Lesbian, gay, bisexual, and other sexual minoritized youth: Epidemiology and health concerns

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INTRODUCTION

The term "sexual minoritized" encompasses a variety of gender and sexual identities and expressions that differ from cultural norms (eg, lesbian, gay, bisexual, transgender), as well as identities and expressions that defy discrete labels [1].

This topic will focus on the epidemiology and health concerns of sexual minoritized youth who identify themselves as lesbian, gay, bisexual, pansexual, or unsure (questioning) of their sexual identity, who avoid discrete sexual orientation labels. An overview of primary care for such youth is presented separately. (See "Lesbian, gay, bisexual, and other sexual minoritized youth: Primary care".)

Gender diversity in children and adolescents is discussed separately. (See "Gender development and clinical presentation of gender diversity in children and adolescents" and "Management of transgender and gender-diverse children and adolescents".)

TERMINOLOGY

- **Sexual orientation** – Sexual orientation is an individual's pattern of physical and emotional arousal (including fantasies, activities, and behaviors) and the gender(s) of

persons to whom an individual is physically or sexually attracted [2].

- Homosexual sexual orientation refers to sexual attraction to same-sex individuals
- Heterosexual sexual orientation refers to sexual attraction to opposite-sex individuals
- Bisexual sexual orientation refers to sexual attraction to both same-sex and opposite-sex individuals
- Pansexual sexual orientation refers to sexual attraction to individuals of any gender identity or biologic sex
- Asexual sexual orientation refers to lack of sexual attraction to any individuals

- **Sexual identity** – Sexual identity is an individual's assessment of his or her sexual orientation; male individuals who self-identify as homosexual are often referred to as gay; female individuals who self-identify as homosexual are often referred to as gay or lesbian [3]. Youth who self-identify as heterosexual are often referred to as straight. Youth who are unsure of or struggle with their sexual identity may be referred to as "questioning" [4].

  The individual youth is the best person to describe and define his or her identity. Some adolescents prefer the terms "mostly heterosexual" or "mostly homosexual," to reflect their feeling of being between categories [5]. Others may avoid categorization, preferring more diffuse terminology such as queer, pansexual, or fluid regarding their sexuality.

- **Sexual behavior** – Sexual behavior refers to particular sexual activities and incorporates the gender(s) of sexual partners. Sexual attraction and identity correlate closely, but not completely, with reports of sexual behavior [6-11]. Youth who self-identify as heterosexual may engage in sexual activity with same-sex partners; youth who self-identify as homosexual may remain sexually inexperienced. Sexual behavior does not necessarily indicate sexual orientation; it may represent experimentation, exploration, or exploitation [12]. Sexual behaviors are more important than self-identified labels in assessing health risk. (See "Lesbian, gay, bisexual, and other sexual minoritized youth: Primary care", section on 'Sexuality'.)

- **Sexual minoritized** – The term "sexual minoritized" encompasses a variety of gender and sexual identities and expressions that differ from cultural norms (eg, lesbian, gay, bisexual, transgender), as well as identities and expressions that defy discrete labels

[1].

This topic will focus on sexual minoritized youth who identify themselves as lesbian, gay, bisexual, or unsure (questioning) of their sexual identity, who avoid discrete sexual orientation labels, and who have had sexual contact with persons of the same sex or persons of both sexes. Gender diversity is discussed separately. (See "Gender development and clinical presentation of gender diversity in children and adolescents" and "Management of transgender and gender-diverse children and adolescents".)

DEVELOPMENTAL PERSPECTIVE

Sexual orientation has multiple dimensions, including attractions, identity, behaviors, and the gender of sexual partners, all of which are important to understanding developing sexuality (figure 1) [3,13,14]. (See "Adolescent sexuality".)

Sexual exploration, experimentation, and discovery are part of the normal process of incorporating sexuality into one's sexual identity [15-17]. Before puberty, many children experiment with cross-gender play and expression. Cross-gender interests and expression in the prepubertal years are neither necessarily nor predictably associated with adolescent or adult sexual orientation. However, gender-diverse prepubertal children more often identify as gay or lesbian than transgender in adolescence and adulthood [18-21]. (See "Gender development and clinical presentation of gender diversity in children and adolescents", section on 'Prepubertal children'.)

