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Discussing Sexual Orientation with Adolescents

In a Pediatric Primary Care Setting

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Submitted to the faculty of The University of North Carolina at Chapel Hill in partial fulfillment
of the requirements for the degree of Master of Science in Nursing

University of North Carolina at Chapel Hill
2012

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Abstract

Perhaps one of the most fulfilling roles of the pediatric primary care provider is developing relationships with patients and supporting them as they grow into adulthood. It is our responsibility to offer developmentally appropriate and culturally relevant care to all whom we serve. Sexual orientation is one important aspect of self-identity which usually comes to the forefront during adolescence. Gay, lesbian, and bisexual (GLB) youth have long been noted to suffer disproportionately from issues such as depression, suicide ideation, substance use, homelessness, and abuse at the hands of their peers and family members. In light of these potential health disparities, it is essential that pediatric providers are comfortable discussing sexual orientation and offering support and resources to GLB patients. Unfortunately, the topic of sexual orientation is often avoided during the clinical encounter and providers are not familiar with resources available for this population. I first became interested in this topic when attending Safe Zone training at the University of North Carolina at Chapel Hill. With a background in pediatrics, I wanted to find a way to take what I had learned back to my chosen population. This manuscript explores aspects of the health care encounter that provide opportunities for building trust and rapport with sexual minority youth including the physical environment, provider attitude, confidentiality, and word choice during the medical interview. A discussion of developmentally appropriate resources is provided as well as a list of clinical recommendations for discussing sexual orientation with pediatric patients and directions for future research. Ultimately, the role of the pediatric primary care provider is not to identify and label all GLB youth but to accept patients for whom they are and assist them in finding help and support when needed so they may grow into confident and well-adjusted adults.

Problem Statement

Creating a safe and supportive environment in which parents and children feel comfortable discussing health concerns and behaviors is essential to the role of a pediatric primary care provider. This role includes providing holistic care that focuses on the overall well-being of the patient (National Association of Pediatric Nurse Practitioners, 2009). As children mature to adolescence, they play an increasingly central role in their own health and health maintenance and develop a personal relationship with their providers. Trust is essential to this relationship, especially when discussing health topics that are sensitive or socially sanctioned. Sexual orientation is a major aspect of personal identity that is explored and developed during the adolescent years. Acceptance of one's own sexual orientation and other's reactions to it may be formative experiences for a growing child. Research has shown that pediatric primary care providers neither feel that they have the skills necessary to address issues related to gay, lesbian, and bisexual (GLB) youth, nor feel that they have adequate knowledge of available resources for these patients (Lena, Wiebe, Ingram & Jabbour, 2002; Kitts, 2010). Therefore, sexual orientation may not be adequately addressed as part of the sexual history during well-child examinations by pediatric primary care providers (Lena, Wiebe, Infram & Jabbour, 2002). Because sexual orientation is an issue essential to the core of a person, addressing this topic is an important part of providing holistic care. Given the challenges of growing up as a GLB youth, it is essential that primary care providers are comfortable discussing sexual orientation and providing trustworthy and culturally-relevant care for their pediatric patients.

Background

“Sexual orientation” and “sexual identity” are terms often used to describe people's attractions with regard to gender, but definitions of these terms in the literature are inconsistent.

While some sources describe “sexual identity” as one aspect of sexual orientation in conjunction with sexual behavior and attraction (Ratelle et al, 2005), others claim that the two are entirely separate concepts (Palo Alto Medical Foundation, 2011). The Joint Commission defines sexual orientation as “a person’s physical and/or emotional attraction to the same and/or opposite gender” (Joint Commission, 2011). This term describes where a person falls along a continuum of attraction (Joint Commission, 2011) from 100 percent heterosexual to 100 percent gay or lesbian. Sexual identity is “what people call themselves with regard to their sexuality” (Gay and Lesbian Medical Association, 2001). For this paper, the term “sexual orientation” will refer to a person’s innate attraction to others with regard to sex. For example, a man primarily attracted to men is said to be gay; a woman primarily attracted to women is said to be lesbian; a person attracted to members of both sexes is bisexual. “Sexual identity” will refer to the label a person has chosen to identify his or her sexuality, possible examples include: “gay,” “lesbian,” “bisexual,” “queer,” “questioning,” “heterosexual,” or “asexual.”

Pediatric primary care providers hold an important position as the first health-care contact of GLB youth and as esteemed adults who can provide information and support during this important time of self development. The formation of sexual identity is a major milestone which usually occurs during the adolescent years. In a study of 454 pediatric fellows, less than one in five reported discussing this topic with their teenage patients during routine physical exams and greater than one in three rarely or never discussed the topic (Henry-Reid et al, 2010). One-hundred and fifteen of 149 physicians in another study agreed that sexual orientation should be addressed more often with patients (Kitts, 2010). Thus, while providers feel sexual identity and orientation are an important part of a person’s health history, the topic remains inadequately addressed. Physicians and nurses cite time pressures inherent in primary care pediatric practice

(Henry-Reid et al, 2010), inadequate knowledge of the psychosocial stressors experienced by GLB patients (Kitts, 2010), and lack of knowledge of resources available to assist these youth (Lena, Wiebe, Ingram & Jabbour, 2002) as reasons for lack of attention to this important issue. In a survey of GLB youth, only thirty-five percent of respondents reported that their primary care physicians knew their sexual orientation (Meckler, 2006). Of those, only twenty-one percent reported that their physician had raised the topic. There are signals in the literature that GLB youth appreciate when providers make the effort to inquire about orientation; fifty-seven percent of respondents whose physicians knew their orientation felt the care they received had improved as a result (Meckler, 2006).

