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CLINICAL REPORT
Guidance for the Clinician in Rendering Pediatric Care

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Sexual Orientation and Adolescents

ABSTRACT. The American Academy of Pediatrics issued its first statement on homosexuality and adolescents in 1983, with a revision in 1993. This report reflects the growing understanding of youth of differing sexual orientations. Young people are recognizing their sexual orientation earlier than in the past, making this a topic of importance to pediatricians. Pediatricians should be aware that some youths in their care may have concerns about their sexual orientation or that of siblings, friends, parents, relatives, or others. Health care professionals should provide factual, current, nonjudgmental information in a confidential manner. All youths, including those who know or wonder whether they are not heterosexual, may seek information from physicians about sexual orientation, sexually transmitted diseases, substance abuse, or various psychosocial difficulties. The pediatrician should be attentive to various potential psychosocial difficulties, offer counseling or refer for counseling when necessary and ensure that every sexually active youth receives a thorough medical history, physical examination, immunizations, appropriate laboratory tests, and counseling about sexually transmitted diseases (including human immunodeficiency virus infection) and appropriate treatment if necessary.

Not all pediatricians may feel able to provide the type of care described in this report. Any pediatrician who is unable to care for and counsel nonheterosexual youth should refer these patients to an appropriate colleague. *Pediatrics* 2004;113:1827–1832; *sexual orientation, adolescents, homosexuality, gay, lesbian, bisexual.*

ABBREVIATIONS. STD, sexually transmitted disease; HIV, human immunodeficiency virus; AAP, American Academy of Pediatrics; AIDS, acquired immunodeficiency syndrome.

INTRODUCTION

Pediatricians are being asked with increasing frequency to address questions about sexual behavior and sexual orientation. It is important that pediatricians be able to discuss the range of sexual orientation with all adolescents and be competent in dealing with the needs of patients who are gay, lesbian, bisexual, or transgendered or who may not identify themselves as such but who are experiencing confusion with regard to their sexual orientation. Young people whose sexual orientation is not heterosexual can have risks to their physical, emotional, and social health, primarily because of societal stigma, which can result in isolation.[1,2] Because self-awareness of sexual orientation commonly occurs during adolescence, the pediatrician should be available to youth who are struggling with sexual orientation issues and support a healthy passage through the special challenges of the adolescent years. Pediatricians may be called on to help parents, siblings, and extended families of nonheterosexual youth. Also, nonheterosexual youth and adults are part of peer groups with whom all pediatric patients and their parents spend time in the neighborhood, at school, or at work. Thus, pediatricians may be called on to help promote better understanding of issues involving nonheterosexual youth.

Gay, lesbian, and bisexual people in the United States have unique health risks. The US Department of Health and Human Services has identified 29 *Healthy People 2010* objectives in which disparities exist between homosexual or bisexual persons and heterosexual persons. These focus areas include access to care, educational and community-based programs, family planning, immunization and infectious disease, sexually transmitted diseases (STDs) including human immunodeficiency virus (HIV) infection, injury and violence prevention, mental health and mental disorders, substance abuse, and tobacco use.[3]

DEFINITIONS

Sexual orientation[4,5] refers to an individual's pattern of physical and emotional arousal toward other persons. Heterosexual individuals are attracted to persons of the opposite sex, homosexual individuals are attracted to persons of the same sex, and bisexual individuals are attracted to persons of both sexes. Homosexual males are often referred to as "gay"; homosexual females are often referred to as "lesbian." In contrast, gender identity is the knowledge of oneself as being male or female, and gender role is the outward expression of maleness or femaleness. Gender identity and gender role usually conform to anatomic sex in both heterosexual and homosexual individuals. Exceptions to this are transgendered individuals and transvestites. Transgendered individuals feel themselves to be of a gender different from their biological sex; their gender identity does not match their anatomic or chromosomal sex. Transvestites are individuals who dress in the clothing of the opposite gender and derive pleasure from such ac-

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tions; their gender role does not match societal norms. Transgendered individuals and transvestites can be heterosexual, homosexual, or bisexual.

