American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

FROM THE AMERICAN ACADEMY OF PEDIATRICS

TECHNICAL REPORT

Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth

David A. Levine, MD, and the COMMITTEE ON ADOLESCENCE

KEY WORDS
sexual orientation, sexual identity, sexual behaviors, adolescents, sexual minority, homosexuality, gay, lesbian, bisexual, transgender

ABBREVIATIONS
CDC—Centers for Disease Control and Prevention
FTM—females transitioning to males
GnRH—gonadotropin-releasing hormone
HPV—human papillomavirus
HSV—herpes simplex virus
IOM—Institute of Medicine
LGBTQ—lesbian, gay, bisexual, transgender, and questioning
MSM—men who have sex with men
MTF—males transitioning to females
STI—sexually transmitted infection
WSW—women who have sex with women
YRBS—Youth Risk Behavior Surveillance

The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

www.pediatrics.org/cgi/doi/10.1542/peds.2013-1283

doi:10.1542/peds.2013-1283

All clinical reports from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

(Continued on last page)

abstract

FREE

The American Academy of Pediatrics issued its last statement on homosexuality and adolescents in 2004.This technical report reflects the rapidly expanding medical and psychosocial literature about sexual minority youth. Pediatricians should be aware that some youth in their care may have concerns or questions about their sexual orientation or that of siblings, friends, parents, relatives, or others and should provide factual, current, nonjudgmental information in a confidential manner. Although most lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth are quite resilient and emerge from adolescence as healthy adults, the effects of homophobia and heterosexism can contribute to increased mental health issues for sexual minority youth. LGBTQ and MSM/WSW (men having sex with men and women having sex with women) adolescents, in comparison with heterosexual adolescents, have higher rates of depression and suicidal ideation, higher rates of substance abuse, and more risky sexual behaviors. Obtaining a comprehensive, confidential, developmentally appropriate adolescent psychosocial history allows for the discovery of strengths and assets as well as risks. Pediatricians should have offices that are teen-friendly and welcoming to sexual minority youth. This includes having supportive, engaging office staff members who ensure that there are no barriers to care. For transgender youth, pediatricians should provide the opportunity to acknowledge and affirm their feelings of gender dysphoria and desires to transition to the opposite gender. Referral of transgender youth to a qualified mental health professional is critical to assist with the dysphoria, to educate them, and to assess their readiness for transition. With appropriate assistance and care, sexual minority youth should live healthy, productive lives while transitioning through adolescence and young adulthood. *Pediatrics* 2013;132:e297–e313

INTRODUCTION

The American Academy of Pediatrics issued its first statement on sexual minority teens in 1983, with revisions in 1993 and 2004. Since the last report, research areas have rapidly expanded and hundreds of new publications have been produced about lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth. In 2011, the Institute of Medicine (IOM) published "The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding."[1]

The comprehensive IOM publication includes a section on childhood and adolescence. This updated clinical report provides definitions and the best information available about the demographics of this group of adolescents. Being a member of this group of teens is not, in itself, a risk behavior; nor should sexual minority youth be considered abnormal. However, the presence of stigma reflected in the terms "homophobia" and "heterosexism" often leads to psychological distress, which may be accompanied by an increase in risk behaviors. "Homophobia" refers to an irrational fear and resulting hatred of homosexual individuals. "Heterosexism" is the societal expectation that heterosexuality is the expected norm and that, somehow, LGBTQ individuals are abnormal. Although limited, studies on the resilience of sexual minority youth will be discussed. Studies specifically focused on the disparities in the health of these teens in mental health, substance abuse, and sexuality will be presented, along with new research about emerging effective individual and community health strategies for reducing risks. Finally, issues in providing clinical care and modifying patient care approaches will be discussed.

Although most LGBTQ youth are quite resilient and emerge from adolescence relatively unscathed, the health disparities of this vulnerable population can be significant and often daunting for pediatricians or other health care providers who are assisting youth in their care. For this report, the term LGBTQ will be used whenever discussing studies and recommendations for all lesbian, gay, bisexual, transgender youth. Some of the studies discussed did not include questioning youth — for these, the term LGBT (lesbian, gay, bisexual, and transgender) will be used. Because many adolescents do not define themselves as a member of a sexual minority group, assisting teens who are men having sex with men (MSM) and women having sex with women (WSW) will also be discussed. Some of the studies in this clinical report reference self-identified LGBTQ individuals, and others reference only sexual behavior (MSM and WSW). For this report, the term "sexual minority" includes LGBTQ and MSM/WSW individuals.

DEFINITIONS

Adolescence is characterized as a time of rapid physical, emotional, and sexual change, during which sexual discovery, exploration, and experimentation are part of the process of incorporating sexuality into one's own identity. Adolescents solidify their gender identification and expression by observing the gender roles of their parents and adults, siblings, peers, and others. Typically, a young person's sexual orientation emerges before or early in adolescence.[2,3] In the previous American Academy of Pediatrics clinical report on sexual minority youth published in June 2004, sexual orientation was referred to as "an individual's pattern of physical and emotional arousal toward other persons." In strict definition, individuals who self-identify as heterosexual are attracted to people of the opposite gender; homosexual individuals self-identify as attracted to people of the same gender; bisexual teens report attraction to people of both genders.[4] As noted in later sections, sexuality is much more complex than these classic definitions. Most self-identified gay and lesbian individuals have had sex with the opposite gender, and some continue to do so. Many heterosexuals have had sex with the same gender, yet self-identify as heterosexual.[1] In common usage, self-identified homosexual people are often referred to as "gay" if male, and "lesbian" if female.[4] Many adolescents struggle with their sexual attractions and identity formation, and some may be referred to as "questioning."[2] Many individuals also resist definition; when reporting same-gender sexual behavior, these individuals are referred to as MSM or WSW.[1]

Gender identity and gender expression usually conform to anatomic and chromosomal sex or "natal" sex for both homosexual and heterosexual teens. Gender identity is knowledge of one's self as being male or female, whereas gender expression is an outward expression of being male or female. For transgender individuals, their gender or identity does not match their natal sex. Gender nonconforming (or variant) refers to people who do not follow other people's ideas about how they should act according to gender roles. They may or may not be distressed from the nonconformity.[5] Gender dysphoria refers to dislike or distress about one's own gender and about the outward manifestations of gender (eg, hair style, clothing, sports, toys). Children often begin to express this dysphoria in the preschool period. Many young children with gender dysphoria will resolve their dysphoria by adolescence, but others will maintain it. It is difficult to predict, however, whether a young child with gender dysphoria will be transgender as a teenager or adult. Thus, it is best to help families to manage this uncertainty and make it clear in the family that all options remain acceptable and available as the child grows up.[2,6]

Transgender people may be heterosexual, homosexual, or bisexual.[7] Transgender people are often also identified by the natal gender and transition to the desired gender; MTF

refers to males transitioning to females and FTM are females transitioning to males. Transgender people may or may not desire to alter their body to match their perceived gender. When people have undergone hormonal and/or surgical alteration, they are often referred to as "transsexual." Gender dysphoria refers to the emotional distress of having a gender identity that is different from natal sex.[1,5,7] In the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, there was also a set of diagnostic criteria for "gender identity disorder," but critics have noted that this "pathologizes" the issue for the patient. In the forthcoming *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, there will be continued diagnostic criteria for gender dysphoria, but "gender identity disorder" will probably be eliminated.[8,9] "Transition" is defined as the process and time when a person goes from living as one gender to living as the other.[7,10,11]

As a society, our culture assumes that individuals who self-identify a sexual identity will have sexual behaviors that remain consistent with that identity. It is assumed that men or women who self-identify as gay or lesbian will only have attractions to or sexual activity with the same gender. However, the paradigm of sexuality is much more complex, according to qualitative studies in sexual minority youth. Sexual attraction is a term that is easy for all youth to understand. In contrast, for a measure describing sexual orientation using the choices heterosexual, bisexual, gay/lesbian, or unsure, most teens preferred the answers "mostly heterosexual" and "mostly homosexual."[12] This range of sexuality may be reflected in the surprising rate of teen pregnancies experienced by women who report having sex with women. WSW have reported lower rates of contraceptive use than do women having sex with men.[13,14]

Many adolescents who self-report as lesbian will still occasionally have sex with males, and many males who self-report as gay may have sex with females; thus, behaviors do not always equal identity.[1,15] Some men who have sex with men (MSM) or women who have sex with women (WSW) actively resist being identified as gay or lesbian. And some individuals who are not yet sexually experienced already self-identify as gay, lesbian, or bisexual.[2] Questioning adolescents struggle with sexuality issues more than others, and their sexual behaviors may be diverse. Studies examining how questioning adolescents resolve their inner struggles and reach a stable sexual identity are ongoing.[16] Definitions are summarized in Table 1.