How sexual identity and sexual orientation are discussed in the pediatric primary care setting varies widely. When it comes to questions of sexuality, the focus is often limited to sexual behavior, excluding questions of sexual identity or attraction. If an adolescent states he or she is not “sexually active,” forty-one percent of physicians report they would not ask follow-up questions regarding sexual health (Kitts, 2010). Unfortunately, the term “sexually active” could mean something different to the patient than it means to the provider, opening the door for misinterpretation and confusion. Sexual experiences with another person are not necessary for a person to develop sexual identity and a lack of these interactions does not preclude a lack of sexual health related concerns. By asking about sexual concerns and openly discussing them, the provider can offer information and support that will help the teen later when these issues are further complicated by sexual experiences. Furthermore, sexual identity and sexual behavior do not always correlate. A teen who self-identifies as heterosexual may also experiment with members of the same sex or vice versa. Females tend to express a greater fluidity along a spectrum of attraction than males with more females identifying as bisexual or mostly

heterosexual than strictly heterosexual or lesbian (Savin-Williams & Diamond, 2000; Kreiss & Patterson, 1997). In recent times, youth have begun to reject labels related to sexual orientation, and experimentation with same-gender sexual partners is now considered within the realm of normal adolescent development (Garofalo & Katz, 2001; Academy of Child and Adolescent Psychiatry, 2006; Thompson & Morgan, 2008). When the medical interview is limited to questions of sexual behavior, the provider may miss the opportunity to discuss core emotional experiences central to a patient's sexual orientation and thus the chance to provide care responsive to the specific needs of that patient.

GLB youth suffer a disproportionately large burden of mental and physical illness (Kreiss & Patterson, 1997; Garofalo & Katz, 2001; Ridner, Frost & LaJoie, 2006; Saewyc, 2011). Sexual orientation is an important component of personal identity, and insecurity with an aspect of one's self may have major health implications. Depression and social isolation increase the risk that all youth will attempt suicide (Garofalo & Katz, 2001). It is, therefore, not surprising that GLB teens, experiencing a higher prevalence of depression and social isolation, also experience higher rates of self-harm, suicidal ideation, and suicide attempts than their heterosexual counterparts (Coker et al, 2010). The likelihood of participating in high risk behaviors is also increased by emotional distress. GLB teens are nearly three times more likely than their heterosexual peers to report substance abuse (Coker et al, 2010). They are more likely to begin drinking alcohol at an early age and participate in higher levels of binge drinking (Coker et al, 2010). GLB teens also tend to engage in sexual behavior earlier than their heterosexual counterparts, have a higher number of lifetime sexual partners, and are two to ten times more likely to be involved in an adolescent pregnancy (Coker et al, 2010).

Many GLB adolescents experience rejection and abuse in response to “coming out,” or disclosing same-sex attraction to others (Riley, 2010); rejection can emanate from both peers and parents. Peer rejection can be devastating at a time when normal developmental tasks involve moving away from parents and toward friends as a major source of support. In a study by the Gay, Lesbian, and Straight Education Network (GLSEN), eighty-six percent of lesbian, gay, bisexual, and transgendered students reported being verbally harassed at school; twenty-two percent reported being physically assaulted in the past year because of their sexual orientation (Kosciw, Diaz & Greytak, 2008). Sexual minority adolescents are also at higher risk of rape and dating violence than their heterosexual counterparts (Williams, Connolly, Pepler & Craig, 2003). Parents may also react to their child’s “coming out” with hostility and rejection. In one longitudinal study of GLB adolescents’ perception of their parents’ reactions, a majority of parents had either negative or very negative responses to their child’s sexual orientation (D’Augelli, Grossman & Starks, 2005). Homelessness is also higher among GLB high school students with sixteen percent reporting homelessness versus three percent of heterosexual students in one study (Fournier et al, 2009). Protective factors such as family connectedness, adult caring, and school safety play an important role in buffering against suicidal ideation and attempts (Eisenberg & Resnick, 2006). In a linear model, suicidal ideation and attempts dropped significantly when all three protective factors were considered (Eisenberg & Resnick, 2006). Targeting interventions to enhance the protective factors may help to decrease mental health morbidity and death by suicide.

Being at higher risk does not mean that all GLB adolescents experience the same challenges or that it is not possible for a GLB adolescent to become a well-adjusted adult. However, it is crucial that high risk thoughts and behaviors be discussed as part of a

comprehensive health history for all adolescent patients. The social stigmatization of non-heterosexual orientation may be an isolating experience for the developing adolescent. It is the role of the primary care provider to identify emotional stressors and support the individual by validating their experiences, providing a safe place to discuss their feelings, and identifying resources. Ultimately, the goal of the primary care provider should not be to merely identify GLB youth, but to create a supportive and comfortable environment in which they can seek medical support.

The purpose of this master's paper is to present what is currently known about how providers address adolescents and sexual orientation in the pediatric primary care practice setting, with a particular focus on how providers can create and facilitate a culturally competent, safe, and supportive health care environment. This objective was addressed through synthesis of current literature pertaining to the elements of the physical environment of a pediatric practice that may convey acceptance and support to GLB patients, attitudes perpetuated within the systemic environment that may affect the care given at the practice, and aspects of the interpersonal relationship between patient and provider that promote open communication and trust. A summary of findings, recommendations for practice, and future research is provided.