As children approach puberty and adolescence, sexuality (ie, attraction, interests, orientation, and behaviors) becomes relevant to the life tasks of developing relationships, intimacy, and creating family. Defining one's sexual orientation occurs over time. First awareness of same-sex attraction, which may or may not persist, has been described as early as age 9 for boys and 10 for girls, but sexual minoritized youth may self-identify orientation at later ages than heterosexual peers [22,23].

Formation of sexual identity among youth may be fluid [16,24]. Adolescents explore their emerging sexuality through attractions, fantasies, and behaviors [16,25]. Adolescent sexual identity and self-identified orientation does not necessarily correlate with sexual behaviors [6-11,26]. Adolescents may have same-sex attractions and fantasies but not

identify as homosexual; they may identify as homosexual but remain sexually inexperienced; or they may identify as heterosexual but engage in same sex behaviors. (See "Adolescent sexuality", section on 'Adolescent development'.)

Strong family and societal expectations may influence the experience and expression of gender and sexuality in children and adolescents [27,28]. Some parents and families may try to redirect gender diverse expression and same-sex attractions, identity, or behavior to fit into heteronormative social parameters (ie, those that view opposite-sex relationships as the only "normal" relationships in society) [29]. Peer pressure may lead adolescents to behaviors that have little to do with attraction. Externalized and internalized sexual prejudice (also known as "homophobia" or "homonegativity") may lead adolescents to avoid sexual activity altogether, adopt heterosexual activity, or mistreat others who they perceive as homosexual [30]. (See "Gender development and clinical presentation of gender diversity in children and adolescents", section on 'Gender development in childhood'.)

EPIDEMIOLOGY

Although epidemiologic studies of sexual minoritized youth use widely different measures [14], in several large surveys, 5 to 12 percent of high school youth report same-sex attractions or behaviors [31,32]. In a nationwide survey of high-school students, approximately 44 percent reported sexual contact with only the opposite sex, 2 percent with only the same sex, and 5 percent with both sexes [33]. Sexual minoritized students were racially, ethnically, socially, economically, and geographically diverse.

POTENTIAL PSYCHOSOCIAL AND HEALTH CONCERNS

Although the majority of sexual minoritized youth are healthy and well adjusted [17,34,35], some sexual minoritized youth are at increased risk for adverse psychosocial and health outcomes. Compared with heterosexual peers, sexual minoritized youth have increased rates of victimization, depression, suicide, substance use, homelessness, sexually transmitted infections, and unplanned pregnancy [32,36-43]. These health disparities are not intrinsic to sexual minoritized status but appear to be related to stigmatization and lack of acceptance of specific sexual behaviors, identities, and orientations [44-52].

Stigmatization and minority stress — Sexual minoritized youth may be stigmatized and marginalized by individuals or in communities and cultures that are dismissive, openly rejecting, or hostile [14]. Stigmatization is an important moderator of the disparities in psychosocial and health outcomes of sexual minoritized youth [44-46,49-51,53-56]. In surveys of sexual minoritized young adults, high levels of family rejection during adolescence was associated with suicidality, depression, illegal drug use, and engaging in unprotected sex; family acceptance was associated with greater self-esteem and social support, and decreased depression, substance abuse, and suicidality [55,57,58]. Other surveys found an association between structural stigma at the state level (eg, lack of nondiscrimination policies for sexual minoritized status) and disparities in drug and cigarette use [59,60].

Minority stress models propose that being minoritized is linked to bias, discrimination, and lack of support that can lead to stress, anxiety, and depression, which contribute to adverse long-term psychosocial and health outcomes (figure 2) [34,61-63]. Structural stigma in the sociocultural environment may interact with individual psychologic characteristics, impacting decision making and behaviors among young sexual minoritized individuals [64]. Whether or not the minority stress model is correct, multiple observational studies demonstrate that rates of mental health problems (eg, anxiety, depression, suicide and self-harm, conduct disorder, substance abuse, and posttraumatic stress disorder) are increased among sexual minoritized youth compared with nonsexual minoritized youth [65-71].