GENDER IDENTITY FORMATION

Awareness of gender identity happens very early in life. Between ages 1 and 2 years, children become conscious of physical differences between the 2 sexes. By age 3, children can identify themselves as a boy or a girl, and, by age 4, gender identity is stable. In middle childhood, gender identification continues to become more firmly established, reflected in children's interests in playing more exclusively with youngsters of their own gender and also in their interest in acting like, looking like, and having things like their same-sex peers. Occasionally, a child may seem to display gender-role confusion. More than just lacking an interest in what society defines as traditionally masculine activities, some boys actually tend to identify with females and/or feminine traits. Likewise, some girls identify more with males and/or masculine traits. Conflicted about their gender, they may come to dislike that part of themselves that is a boy or a girl.[5,11,17] Many children resolve their dysphoria by the time they complete adolescence. Others will continue to feel dysphoria and may seek treatment to transition to the opposite gender.[1] The etiology of transgender is unknown and likely quite complex.[10]

HETEROSEXISM, HOMOPHOBIA, AND IDENTITY FORMATION

Although overt homophobia may damage the emerging self-image of an LGBTQ adolescent, often, heterosexism

TABLE 1 Definitions

Term	Definition
Homophobia	An irrational fear and resulting hatred of homosexual individuals
Heterosexism	The societal expectation that heterosexuality is the expected normal
MSM	Men having sex with men
WSW	Women having sex with women
Gender identity	Knowledge of one's self as male or female
Gender expression	Outward expression of being male or female
Gender nonconforming	Does not follow society's ideas about how they should act according to gender roles
Natal sex	Chromosomal and anatomic gender
Transition	Process and time when a person goes from living as one gender to living as the other
MTF	Male transitioning to female
FTM	Female transitioning to male
Conversion or reparative therapy	Attempts to "convert" the individual to heterosexual
Survival sex	Engaging in sexual intercourse in exchange for shelter, food, or money; often includes high-risk or unprotected sexuality

is more insidious and damaging. Homophobia refers to an irrational fear and resulting hatred of homosexuality and homosexual individuals. Pervasive in our culture, homophobia is institutionalized in stereotypes promoted in the media and in casual conversation.[18] Heterosexism is the societal expectation that heterosexuality is the expected norm and that somehow LGBTQ teens are "abnormal." Although it is often easy for the majority of sexual minority youth to hide their sexuality from family and friends, nondisclosure may ultimately be damaging to adolescents' developing self-image.[19,20] Homophobia perceived by LGBTQ youth may lead to self-destructive behaviors.[21] Societal homophobia is reflected in the higher rates of bullying and violence suffered by sexual minority youth.[22] Many sexuality education curricula taught in schools limit discussion to "'abstinence-only' until heterosexual marriage." This expected standard may serve to further isolate and alienate many sexual minority youth and contributes to increased risks of personal violence, mental health issues, substance abuse, and risky sexual behaviors.[19,23–25]

With proper support and guidance, the majority of LGBTQ youth emerge as adults with sexual identities that are associated with little or no significant increase in risk behaviors compared with other youth. These resilient young adults lead happy, productive lives.[26] Pediatricians have a role in helping teenagers sort through their feelings and behaviors. Young people need information about healthy, positive expressions of sexuality, and pediatricians should assist adolescents as they develop their identities and to avoid the consequences of unwanted pregnancy and sexually transmitted infections (STIs), regardless of sexual orientation.[27] Research suggests that LGBTQ youth really value these opportunities for discussions with their pediatricians or primary health care providers.[28] The role of the pediatrician is further described in the section "Making the Office Teen-Friendly for Sexual Minority Youth."

There may be several barriers for pediatricians in working with LGBTQ youth. Until recently, there was not a focus on LGBTQ issues in medical education. The Association of American Medical Colleges has recently begun to develop additional resources for medical educators to use in implementing curricular reform on this topic.[29] The Joint Commission also recently published a comprehensive guidebook for hospital organizations.[30] Although confidentiality is recommended for all adolescents, there may be inadvertent breaches related to electronic health record access and insurers that send explanations of benefit information to parents.

Parental and other adult reactions to "coming out" vary, and often, adolescents and their families will also need support from their pediatrician during this process. Parents play a critical role in support of development for their sexual minority children. The IOM report noted that "parental support either partially or fully mediated associations related to suicidal thoughts, recent drug use, and depressive symptomatology."[1] Negative parental reactions were also associated with higher rates of risk behaviors.[1,31] Parent support organizations, such as Parents, Families and Friends of Lesbians and Gays (www.pflag.org), can provide essential resources for parents.

NATIONAL STATISTICS

There are inherent difficulties in obtaining accurate data about sexual minority youth. Virtually all of the available information is self-report data on survey instruments; sample bias and general limitations of self-reported data limit accuracy.[32] Although some adolescents are comfortable enough to reveal their sexuality on these instruments, many may not trust that their information will truly be protected. It may take some time for an adolescent to come to an understanding of his/her sexual identity before it is possible to label or describe it or discuss it with others. Some of the best data about the number of gay or lesbian teenagers are state or city specific. Some states and communities have added questions to the Centers for Disease Control and Prevention's (CDC's) Youth Risk Behavior Surveillance (YRBS) System: at the time of this writing, Minnesota,[33] Vermont,[34] Massachusetts,[35] and New York City[36] have added these questions. More nationally representative data are found in the few recent national studies available.

In the 2006–2008 National Survey of Family Growth, 13.4% of females and 4.0% of males 15 to 24 years of age self-reported that they had sex with someone of the same gender.[37] This number is much larger than those who would describe themselves as gay, lesbian, or bisexual. Among participants in the Growing Up Today Study, a US community-based longitudinal cohort study in 9039 female and 7843 male children recruited at 9 to 14 years of age whose mothers were participating in the Nurses' Health Study II, 16.3% of females and 8.7% of males reported a sexual orientation other than heterosexual.[38] In wave 1 of the National Longitudinal Study of Adolescent Health administered to students in grades 7 through 12, same-gender relationships or attractions were reported in 7% of girls and 8.4% of boys.[39] Recently, the CDC combined data from several YRBS survey administrations studying behaviors among 9th through 12th grade sexual minority youth in the states that inquired about

sexual identity and the gender of sexual contacts. Seven states (Delaware, Maine, Massachusetts, Rhode Island, Vermont, Connecticut, and Wisconsin) and 6 large urban school districts (Boston, Chicago, Milwaukee, New York, San Diego, and San Francisco) elected to participate and used questions offered by the CDC. Across the 12 sites that assessed gender of sexual contacts, 53.5% reported having had sex with the opposite gender, 2.5% reported having had sex with the same gender, 3.3% reported having had sexual contact with both genders, and 40.5% reported having had no sexual contact.[22]

Estimation of the prevalence of gender identity disorder and transgender youth is more difficult because of the lack of population-based studies. The World Professional Association for Transgender Health published their seventh version of Standards of Care in 2011. Acknowledging the difficulty in obtaining true prevalence data, the World Professional Association for Transgender Health estimated prevalences of 1 in 11 900 to 1 in 45 000 for MTF youth and 1 in 30 400 to 1 in 200 000 for FTM youth.[5] Because most studies have been performed in services providing transition care, population-based studies are needed to capture the hidden populations not accessing such care.[10]

HEALTH DISPARITIES FOR GAY, LESBIAN, AND BISEXUAL YOUTH

Stigmatization, ostracism, and parental rejection remain common. Resulting struggles with self-image and self-esteem often put sexual minority youth at risk. Depression and other mental health issues may be manifest as these teens struggle with developing a stable self-identity and family/community acceptance.[13,40,41] As many as 25% to 40% of homeless youth may be LGBTQ or MSM/WSW, leading to additional risk-taking behaviors. Many sexual minority youth become homeless as a consequence of coming out to their families. After coming out or being discovered, many LGBTQ youth have been thrown out of their homes or mistreated, leading to runaway status and homelessness. Unfortunately, sexual minority youth who are homeless may engage in survival sex, leading to riskier behaviors and contributing to health disparities.[42]

Mental Health Disparities

Significant health disparities exist for sexual minority youth related to depression and suicidality, substance abuse, social anxiety, altered body image, and other mental health issues.[1,18,22,43] Data from the 2007 Washington, DC, administration of the YRBS survey revealed that 40% of sexual minority youth, compared with 26% of heterosexual youth, reported feeling sad or hopeless in the past 2 weeks. LGBTQ youth were more than twice as likely to have considered suicide in the past year (31% vs 14%).[18] This increased risk has been extensively replicated in other studies and communities.[1,22,44,45] Even for these teens, however, protective factors come into play. Data from the 2004 Minnesota Student Survey of 9th and 12th graders, in which 2255 respondents reported a same-gender romantic or sexual experience, revealed that more than half of LGBTQ students had thought about suicide, and 37.4% had reported a suicide attempt. In this study, the factors that were significantly protective against suicidal ideation and attempts included family connectedness, caring adults, and school safety.[46] Another study found that suicide attempts among sexual minority youth were positively correlated with parental psychological abuse of the child, being considered gender atypical in childhood by parents, and parental efforts to discourage gender atypical behavior.[47] Sexual minority teens who run away or are put out by their families after acknowledging their sexuality are often victimized, which leads to further mental health issues. Homeless LGBTQ teens are more likely than heterosexual teens to meet criteria for each of 4 mental disorders: major depressive disorder, post-traumatic stress disorder, substance abuse, and conduct disorder.[48]

Social anxiety symptoms are experienced more often by LGBTQ adolescents. In a study in 100 young gay men in a 3-state area of the US East Coast, it was discovered that social anxiety predicted an increased probability of having engaged in unprotected anal intercourse in the previous 6 months.[49] Another study comparing 87 heterosexual and gay male undergraduates at the State University of New York at Stonybrook found that gay men reported greater fear of negative evaluation, greater social interaction anxiety, and lower self-esteem than did heterosexual men.[50]

Unfortunately, an additional barrier to care for LGBTQ (and other) adolescents may be a lack of mental health services in certain communities or mental health services that are not adolescent or sexual minority friendly. Services for adolescents in poverty may be even more limited.[51] In no situation is a referral for conversion or reparative therapy indicated. An American Psychological Association task force to review peer-reviewed studies on efforts to change sexual orientation concluded that conversion therapy is not effective and may be harmful to LGBT individuals by increasing internalized stigma, distress, and depression.[1]

Bullying and Victimization

When sexual minority teens "come out" and acknowledge their sexuality as adolescents, there are often significant

repercussions, especially victimization.[1,4,22,23,25] Even if not open about sexuality, 16% of MSM reported experiencing violence. Sometimes it is simply the perception that an individual might be LGBT that may lead to bullying, harassment, and violence.[52] LGBTQ and MSM individuals report that the violence directed toward them is because of perceived sexual orientation or femininity.[53] When sexual minority youth are victimized, the physical assault may lead to death (homicide). Victimized LGBTQ, MSM, and WSW youth may experience increased mental health disorders including depression, sometimes leading to death by suicide. There is a strong association between victimization and suicidality among sexual minority adolescents recruited from gay youth community or university-based organizations.[54]

Bullying at school with resultant adolescent suicide has received increased national attention.[55] Of adolescents who are open about their LGBTQ sexual orientation, 84% reported verbal harassment; 30% reported being punched, kicked, or injured; and 28% dropped out of school because of harassment. The Consortium of Higher Education LGBT Resource Professions published a press release in October 2010 documenting the violence, injuries, and in some cases, deaths of LGBTQ adolescents.[56] The study of pooled CDC data from the 2001–2009 administrations of the YRBS survey to examine risk behaviors faced by sexual minority youth included questions on being victims of threats or violence. In the 9 communities that included relevant questions, sexual minority youth were more likely than heterosexual youth to be in a physical fight, to be injured in a fight, to be threatened on school grounds, and to stay home from school because of perceived risk of violence.[22]