Sexual orientation is not synonymous with sexual activity or sexual behavior (the way one chooses to express one's sexual feelings). Certain sexual behaviors can put individuals of any sexual orientation at risk of pregnancy (penile-vaginal sexual intercourse) and/or certain diseases (penile-vaginal, oral, and anal sexual intercourse). Especially during adolescence, individuals may participate in a variety of sexual behaviors. Many homosexual adults report having relationships and sexual activity with persons of the opposite sex as adolescents,[6,7] and many adults who identify themselves as heterosexual report sexual activity with persons of the same sex during adolescence.[8–10] Also, many youth label themselves as gay, lesbian, or bisexual years after labeling their attractions as such.[11] In addition, adolescents may also self-identify as nonheterosexual without ever being sexually active. Pediatricians need to understand that they should inquire about sexual attraction or orientation even when youth do not report being gay or lesbian.

ETIOLOGY AND PREVALENCE

Homosexuality has existed in most societies for as long as recorded descriptions of sexual beliefs and practices have been available.[4] Societal attitudes toward homosexuality have had a decisive effect on the extent to which individuals have hidden or made known their sexual orientation.

Human sexual orientation most likely exists as a continuum from solely heterosexual to solely homosexual. In 1973, the American Psychiatric Association reclassified homosexuality as a sexual orientation or expression and not a mental disorder.[12] The mechanisms for the development of a particular sexual orientation remain unclear, but the current literature and most scholars in the field state that one's sexual orientation is not a choice; that is, individuals do not choose to be homosexual or heterosexual.[8,11]

A variety of theories about the influences on sexual orientation have been proposed.[5] Sexual orientation probably is not determined by any one factor but by a combination of genetic, hormonal, and environmental influences.[2] In recent decades, biologically based theories have been favored by experts. The high concordance of homosexuality among monozygotic twins and the clustering of homosexuality in family pedigrees support biological models. There is some evidence that prenatal androgen exposure influences development of sexual orientation, but postnatal sex steroid concentrations do not vary with sexual orientation. The reported association in males between homosexual orientation and loci on the X chromosome remains to be replicated. Some research has shown neuroanatomic differences between homosexual and heterosexual persons in sexually dimorphic regions of the brain.[5] Although there continues to be controversy and uncertainty as to the genesis of the variety of human sexual orientations, there is no scientific evidence that abnormal parenting, sexual abuse, or other adverse life events influence sexual orientation.[4,5] Current knowledge suggests that sexual orientation is usually established during early childhood.[1,2,4,5]

The estimated proportion of Americans who are homosexual is imprecise at best, because surveys are hampered by the stigmatization and the climate of fear that still surround homosexuality. Past studies asked more often about sexual behavior and not sexual orientation. Kinsey et al,[9,13] from their studies in the 1930s and 1940s, reported that 37% of adult men and 13% of adult women had at least 1 sexual experience resulting in orgasm with a person of the same sex and that 4% of adult men and 2% of adult women are exclusively homosexual in their behavior and fantasies. A more recent review of various US studies estimated that 2% of men are exclusively homosexual and 3% are bisexual.[14] Other current studies conclude that somewhere between 3% and 10% of the adult population is gay or lesbian, and perhaps a larger percentage is bisexual.[4,5] Sorenson[15] surveyed a group of 16- to 19-year-olds and reported that 6% of females and 17% of males had at least 1 sexual experience with a person of the same sex. Remafedi et al,[10] in a large, population-based study of junior and senior high school students performed in the late 1980s that measured sexual fantasy, emotional attraction, and sexual behavior, found that more than 25% of 12-year-old students felt uncertain about their sexual orientation. This uncertainty decreased with the passage of time and increasing sexual experience to only 5% of 18-year-old students. Only 1.1% of students reported themselves as predominantly homosexual or bisexual. However, 4.5% reported primary sexual attractions to persons of the same sex, which better reflects actual sexual orientation. The Garofalo et al study,[16] based on the 1995 Massachusetts Youth Risk Behavior Survey, found that 2.5% of youth self-identified as gay, lesbian, or bisexual.

These data illustrate the complexity of labeling sexual orientation in adolescents. Health care professionals should be aware that a large number of adolescents have questions about their sexual feelings; some are attracted to and may have sexual relations with people of the same sex, and a small number may know themselves to be gay or lesbian.