Potential protective factors — Factors that contribute to resilience and counteract stigmatization include [45,64,72-80]:

- Acceptance
- Competence
- Higher levels of self-esteem and psychologic well-being
- Strong sense of self and self-acceptance
- Strong ethnic identification
- Strong connections to family and school
- Caring adult role models outside the family
- Community involvement

Personal, family, and societal acceptance of sexual identity may provide protection against

some of the adverse psychosocial and health outcomes for sexual minoritized youth. Family acceptance is particularly salient [2,3,35]. In multiple observational studies, parental support and acceptance of sexual minoritized youth are correlated with positive mental health outcomes, and parental rejection and lack of support are correlated with negative mental health outcomes [58,81].

Health care providers may contribute to resilience by serving as role models and demonstrating openness, support, and respect for diversity. They also can provide information and a safe place for parent and child discussion and help parents overcome their fears and biases to more fully accept and nurture their sexual minoritized children. (See 'Parents and family' below.)

Health risks — Sexual minoritized youth are more likely than their heterosexual peers to report health risk behaviors, including attempted suicide, substance use, high-risk sexual behaviors, and unhealthy eating or exercise patterns, and experience of victimization/violence [32,36,42,43,69,70,82-84]. Adverse social experience, including discrimination and victimization, have been associated with health problems, sexual risk taking, and HIV exposure [85]. Some risk behaviors appear to vary depending upon subgroups, but the data are limited [44,86-89].

Victimization and violence — Sexual minoritized youth are at higher risk than their nonsexual minoritized peers for sexual prejudice ("homophobia"); verbal harassment; physical threats, harassment, or assault; and physical and sexual abuse [90]. Victimization is an important mediator of psychologic distress and mental health outcomes, including suicidality, among sexual minoritized youth [39,47,91-96]. Sexual minoritized youth may experience victimization and violence at home, school, or in the community [32,37,44,97-99]. Victimization and psychologic distress appear to decrease with age and over time [96,100].

In a 2011 meta-analysis of school-based studies, sexual minoritized individuals were 1.2 times more likely to report parental physical abuse and 3.8 times more likely to report sexual abuse (the site of abuse and perpetrator were not addressed) than their nonsexual minoritized peers [44]; they also were 1.7 times more likely to have been assaulted at school and 2.4 times more likely to miss school out of fear.

In a nationwide survey of high school students, 28 percent reported being electronically bullied; 19 percent reported having been forced to have sexual intercourse at some point

in their lives; and among those who had dated or went out with someone during the 12 months before the survey, 16 percent reported sexual dating violence and 13 percent reported physical dating violence [32]. These rates were generally approximately twice as high as those among heterosexual students.

School victimization — In a 2019 national survey of high school students, sexual minoritized students were more likely than their heterosexual peers to report being threatened or injured with a weapon (12 versus 6 percent) or bullied (32 versus 17 percent) on school property in the previous 12 months or to report not going to school for at least 1 of the previous 30 days because of safety concerns (14 versus 8 percent) [32]

In a 2011 national survey of 8584 lesbian, gay, bisexual, and transgender students (13 to 20 years) [37]:

- 71 to 85 percent reported hearing sexual prejudicial remarks (eg, "that's so gay," "dyke," "faggot") frequently or often at school; 57 percent reported hearing such remarks from teachers or other staff
- 64 percent felt unsafe at school because of their sexual orientation
- 82 percent were verbally harassed (called names or threatened), 38 percent were physically harassed (eg, pushed or shoved), and 18 percent were physically assaulted (eg, punched, kicked, injured with a weapon) at school in the past year because of their sexual orientation
- 55 percent were harassed or threatened by their peers via electronic mediums (eg, text messages, postings on Facebook)
- 32 percent missed at least one day of school in the past month because they felt unsafe or uncomfortable

Middle school sexual minoritized youth were more likely than high school sexual minoritized youth to experience harassment and assault based on sexual orientation or gender expression [37]. School characteristics associated with discrimination included public or religious schools (versus private/nonreligious schools), location in the Southern or Midwestern United States, and location in small town or rural areas.