Positive, supportive school environments, those with zero or at least low tolerance for homophobic teasing, bullying, or abuse, were recently shown to be protective, with significantly lower rates of depression and suicidality for sexual minority youth.[25] Supporting the development of policies in school districts that limit teasing and bullying is an important role of the pediatrician. The US Department of Health and Human Services recently has increased antibullying efforts, and among other initiatives, has launched a new Web site, http://www.StopBullying.gov, which includes a specific section for sexual minority youth.[57]

Unfortunately, schools are not the only source of homophobic/heterosexist bullying. Although less research has focused on nonschool settings, LGBT youth experience victimization in their homes, communities, and other institutions.[1] Even after the repeal of the "Don't ask, don't tell" policy, there continues to be victimization in the military.[58]Although many churches are offering education to their members about the issue of bullying in general, some churches continue to bully sexual minority youth.[59] "Cyberbullying," or bullying with electronic means (eg, Internet, texting), is rampant; 32% of all teens say they have been targeted in some form.[60] In 1 study, 52% of LGBT adolescents noted they had been cyberbullied in the past 30 days.[61]

Eating Disorders

Although 10% to 15% of all cases of eating disorders are in men, as many as 42% of young men affected may be gay or bisexual.[62] Male sexual minority youth demonstrated more binge eating and purging than did male heterosexual youth.[63,64] The IOM report acknowledged these findings but noted that they were from small studies and that additional research is necessary.[1] There also may be an association with eating disorders in transgender MTF individuals, but more research is necessary.[65]

Substance Abuse

With the psychosocial and anxiety-provoking stressors of homophobia and heterosexism, the enticement and escape of getting high may be addictive and can lead to increasing use of substances. The pooled YRBS study combining 2001–2009 data revealed significantly higher rates of current alcohol use in the past 30 days in self-identified sexual minority youth (bisexual, 55.6%; gay/lesbian, 47.5%; questioning, 35.1%; and heterosexual, 37.6%).For current use of marijuana, the rates were 36.8% among bisexual youth, 34.5% among gay/lesbian youth, 25.4% among questioning youth, and 21.8% among heterosexual youth. More striking differences were observed among youth for the following: (1) current cocaine use (gay/lesbian, 16.6%; bisexual, 11%; questioning, 11.4%; and heterosexual, 1.8%), (2) ever having used ecstasy (gay/lesbian, 22.9%; bisexual, 20.4%; questioning, 11.4%; and heterosexual, 4.6%), (3) ever having used heroin (gay/lesbian, 17.7%; bisexual, 9.6%; questioning, 13%; and heterosexual, 1.8%), and (4) ever having used methamphetamine (gay/lesbian, 21.5%; bisexual, 14.9%; questioning, 13.2%; and heterosexual, 3.4%).[22] Because this study combined the data for MSM and WSW and included information only from the 7 states and 6 school districts that volunteered to ask more sexuality questions, the data may not be as nationally representative. Tobacco use is also overrepresented among gay and lesbian youth.[1,66–69] Research into best practices to prevent and reduce tobacco use in sexual minority youth is underway.[70–72]

The Young Men's Survey, from 1994 to 1998, was the first study that was considered to have a nationally representative sample of substance-using young MSM. The sample was from 7 major cities, with young men 15 to 22 years of age. The primary objective

was to improve access to HIV testing in a high-risk population. In the study, 93% had used alcohol, 71% had used marijuana, 31% had used cocaine, 28% had used methamphetamine, and 27% had used ectasy.[73] A more recent study from 2007 attempted to assess the substance abuse rates for MSM 18 to 22 years of age in Los Angeles. Ninety percent of the sample reported use of alcohol (including 21% who had engaged in binge drinking), 64% reported use of marijuana, 23% reported use of cocaine, 20% reported use of methamphetamine, and 21% reported use of ectasy. The comparison group used was the national sample from the 2006 Monitoring the Future Study (sexual minority and heterosexual youth combined), in which 75% reported alcohol use, 45% reported marijuana use, 8% reported cocaine use, 5% reported methamphetamine use, and 5% reported ecstasy use. Rates of crack cocaine and heroin use were low in both study groups.[74]

Many studies have examined substance use by gay men, but fewer studies have explored WSW or lesbian youth's and young adults' substance use. WSW at a Midwestern university were 4.9 times more likely to smoke, 10.7 times more likely to drink, and 4.9 times as likely to smoke marijuana compared with women having sex with men.[75]

Use of club drugs (eg, cocaine, methamphetamine, and ecstasy, along with GHB [γ-hydroxybutyric acid], ketamine, and LSD [lysergic acid diethylamide] or "acid") is especially a health concern because of the association with other risk behaviors, including unprotected sexual intercourse. Initiation of young MSM into methamphetamine use seems to occur in social, not specifically sexual, settings, with users admitting to limited knowledge of its adverse effects and consequences.[76] Sexual minority youth who "party and play" (PNP) advertise every day on Web sites that attract LGBTQ youth and young adults. When young men attend gay clubs and other gay-oriented activities, their risk of alcohol and marijuana use increases. Interventions designed to address safety and responsible behaviors in these venues for young MSM need to be developed, implemented, and evaluated.[77]

Sexual and Reproductive Health Disparities

Significant health disparities exist in sexual health outcomes with respect to HIV/AIDS, other STIs, and teen pregnancy among LGBTQ youth. As mentioned previously, sexual minority youth do not necessarily engage in sexual behaviors that are predicted by their orientation. In the CDC's pooled YRBS study, although 1.3% identified themselves as gay or lesbian, 2.5% reported having intercourse with the same gender only and 3.3% reported having sex with both genders.[22]

Regarding sexual behavior, the YRBS pooled data study found that sexual minority youth were more likely than heterosexual youth to report having had intercourse, to have had intercourse before 13 years of age, and to have had intercourse with ≥4 people. Gay or lesbian youth were about half as likely as heterosexual youth (35.8% vs 65.5%) to have used a condom at the last intercourse.[22] In a study in young gay men in college, even after adjusting for age, race, academic classification, and residence, gay men reported higher odds of inconsistent condom use, increased numbers of multiple partners in the past 30 days, and increased risk of illicit drug use than did their heterosexual peers.[78] Between 27% and 48% of young MSM have engaged in unprotected anal intercourse in the previous 6 months.[42] Involvement in these behaviors may explain, in part, why during the past 15 years, reported rates of gonorrhea, chlamydia, and syphilis have trended downward for all adolescents, except for MSM.[79] Substance-abusing gay or lesbian teens may also have more risky sexual behaviors, leading to higher rates of HIV seropositivity.[80,81]

One particular disparity is in HIV infection. The IOM report notes that "the burden of HIV infection among young people falls disproportionally on young men under 25 who have sex with men, particularly those who belong to racial/ethnic minority groups."[1] Data from the CDC reveal that HIV rates continue to increase among young MSM 13 to 24 years of age. For all men, HIV rates between 2001 and 2006 increased by 9%, whereas rates for young MSM (13 to 24 years of age) increased by 12.4% and rates for young black MSM increased by 14.9%. In the age range of 13 to 24 years, MSM of all ethnicities accounted for 60% of the total HIV infections.[82] Despite these alarming data, the IOM report noted that there has been no commensurate response to develop interventions to decrease this risk. The vast majority of published reports on HIV-prevention programs focus on heterosexual adolescents and young adults.[1]

Information on sexual health disparities experienced by WSW is limited; until recently, little research was devoted to lesbian health and many, including physicians, incorrectly assumed that lesbians were at minimal risk of STIs.[83] As noted, many WSW have also had intercourse with men.[1] High rates of STIs have been documented in lesbians and bisexual women with recent sexual contact with men. Viral infections, such as human papillomavirus (HPV) and herpes simplex virus infection (HSV), may be transmitted via exclusive female-to-female sexual contact. In a study in bisexual and lesbian college women, 9% of those who had had sex with both men and women

reported that they had had an STI, but 2% of women who exclusively had sex with women also reported that they had had an STI.[84]

LGBTQ youth are less likely to report use of hormonal or barrier contraceptives at last sexual encounter when having sex with the opposite gender. Young women who identified themselves as "unsure" of their sexual orientation were half as likely to report using contraception at last intercourse.[42] Given the high rates of earlier sexual initiation, a greater number of partners, and less contraceptive use, WSW are at higher risk of teen pregnancy than are teens who only have sex with the opposite gender. In the 1999 Minnesota Adolescent Health Survey, lesbian and bisexual women, when compared with heterosexual youth, were found to be about as likely to have had vaginal intercourse (33% vs 29%) but had twice the rate of pregnancy (12% vs 6%) and were more likely to have had ≥2 pregnancies (23.5% vs. 9.8%). In a small study in 137 young women having sex with women (ages 16 to 24 years), 20% reported having had been pregnant.[1]

WSW and MSM report high rates of physical and sexual abuse.[85,86] In 1 study, the rate was 19% to 22%.[87] Consequences for sexual minority youth who have experienced physical or sexual abuse include higher rates of intimate partner violence as adults,[86] frequent drug use and higher-risk sex,[88] and higher rates of HIV.[89] Homeless sexual minority youth are more likely to report histories of physical and sexual abuse and report engaging in risky sexual behaviors as survival strategies.[48] Childhood sexual abuse does not cause children to become LGBTQ.[90]

Health Disparities for Transgender Youth

National data detailing the scope of medical, mental health, and substance abuse issues for transgender youth are lacking. Like other sexual minority youth, self-identifying as transgender does not necessarily indicate the existence of other mental health issues.[91] However, challenges faced by such youth and the potential of family and societal disapproval may increase the risk that transgender adolescents will experience mental health issues, substance abuse, and sexual risk-taking behaviors.[1] Family rejection, peer rejection, harassment, trauma, abuse, legal problems, educational problems, and resulting poverty and homelessness are faced by transgender youth and adults. Transgender people face alarmingly high rates of verbal harassment and physical violence, including at home and at school.[1] Transgender youth face significant mental health issues as a consequence, including depression and suicidality, anxiety, body image distortion, substance abuse, and post-traumatic stress disorder. As with all teens, supportive families can buffer an adolescent from these negative outcomes and promote positive health and well-being.[10]