Methods

With the assistance of a research librarian at the University of North Carolina's Health Sciences Library, a search of PubMed was performed. Medical subject headings (MeSH) initially included (homosexuality OR bisexuality) AND (physician OR nurse), limits: human, English, adolescent ages 13-18 years, and published in the last five years. The initial search yielded twenty-six results of which seven were relevant to the research topic based on review of abstracts. Additional searches were performed on Pubmed.gov and Google Scholar using a

variety of key words to expand on a variety of topics relevant to the health care needs of GLB adolescents. For example, the MeSH headings (gay OR lesbian OR bisexual) AND (stigma OR bias) AND (health care) as well as (adolescent) AND (confidentiality) AND (physician OR nurse) were used to elicit data on homophobia in health care and the discussion of confidentiality with adolescents in the clinic setting. For certain topics where literature was scarce, the search criteria was expanded to include research from countries other than the United States, research in adults, and research from as far back as 1994; all of these cases were noted in this review. A manual search of bibliographies from identified papers was performed to find additional articles related to the topic of discussing sexual orientation with adolescents in the pediatric primary care setting. The resulting articles were organized by topic into four groups which make up the main subject headings of this paper: physical environment, systemic environment, interpersonal environment, and resources. Physical environment refers to the display of visual cues within a medical office setting that signal tolerance and support of people who identify as sexual minority. Systemic environment is the attitude within a practice toward individuals of cultural variability, including GLB patients. Interpersonal environment deals with aspects of communication that affect rapport between patient and provider when discussing sexual orientation during the medical interview. The section on resources considers the provider's role in helping GLB patients find reliable information and support outside the walls of a medical practice. The paper concludes with a list of clinical recommendations and discussion of directions for future research.

Physical Environment

The physical environment of a pediatric primary care office is important to the establishment of trust between patient and provider. A qualitative study involving focus groups

of thirty adult GLB and transgender patients as well as medical providers has identified many components of a culturally competent clinical environment (Wilkerson, Rybicki, Barber & Smolenski, 2011). Patient participants reported searching for cues signaling LGB-friendliness upon entering a medical practice for the first time (Wilkerson, Rybicki, Barber & Smolenski, 2011). Many look for the GLB-affirming symbols of a rainbow or pink triangle in the office as a signal that this is a supportive place to discuss issues of sexual orientation (Wilkerson, Rybicki, Barber & Smolenski, 2011). Visual displays indicating tolerance of many types of people may help to build an atmosphere of support and acceptance. Offering brochures and pamphlets on a wide range of health topics is common practice in exam rooms and waiting areas of medical facilities. The Gay and Lesbian Medical Association suggests providing written material on issues that may be of interest of GLB youth, including safe sex, sexually transmitted infections, substance use, and mental health (Gay and Lesbian Medical Association, 2006). Brochures written about adolescent sexuality should not assume heterosexuality but should address issues related to a range of sexual orientations (Perrin et al, 2004). Posters and pamphlets should feature diversity, including people of different races and sexual orientations. Research shows that adolescents prefer pamphlets about sexual orientation be placed in exam rooms as opposed to waiting rooms (Allen, Glick, Beach & Naylor, 1998). A visible antidiscrimination policy which expresses a promise to provide quality care to all individuals regardless of race, ethnicity, religion, or sexual orientation may reassure patients that disclosure of their sexual orientation will not affect the health care they receive (Gay and Lesbian Medical Association, 2006).

Systemic Environment

It is important that everyone who interacts with patients in the pediatric office setting, including both staff and medical providers, practice culturally sensitive care given the potential

harm that can be caused by negative or homophobic reactions to GLB patients (Crisp & McCave, 2007). Patients come into contact with a variety of staff members in a medical facility from the time they check in to the time they leave, and each interaction has the potential to form a lasting impression. Policies against insensitive or inappropriate remarks by employees should be consistently enforced (Frankowski, 2004), as they create a hostile environment in which to work and receive medical care. In addition, it is recommended that all staff members receive annual diversity training to facilitate respectful interaction with those of differing beliefs and practices (Wilkerson, Rybicki, Barber & Smolenski, 2011). A common approach to this type of instruction focuses on learning facts about different cultural groups so that one is familiar with specific practices and preferences that may be encountered when interacting with members of these groups (Kumagai & Lypson, 2009; Juarez et al, 2006). As Kumagai and Lypson (2009) point out, this method may be helpful in certain situations, but treats culture as a static, unevolving entity and runs the risk of over-simplifying the behavior of minority cultural groups. They suggest an alternative approach to cultural competency is “cultural humility,” in which a person engages in self-reflection of one’s own values, assumptions, and biases and approaches others with humility in order to build partnerships of mutual respect (Kumagai & Lypson, 2009; Juarez et al, 2006). Cultural humility can be practiced by setting aside preconceived notions and approaching each interaction with genuine concern for the person at hand.