Rates of bullying and victimization of lesbian, gay, and bisexual youth decreased with

increasing age, as demonstrated in a prospective survey (2004 to 2010) from England [100]. However, there were differences between males and females: By the final wave of the survey, lesbian/bisexual females were no more likely to report bullying than their heterosexual peers, whereas gay/bisexual males were more likely to report bullying than their heterosexual peers.

School victimization is associated with truancy, feeling unsafe, and decreased school engagement and academic achievement, as well as long-term health and behavioral risk factors, emphasizing the importance of early interventions that decrease school victimization and promote life-long educational attainment [101-104]. (See 'School' below.)

Sexual victimization — Rates of sexual violence and victimization (eg, dating violence, child and adolescent sexual abuse) are higher in sexual minoritized individuals than in their peers [105-112]. Adolescents who identify as having partners of both sexes seem to be at highest risk [36]. In a 2011 systematic review of 75 studies (139,635 participants) evaluating sexual assault against sexual minoritized persons, lifetime sexual assault ranged from 16 to 85 percent for women and 12 to 54 percent for men [110]. Lesbian/bisexual women were more likely to report childhood sexual assault, adult sexual assault, and intimate partner violence than gay/bisexual men. Gay/bisexual men were more likely to report hate-crime related assault than lesbian/bisexual women.

Mental health and self-harm — Adolescence is a challenging time for all youth. Sexual minoritized youth have the same mental health needs as their heterosexual peers but face the additional challenge of societal bias against sexual and gender minorities.

Sexual minoritized youth report higher levels of social isolation, low self-esteem, impaired self-concept, and a variety of internalizing (eg, anxiety, depression) and/or externalizing (eg, aggression) symptoms than their peers [41,113-119]. These symptoms may be induced by stigmatization and minority stress or victimization [100]. (See 'Stigmatization and minority stress' above.)

Sexual minoritized youth also report higher levels of suicidality and nonsuicidal self-injury than their peers [32,38,69,120,121]. In a 2018 meta-analysis of 22 observational studies from 10 countries, the risk of suicide attempt was greater in sexual minoritized than heterosexual youth (23.7 versus 6.4 percent, odds ratio [OR] 3.5, 95% CI 3.0-4.1); in subgroup analysis, the risk was greater among bisexual than homosexual youth (OR 4.9 versus 3.7) [87]. In a national survey of high school students in the United States, the

prevalence of nonsuicidal self-injury ranged from 38 to 53 percent among sexual minoritized youth between 2005 and 2017 (compared with 11 to 20 percent among heterosexual youth) [121].

In the National Longitudinal Study of Adolescent Health, symptoms of depression among sexual minoritized youth decreased between adolescence (1994-1995) and young adulthood (2007-2008), but suicidality did not [122].

Use of multiple measures of sexual minoritized status and factors related to racial/ethnic background, religious affiliation, and self-identification may help to explain within-group disparities in rates of mental health problems (eg, depression, substance use, eating disorders) and suicidal ideation [123-125].

Tobacco and substance use — Sexual minoritized youth appear to be at increased risk for tobacco, alcohol, and drug use compared with their nonsexual minoritized peers, but the risk varies with the subgroup, substance, and other factors such as race/ethnicity, socioeconomic status, victimization, and family support [70,71,126-133].

In a national survey, female sexual minoritized youth (self-categorized as lesbian, bisexual, or "mostly heterosexual") and "mostly heterosexual" males were at least two times more likely to use tobacco than heterosexual youth; tobacco use was not increased among self-categorized gay/bisexual boys [134]. In other national surveys, bisexual youth report greater substance use than homosexual youth [70,71,135,136].