MTF transgender youth face even more sexual health disparities than other sexual minority youth, with very high rates of HIV and other STIs. One study by the Department of Public Health in San Francisco revealed that HIV prevalence among MTF transgender individuals was 38% (the rate for FTM transgender individuals was much lower, at 2%). Risk factors for HIV infection among MTF transgender individuals in this study included African American race, attaining low education status, having a history of injection drug use, and reporting multiple sexual partners.[92] Another study addressing racial disparity in MTF transgender individuals in New York revealed higher rates of STIs and HIV in African American and Hispanic, compared with white, individuals. The higher STI rates in the study were associated with more lifetime partners, having engaged in commercial sex, unemployment, and injection drug use.[93] An HIV risk study examined 51 transgender MTF ethnic minority adolescents and young adults 16 to 25 years of age in Chicago and found that 22% were HIV-positive. Contributing factors included history of incarceration (37%), homelessness (18%), exchanging sex for resources (59%), nonconsensual sex (52%), and difficulty accessing health care (41%). Among HIV-positive MTF transgender individuals, 98% reported having had sex with men, including unprotected receptive anal intercourse (49%). The study also noted that 53% had had sex while under the influence of drugs or alcohol and 8% had used injection drugs. Twenty-nine percent had injected liquid silicone (as part of their MTF transition) in their lifetime; 8% had shared needles for hormone or silicone injection, increasing HIV transmission risk. For transgender individuals who purchase or obtain transgenic hormones (estrogen or testosterone) on the street or from the Internet, there may be significant health problems if used improperly, even if they are pure.[94]

THE RESILIENCE OF LGBTQ YOUTH

Even with the unique challenges faced by sexual minority youth, the majority grow up healthy and lead happy, productive lives. Research is now beginning to analyze the patterns of resilience in LGBTQ youth. A qualitative study in gay male youth 16 to 22 years of age noted that "general developmental dysfunction is not inevitable for gay adolescents, nor is identifiable personal or family pathology directly related to sexual identity."[95] Similar to other studies in adolescents, another study found that family connectedness, school connectedness, and religious involvement were protective factors, leading to fewer risk behaviors.[26]

Several studies have confirmed that a supportive family network, supportive teachers, and access to gay-straight student alliances at school were all significantly protective.[96,97]

HEALTH CARE FOR SEXUAL MINORITY YOUTH

Pediatricians have the responsibility to provide culturally effective care to help reduce health disparities. Such care should be individualized and meet the needs of the patient regardless of social, educational, or cultural background. This requires an understanding of a patient's ethnic group, neighborhood group, family identification, and religious affiliation.[98] Understanding sexual orientation, behavior, and gender identity is another part of this process.

Being gay, lesbian, bisexual, transgender, or questioning, is not a "problem" or "risk behavior" in itself. These teens, like all teens, should be individually assessed for challenges, vulnerabilities, strengths, and assets. Positive behaviors should be reinforced; teens can be engaged in targeted behavioral interventions to reduce existing risk behaviors. As noted in *Bright Futures*,[27] it is part of the responsibility of the pediatrician to help adolescents identify their strengths and build on their existing talents. Pediatricians and their office staff can encourage teenagers to feel comfortable to talk to them about their emerging sexual identity and concerns about their sexual activities. On the other hand, it is not the role of pediatricians to identify a young person as being gay, or lesbian, unless the teenager has chosen to discuss this. Care should be confidential, and it is not the role of the pediatrician to inform parents/guardians about the teenager's sexual identity or behavior; doing so could expose the youth to harm.[88]

Making the Office Teen-Friendly for Sexual Minority Youth

One of the challenges to health care is removing barriers to care and creating an environment welcoming all teens. Even LGBTQ youth who are open about their sexuality may not feel comfortable disclosing sexuality to their pediatrician. In a study in 131 sexual minority youth attending an empowerment conference, only 35% reported that their physician knew that they were lesbian, gay, or bisexual.[99] LGBTQ adolescents who are hiding their sexuality become quite adept at using gender-neutral terms to describe their relationships and sexual behaviors. Pediatricians' use of gender-neutral terms can encourage teenagers to discuss any questions they have about their sexual behaviors or sexual orientation.[27] Table 2 offers suggestions for gender-neutral questions a pediatrician can use as components of the psychosocial interview.[100] Although pediatricians may use gender-neutral items in obtaining histories, some teens may still choose not to disclose or may delay doing so until a subsequent visit.[101]

It is just as important that the pediatrician's office staff is nonjudgmental and welcoming. Internalized homophobia and heterosexism in the office setting may not be recognized by staff members but will inadvertently interfere with appropriate care. A nurse asking a teenage girl who is in a relationship with another woman about her boyfriend may be interpreted as nonaccepting of her relationship. This negative interaction may then hinder the health care provider's ability to form a trusting relationship.[88,102] Likewise, intake forms and questionnaires should not assume heterosexuality. Another advantage of altering intake forms is to be welcoming to parents who are in same-sex relationships. As for all adolescents, confidentiality should be ensured. An environment that respects the confidentiality of each client is critical for a facility that provides care for MSM/WSW and LGBTQ youth. Confidentiality must be emphasized at all levels of the clinic staff; many offices and teen clinics have developed a clinic confidentiality policy statement that should be shared with the patient and his or her identified caregiver. Parents should not have access to protected information without the adolescent's consent.[27,28] Current electronic health records may need to be modified to protect adolescents' confidentiality.

The office environment can be made welcoming for all teens by placing in the waiting room items such as brochures on a variety of adolescent topics, including sexual orientation, posters showing both same- and opposite-gender couples, and notices about support groups, if available in the region.[103] Brochures and information left in the privacy of the examination room may be more likely to be picked up by adolescent patients who are not open about their sexuality. If there are no local support groups, Web sites can be suggested so that the sexual minority adolescent does not feel isolated.[42] Even a small "rainbow" button (often a symbol of acceptance of sexual minority individuals) or decal on an office bulletin board or door symbolizes openness and acceptance of diverse sexual orientation and will be appreciated by sexual minority teens and their parents.[88]

Sexuality and Obtaining a Sexual History

For pediatricians to offer optimal clinical care, it is crucial to promote healthy sexuality, even if the teen is not sexually active. Creating an accepting environment will optimize opportunities to learn about a youth's sexual

behaviors. Teens who are abstinent should have their abstinence acknowledged and reinforced as a preferred method of prevention for both STIs and unwanted pregnancies.[27] If the adolescent notes that he or she has engaged in sexual activity, 1 classic question is "Are you having sex with males, females, or both?" For adolescents who are not yet sexually active, inquiring "Are you attracted to males, females, or both" will allow for discussions to prevent sexual risk behaviors. If the pediatrician gets an unusual response from the adolescent, a bridging statement such as "Many teenagers your age have sex with members of the opposite or the same sex" can facilitate communication.[101] It may be difficult for some teenagers to answer these questions if they have not yet established trust in the pediatrician. Previous negative experiences in health care or internalized shame as a result of societal homophobia/heterosexism may cause some teenagers to not disclose their sexual orientation or same-gender sexual activity. Sexual minority adolescents also may not trust that their confidential information will truly be kept confidential from their parents/guardians or others. It has been shown that it is easier for some teens to reveal sensitive information (eg, sexual behavior and sexual orientation) before face-to-face visits with the pediatrician.[104] The most comfortable method is on a computer, and the next best is on a paper questionnaire.[105] Once a teen has acknowledged on a previsit form that he or she has a question about sexual activity or sexual identity, it is the responsibility of the pediatrician to introduce a conversation during the subsequent interview. Often, sexuality is disclosed at a future visit after the pediatrician has built a trusting relationship with the patient.

TABLE 2 Using Gender Neutral Terms in the Psychosocial History

Heterosexist Question	Instead Ask
"Do you have a girlfriend?"	"Are you dating anybody?" "Are you involved any romantic relationship?"
"What do you and your boyfriend do together?"	"What do the 2 of you do together?" "Tell me about your partner."
"Are you and your girlfriend sexually active?"	"Are you having sex?" "Are the 2 of you in a sexual relationship?"

Sexual practices are not dissimilar for heterosexual and lesbian, gay, or bisexual or MSM/WSW teens. Many heterosexual youth engage in oral intercourse, and some engage in anal intercourse.[106] Table 3 offers some suggestions for asking about specific sexual behaviors.

Once sexual history is obtained, in the context of the remainder of the psychosocial history, then specific health-promotion activities can be encouraged. Use of substances, depression, and other mental health disorders place youth at higher sexual risk because of lack of ability to make good decisions regarding use of condoms or contraception, and these issues should be addressed.[107] Using a strength- and asset-based approach and encouraging positive youth development is an effective way to reduce risks in all teenagers, including sexual minority youth.[27,108] Frankowski et al's[109] "Strength-Based Interviewing" is a method that can be applied to all adolescents and young adults.

Pediatricians also may assist sexual minority youth in coming out to their parents/families on the patient's own terms and timetable. This includes offering supportive suggestions and counseling and providing resources to assist the patient and family.[42]

STI/HIV Testing and Prevention Recommendations for Sexual Minority Youth

Recent guidelines from the CDC recommend assessing for STI risk, which includes asking about the gender of all partners. Pediatricians should then make decisions about STI testing on the basis of the sexual behaviors identified by the sexual history.[110] Similar to other populations of adolescents, if adolescents are having protected intercourse (monogamous relationship, using condoms 100% of the time and correctly, and no substance abuse involved), it is reasonable to test them once per year. However, adolescents with multiple or anonymous partners, having unprotected intercourse, or having substance abuse issues or any other risk factors should be tested at shorter intervals.[110] Condoms should be promoted for all sexual activities that involve insertive or receptive intercourse. STI screening recommendations for MSM are described in Table 4.

