identity development.[2] Adolescents who are developing as gay, lesbian, bisexual or transgender face a tremendous challenge of establishing their identity which is often complex.[3] They cope with the feelings of being different and are in constant dilemmas about revealing their identity ("coming out") which is different from family and social expectations.[3,4] While acceptance in certain segments of society is growing, sexual minority youth continue to be at risk for family rejection and face harassment, prejudice, discrimination and social isolation in schools as well as communities.

According to a national school climate survey[5] conducted on students between the ages of 13 and 21 years in grades 6$^{th}$-12$^{th}$ found that majority of schools had unsupportive environment for sexual minority youth. The survey examined the experiences of LGBT students with regards to hearing biased, homophobic remarks, feeling unsafe because of sexual orientation or gender expression, school absenteeism, harassment and assault in school. In the survey, 70- 90% of students heard "gay" being often used in a negative way and other homophobic remarks (e.g. "dyke" or "faggot") frequently at schools. Majority of students reported verbal harassment because of their sexual orientation and gender expression, 53% also experienced harassment via electronic mediums such as text messages, emails, instant messages, or postings on social media like Facebook. Approximately 20-40%students were subjected to physical harassment (e.g. shoved, punched, kicked, injured with weapon) at school. The LGBT students reported feeling unsafe because of the hostile school environment and were 3-4 times likely to miss classes and school leading to poor grades as compared to their peers. In addition, students who were victimized reported lack of interest in pursuing higher education and suffered low self- esteem. Further, sexual minority youth reported sexual victimization including dating violence and forced sexual intercourse. It is estimated that 19% to 29% of gay and lesbian students and 18% to 28% of bisexual students experienced dating violence. Approximately 14% to 31% of gay and lesbian students and 17% to 32% of bisexual students have been forced to have sexual intercourse at some point in their lives.[6]

## RISK TAKING BEHAVIOR AND HEALTH IMPLICATIONS IN SEXUAL MINORITY YOUTH

In- school experiences and lack of family and community support[7] affects the overall psychological and physical well- being of sexual minority youth. They often engage in high

ISSN 2382-1019

risk behaviors such as substance abuse, multiple sexual partners, unprotected sexual intercourse leading to increased risk for sexual transmitted infection and mental health issues.[9] According to youth risk behavior surveillance among high school students, gay, lesbian and bisexual students had higher prevalence rates than heterosexual students for seven of the 10 risk behavior categories including interpersonal violence, attempted suicide, tobacco, alcohol and other drug use, sexual behaviors, and weight management.[6] LGB teens are more likely to be sexually active before 13 years of age and have multiple sexual partners. They are about half as likely as heterosexual youth to have used hormonal or barriers methods at the last intercourse. Lesbian and bisexual females in particular, are at risk for teen pregnancy and sexually transmitted infections.[9] The prevalence of being drunk or using drugs before last sexual encounter is also higher among gay, lesbian and bisexual teens across various state surveys.[6] There has been an increase in HIV infections particularly among 13-24 year old males who have sex with males. Recent data from CDC shows that young gay and bisexual men accounted for an estimated 19% of all new HIV infections and 72% of new HIV infections among youth. While limited data exists on transgender youth, recent studies have shown higher rates of new HIV infection among male to female transgender people. Rise in HIV rates have been attributed to multiple factors including low perception of risk, less condom use and overall lower rates of testing for STI. In addition, teens may have older partners, engage in substance abuse such as intravenous drug use, be homeless and involve in survival sex which increase their risk for acquiring HIV.[9]

Suicidality is much higher among gay, lesbian and bisexual youth and is four times more likely to attempt suicide as their heterosexual peer.[10, 11] In addition, youth who face family rejection are at much higher risk to attempt suicide than LGB peers with supportive family. Every episode of LGBT victimization, such as physical, verbal harassment or abuse increases the likelihood of self-harming behaviors.[12, 13]