Tobacco and/or substance use may be a marker for other risky health behaviors (eg, exchange sex, sex with drug users, multiple partners, unprotected sex) [137-139]. In a survey of young men who have sex with men (MSM) in New York City, tobacco use was associated with increased use of illicit substances, alcohol, abuse of prescription drugs, and more casual and transactional sex partners [137]. Young MSM tobacco users were also more likely to use substances before or during sex. In a cross-sectional survey of young MSM, use of methamphetamine was associated with use of other illicit drugs, sex with drug users, multiple partners, lower rates of condom use, and higher rates of sexually transmitted infections [138].

Homelessness — Sexual minoritized youth who are rejected by their parents and families may run away or be forced to leave home [140]. In convenience samples of homeless youth, sexual minoritized youth are disproportionately represented [141,142]. In

two surveys (2005 and 2007) of 6317 high school students from one state, 25 percent of self-identified lesbian/gay and 15 percent of self-identified bisexual youth were homeless, compared with 3 percent of heterosexual youth [143].

Homeless youth may be forced to engage in risky behaviors to survive [140]. Compared with nonsexual minoritized peers, runaway and homeless sexual minoritized youth report higher rates of substance use, suicide attempts, risky sexual behaviors (eg, prostitution, survival sex, unprotected intercourse), and sexual victimization [144-150].

Sexually transmitted infections — Although many adolescents become sexually active during high school, sexual minoritized youth are more likely to report engaging in behaviors, or being forced to engage in behaviors, that increase their risk of sexually transmitted infections (eg, multiple partners, lack of condom use, using alcohol or drugs before sexual activity) [33,83,151-155]. Sexual minoritized youth may begin experimenting with sex earlier than their heterosexual peers (ie, before age 13 years), use alcohol or drugs with intercourse, lack medically accurate information regarding same-sex safer sex, and lack social support or access to services [33,105]. In a meta-analysis of six studies, sexual minoritized youth were almost twice as likely to report sex while intoxicated as heterosexual peers [156].

Young MSM account for a disproportionate number of new HIV infections in the United States [157,158]. This is particularly true for those who are Black/African American, Hispanic/Latino, homeless, or engage in survival sex [159,160]. New HIV diagnoses attributed to sexual contact among men who have sex with men is highest among young MSM (ie, ages 13 to 24 years) [161]. (See "The adolescent with HIV infection", section on 'Epidemiology'.)

Young MSM and young transfeminine youth who engage in receptive anal sex, have multiple partners, or have a partner who is known to be HIV positive may be candidates for HIV pre-exposure prophylaxis (PrEP). Additional considerations, including assessment of the risk of acquiring HIV and the ability to adhere to PrEP, are discussed separately. (See "Patient evaluation and selection for HIV pre-exposure prophylaxis".)

Young women who have sex with women also may be at risk for HIV depending upon their sexual history and behaviors (eg, coerced sexual contact; exchange sex; digital-vaginal or digital-anal contact, particularly with shared penetrative sex items) [7,162-165].

Unplanned pregnancy — Unplanned pregnancy may occur in sexual minoritized females and transmasculine youth and young adults. Sexual minoritized females may have sex with males as they explore their sexual identity. They also may engage in heterosexual dating and sexual behaviors to avoid being identified as lesbian or bisexual, may engage in exchange sex, or may have coerced sexual contact [7,166-169]. (See "Contraception: Counseling and selection" and "Emergency contraception".)

Several population-based surveys have documented higher rates of pregnancy involvement among lesbian, gay, and bisexual youth than their heterosexual peers [82,167,170-173]. In one survey, lesbian and bisexual respondents were as likely to have had penile-vaginal intercourse as heterosexual or unsure adolescents; they were more likely to have used an ineffective method of contraception or no method of contraception and to become pregnant [166]. Adolescents self-identified as lesbians also reported higher rates of a history of sexual abuse and prostitution [174]. In the National Survey of Family Growth (2006 to 2010), lesbian and bisexual young women (15 to 20 years of age) reported earlier heterosexual debut, more male sexual partners, more female sexual partners, and more forced sexual encounters by a male partner than heterosexual young women [82,173].