The connection between medical provider and patient is unique and essential to the provision of medical care. Medical providers ideally offer individualized care which nurtures a therapeutic relationship between themselves and the patient (Esposito, 2005). Ultimately, the provider’s attitude colors how he or she consciously and unconsciously treats GLB patients; understanding ones own attitudes and beliefs is the first step to providing culturally competent

care to others. In a study of physicians, twenty-three percent reported that same-sex relationships were always or almost always wrong (Kitts, 2010). In an Australian study by Khan, Plummer, Hussain, and Minichiello (2008), it was found that practitioners who were uncomfortable dealing with marginalized populations, such as sex workers, indigenous persons, intravenous drug users, and gay and lesbian people, had difficulty meeting these patients' clinical needs and expectations for unbiased care. Uncomfortable providers perceived a lack of ability to influence the risk behaviors of these patients, identified more constraints to taking a sexual history, including patient embarrassment, and recognized a need for additional training in sexual history taking (Khan, Plummer, Hussain & Minichiello, 2008). Practitioners who were comfortable working with these populations were more likely to take a sexual history, have pamphlets available for patients to read about sexually transmitted infections, provide safe-sex counseling, and encourage partner treatment. Thus, negative provider attitudes cannot simply be hidden from patients without affecting the care provided, but at least some uncomfortable providers recognize the need to improve their care (Khan, Plummer, Hussain, & Minichiello, 2008). In another study of adult lesbian patients in the United States, there was a strong positive correlation found between providers knowing a woman's sexual orientation and regular health service use by respondents (Steele, Tinmouth & Lu, 2006). Providers who asked about sexual orientation and were perceived as being GLB-supportive were more likely to encourage disclosure; in fact, gay-positivity was found to be a better determinant of disclosure than the degree to which patients are "out" to others (Steele, Tinmouth & Lu, 2006). If a clinician is experiencing personal issues that do not allow him or her to provide unbiased care to any patient, the patient should be referred to a different provider who can provide non-judgmental care (Sison & Greydanus, 2007; Frankowski, 2004).

Interpersonal Environment

The interpersonal aspect of a medical encounter involves direct communication between patient and provider. Questionnaires are often the first contact patients have with a medical organization and, thus, have the ability to leave a positive or negative first impression. Forms may be utilized to decrease some of the stress associated with discussing sensitive issues (Perrin et al, 2004), facilitating the initiation of meaningful discussion of topics relevant to the adolescent patient. Perrin et al (2004) suggest constructing a checklist of possible concerns relevant to the adolescent patient, of which one is sexual orientation. Teens tend to support this approach to introducing sensitive topics such as drug use and sexual issues (Allen, Glick, Beach & Naylor, 1998). This checklist can then be used to help guide the medical interview to address specifically topics important to the individual patient. GLB adolescents appreciate forms with questions that provide cues the clinic is GLB-friendly (Wilkerson, Rybicki, Barber & Smolenski, 2011). If a patient is asked to identify his or her sexual orientation on a questionnaire, numerous choices should be available. In addition to heterosexual, gay, lesbian, bisexual, and questioning, the options “I do not know” and “I’d rather not respond,” or a blank space on the questionnaire in which the patient can write his or her own response will indicate an awareness and acceptance of all forms of sexual orientation (Wilkerson, Rybicki, Barber & Smolenski, 2011; Perrin et al, 2004). A question may also be included inquiring if more information is wanted regarding safer sex techniques; if yes, “with men, women, or both?” (Perrin et al, 2004). It should be noted that some GLB adolescents may not feel comfortable revealing their sexual orientation on a form until they have established a trusting relationship with a provider (Wilkerson, Rybicki, Barber & Smolenski, 2011). Forms should not replace verbal discussion of sexual orientation, as verbal and non-verbal cues given by the provider may

encourage the patient to share information he or she was not comfortable sharing on paper prior to meeting the provider in person.

Perhaps one of the most important conversations a provider can have with his or her teenage patient is a discussion of confidentiality. Assuring adolescents that what they say in the office will remain between the patient and provider unless the patient is in danger or harming self or others is an important part of building trust and confidence in the provider. Research has shown that adolescents are more likely to seek medical care, openly discuss sensitive subjects, and return for future care if confidentiality is explicitly discussed at their office visit (Ford et al, 1997). In a retrospective study, twenty-four percent of GLB adolescents who discussed confidentiality with their health care providers revealed their sexual orientation, versus only eight percent who did not have this discussion; seventy-two percent said they would have been more likely to talk about sexual orientation with their provider if they had known of their right to confidentiality (Allen, Glicken, Beach & Naylor, 1998). It is also important that adolescents meet alone with the provider for at least part of each appointment. Not only does this provide time for the confidential discussion of sensitive issues but allows the patient to develop a personal relationship with the provider and become more actively involved in meeting his or her own healthcare needs. In a study of patient and provider discussion of sexual orientation, twenty-five percent of GLB teens reported they would feel more comfortable talking with a provider about this topic if parents were not in the room and they were assured the provider would not tell their parents (Meckler, Elliott, Kanouse, Beals & Schuster, 2006; Allen, Glicken, Beach & Naylor, 1998). It is the provider's responsibility to educate teens and parents about their legal rights to confidential care. Although parents acknowledge the utility of their child seeing the provider alone, they often expect the provider to disclose any risky behavior revealed

in the confidential meeting, even if the child does not want that information shared (Duncan et al, 2010). Offering parents information, written or verbal, about topics that will be discussed behind closed doors, and reviewing the confidentiality policy prior to asking them to step out of the room are strategies that have effectively changed parents opinions about confidentiality for their teen (Hutchinson & Safford, 2005).

It is no secret that discussing sexuality during the medical interview can be uncomfortable for either the provider or the patient or both. The issue of sexual orientation should be approached sensitively and non-judgmentally by the provider. Teens prefer the provider to be direct. When asked what would make the discussion of sexual orientation with a health care practitioner more comfortable, sixty-four percent of GLB teens in one study responded “just ask me” (Meckler et al, 2006). For most patients, trust is essential to feeling safe with a provider and influences their decision to disclose GLB status in a medical setting (Wilkerson, Rybicki, Barber & Smolenski, 2011); building this trust may take place over time and multiple visits. Other patients may be very forthcoming about their sexual orientation in order to check the provider’s reaction. Although risking a negative response, this helps the patient determine how he or she wants the relationship to proceed from that point (Wilkerson, Rybicki, Barber & Smolenski, 2011).