TABLE 3 Sexual History Questions About Sexual Behaviors

- Have you ever had sex? What have you done sexually with a partner?
- Have you ever had oral sex? Has a partner ever "gone down" on you or have you ever "gone down" on a partner?
- Have you ever had vaginal sex? Have you ever engaged in penile-vaginal sex?
- Have you ever had anal sex? Did you put your penis in your partner's anus or did your partner put his penis in your anus?
- *If there was any insertive or receptive sex:* Do you use condoms? What percentage of the time? What about last time?
- *If there was any oral-genital contact:* Do you use dental dam or another barrier? What percentage of the time? What about last time?

A growing number of experts recommend testing for HSV (by serology) if infection status is unknown. Because of the increased incidence of anal cancer in HIV-infected MSM, screening

for anal cytologic abnormalities has been proposed.[110,111] An Atlanta study investigated cytologic screening results from HIV-positive patients, and the authors found highly significant rates of anal dysplasia (47%).[112] However, evidence is limited concerning the natural history of anal intraepithelial neoplasia, the reliability of screening methods, and the safety and response to treatments.[110] WSW are at risk of acquiring bacterial, viral, and protozoan infections from current and previous partners, both male and female. STD treatment guidelines from the CDC recommend a frank discussion of sexual identity and behavioral risk so that the physician can make decisions about which STI tests to perform. Digital-vaginal and digital-anal contact, especially with shared insertive devices, can transmit cervicovaginal secretions. Skin-to-skin or skin-to-mucosa transmission of HPV can occur. Additionally, because many WSW have also had sex with men, HPV vaccine and routine cervical cancer screening should be offered to women according to recommended guidelines. Limited data show inefficient transmission of HSV-2; however, the relatively frequent practice of orogenital sex may increase the risk of HSV-1. Bacterial vaginosis is common among women in general and even more so among WSW. Chlamydia and syphilis transmission may have been more common than previously thought; STD treatment guidelines from the CDC endorse targeted testing on the basis of sexual history. Reports by young women of sex with someone of the same gender should not deter pediatricians from screening them for STIs because of the possibility of a past history of sexual contact with male partners. Condoms should be promoted if using sex toys and dental dam should be promoted for any oral-vaginal or oral-anal contact.[110]

TABLE 4 Summary of Sexually Transmitted Diseases Screening Guidelines for MSM

- HIV serology, if HIV negative or not tested within the previous year
- Syphilis serology
- Test for urethral infection with *Neisseria gonorrheae* and *Chlamydia trachomatis* using NAATs in men who have had insertive anal intercourse during the preceding year
- Test for rectal infection with *N gonorrheae* and *Ctrachomatis* in men who have had receptive anal intercourse during the preceding year, using either preferred NAATs (for laboratories that have met regulatory requirements for an off-label procedure) or culture for *N gonorrheae* and enzyme immunoassay or direct fluorescent antibody assay for *C trachomatis*
- Test for pharyngeal infection with *N gonorrheae* in men who have acknowledged practicing receptive oral intercourse during the preceding year using NAATs (for those laboratories that have met regulatory requirements for an off-label procedure) or culture; testing for *Ctrachomatis* pharyngeal infection is not recommended[98]

NAAT, nucleic acid amplification test.

In 2011, the CDC expanded its recommendations for the quadrivalent HPV vaccine (HPV-4 [Gardasil, Merck Sharp & Dohme Corp, Whitehouse Station, NJ]). The CDC recommends routine immunization of males and females 11 or 12 years of age with HPV-4, administered as a 3-dose series. The immunization series may be started as early as 9 years of age, and if not started at 11 or 12 years of age catch-up immunization is recommended for females 12 through 26 years of age and males at 13 through 21 years of age. HPV-4 is recommended in males for the prevention of genital warts and precancerous/dysplastic lesions of the anus caused by the 4 strains in the vaccine (6, 11, 16, and 18). HPV-4 was noted to be 78% effective at preventing anal intraepithelial neoplasia from strains 16 and 18 in males. Ninety percent of all anal cancer is caused by HPV. For females, HPV-4 is recommended for prevention of genital warts and precancerous/dysplastic lesions of the cervix, vagina, vulva, and anus caused by the 4 strains contained in the vaccine. For MSM, the CDC recommends routine immunization through 26 years of age.[110,113–115] Bivalent HPV vaccine (HPV-2 [Cervarix, GlaxoSmithKline, Middlesex, United Kingdom]) has been approved for the prevention of cervical cancer and precancerous/dysplastic lesions of the cervix caused by HPV types 16 and 18 in females 8 through 25 years of age and may be offered. There are no special recommendations for sexual minority adolescents and young adults.[116]

The 2010 STD treatment guidelines from the CDC also recommend that all MSM should be tested for hepatitis B by testing blood for hepatitis B surface antigen.[110] This test may not need to be performed, however, if the pediatrician has clear evidence that the adolescent has received all doses of the hepatitis B vaccine. If not already immunized against hepatitis B or hepatitis A, all MSM should receive these vaccines. Hepatitis C testing should be conducted if the patient is a current or past drug user or if HIV infected.[117]

Because many teens who self-identify as gay, lesbian, or bisexual may have sexual encounters that may not be predicted by their orientation, conversation about birth control is important.[13,14] Emergency contraception should also be discussed. Emergency contraception is available over-the-counter if the patient is older than 17 years. A prescription may be required for a patient younger than 17 years; additional requirements vary by state.[117]

Treatment of Transgender Youth

In 2009, the Endocrine Society published "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline."[11] This was a refinement of the 2001 publication of The World Professional Association for Transgender Health's Standards of

Care, which was updated in 2011.[5] These documents integrate the best available evidence with clinical experience from experts in the field of assisting transgender patients with transition. The guidelines were further refined by Olson et al[10] in a subsequent publication on the basis of clinical experiences with a large number of transgender patients in Los Angeles. These publications discuss the importance of psychological treatment approaches. The mental health professional is called on to accurately diagnose gender dysphoria and any comorbid conditions, to counsel about the range of treatment options, to ascertain readiness for hormone and surgical therapy, to make formal recommendations to medical and surgical colleagues as part of the team of care, to educate the patient and family, and to provide follow-up. The skilled therapist will use affirming strategies: affirming the adolescent's sense of self, allowing for exploration of gender and self-definition, and conveying the message that it is "entirely acceptable to be whoever you turn out to be." It is recommended that all transgender adolescents be involved in psychological therapy, even those who are functioning well, to ensure that they have the necessary support they need and a safe place to explore identities and consider the transitioning experience.[5,10,11]

Classifications for the process of gender transition include reversible, partially reversible, and irreversible phases. Reversible transition includes the adoption of outward gender expression: wearing preferred clothing, adopting preferred hairstyles, and perhaps acquiring a new name. The use of gonadatropin-releasing hormone (GnRH) analogs is also part of the reversible stage. The Endocrine Society guidelines state, "suppression of pubertal hormones starts when girls and boys first exhibit physical changes of puberty (confirmed by pubertal levels of estradiol and testosterone, respectively) but no earlier than Tanner stages 2-3." Suppression is similar to the treatment of precocious puberty. In general, it is recommended that transgender adolescents be maintained on suppressive GnRH analogs until they are emotionally and cognitively ready for cross-gender sex hormones.[10,11] The rationale for using GnRH analogs early (at sexual maturity rating 2) and then waiting to begin hormonal therapy is so that MTF adolescents experience desired outcomes. However, as noted from 1 large center treating transgender youth, they commonly present at older ages with pubertal development too far advanced for suppressive therapy. The average age of presentation at this center was 14.8 years, with an average sexual maturity rating of 4.1.[118] Waiting too long may result in male voice pitch, laryngeal prominences, and facial hair pattern, which precludes the option of pubertal suppressive therapy.[10,11,118]

The partially reversible treatment phase involves the use of cross-gender hormone therapies. The Endocrine Society guidelines state that "pubertal development of the desired opposite gender be initiated at about the age of 16 years, using a gradually increasing dose schedule of cross-sex steroids."[11] Olson's group follows these guidelines but may choose to provide therapy earlier after careful review of the risks and benefits with the youth and parents.[10] It is recommended that cross-gender hormone therapy begin after assessment of readiness by a medical professional, including a careful review of any hormone contraindications, and by the mental health professional who documents psychological readiness. For FTM patients, testosterone is used. For MTF patients, estrogen is used, sometimes in combination with an androgen inhibitor, such as spironolactone.[10,11,118]

Adolescents undergoing partially reversible cross-gender hormone therapy should be monitored for progress in transition and for any potential medical complications. MTF patients started on estrogen might develop deep venous thrombosis, prolactinomas, hypertension, liver disease, and decreased libido and are at increased risk of breast cancer. Spironolactone can lead to hyperkalemia and decreased blood pressure. FTM patients receiving testosterone may develop hyperlipidemia, polycythemia, male pattern baldness, acne, and other significant side effects.[10,11]

Irreversible therapy occurs during the surgical phase, with many different procedures now available to create a more masculine or feminine appearance. The Endocrine Society guidelines and the World Professional Association for Transgender Health's Standards of Care recommend deferring surgery until an individual is at least 18 years of age.[5,11]

There are many barriers to transgender adolescents receiving desired medical therapies. It is difficult for transgender youth and their families to find comprehensive medical and mental health services. Pediatricians may not feel comfortable or knowledgeable enough to assist transition plans in transgender youth, in which case they should refer to another physician with experience or expertise around gender nonconformity. Most insurance companies do not pay for this care, and the use of GnRH analogs is quite expensive. Medical treatments are neither standardized nor approved by the Food and Drug Administration, although they are increasingly supported by medical literature.[11] Consent is another obstacle, and only Illinois' and West Virginia's state statutes can be interpreted favorably for transgender

adolescents to be able to consent for care.[120]

Injectable medical-grade silicone gel and oil have been used by physicians for soft-tissue augmentation.[121] Many transgender adolescents who do not have parental support or who are homeless have injected themselves or others with impure, nonmedical silicone, with significant health consequences. In the Chicago study in ethnic minority transgender youth, the authors found that 29% had injected silicone and 8% had shared needles, half of which were obtained on the street or via the Internet.[94] Injected industrial (nonmedical) silicones or medical silicones used incorrectly have been shown to cause multiorgan dysfunction,[122] silicone pulmonary embolization,[123] and death.[124]

ASSISTING PARENTS OF SEXUAL MINORITY YOUTH

Another critically important role of the pediatrician is to assist parents of sexual minority youth. Some parents have emotional reactions related to societal homophobia and may have extreme difficulty accepting their LGBT teens. Others mourn the loss of the image of the adolescent that they had before the disclosure. Pediatricians should acknowledge the parents' feelings but should provide information and support for the adolescent who has disclosed. Parents' reactions and attitudes may adjust over time and the pediatrician should check in regularly and offer support to the entire family. Organizations like Parents, Families and Friends of Lesbians and Gays (http://www.pflag.org) or Gay Family Support (http://www.gayfamily-support.com) provide valuable resources for discussion. Lead with Love is another excellent resource that includes a film for viewing and discussion (http://leadwithlovefilm.com). For sexual minority youth who have been bullied or victimized, the It Gets Better Project may assist parents and families (http://www.itgetsbetter.org/).