Weight control and anabolic steroids — Sexual minoritized youth are more likely than their heterosexual peers to report unhealthy weight control behaviors (eg, not eating for ≥24 hours; taking diet pills, powders, or liquids; vomiting or taking laxatives) and misuse of anabolic-androgenic steroids [33,175,176].

Patterns of disordered eating appear to differ according to subgroup, but data are limited [177-182]. Male sexual minoritized youth are more likely to report symptoms of eating disorders (dissatisfaction and idealized body image, dieting, binging and purging, using weight control products) than heterosexual male peers [179-181]. Female sexual minoritized youth are more likely to report binging with or without purging than their heterosexual female peers.

Male sexual minoritized youth also are more likely to misuse anabolic-androgenic steroids than their heterosexual peers. In a national survey of high school students (2005 to 2007), misuse of anabolic-androgenic steroids was more common among sexual minoritized than heterosexual boys (21 versus 4 percent, OR 5.8, 95% CI 4.1-8.2) [175]. Secondary analysis suggested that depression/suicidality, victimization, and substance use

contributed to misuse of steroids; body dissatisfaction was not assessed.

Unintentional injury — Other risk behaviors that have been more frequently reported among sexual minoritized than nonsexual minoritized youth in the Youth Risk Behavior Surveillance System include behaviors that contribute to unintentional injury (eg, rarely/never wore seatbelt, rode with a driver who had been drinking alcohol, drove when drinking alcohol) [33,183].

SUPPORT AND ADVOCACY

Medical providers are in a unique position to provide and model positive regard, support, and open acceptance for youth of all sexual orientations and identities. Health care providers who accept and support gender or sexual diversity can serve as models for parents and other family members. Negative messaging from adults about sexual minorities may be subtle or overt, but is picked up by youth of all ages. Prepubertal children are particularly sensitive to social cues and often learn to hide their interests, preferences, and play after getting negative feedback from peers and adults.

Normalization of sexuality — Health care professionals who provide developmental screening and anticipatory guidance can integrate conversations around gender and sexuality into their education and counseling. Ongoing conversations about gender and sexuality may allow earlier identification and support for sexual minoritized youth and their families.

- Including questions about gender play and preferences, body image and esteem, expression of femininity and masculinity in routine health care visits from the toddler (table 1 and table 2) through teenage years (table 3) normalizes the youth's ongoing and evolving sexuality, a universal developmental experience.

  Asking such questions provides a developmentally appropriate introduction to upcoming discussions about puberty and adolescence and can be helpful for both the parents and the child to practice open communication about these sensitive issues within the medical setting. It also allows parents, children, and adolescents, including those who are sexual minoritized or have experienced sexual prejudice, to realize that the medical visit can be a safe place to explore questions and concerns about sexual health.

- The health care provider's asking parents about their child's activities and preferences in the prepubertal years demonstrates that adults should be interested in their child's development of identity and provides appropriate models for communication and support about these issues (table 1).

- The provider's open and curious approach to understanding the ways children embrace their gender and sexual selves can guide parents in approaching their gender-diverse child or sexual minoritized adolescent.

Early identification of gender or sexual diversity — Early identification of gender or sexual diversity may permit earlier supportive interventions for the child and family. Asking the child and parent(s) about how the child might view their gender, their body, and their femininity or masculinity is usually well tolerated (table 1 and table 2). Parents may be reassured to hear that most children explore and experiment with gender and sexuality to some extent during childhood. The provider can then encourage the parents to focus on supporting their child as he or she explores and develops his or her sexuality rather than trying to predict future sexual orientation. (See "Gender development and clinical presentation of gender diversity in children and adolescents", section on 'Gender development in childhood'.)

Obtaining a more detailed exploration of gender and sexuality may be warranted for children and adolescents who present with suicidality, mood, behavior, or school problems. Sexual minoritized children may initially present with depression, anxiety, behavior problems, or school problems rather than explicitly identifying or verbalizing more complex constructs of same-sex sexual attractions or brain and body gender incongruence.