Because GLB patients come from diverse backgrounds and cannot be identified by mere appearance, the provider should use affirmative, non-discriminatory language with every encounter when discussing sexual orientation. Questions such as “are you dating?” or “are you in a relationship?” do not assume heterosexuality in the same way that asking a male patient if he has a girlfriend or a female patient if she has a boyfriend do (Gay and Lesbian Medical Association, 2006). Another approach is to ask all patients, male and female, if they are attracted

to boys, girls, or both (Perrin et al, 2004). This word choice acknowledges that some youth are attracted to members of the same sex and is affirming to GLB patients. When discussing prevention, the provider should ask about strategies of “protection” as well as “birth control,” keeping in mind that adolescents who participate in same sex sexual activity exclusively are at risk for sexually transmitted infections but not pregnancy (Frankowski, 2004). When a provider assumes heterosexuality, the GLB teen is not likely to correct the assumption, which will only add to the sense of isolation the patient already feels (Kreiss & Patterson, 1997). The term “homosexual” is considered offensive in the GLB community; this term traditionally refers to sexual behavior and should not be used as a noun referring to person (Messina, 1994). Words such as “gay,” “lesbian,” or “bisexual” are generally accepted terms, but the provider should avoid using such labels until the patient has identified as such (Crisp & McCave, 2007). The practitioner may inquire what label the patient uses to describe his or her sexual orientation and should support the youth’s own self-identification (Crisp & McCave, 2007).

When an adolescent discloses himself or herself as GLB, the provider should assess where the teen is in the coming out process (Crisp & McCave, 2007). This process begins with coming out to self, a time during which adolescents realize that they are different from their heterosexual peers (Riley, 2010) which can be very distressing to the adolescent whose natural tendency is to seek acceptance from his or her peers. The next step is coming out to others (Riley, 2010; Crisp & McCave, 2007). If the adolescent has come out to friends or family, the practitioner should inquire to whom they have come out and how those people reacted to this revelation (Crisp & McCave, 2007). The practitioner should inquire about or help the adolescent identify a supportive adult in their life. According to the Gay, Lesbian, and Straight Education Network, GLB students who can identify at least one supportive adult at their school on average

have higher grade point averages and are more likely to plan to pursue post-secondary education (GLSEN, 2007). It is not the role of the provider to encourage the teen to come out to friends or family. The teen may not be ready or may have appraised their social situation as unsafe for disclosure. The provider should be a supportive figure who accepts and respects the patient for who they are (Crisp & McCave, 2007). Finally, the provider should keep in mind the reason for the medical visit (Crisp & McCave, 2007). GLB adolescents have many of the same health care needs as their heterosexual counterparts, but providers should also keep in mind the health disparities that are unique to this population. GLB patients may be seen in clinic for health promotion, physical assessment, minor care of illness and injury, sports physicals, mental health screening and referral, testing and treatment for sexually transmitted infections, safe sex counseling, drug and alcohol counseling, pregnancy testing, and crisis intervention (Frankowski, 2004; Kreiss & Patterson, 1997). Screening tests should be performed based on reported behavior, not sexual orientation (Garofalo & Katz, 2001).

Sometimes it is appropriate to help facilitate communication within a family by meeting with both the teen and parent or parents. This should not be done without the explicit permission of the adolescent (Crisp & McCave, 2007). Hearing the news that their child is GLB is difficult for many parents. In a qualitative research study of parents of gay and lesbian adolescents, Saltzburg (2004) found that all parents interviewed, even those who had suspected their child's sexual minority status since childhood, were stunned and unprepared by the finality of the disclosure. Additional feelings expressed were panic, deep loss of idealized dreams, aloneness, and shame (Saltzburg, 2004). Research has shown that some parents react with violence and hostility to their child's disclosure, while others are accepting of the news (Perrin et al, 2004). When an adolescent comes out to family, parents are forced to reorganize their views of their

child, themselves, and their family in a larger social context (Saltzburg, 2004). Through discussion with parents, providers have the opportunity to model unconditional positive regard for the adolescent, which may help the family adjust to news that their child is GLB (Crisp & McCave, 2007). The provider should discuss with families how their love and support will benefit their child during this time when the adolescent is struggling to unify his or her identity (Perrin et al, 2004; National Association of Pediatric Nurse Practitioners, 2011). In a study of how family support and acceptance of GLB teens affected their health as young adults, it was found that children of accepting families scored higher on scales of self-esteem, social support, and general health (Ryan, Huebner, Diaz & Sanchez, 2009). Families with low levels of acceptance had children with significantly more depression, substance abuse, and suicidal thoughts and attempts (Ryan, Huebner, Diaz & Sanchez, 2009). The provider should be supportive of parents whose child has disclosed, remind parents that GLB individuals can still have families, be successful parents themselves, and refer families to appropriate resources (Fankowski, 2004).