Other risk behaviors among LGB teens are use of both legal and illegal substances including cigarettes, alcohol, marijuana and other club drugs. A recent meta-analysis found 3 times the odds of substance use for LGB youth when compared with non- LGB youth.[14] According to national and state surveys[6], higher percentage of gay and lesbian students reported current tobacco and alcohol use and engaged in binge drinking. Use of other drugs such as marijuana, cocaine, heroin and inhalants was noted to be higher than heterosexual peers. Substance use among LGB and bisexual youth is often associated with unprotected sexual intercourse and increase risk of suicide.[12]

Body image concerns and eating disorders are also prevalent among lesbian, gay, and bisexual females as well as males. In a study, lesbian and bisexual females had higher rates of purging throughout adolescence compared with their heterosexual peers. Gay males were more likely to report both binging and purging than heterosexual males.[15]

## ROLE OF HEALTH CARE PROVIDER

Adolescents and young adults often seek care with their health care providers for acute care, health maintenance visits, or sports physicals. These clinical encounters can be utilized as an opportunity to teach adolescents about healthy sexuality and encouraging them to talk about their sexual or gender identity with emphasis on confidentiality.[16] LGBTQ youth often have fear of rejection or stigmatization. Providers and their staff can play an important role to help make adolescents comfortable at each of their clinic visits. Using gender neutral terms encourages teenagers to talk about sexuality, gender identity and sexual behaviors.[17, 19] Obtaining psycho- social histories during the visit can often help to identify risk taking

ISSN 2382-1019

behaviors. Particularly, providers may also focus on the presence of supportive family members or friends, mental health concerns and overall well-being.[18] Similar to their heterosexual counterparts, LGBTQ teens should be assured confidential care but also be informed of the conditions under which their confidentiality may be broken. If any serious situation arises, it is important to help the teen discuss the issue with their parent or guardian as deemed appropriate. Additional services with mental health professionals can be obtained to provide ongoing support.[16]

It is important to have a frank discussion with adolescents about their sexual practices and provide appropriate counseling. Teens that are abstinent should be encouraged to delay sexual initiation.[19] Safe sex education should be provided to all sexually active teens with emphasis on consistent and correct use of barriers methods such as condoms or dental dams for prevention of sexually transmitted diseases. Sexually active females, regardless of their sexual orientation, should be counseled on various hormonal contraception options including emergency contraception for pregnancy prevention[16, 17]. LGBTQ youth should be screened for eating disorders, depression, suicidality and substance use and appropriate referrals made as necessary[19].

Routine screening for gonorrhea and chlamydia is recommended for sexually active female adolescents at least once a year. Screening for HIV should be offered and discussed. Adolescents with high risk behaviors such as multiple partners, unprotected sexual intercourse and substance use may need to be screened frequently.[20] Annual screening for HIV and syphilis is recommended for young males who have sex with males. In addition, screening for gonorrhea and chlamydia using appropriate specimen based on sexual practices is recommended on a yearly basis.[20] Primary prevention through HPV vaccine is recommended for all male and female between 11-26yrs of age.[21] Routine cervical cancer screening should be offered to all females >21yrs of age regardless of sexual orientation or sexual practices.[22, 23, 24]

Transgender youth face similar challenges and health implication as other gay, lesbian and bisexual youth. In addition to screening them for high risk behaviors, transgender youth should be counseled about transition process and avoidance of using hormones prescribed by non-licensed physician or obtained via internet.[17]

Health care providers can play another important role in assisting parents and families of LGBTQ youth in educating and providing information about adolescent sexuality. Various community based organizations and programs provide supportive and empowering experiences for sexual minority youth and families.[8] Providers can help teens and their families identify useful resources in communities and encourage utilizing programs through organizations such as Parents, Friends, and Families of Lesbians and Gays (PFLAG, www.pflag.org) and the Gay, Lesbian and Straight Education Network (GLSEN).[19] Proper support, guidance and care during adolescence helps majority of LGBTQ youth to emerge as resilient adults who lead happy and productive lives.[17, 19]

## References

1) Steinberg L, Morris AS. Adolescent development. Annul Rev Psychol. 2001; 52:83-110.