Parents and family — The parents and family of sexual minoritized youth play an important role in healthy adolescent development [12,57,81,184-186]. However, they may have difficulty accepting having a sexual minoritized child or family member. Their difficulty may be related to fear of the unknown, fear of social stigma, and fear for their child's or relative's safety. These concerns may reflect their own biases and personal, cultural, religious, and historical background. Parents should understand that their concerns may be communicated to the child, both explicitly and implicitly, and affect how the child views himself or herself.

Health care providers can help parents work through their values and beliefs in a way that

consistently supports the child. Education, parent-to-parent support groups, or therapy may be helpful in this regard. In the experience of the authors of this topic review, parents appreciate and value a health care provider who acknowledges their confusion or distress. Providers can guide parents towards resources that may be helpful to them and other family members and help them to focus on creating an accepting and safe environment for their child (table 4).

It may be helpful to explain that same sex attractions are a normal variant of sexuality; being attracted to members of the same sex is not a mental disorder [2,3,34,35,187]. Familial support and acceptance of the sexual minoritized youth (ie, affirmation) helps adolescents explore their sexual identities in a safe environment [35]. Interventions that attempt to change sexual orientation (ie, "reparative" or "conversion" therapy) are ineffective, coercive, and potentially harmful (by increasing internalized stigma, distress, and depression) [2,34,35,187,188].

Health care providers of sexual minoritized youth can model consistent, positive, and strength-based acceptance and support for parents and family members who want to be more supportive of their sexual minoritized youth. They can also explore and address parental concerns and provide early referrals to community and advocacy resources. (See 'Resources' below.)

Disclosure — Children and adolescents who are sexual minorities may or may not feel initial confusion, discomfort, or emotional turmoil as they come to terms with their sexual attractions, desires, and behaviors.

It is important to allow children, youth, and adults the freedom and autonomy to choose, consciously or unconsciously, the right time to disclose their sexual minoritized status ("come out") to their provider, family members, or peers. The process of coming out can be lifelong, as youth meet new people and experience new social situations. Sexual minoritized youth typically first disclose to a friend [189]. Most youth tell at least one parent, more often the mother, or they tell the mother before the father (in heterosexual parent dynamics) [190]. When a sexual minoritized youth has disclosed to a provider, maintaining privacy, confidentiality, and respecting the youth's plan for disclosure is paramount [2].

Health care providers may be asked to address questions or concerns about disclosure to family or friends [12]. Discussions about disclosure should include the timing, approach,

and potential repercussions (table 5). Providers can help adolescents think through the pros and cons of disclosure, whom to tell, how to make the disclosure, and provide other guidance in revealing, asserting, and feeling good about their sexual orientation or other sexual minoritized status.

Given the potential for discrimination and bias against sexual minorities, disclosure can be an enormous challenge. Reactions to disclosure (positive or negative) are not always predictable. Positive and accepting, or negative and rejecting, family reactions have long-term implications on the health and well-being of sexual minoritized youth [57,81,184]. (See 'Potential protective factors' above.)

Coming out can be an opportunity as well as a challenge. Potential benefits of disclosure include improved communication, support, and intimacy with family and friends; decreased fears and worry about inadvertent disclosure; increased opportunities to access care, social networks, and resources; more authentic internal and external presentation; and acceptance of one's true self [191]. Negative reactions should be discussed and anticipated. Disclosure may increase the rate of victimization [191]. The safety of the youth is paramount. There are particular situations where it may not be safe, helpful, or advisable to disclose. Some youth have significant and real concerns regarding physical safety or abuse from a parent or guardian due to sexual minoritized status. Others may not be physically unsafe but may be rejected, emotionally and verbally abused, or coerced financially. Dependence on parents for housing, schooling, food, and other expenses is a real concern for many youth. If a youth is uncertain how a parent or guardian will react, it may be safer to wait to disclose until the youth is in a more independent or supported position. Disproportionate numbers of homeless youth are sexual minorities, suggesting that many were rejected or not safe at home in their asserted sexual identity [144,192,193]. (See 'Homelessness' above.)