Resources

The American Academy of Pediatrics and the National Association of Pediatric Nurse Practitioners in their position statements for the treatment of GLB youth emphasize it is the responsibility of the provider to offer resources and referrals to non-heterosexual youth as well as their friends and families as needed (National Association of Pediatric Nurse Practitioners, 2011; Frankowski, 2004). In a study of the health care experiences of 102 GLB youth, none of the thirteen participants who disclosed their sexual orientation to their provider were offered information about resources such as support groups (Allen, Glicker, Beach & Naylor, 1998). It is unclear if and how practice has changed since that time, as a review of published literature

failed to produce further studies examining resource provision for sexual minority patients. Many providers cite lack of knowledge of available resources for the GLB community as a reason for not addressing this issue. In a study of pediatricians, fifty-nine percent reported being unfamiliar with GLB resources, thirty-eight percent somewhat familiar, and three percent familiar (Lena, Wiebe, Ingram & Jabbour, 2002).

The American adolescent increasingly relies on the internet and other technology for both information and socialization (Sison & Greydanus, 2007). The internet provides adolescents with a variety of services including information acquisition and social networking. Adolescents find information on the internet accessible (Gray, Klein, Noyce, Sesselberg & Cantrill, 2005). A qualitative study of adolescent online health information seeking behavior with participants from the United States and the United Kingdom found many teens use the internet as a resource for health data because it minimizes their perceived barriers to health care access, it is always open for service, embarrassment is decreased, and anonymity is maintained as controlled by the user (Gray, Klein, Noyce, Sesselberg & Cantrill, 2005). Many adolescents viewed the internet as preferable to books and pamphlets, which are quickly outdated, although it was recognized that information on internet homepages may not be as credible as other sources (Gray, Klein, Noyce, Sesselberg & Cantrill, 2005). The internet is a medium that has the potential to meet many needs of GLB youth, including the need for empathy, expertise and professional resources, and personal feedback (Gray, Klein, Noyce, Sesselberg & Cantrill, 2005). A number of credible internet resources and toll-free hotlines for GLB youth were identified in the literature and are included in the Appendix of this manuscript. Even when the pediatric primary care practitioner feels some degree of discomfort discussing the topic of sexual orientation with sexual minority patients, the ability to provide GLB youth with reliable information and safe social outlets goes a

long way toward building trust and providing the best care possible for the patients and their families (Frankowski, 2004).

Conclusion

Sexual orientation is a topic frequently omitted from the sexual history of adolescent patients in the pediatric primary care setting. Sexuality is an important aspect of self that begins to develop and mature during the adolescent years. GLB adolescents are frequently persecuted or socially isolated, which increases the risk of physical and psychological morbidity. It is the role of the pediatric primary care provider to offer culturally competent care to all adolescent youth, including those of sexual minority status. This can be done by: creating a physical environment that offers cues of acceptance, examining one's own attitudes and referring patients if there are personal barriers to providing care, assuring the adolescent of confidentiality, helping the adolescent think through his or her feelings, identifying risky behaviors, asking about mental health concerns, and providing support and resources (Frankowski, 2004).

Clinical Recommendations

The following is a summary of practice recommendations generated based on the above review of current literature:

1. Post GLB-affirming symbols in windows or other highly visible places.
2. Have brochures and pamphlets on a wide range of topics available in exam rooms; this material should feature diversity of race and sexual orientation.
3. Post an anti-discrimination policy where it is easily seen.
4. Annual diversity training should be provided for all staff who may come in contact with patients.
5. Refer to another provider if unbiased care cannot be given.

6. Support the patient in his or own choice of sexual label, or lack thereof.
7. Explicitly discuss confidentiality at each visit and allow the adolescent time alone with the provider.
8. Be direct when asking about sexual orientation; do not assume heterosexuality.
9. Find out where the patient is in the coming out process.
10. Help the patient identify at least one supportive adult.
11. Facilitate communication between parents and teen only with explicit permission from the patient.
12. Refer to appropriate resources.

Directions for Future Research

The topic of adolescent sexual orientation as it relates to health care provision is relatively unstudied and there are many areas for future research. First, it is important to understand whether provider bias truly affects short and long-term health outcomes of adolescent patients, and if so, the mechanism by which this occurs. Current research has approached this issue from an adult standpoint and has not focused on health outcomes but rather services provided to patients and health care seeking behaviors (Khan, Plummer, Hussain, & Minichiello, 2008; Steele, Tinmouth & Lu, 2006). Research examining the word preference of adolescents when discussing sexual orientation during the medical interview may also be helpful. In a study of 184 physicians, thirty-three percent sometimes or regularly did not discuss sexual orientation in a sexual history because they felt uncomfortable, and forty-four percent did not discuss it because they felt it would make the patient uncomfortable (Kitts, 2010). In a smaller study of 112 pediatricians, twenty-four percent expressed reservations about discussing sexual orientation because of fears of offending patients (Lena, Wiebe, Ingram & Jabbour, 2002). Knowing what

words are most acceptable to teens of all sexual orientations may help to build trust more effectively and elicit better responses, in addition to quelling provider anxiety about offending patients with word choice. Finally, more research needs to be done describing how protective factors can be enhanced to promote mental and physical health among GLB adolescents.

Protective factors such as family connectedness, adult caring, and school safety have been shown to buffer against suicidal ideation and attempts (Eisenberg & Resnick, 2006). Research into evidenced-based interventions implemented by providers to support these connections could not only improve the health of GLB adolescents, but surveillance by pediatric primary care providers who may then feel like they can do something with the information they collect about sexual orientation during routine physical exams.