2) Glover JA, Galliher RV, Lamere TG. Identity development and exploration among sexual

ISSN 2382-1019

Minority adolescents: examination of a multidimensional model. J Homosex. 2009; 56(1):77–101
3) Frankowski BL; Sexual orientation and adolescents. American Academy of Pediatrics Committee on Adolescence. Pediatrics.2004;113(6):1827–1832
4) Zucker KJ. Gender identity development and issues. Child Adolescent Psychiatry Clin N Am. 2004;13:551-568, vii.
5) Kosciw JG, Greytak EA, Diaz EM, Bartkiewicz MJ. The 2009 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual and Transgender Youth in Our Nation's Schools, External Web Site Icon. New York: Gay, Lesbian Straight Education Network; 2010
6) Centers for Disease Control and Prevention. Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9-12—Youth Risk Behavior Surveillance, selected sites, United States, 2001-2009. MMWR. 2011.
7) Ryan C, Huebner D, Diaz RM, Sanchez J. 2009. Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. Pediatrics 123:346–52
8) Coker TR, Austin SB, Schuster MA. The health and health care of lesbian, gay, and bisexual adolescents. Annual Review of Public Health 2010;31:457–477.
9) Centers for Disease Control and Prevention. HIV among youth http://www.cdc.gov/hiv/group/age/youth/index.html

10) Silenzio VM, Pena JB, Duberstein PR, CerelJ, Knox KL. Sexual orientation and risk factors for suicidal ideation and suicide attempts among adolescents and young
adults. Am J Public Health. 2007;97(11): 2017–2019
11) Russell ST, Joyner K. Adolescent sexual orientation and suicide risk: Evidence from a national study. American Journal of Public Health 2001;91:1276–1281.
12) Mustanski BS1, Garofalo R, Emerson EM. Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. Am J Public Health. 2010 Dec;100(12):2426-32
13) Eisenberg ME, Resnick MD. Suicidality among gay, lesbian and bisexual youth: the
role of protective factors. J Adolesc Health.2006;39(5):662–668
14) Marshal MP, Friedman MS, Stall R, King KM, Miles J, et al. 2008. Sexual orientation and adolescent substance use: a meta-analysis and methodological review. Addiction 103:546–56
15) Austin SB, Ziyadeh NJ, Corliss HL, Rosario M,Wypij D, et al. 2009. Sexual orientation in purging and binge eating from early to late adolescence. J. Adolesc. Health 45:238–45
16) Hagan JF, Shaw JS, Duncan P, eds. Promoting Healthy Sexual Development and Sexuality Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 3rd ed. Elk Grove Village, IL: American Academy
of Pediatrics; 2008
17) Adelson SL, Walter HJ, Bukstein OG, Bellonci C, Benson RS et al. Practice Parameter on Gay Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents. American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Journal of the American Academy of Child & Adolescent Psychiatry. 2012; 51(9)

**ISSN 2382-1019**

18) Goldenring JM, Rosen DS. Getting into adolescent heads: an essential update. Contemp
Pediatr. 2004;21(1):64–90
19) Braverman PK, Adelman WP, Breuner CC, Levine DA, et al. Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth, Committee on Adolescence. Pediatrics. 2013 Jul;132(1):198-203.
20) Workowski KA, Bolan GA; Centers for Disease Control and Prevention. Sexually
transmitted diseases treatment guidelines,2015. MMWR Recomm Rep. 2015 Jun 5;64(RR-03):1-137.
21) Markowitz LE, Dunne EF, Saraiya M, et al.; Centers for Disease Control and Prevention (CDC). Human papillomavirus vaccination: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR Recomm Rep 2014;63(No. RR-05):1–30.
22) Saslow D, Solomon D, Lawson HW, et al. American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer. CA Cancer J Clin 2012;62:147–72.
23) American College of Obstetricians and Gynecologists (ACOG). Screening for cervical cancer. ACOG Practice Bulletin Number 131. Obstet Gynecol 2012;120:1222–38.
24) Moyer VA. Screening for cervical cancer: US Preventive Services Task Force recommendation statement. Ann Intern Med 2012;156:880–91.