SPECIAL NEEDS OF NONHETEROSEXUAL AND QUESTIONING YOUTH

The overall goal in caring for youth who are or think they might be gay, lesbian, or bisexual is the same as for all youth: to promote normal adolescent development, social and emotional well-being, and physical health. If their environment is critical of their emerging sexual orientation, these adolescents may experience profound isolation and fear of discovery, which interferes with achieving developmental tasks of adolescence related to self-esteem, identity, and intimacy.[17,18] Nonheterosexual youth often are subjected to harassment and violence; 45% of gay men and 20% of lesbians surveyed were victims of verbal and physical assaults in secondary school specifically because of their sexual orientation.[1,19]

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Nonheterosexual youth are at higher risk of dropping out of school, being kicked out of their homes, and turning to life on the streets for survival. Some of these youth engage in substance use, and they are more likely than heterosexual peers to start using tobacco, alcohol, and illegal drugs at an earlier age.[20] Nonheterosexual youth are more likely to have had sexual intercourse, to have had more partners, and to have experienced sexual intercourse against their will,[20] putting them at increased risk of STDs including HIV infection. In a recent study of HIV seroprevalence, 7% of 3492 15- to 22-year-old males who have sex with males living in 7 US cities were HIV-seropositive. Among adolescent males who have sex with males, HIV seroprevalence rates in descending order were highest among black adolescents, then "mixed race or other" adolescents, and then Hispanic adolescents and were lowest among Asian and white adolescents.[21] Women having sex with women have the lowest risk of any STD, but lesbian adolescents remain at significant risk because they are likely to have had sexual intercourse with males. Youth in high school who identify themselves as gay, lesbian, or bisexual; engage in sexual activity with persons of the same sex; or report same-sex romantic attractions or relationships are more likely to attempt suicide, be victimized, and abuse substances.[20,22] Although only representing a portion of youth who someday will self-identify as gay, lesbian, or bisexual, school-based studies have found that these adolescents, compared with heterosexual peers, are 2 to 7 times more likely to attempt suicide,[16,19,23,24] are 2 to 4 times more likely to be threatened with a weapon at school,[16,23] and are more likely to engage in frequent and heavy use of alcohol, marijuana, and cocaine. It is important to note that these psychosocial problems and suicide attempts in nonheterosexual youth are neither universal nor attributable to homosexuality per se, but they are significantly associated with stigmatization of gender nonconformity, stress, violence, lack of support, dropping out of school, family problems, acquaintances' suicide attempts, homelessness, and substance abuse.[2,25] In addition to suicidality, young gay and bisexual men might also suffer body image dissatisfaction and disordered eating behaviors for some of the same reasons.[26]

Nonheterosexual youth are represented within all populations of adolescents, all social classes, and all racial and ethnic groups. Ethnic minority youth who are nonheterosexual are required to manage more than one stigmatized identity, which increases their level of vulnerability and stress.[27] They retain their minority status when they seek help in the predominately white gay and lesbian support communities. In addition, sexual minority youth are represented among handicapped adolescents, homeless adolescents, and incarcerated youth.[1]

Most nonheterosexual youths are "invisible" and will pass through pediatricians' offices without raising the issue of sexual orientation on their own. Therefore, health care professionals should raise issues of sexual orientation and sexual behavior with all adolescent patients or refer them to a colleague who can. Such discussions normalize the notion that there is a range of sexual orientation. The portrayal of openly gay or lesbian characters in media is starting to change how adolescents view these differences. Even adolescents who are quite sure of their own heterosexuality are likely to have friends, relatives, teachers, etc whom they know or suspect to be gay or lesbian or who are struggling with questions about their sexual orientation. Rather than asking patients whether they have a "boyfriend" or "girlfriend," pediatricians could ask, "Have you ever had a romantic relationship with a boy or a girl?" or "When you think of people to whom you are sexually attracted, are they men, women, both, neither, or are you not sure yet?" By doing so, pediatricians open the door to additional communication and start to break down stereotypes and stigmatization. It implies that any of the options is possible and that an adolescent may not be sure of his or her sexual orientation. If these issues are addressed, specifically targeted medical screening, medical treatment, and anticipatory guidance can be provided to adolescents who need it. Pediatricians can have an important positive effect on young people and their families by addressing sexual orientation and sexual behavior on several levels: office and hospital policies, clinical care, and community advocacy.[2]