RESOURCES FOR SEXUAL MINORITY YOUTH

Pediatricians' knowledge about national and local resources to assist sexual minority youth is critical to provide LGBTQ patients and their families guidance and support as they progress through adolescence into young adulthood. Nonprofit organizations, such as the United Way in some communities, are a great place to start, as are adult LGBTQ and sexual health advocacy organizations. Table 5 provides selected Web sites of LGBTQ-serving organizations and resources for sexual minority youth, their families, and communities.

SUMMARY

Pediatricians and other health care providers already have many of the skills needed to provide culturally effective, developmentally appropriate care for sexual minority youth. LGBTQ teens/young adults and MSM/WSW are an underserved population, many of whom struggle with acceptance of their sexuality at the same time that they are managing the other rigors of adolescence. The adolescent psychosocial history will allow for discovery of any high-risk behaviors, and targeted behavioral interventions may be developed with the adolescent.

TABLE 5 LGBTQ Support and Advocacy Organizations

- The Gay, Lesbian, and Straight Education Network mission is "Every student deserves a safe space" (http://www.glsen.org).
- Parents, Families, and Friends of Lesbians and Gays (PFLAG) is a long-standing support and advocacy organization (http://community.pflag.org).
- The National Youth Advocacy Coalition (NYAC) is a social justice organization that advocates for and with young people who are lesbian, gay, bisexual, transgender, or questioning in an effort to end discrimination against these youth and to ensure their physical and emotional well-being (http://www.nyacyouth.org).
- The Trevor Project (http://www.thetrevorproject.org) operates the only nationwide, around-the-clock crisis and suicide prevention hotline for sexual minority youth (866-4-U-TREVOR).
- Youth Resource is a Web site created by and for LGBTQ young people. Sponsored by Advocates for Youth, Youth Resource takes a holistic approach to sexual health and exploring issues of concern to LGBTQ youth, by providing information and offering support on sexual and reproductive health issues through education and advocacy (http://www.amplifyyourvoice.org/youthresource).
- For patients, communities, and health care professionals, the Gay and Lesbian Medical Association (http://glma.org) has referral and information resources.
- TransKids Purple Rainbow is a foundation that advocates and organizes events on behalf of transgender children (http://www.transkidspurplerainbow.org).
- The World Professional Association for Transgender Health, Inc (WPATH). Formerly known as the Harry Benjamin International Gender Dysphoria Association, Inc, WPATH is a professional organization devoted to the understanding and treatment of gender identity disorders (http://www.wpath.org).
- Transfamily provides support and education for transgender people, their families, friends, and significant others. The group is associated with PFLAG to bring awareness to school systems, through their principals and counselors, by offering literature, speakers, consultation, and support (http://www.transfamily.org).
- Family Acceptance Project (Marian Wright Education Institute–Resource for LGBTQ youth and families) (http://familyproject.sfsu.edu)
- Other resources are available on the Adolescent Reproductive and Sexual Health Education Project Web site at the end of the presentations, "Gay, Lesbian, Bisexual, Transgender, and Questioning Youth" and "Caring for Transgender Adolescent Patients" found at http://www.prh.org/ARSHEP. These presentations are also outstanding for both self-education and for use in training current and future medical professionals.

Referrals for mental health and substance abuse treatment may be warranted. Pediatricians have an obligation to ensure that sexual minority youth have access to a full range of appropriate health care services. As with all adolescents and young adults, sexual minority youth need honest answers and compassion in dealing with issues and questions around sexual orientation, identity, and sexual behaviors.

LEAD AUTHOR

David A. Levine, MD

COMMITTEE ON ADOLESCENCE, 2012–2013

Paula K. Braverman, MD, Chairperson
William P. Adelman, MD
Cora C. Breuner, MD, MPH
David A. Levine, MD
Arik V. Marcell, MD, MPH
Pamela J. Murray, MD, MPH
Rebecca F. O'Brien, MD, MD

LIAISONS

Loretta E. Gavin, PhD, MPH – *Centers for Disease Control and Prevention*
Rachel J. Miller, MD – *American College of Obstetricians and Gynecologists*
Jorge L. Pinzon, MD – *Canadian Pediatric Society*
Benjamin Shain, MD, PhD – *American Academy of Child and Adolescent Psychiatry*

STAFF

Karen S. Smith
James Baumberger

REFERENCES

1. Institute of Medicine, Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: National Academies Press; 2011
2. Spigarelli MG. Adolescent sexual orientation. *Adolesc Med State Art Rev*. 2007;18(3):508–518, vii
3. Glover JA, Galliher RV, Lamere TG. Identity development and exploration among sexual minority adolescents: examination of a multidimensional model. *J Homosex*. 2009;56(1):77–101
4. Frankowski BL; American Academy of Pediatrics Committee on Adolescence. Sexual orientation and adolescents. *Pediatrics*. 2004;113(6):1827–1832
5. World Professional Association for Transgender Health. Standards of care for the health of transsexual, transgender, and gender nonconforming people. Minneapolis, MN: World Professional Association for Transgender Health; 2011. Available at: www.wpath.org. Accessed June 11, 2012
6. Wallien MS, Cohen-Kettenis PT. Psychosexual outcome of gender-dysphoric children. *J Am Acad Child Adolesc Psychiatry*. 2008;47(12):1413–1423
7. Zucker K, Bradley S. Gender identity and psychosexual disorders. *J Lifelong Learn Psychiatry*. 2005;3(4):598–617
8. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed, text revision. Washington, DC: American Psychiatric Association; 2000
9. Sexual and Gender Disorders Work Group for American Psychiatric Association DSM-5 Development. 2011. Available at: www.dsm5.org/ProposedRevision/Pages/GenderDysphoria.aspx. Accessed June 11, 2012
10. Olson J, Forbes C, Belzer M. Management of the transgender adolescent. *Arch Pediatr Adolesc Med*. 2011;165(2):171–176
11. Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, et al; Endocrine Society. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2009;94(9):3132–3154
12. Austin SB, Conron K, Patel A, Freedner N. Making sense of sexual orientation measures: findings from a cognitive processing study with adolescents on health survey questions. *J LGBT Health Res*. 2007;3(1):55–65
13. Herrick AL, Matthews AK, Garofalo R. Health risk behaviors in an urban sample of young women who have sex with women. *J Lesbian Stud*. 2010;14(1):80–92
14. Goodenow C, Szalacha LA, Robin LE, Westheimer K. Dimensions of sexual orientation and HIV-related risk among adolescent females: evidence from a statewide survey. *Am J Public Health*. 2008;98(6):1051–1058
15. Igartua K, Thombs BD, Burgos G, Montoro R. Concordance and discrepancy in sexual identity, attraction, and behavior among adolescents. *J Adolesc Health*. 2009;45(6):602–608
16. Wilson BD, Harper GW, Hidalgo MA, Jamil OB, Torres RS, Fernandez MI; Adolescent Medicine Trials Network for HIV/AIDS Interventions. Negotiating dominant masculinity ideology: strategies used by gay, bisexual and questioning male adolescents. *Am J Community Psychol*. 2010;45(1–2):169–185
17. American Academy of Pediatrics. Gender identity and gender confusion in children. Elk Grove Village, IL: American Academy of Pediatrics; 2010. Available at: www.healthychildren.org/English/ages-stages/gradeschool/Pages/Gender-Identity-and-Gender-Confusion-In-Children.aspx. Accessed June 11, 2012
18. Almeida J, Johnson RM, Corliss HL, Molnar BE, Azrael D. Emotional distress among LGBT youth: the influence of perceived discrimination based on sexual orientation. *J Youth Adolesc*. 2009;38(7):1001–1014
19. Walls NE. Toward a multidimensional understanding of heterosexism: the changing nature of prejudice. *J Homosex*. 2008;55(1):20–70
20. Chesir-Teran D, Hughes D. Heterosexism in high school and victimization among lesbian, gay, bisexual, and questioning students. *J Youth Adolesc*. 2009;38(7):963–975
21. McDermott E, Roen K, Scourfield J. Avoiding shame: young LGBT people, homophobia and self-destructive behaviours. *Cult Health Sex*. 2008;10(8):815–829
22. Kann L, Olsen EO, McManus T, et al; 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 Surveill Summ*. 2011;60(7):1–133
23. Kelley TM, Robertson RA. Relational aggression and victimization in gay male relationships: the role of internalized homophobia. *Aggress Behav*. 2008;34(5):475–485
24. Friedman MS, Marshal MP, Stall R, Cheong J, Wright ER. Gay-related development, early abuse and adult health outcomes among gay males. *AIDS Behav*. 2008;12(6):891–902
25. Birkett M, Espelage DL, Koenig B. LGB and questioning students in schools: the

moderating effects of homophobic bullying and school climate on negative outcomes. *J Youth Adolesc*. 2009;38(7):989–1000