References

- Academy of Child and Adolescent Psychiatry (2006). *Facts for families: gay and lesbian adolescents*. Retrieved November 18, 2009 from http://www.aacap.org/galleries/FactsForFamilies/63_gay_and_lesbian_adolescents.pdf.
- Allen, L.B., Glicklen, A.D., Beach, R.K., and Naylor, K.E. (1998). Adolescent health care experience of gay, lesbian, and bisexual young adults. *Journal of Adolescent Health* 23, 212-220.
- Coker, T.R., Austin, S.B., and Schuster, M.A. (2010). The health and health care of lesbian, gay, and bisexual adolescents. *Annual Review of Public Health* 31(1), 457-477.
- Crisp, C. and McCave, E.L. (2007). Gay affirmative practice: a model for social work practice with gay, lesbian, and bisexual youth. *Child and Adolescent Social Work Journal* 24(4), 403-421.
- D'Augelli, A.R., Grossman, and Starks, M.T. (2005). Parents' awareness of lesbian, gay, and bisexual youths' sexual orientation. *Journal of Marriage and Family* 67(2), 474-482.
- Duncan, R.E., Vandeleur, M., Derks, A., and Sawyer, S. (2010). Confidentiality with adolescents in the medical setting: what do parents think? *Journal of Adolescent Health* 49(4), 428-430.
- Eisenberg, M.E. and Resnick, M.D. (2006). Suicidality among gay, lesbian, and bisexual youth: the role of protective factors. *Journal of Adolescent Health* 39(5), 662-668.
- Esposito, N. (2005). Agenda dissonance: immigrant Hispanic women's and provider's assumptions and expectations for menopause health care (2005). *Clinical Nursing Research* 14(1), 32-56.

- Ford, C.A., Millstein, S.G., Halpern-Felsher, B.L., Irwin, C.E. (1997). Influence of physician confidentiality assurances on adolescents' willingness to disclose information and seek future care. *Journal of the American Medical Association* 278(12), 1029-1034.
- Fournier, M.E., Austin, S.B., Samples, C.L., Goodenow, C.S., Wylie, S.A., and Corliss, H.L. (2009). A comparison of weight-related behaviors among high school students who are homeless and non homeless. *Journal of School Health* 79(10), 466–73.
- Frankowski, B.L. and the Committee on Adolescence (2004). Clinical report: guidance for the clinician in rendering pediatric care: sexual orientation and adolescents. *Pediatrics* 113(6), 1827-1832.
- Garofalo, R. and Katz, E. (2001). Health care issues of gay and lesbian youth. *Current Opinions in Pediatrics* 13(4), 298-302.
- Gay and Lesbian Medical Association (2001). *Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health*. Retrieved November 18, 2011 from <http://www.nalgap.org/PDF/Resources/HP2010CDLGBTHealth.pdf>.
- Gay and Lesbian Medical Association (2006). *Guidelines for care of lesbian, gay, bisexual, and transgender patients*. Retrieved July 13, 2011 from http://www.qahc.org.au/files/shared/docs/GLMA_guide.pdf.
- GLSEN (2007). *Gay-Straight Alliances: Creating Safer Schools for LGBT Students and Their Allies* (GLSEN Research Brief). New York: Gay, Lesbian, and Straight Education Network.
- Gray, N.J., Klein, J.D., Noyce, P.R., Sesselberg, T.S., & Cantrill, J.A. (2005) Health information-seeking behaviour in adolescence: the place of the internet. *Social Science and Medicine* 60(12), 1467-1478.

- Henry-Reid, L.M., O'Connor, K.G., Klein, J.D., Cooper, E., Flynn, P., et al. (2010). Current pediatrician practices in identifying high-risk behaviors of adolescents. *Pediatrics* 125(4), e741-747.
- Hutchinson, J.W. and Safford, E.M. (2005). Changing parental opinions about teen privacy through education. *Pediatrics* 116(4), 966-971.
- Joint Commission (2011). Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide. Retrieved November 18, 2011 from <http://www.jointcommission.org/assets/1/18/LGBTFieldGuide.pdf>.
- Juarez, J.A., Marvel, K., Brezinski, K.L., Glazner, C., Towbin, M.M., and Lawton, S. (2006). Bridging the gap: a curriculum to teach residents cultural humility. *Family Medicine* 38(2), 97-102.
- Khan, A., Plummer, D., Hussain, R., Minichiello, V. (2008). Does physician bias affect quality of care they deliver? Evidence in the care of sexually transmitted infections. *Sexually Transmitted Infections* 84(2), 150-151.
- Kitts, R.L. (2010). Barriers to optimal care between physicians and lesbian, gay, bisexual, transgender, and questioning adolescent patients. *Journal of Homosexuality* 57(6), 730-747.
- Kosciw, J.G., Diaz, E.M., and Greytak, E.A. (2008). *2007 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual and Transgender Youth in Our Nation's Schools*. New York: GLSEN.
- Kreiss, J.L. and Patterson, D.L. (1997). Psychological issues in primary care of lesbian, gay, bisexual, and transgender youth. *Journal of Pediatric Health Care* 11(6), 266-274.