OFFICE PRACTICE: ENSURE A SAFE AND SUPPORTIVE ENVIRONMENT

A pediatric encounter may give adolescents a rare opportunity to discuss their concerns about their sexual orientation and/or activities. Adolescents' level of comfort in the pediatric office sets the tone for their other health care interactions. The way sexuality and other important personal issues are discussed also sets an example for all adolescents and their parents. In the office, pediatricians are encouraged to[28]:

1. Assure the patient that his or her confidentiality is protected.[29]
2. Implement policies against insensitive or inappropriate jokes and remarks by office staff.
3. Be sure that information forms use gender-neutral, nonjudgmental language.
4. Consider displaying posters, brochures, and information on bulletin boards that demonstrate support of issues important to nonheterosexual youth and their families (eg, the American Academy of Pediatrics [AAP] brochure "Gay, Lesbian, and Bisexual Teens: Facts for Teens and their Parents").
5. Provide information about support groups and other resources to nonheterosexual youth and their friends and families if requested.

COMPREHENSIVE HEALTH CARE FOR ALL ADOLESCENTS

Pediatricians are not responsible for labeling or even identifying nonheterosexual youth. Instead, the pediatrician should create a clinical environment in which clear messages are given that sensitive personal issues including sexual orientation can be discussed whenever the adolescent feels ready to do so. A major obstacle to effective medical care is adoles-

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cents' misunderstanding of their right to confidential care.[30] The pediatrician should be ready to raise and discuss issues of sexual orientation with all adolescents, particularly those in distress or engaged in high-risk behaviors. The pediatrician should be able to explore the adolescent's understanding and concerns about sexual orientation, dispel any misconceptions, provide appropriate medical care and anticipatory guidance, and connect the adolescent to appropriate supportive community resources. Pediatricians are encouraged to[29,31]:

1. Be aware of the special issues surrounding the development of sexual orientation.[29]
2. Assure the patient that his or her confidentiality is protected.[29]
3. Discuss emerging sexuality with all adolescents.[32]
   - Be knowledgeable that many heterosexual youth also may have sexual experiences with people of their own sex. Labeling as homosexual an adolescent who has had sexual experiences with persons of the same sex or is questioning his or her sexual orientation could be premature, inappropriate, and counterproductive.
   - Use gender-neutral language in discussing sexuality; use the word "partner" rather than "boyfriend" or "girlfriend," and talk about "protection" rather than just "birth control."
   - Give evidence of support and acceptance to adolescents questioning their sexual orientation.
   - Provide information and resources regarding gay, lesbian, and bisexual issues to all interested adolescents.
   - Ask all adolescents about risky behaviors, depression, and suicidal thoughts.
   - Encourage abstinence, discourage multiple partners, and provide "safer sex" guidelines to all adolescents.[33] Discuss the risks associated with anal intercourse for those who choose to engage in this behavior, and teach them ways to decrease risk.
   - Counsel all adolescents about the link between substance use (alcohol, marijuana, and other drugs) and unsafe sexual intercourse.
   - Ask all adolescents about personal experience with violence including sexual or intimate-partner violence.

   Provide additional screening and education as indicated for each adolescent's sexual activity:
   - STD testing from appropriate sites[34]
   - HIV testing with appropriate support and counseling[35]
   - Pregnancy testing and counseling[36,37]
   - Papanicolaou testing
   - Hepatitis B and, when appropriate, hepatitis A immunization
4. Ensure that colleagues to whom adolescents are referred or with whom you consult are respectful of the range of adolescents' sexual orientation.