26. Saewyc EM, Homma Y, Skay CL, Bearinger LH, Resnick MD, Reis E. Protective factors in the lives of bisexual adolescents in North America. *Am J Public Health*. 2009;99(1):110–117
27. Hagan JF, Shaw JS, Duncan P, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008
28. Hoffman ND, Freeman K, Swann S. Healthcare preferences of lesbian, gay, bisexual, transgender and questioning youth. *J Adolesc Health*. 2009;45(3):222–229
29. American Association of Medical Colleges. Diversity policy and programs: who we are, what we do, where we're going. Washington, DC: American Association of Medical Colleges; 2011. Available at: https://www.aamc.org/download/266998/data/dpp-briefing-book-2011.pdf. Accessed June 11, 2012
30. The Joint Commission. Advancing effective communication, cultural competence, and patient- and family- centered care for the lesbian, gay, bisexual, and transgender (LGBT) community: a field guide. Oakbrook Terrace, IL: 2011. Available at: www.jointcommission.org/assets/1/18/LGBTFieldGuide.pdf. Accessed June 11, 2012
31. Bouris A, Guilamo-Ramos V, Pickard A, et al. A systematic review of parental influences on the health and well-being of lesbian, gay, and bisexual youth: time for a new public health research and practice agenda. *J Prim Prev*. 2010;31(5–6):273–309
32. Bauhoff S. Systematic self-report bias in health data: impact on estimating cross-sectional and treatment effects. *Health Serv Outcomes Res Methodol*. 2011;11(1–2):44–53
33. Anfinson A, ed. 2007 Minnesota Student Survey statewide tables. Minnesota Student Survey Interagency Team. Roseville, MN: Minnesota Department of Education; 2007. Available at: http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=latestReleased&Rendition=primary&dDocName=042114. Accessed June 11, 2012
34. Moffat S, Cate R. *The 2007 Vermont Youth Risk Behavior Survey*. Burlington, VT: Vermont Department of Health, Division of Health Surveillance; 2007
35. Massachusetts Department of Elementary and Secondary Education, Massachusetts Department of Public Health. Massachusetts high school students and sexual orientation: results of the 2007 Youth Risk Behavior Survey. Malden, MA: Massachusetts Department of Elementary and Secondary Education; 2008. Available at: www.mass.gov/cgly/yrbs07.pdf. Accessed June 13, 2012
36. Pathela P, Schillinger JA. Sexual behaviors and sexual violence: adolescents with opposite-, same-, or both-sex partners. *Pediatrics*. 2010;126(5):879–886
37. Chandra A, Mosher WD, Copen C, Sionean C. Sexual behavior, sexual attraction, and sexual identity in the United States: data from the 2006-2008 National Survey of Family Growth. *Natl Health Stat Rep*. 2011: Mar 3(36):1–36
38. Corliss HL, Rosario M, Wypij D, Fisher LB, Austin SB. Sexual orientation disparities in longitudinal alcohol use patterns among adolescents: findings from the Growing Up Today Study. *Arch Pediatr Adolesc Med*. 2008;162(11):1071–1078
39. Russell ST, Joyner K. Adolescent sexual orientation and suicide risk: evidence from a national study. *Am J Public Health*. 2001;91(8):1276–1281
40. Kipke MD, Kubicek K, Weiss G, et al. The health and health behaviors of young men who have sex with men. *J Adolesc Health*. 2007;40(4):342–350
41. Coker TR, Austin SB, Schuster MA. Health and healthcare for lesbian, gay, bisexual, and transgender youth: reducing disparities through research, education, and practice. *J Adolesc Health*. 2009;45(3):213–215
42. Physicians for Reproductive Choice and Health. Gay, lesbian, bisexual, transgender, and questioning youth. 4th ed. New York, NY: The Adolescent Reproductive and Sexual Health Education Program; 2011. Available at: www.prch.org/arshep. Accessed June 13, 2012
43. Berg MB, Mimiaga MJ, Safren SA. Mental health concerns of gay and bisexual men seeking mental health services. *J Homosex*. 2008;54(3):293–306
44. Silenzio VM, Pena JB, Duberstein PR, Cerel J, 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
45. Walls NE, Freedenthal S, Wisneski H. Suicidal ideation and attempts among sexual minority youths receiving social services. *Soc Work*. 2008;53(1):21–29
46. Eisenberg ME, Resnick MD. Suicidality among gay, lesbian and bisexual youth: the role of protective factors. *J Adolesc Health*. 2006;39(5):662–668
47. D'Augelli AR, Grossman AH, Salter NP, Vasey JJ, Starks MT, Sinclair KO. Predicting the suicide attempts of lesbian, gay, and bisexual youth. *Suicide Life Threat Behav*. 2005;35(6):646–660
48. Whitbeck LB, Chen X, Hoyt DR, Tyler KA, Johnson KD. Mental disorder, subsistence strategies, and victimization among gay, lesbian, and bisexual homeless and runaway adolescents. *J Sex Res*. 2004;41(4):329–342
49. Hart TA, Heimberg RG. Social anxiety as a risk factor for unprotected intercourse among gay and bisexual male youth. *AIDS Behav*. 2005;9(4):505–512
50. Pachankis JE, Goldfried MR. Social anxiety in young gay men. *J Anxiety Disord*. 2006;20(8):996–1015
51. Schwartz SW. Adolescent mental health in the United States. New York, NY: National Center for Children in Poverty, Mailman School of Public Health, Columbia University; 2009. Available at: http://nccp.org/publications/pdf/text_878.pdf. Accessed June 13, 2012
52. Lampinen TM, Chan K, Anema A, et al. Incidence of and risk factors for sexual orientation-related physical assault among young men who have sex with men. *Am J Public Health*. 2008;98(6):1028–1035
53. Herek GM, Sims C. Sexual orientation and violence victimization: hate crimes and intimate partner violence among gay and bisexual men in the US. In: Wolitski RJ, Stall R, Valdiserri RO, eds. *Unequal Opportunity: Health Disparities Affecting Gay and Bisexual Men in the US*. New York, NY: Oxford University Press; 2008:35–71
54. Friedman MS, Koeske GF, Silvestre AJ, Korr WS, Sites EW. The impact of gender-role nonconforming behavior, bullying, and social support on suicidality among gay male youth. *J Adolesc Health*. 2006;38(5):621–623
55. Cloud J. Bullied to death. Time. 2010;176(16):60–63
56. Consortium of Higher Education LGBT Resource Professionals. Press release. Syracuse, NY: Consortium of Higher Education LGBT Resource Professionals; October 4, 2004. Available at: www.lgbtcampus.org/about/news-2010-10-04-deaths. Accessed June 13, 2012
57. US Department of Health and Human Services. stopbullying.org Web site. Available at: www.stopbullying.gov. Accessed June 13, 2012
58. Burks DJ. Lesbian, gay, and bisexual victimization in the military: an unintended