- Kumagai, A.K. and Lypson, M.L. (2009). Beyond cultural competence: Critical consciousness, social justice, and multicultural education. *Academic Medicine* 84(6), 782-787.
- Lena, S.M., Wiebe, T, Ingram, S., Jabbour, M. (2002). Pediatricians' knowledge, perceptions, and attitudes towards providing health care for lesbian, gay, and bisexual adolescents. *Annals (Royal College of Physicians and Surgeons of Canada)* 35(7), 406-410.
- Messina S.A. (1994). *A Youth Leader's Guide to Building Cultural Competence*. Washington, DC: Advocates for Youth.
- Meckler, G.D., Elliott, M.N, Kanouse, D.E., Beals, K.P, and Schuster, M.A. (2006). Nondisclosure of sexual orientation to a physician among a sample of gay, lesbian, and bisexual youth. *Archives of Pediatrics and Adolescent Medicine* 160(12), 1248-1254.
- National Association of Pediatric Nurse Practitioners (2009). NAPNAP position statement on health care/medical home: key issues on delivery, reimbursement, and leadership. *Journal of Pediatric Health Care* 23(3), A23-A24.
- National Association of Pediatric Nurse Practitioners (2011). Health risks and needs of lesbian, gay, bisexual, transgender, and questioning adolescents position statement. Retrieved December 14, 2011 from http://www.napnap.org/Files/NAPNAP%20PS%20Health%20Risks%20and%20Needs%20of%20LGBTQ%20Adoles_Final%202011.pdf.
- Palo Alto Medical Foundation (2011). Sexual orientation. Retrieved November 3, 2011 from <http://www.pamf.org/teen/sex/orientation.html>.
- Perrin, E.C., Cohen, K.M., Gold, M., Ryan, C., Savin-Williams, R.C., and Schorzman, C.M. (2004). Gay and lesbian issues in pediatric health care. *Current Problems in Pediatric and Adolescent Health Care* 34, 355-398.

- Ratelle, S., Mayer, K.H., Goldhammer, H., Mimiaga, M., Coury-Doniger, P., et al. (2005). Toolkit for the prevention and management of sexually transmitted diseases. Retrieved November 3, 2011 from http://www.fenwayhealth.org/site/DocServer/Prevention_and_Management_of_Sexually_Transmitted_Diseas.pdf?docID=721.
- Ridner, S.L., Frost, K., and LaJoie, A.S. (2006). Health information and risk behaviors among lesbian, gay, and bisexual college students. *Journal of the American Academy of Nurse Practitioners* 18(8), 374-378.
- Riley, B.H. (2010). GLB adolescent's "coming out". *Journal of Child and Adolescent Psychiatric Nursing* 23(1), 3-10.
- Ryan, C., Huebner, D., Diaz, R.M., and Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics* 123(1), 346-352.
- Saltzburg, S. (2004). Learning that an adolescent child is gay or lesbian: the parent experience. *Social Work* 49(1), 109-118.
- Savin-Williams, R. C. and Diamond, L. (2000). Sexual identity trajectories among sexual minority youths: gender comparisons. *Archives of Sexual Behavior* 29, 607-627.
- Saewyc, E.M. (2011). Research on adolescent sexual orientation: development, health disparities, stigma, and resilience. *Journal of Research on Adolescence* 21(1), 256-272.
- Sison, A.C. and Greydanus, D.E. (2007) Deconstructing adolescent same-sex attraction and sexual behavior in the twenty-first century: perspectives for the clinician. *Primary Care: Clinics in Office Practice* 34(2), 239-304.

- Steele, L.S., Tinmouth, J.M., and Lu, A. (2006). Regular health care use by lesbians: a path analysis of predictive factors. *Family Practice* 23(6), 631-636.
- Thompson, E. M., & Morgan, E. M. (2008). “Mostly straight” young women: Variations in sexual behavior and identity development. *Developmental Psychology*, 44(1), 15–21.
- Wilkerson, J.M., Rybicki, S., Barber, C.A., and Smolenski, D.J. (2011). Creating a culturally competent clinical environment for LGBT patients. *Journal of Gay and Lesbian Social Services* 23(3), 376-394.
- Williams, T. Connolly, J. Pepler, D., and Craig, W. (2003). Questioning and sexual minority adolescents: high school experience of bullying, sexual harassment, and physical abuse. *Canadian Journal of Community Mental Health* 22(2), 47-58.

Appendix

Name	Information Provided	Contact
Ambiente Joven	Website for Spanish-speaking GLB youth	http://www.ambientejoven.org/
Gay, Lesbian, and Straight Education Network (GLSEN)	Resources for school-related issues and gay-straight alliances, local chapters	http://www.glsen.org/
GLBT Near Me	Local GLB resources	http://www.glbtnearme.org/
GSA Network	Networking, training for student leaders, events, information	http://gsanetwork.org/
It Gets Better Project	Coming out support	http://www.itgetsbetter.org/
Lambda Youth Network	Confidential email group for under 21, published resources, support for hate crime victims	http://www.lambda.org/youth.htm
National Federation of Parents, Families, and Friends of Lesbian and Gays (PFLAG)	Local chapters, story sharing, dos and don'ts for families and friends, specific tips for people of color	http://www.pflag.org
National Gay and Lesbian Task Force	Research on GLB related topics, advocacy information and events	http://thetaskforce.org/
The Trevor Project	Crisis intervention and suicide prevention	http://www.thetrevorproject.org/
Trevor Space	Social Networking for GLBTQ youth	http://www.trevorspace.org/
True Colors	Resources for teens and their families, mentoring program	http://www.ourtruecolors.org/index.html
Youth Guardian Services	Age-specific support groups via email	http://youth-guard.org/youth/
Youth Resource	BLG blogs, health facts, online peer education program	http://www.amplifyyourvoice.org/youthresource
GLBT National Help Center	Youth specific GLB peer counseling, information, local resources (http://www.glnh.org/talkline/index.html for times)	1-800-246-7743
Peer Listening Line (Fenway Health)	Anonymous & confidential information, referrals, support for GLB youth	1-800-399-PEER
The Trevor Project	GLB suicide hotline with counselors available 24/7	1-866-488-7386