SPECIAL CONSIDERATIONS FOR NONHETEROSEXUAL YOUTH

For adolescents who self-identify as gay, lesbian, or bisexual, pediatricians should be particularly aware of several points:

1. Be prepared to refer adolescents' care if you have personal barriers to providing such care. Many individuals have strong negative attitudes about homosexuality or may simply feel uncomfortable with the subject. Even discomfort expressed through body language can send a very damaging message to nonheterosexual youth. It is an ethical and professional obligation to make an appropriate referral in these situations for the good of the child or adolescent.
2. Assure the patient that his or her confidentiality is protected.[29] Discuss with adolescents and, if appropriate, their parents whether they wish to have their sexual orientation recorded in office and hospital charts. Many nonheterosexual adults prefer to have this information recorded so that health care professionals will not assume heterosexuality.
3. Help the adolescent think through his or her feelings carefully; strong same-sex feelings and even sexual experiences can occur at this age and do not define sexual orientation.
4. Carefully identify all risky behaviors (sexual behaviors; use of tobacco, alcohol, and drugs; etc) and offer advice and treatment if indicated.
5. Ask about mental health concerns and evaluate or refer patients with identified problems.
6. Offer support and advice to adolescents faced with or anticipating conflicts with families and/or friends.
7. Encourage transition to adult health care when age-appropriate.

Pediatricians should be aware that the revelation of an adolescent's homosexuality (also called disclosure or "coming out") has the potential for intense family discord.[1,2,28] In many families, it precipitates physical and/or emotional abuse or even expulsion. The pediatrician can advise the adolescent to use certain language that may be helpful at the time of disclosure, such as "I am the same person, you just know one more thing about me now." However, there is no one disclosure technique that will preclude negative reactions. Parents, siblings, and other family members may require professional help to deal with their confusion, anger, guilt, and feelings of loss, and professionals who work with adolescents may be required to intervene on the adolescent's behalf. If the pediatrician has a relationship with the parents from ongoing primary care, he or she can be an important initial source of support and information. However, adolescents should be counseled to think carefully about the consequences of disclosure and to take their time in sharing information that could have many repercussions.[1]

With regard to parents of nonheterosexual adolescents, pediatricians are encouraged to:

1. Advise adolescents about whether, when, and how to disclose their nonheterosexuality to their parents. If unsure, assist the adolescent in finding a knowledgeable professional who can help.
2. Be knowledgeable about the process of disclosure.

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3. Be supportive of parents of adolescents who have disclosed that they are not heterosexual. Most states have chapters of Parents and Friends of Lesbians and Gays (PFLAG) to which interested families may be referred.
4. Remind parents and adolescents that gay and lesbian individuals can be successful parents themselves.[38–41]
5. Be prepared to refer parents if you do not feel personally comfortable accepting this responsibility.

COMMUNITY ADVOCACY

Despite AAP statements issued in 1983[42] and 1993[43] urging excellent clinical care for nonheterosexual adolescents, these patients still experience many risks to their physical and mental health and safety that occur outside the scope of usual office practice. Some pediatricians may wish to take a broader role in their communities to help decrease these risks. Pediatricians could model and provide opportunities for increasing awareness and knowledge of homosexuality and bisexuality among school staff, mental health professionals, and other community leaders. They can make themselves available as resources for community HIV and acquired immunodeficiency syndrome (AIDS) education and prevention activities. It is critical that schools find a way to create safe and supportive environments for students who are or wonder about being nonheterosexual or who have a parent or other family member who is nonheterosexual. Support from respected pediatricians can facilitate these efforts greatly. Pediatricians who choose to be active on these issues may wish to[2,28]:

1. Help raise awareness among school and community leaders of issues relevant to nonheterosexual youth.
2. Help with the discussion of when and how factual materials about sexual orientation should be included in school curricula and in school and community libraries.
3. Support the development and maintenance of school- and community-based support groups for nonheterosexual students and their friends and parents.
4. Support HIV and AIDS prevention and education efforts.
5. Develop and/or request continuing education opportunities for health care professionals related to issues of sexual orientation, nonheterosexual youth, and their families.

SUMMARY OF PHYSICIAN GUIDELINES

The AAP reaffirms the physician's responsibility to provide comprehensive health care and guidance in a safe and supportive environment for all adolescents, including nonheterosexual adolescents and young people struggling with issues of sexual orientation. Some pediatricians might choose to assume the additional role of advocating for nonheterosexual youth and their families in their communities. The deadly consequences of HIV and AIDS, the damaging effects of violence and ostracism, and the increased prevalence of adolescent suicidal behavior underscore the critical need to address and seek to prevent the major physical and mental health problems that confront nonheterosexual youths in their transition to a healthy adulthood.

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