consequence of "Don't Ask, Don't Tell"? *Am Psychol*. 2011;66(7):604–613
59. Hand K. United States: Mormon apostle bullies gay youth. *Green Left Weekly*. Octo 10, 2010. Available at: www.greenleft.org.au/node/45676. Accessed June 13, 2012
60. Parents, Families and Friends of Lesbians and Gays. Seven: cyber bullying. Available at: http://community.pflag.org/page.aspx?pid=1025. Accessed June 13, 2012
61. Blumenfeld WJ, Cooper RM. LGBT and allied youth responses to cyberbullying: policy implications. *Int J Crit Pedagogy*. 2010;3(1):114–133
62. Russell CJ, Keel PK. Homosexuality as a specific risk factor for eating disorders in men. *Int J Eat Disord*. 2002;31(3):300–306
63. Austin SB, Ziyadeh NJ, Corliss HL, et al. Sexual orientation disparities in purging and binge eating from early to late adolescence. *J Adolesc Health*. 2009;45(3):238–245
64. Feldman MB, Meyer IH. Childhood abuse and eating disorders in gay and bisexual men. *Int J Eat Disord*. 2007;40(5):418–423
65. Hepp U, Milos G. Gender identity disorder and eating disorders. *Int J Eat Disord*. 2002;32(4):473–478
66. D'Augelli AR. High tobacco use among lesbian, gay, and bisexual youth: mounting evidence about a hidden population's health risk behavior. *Arch Pediatr Adolesc Med*. 2004;158(4):309–310
67. Remafedi G, Jurek AM, Oakes JM. Sexual identity and tobacco use in a venue-based sample of adolescents and young adults. *Am J Prev Med*. 2008;35(6 suppl):S463–S470
68. Lee JG, Griffin GK, Melvin CL. Tobacco use among sexual minorities in the USA, 1987 to May 2007: a systematic review. *Tob Control*. 2009;18(4):275–282
69. Ortiz-Hernández L, Tello BL, Valdés J. The association of sexual orientation with self-rated health, and cigarette and alcohol use in Mexican adolescents and youths. *Soc Sci Med*. 2009;69(1):85–93
70. Remafedi G, Carol H. Preventing tobacco use among lesbian, gay, bisexual, and transgender youths. *Nicotine Tob Res*. 2005;7(2):249–256
71. Remafedi G. Lesbian, gay, bisexual, and transgender youths: who smokes, and why? *Nicotine Tob Res*. 2007;9(suppl 1):S65–S71
72. Schwappach DL. Queer quit: gay smokers' perspectives on a culturally specific smoking cessation service. *Health Expect*. 2009;12(4):383–395
73. Valleroy LA, MacKellar DA, Karon JM, et al; Young Men's Survey Study Group. HIV prevalence and associated risks in young men who have sex with men. *JAMA*. 2000;284(2):198–204
74. Kipke MD, Weiss G, Ramirez M, et al. Club drug use in Los Angeles among young men who have sex with men. *Subst Use Misuse*. 2007;42(11):1723–1743
75. Ridner SL, Frost K, Lajoie AS. Health information and risk behaviors among lesbian, gay, and bisexual college students. *J Am Acad Nurse Pract*. 2006;18(8):374–378
76. Parsons JT, Kelly BC, Weiser JD. Initiation into methamphetamine use for young gay and bisexual men. *Drug Alcohol Depend*. 2007;90(2–3):135–144
77. Rosario M, Schrimshaw EW, Hunter J. Predictors of substance abuse over time among gay, lesbian, and bisexual youths: an examination of three hypotheses. *Addict Behav*. 2004;29(8):1623–1631
78. Rhodes SD, McCoy T, Hergenrather KC, Omli MR, Durant RH. Exploring the health behavior disparities of gay men in the United States: comparing gay male university students to their heterosexual peers. *J LGBT Health Res*. 2007;3(1):15–23
79. Benson PA, Hergenroeder AC. Bacterial sexually transmitted infections in gay, lesbian, and bisexual adolescents: medical and public health perspectives. *Semin Pediatr Infect Dis*. 2005;16(3):181–191
80. Kipke MD, Weiss G, Wong CF. Residential status as a risk factor for drug use and HIV risk among young men who have sex with men. *AIDS Behav*. 2007;11(6 suppl):56–69
81. Rudy ET, Shoptaw S, Lazzar M, Bolan RK, Tilekar SD, Kerndt PR. Methamphetamine use and other club drug use differ in relation to HIV status and risk behavior among gay and bisexual men. *Sex Transm Dis*. 2009;36(11):693–695
82. Centers for Disease Control and Prevention. Trends in HIV/AIDS diagnoses among men who have sex with men—33 states, 2001-2006. *MMWR Morb Mortal Wkly Rep*. 2008;57(25):681–686
83. Robertson P, Schachter J. Failure to identify venereal disease in a lesbian population. *Sex Transm Dis*. 1981;8(2):75–76
84. Lindley LL, Barnett CL, Brandt HM, Hardin JW, Burcin M. STDs among sexually active female college students: does sexual orientation make a difference? *Perspect Sex Reprod Health*. 2008;40(4):212–217
85. Stoddard JP, Dibble SL, Fineman N. Sexual and physical abuse: a comparison between lesbians and their heterosexual sisters. *J Homosex*. 2009;56(4):407–420
86. Welles SL, Corbin TJ, Rich JA, Reed E, Raj A. Intimate partner violence among men having sex with men, women, or both: early-life sexual and physical abuse as antecedents. *J Community Health*. 2011;36(3):477–485
87. Saewyc EM, Bearinger LH, Blum RW, Resnick MD. Sexual intercourse, abuse and pregnancy among adolescent women: does sexual orientation make a difference? *Fam Plann Perspect*. 1999;31(3):127–131
88. Arreola S, Neilands T, Pollack L, Paul J, Catania J. Childhood sexual experiences and adult health sequelae among gay and bisexual men: defining childhood sexual abuse. *J Sex Res*. 2008;45(3):246–252
89. Mimiaga MJ, Noonan E, Donnell D, et al. Childhood sexual abuse is highly associated with HIV risk-taking behavior and infection among MSM in the EXPLORE Study. *J Acquir Immune Defic Syndr*. 2009;51(3):340–348
90. Perrin E. *Sexual Orientation in Child and Adolescent Health Care*. New York, NY: Kluwer Academic; 2002
91. American Psychological Association. *Task Force on Gender Identity and Gender-Variance. Report of the Task Force on Gender Identity and Gender Variance*. Washington, DC: American Psychological Association; 2009
92. Clements-Nolle K, Marx R, Guzman R, Katz M. HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: implications for public health intervention. *Am J Public Health*. 2001;91(6):915–921
93. Nuttbrock L, Hwahng S, Bockting W, et al. Lifetime risk factors for HIV/sexually transmitted infections among male-to-female transgender persons. *J Acquir Immune Defic Syndr*. 2009;52(3):417–421
94. Garofalo R, Deleon J, Osmer E, Doll M, Harper GW. Overlooked, misunderstood and at-risk: exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *J Adolesc Health*. 2006;38(3):230–236
95. Eccles TA, Sayegh MA, Fortenberry JD, Zimet GD. More normal than not: a qualitative assessment of the developmental experiences of gay male youth. *J Adolesc Health*. 2004;35(5):425.e11–425.e18
96. Cohn TJ, Hastings SL. Resilience among rural lesbian youth. *J Lesbian Stud*. 2010;14(1):71–79
97. Russell ST, Muraco A, Subramaniam A, Laub C. Youth empowerment and high school gay-straight alliances. *J Youth Adolesc*. 2009;38(7):891–903
98. Satcher D. The Surgeon General's call to action to promote sexual health and

responsible sexual behavior. Washington, DC: US Department of Health and Human Services; 2001. Available at: www.surgeongeneral.gov/library/sexualhealth/index.html. Accessed June 13, 2012

99. Meckler GD, Elliott MN, Kanouse DE, Beals KP, Schuster MA. Nondisclosure of sexual orientation to a physician among a sample of gay, lesbian, and bisexual youth. *Arch Pediatr Adolesc Med*. 2006;160(12):1248–1254
100. Levine DA. Office-based care for gay, lesbian, bisexual, and questioning youth. *Adolesc Med State Art Rev*. 2009;20(1):223–242, xi–xii
101. Goldenring JM, Rosen DS. Getting into adolescent heads: an essential update. *Contemp Pediatr*. 2004;21(1):64–90
102. Mayer KH, Bradford JB, Makadon HJ, Stall R, Goldhammer H, Landers S. Sexual minority health: what do we know and where do we need to go? *Am J Public Health*. 2008;98(6):989–995
103. Canadian Paediatric Society, Adolescent Health Committee. Adolescent sexual orientation. *Paediatr Child Health (Oxford)*. 2008;13(7):619–623
104. Moyer C. LGBT patients: reluctant and underserved. *Am Med News*. Sept 5 2011. Available at: www.ama-assn.org/amednews/2011/09/05/prsa0905.htm. Accessed June 13, 2012
105. Gutiérrez JP, Torres-Pereda P. Acceptability and reliability of an adolescent risk behavior questionnaire administered with audio and computer support. *Rev Panam Salud Publica*. 2009;25(5):418–422
106. Kaiser Permanente National Diversity Council. *A Provider's Handbook on Culturally Competent Care*. 2nd ed. Oakland, CA: Kaiser Foundation Health Plan Inc; 2004
107. Rosario M, Schrimshaw EW, Hunter J. A model of sexual risk behaviors among young gay and bisexual men: longitudinal associations of mental health, substance abuse, sexual abuse, and the coming-out process. *AIDS Educ Prev*. 2006;18(5):444–460
108. Duncan PM, Garcia AC, Frankowski BL, et al. Inspiring healthy adolescent choices: a rationale for and guide to strength promotion in primary care. *J Adolesc Health*. 2007;41(6):525–535
109. Frankowski BL, Leader IC, Duncan PM. Strength-based interviewing. *Adolesc Med State Art Rev*. 2009;20(1):22–40, vii–viii
110. Workowski KA, Berman SM; Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines, 2010. *MMWR Recomm Rep*. 2010;59(RR-12):1–110
111. Ho KS, Cranston RD. Anal cytology screening in HIV-positive men who have sex with men: what's new and what's now? *Curr Opin Infect Dis*. 2010;23(1):21–25
112. Bakotic WL, Willis D, Birdsong G, Tadros TS. Anal cytology in an HIV-positive population: a retrospective analysis. *Acta Cytol*. 2005;49(2):163–168
113. US Food and Drug Administration. FDA: Gardasil approved to prevent anal cancer [news release]. Silver Spring, MD: US Food and Drug Administration; December 22, 2010
114. Centers for Disease Control and Prevention. FDA licensure of quadrivalent human papillomavirus vaccine (HPV4, Gardasil) for use in males and guidance from the Advisory Committee on Immunization Practices (ACIP). *MMWR Morb Mortal Wkly Rep*. 2010;59(20):630–632
115. Centers for Disease Control and Prevention. Recommendations on the use of quadrivalent human papillomavirus vaccine in males—Advisory Committee on Immunization Practices (ACIP), 2011. *MMWR Morb Mortal Wkly Rep*. 2011;60(50):1705–1708
116. Centers for Disease Control and Prevention. FDA licensure of bivalent human papillomavirus vaccine (HPV2, Cervarix) for use in females and updated HPV vaccination recommendations from the Advisory Committee on Immunization Practices (ACIP). *MMWR Morb Mortal Wkly Rep*. 2010;59(20):626–629
117. Blythe MJ, Diaz A; American Academy of Pediatrics Committee on Adolescence. Contraception and adolescents. *Pediatrics*. 2007;120(5):1135–1148
118. Spack NP, Edwards-Leeper L, Feldman HA, et al. Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics*. 2012;129(3):418–425
119. Ashbee O, Goldberg J. Trans care gender transition: hormones: a guide for MTFs. Vancouver, British Columbia, Canada: Vancouver Coastal Health, Transcend Transgender Support & Education Society and Canadian Rainbow Health Coalition; 2006. Available at: http://transhealth.vch.ca/resources/library/tcpdocs/consumer/hormones-MTF.pdf. Accessed June 13, 2012
120. Carroll M. Transgender youth, adolescent decision making, and Roper v. Simmons. *UCLA Law Rev*. 2009;56(3–4):725–753
121. Chasan PE. The history of injectable silicone fluids for soft-tissue augmentation. *Plast Reconstr Surg*. 2007;120(7):2034–2040, discussion 2041–2043
122. Clark RF, Cantrell FL, Pacal A, Chen W, Betten DP. Subcutaneous silicone injection leading to multi-system organ failure. *Clin Toxicol (Phila)*. 2008;46(9):834–837
123. Schmid A, Tzur A, Leshko L, Krieger BP. Silicone embolism syndrome: a case report, review of the literature, and comparison with fat embolism syndrome. *Chest*. 2005;127(6):2276–2281
124. Rosioreanu A, Brusca-Augello GT, Ahmed QA, Katz DS. CT visualization of silicone-related pneumonitis in a transsexual man. *AJR Am J Roentgenol*. 2004;183(1):248–249

(Continued from first page)

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

COMPANION PAPER: A companion to this article can be found on page 198, and online at www.pediatrics.org/cgi/doi/10.1542/peds.2013-1282.

Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth

David A. Levine and the COMMITTEE ON ADOLESCENCE

Pediatrics 2013;132;e297
DOI: 10.1542/peds.2013-1283 originally published online June 24, 2013;

PEDIATRICS®
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth

David A. Levine and the COMMITTEE ON ADOLESCENCE

Pediatrics 2013;132;e297
DOI: 10.1542/peds.2013-1283 originally published online June 24, 2013;