Health care providers can help sexual minoritized youth who do not have supportive families identify and engage in other social and support networks (eg, gay-straight alliances [GSAs], community organizations). It is helpful for providers to be familiar with local groups or agencies that offer a positive environment and support for sexual minoritized youth; providers may identify local groups through national organizations or networking with local providers or groups (table 6). It is also helpful for the agencies to know which providers in the community provide safe and appropriate health services for sexual minoritized youth. (See 'Resources' below and "Lesbian, gay, bisexual, and other

sexual minoritized youth: Primary care", section on 'Resources'.)

School — Difficult school environments for sexual minoritized youth may result in lower educational achievement and increased risk for depression and suicide [37,48,194]. Schools that institute specific policies and programs promoting safety and diversity create an opportunity for all students to achieve both academic and social goals [195].

A tolerant and supportive school climate includes a leadership plan with staff who are trained, committed, and can implement strategies designed to promote zero tolerance of harassment and reduce victimization. School personnel who promote tolerance of diversity improve sexual minoritized students' feelings of connectedness and safety [196]. Protective school environments have been correlated with lower risks of substance use and suicidality among sexual minoritized youth [48,197].

Schools can promote a safer climate for sexual minoritized youth when [100,170,198-201]:

- Antidiscrimination and antiharassment policies include sexual minoritized youth and are strongly enforced, with staff actively intervening to enforce the policies whenever it is necessary.
- They have identified an individual (eg, guidance counselor, principal) and/or a process to addresses concerns of sexual minoritized youth.
- There are social opportunities such as GSAs integrated into the school setting; GSAs are student-led clubs that provide a place for sexual minoritized youth to gather, socialize, and educate in a safe and supportive context. The GSAnetwork can provide resources for students who would like to start a GSA. Participation in and perceived effectiveness of a GSA may decrease victimization and its effects on well-being [202].
- Sexual minoritized issues are integrated into the larger school curriculums (eg, discussion of same-sex relationships in sex education courses, discussion of sexual prejudice in athletics programs and physical education classes) [170,203].

A detailed discussion of policy recommendations to increase the safety of sexual minoritized youth at school is beyond the scope of this review but is available in Safe at School: Addressing the School Environment and LGBT safety through Policy and Legislation [194].

Resources — The tables provide lists of resources that may be helpful to sexual minoritized youth (table 6), parents and family members (table 4), and clinicians (table 7).

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Adolescent sexual health and pregnancy" and "Society guideline links: Sexually transmitted infections" and "Society guideline links: HIV infection in adolescents" and "Society guideline links: Contraception" and "Society guideline links: Medical care for homeless persons".)

SUMMARY

- Sexual orientation has multiple dimensions, including attractions, identity, behaviors, and the gender(s) of partners. Sexual identity is an individual's assessment of his or her sexual orientation. It is best defined by the individual adolescent; many avoid discreet labels. (See 'Terminology' above.)
- The term "sexual minoritized" encompasses a variety of gender and sexual identities and expressions that differ from cultural norms. In this topic, we focus on youth who identify themselves as lesbian, gay, bisexual, pansexual, or unsure of their sexual identity, who avoid discrete sexual orientation labels. (See 'Terminology' above.)
- Adolescents explore their emerging sexuality through attractions, fantasies, and behaviors. Adolescent sexual identity and self-identified orientation does not necessarily correlate with sexual behaviors. (See 'Developmental perspective' above.)
- In large surveys, 4 to 7 percent of high school youth report same-sex attractions or behaviors. (See 'Epidemiology' above.)
- The majority of sexual minoritized youth are healthy and well adjusted. However, compared with heterosexual peers, sexual minoritized youth are at increased risk of adverse psychosocial and health outcomes, including victimization, depression, suicide, substance use, homelessness, sexually transmitted infections, and unplanned

pregnancy. (See 'Potential psychosocial and health concerns' above.)

- Adverse psychosocial and health outcomes may be related to stigmatization and lack of acceptance by individuals, communities, and cultures (figure 2). Factors that may counteract stigmatization include acceptance, competence, increased self-esteem, strong connections to family and school, caring adult role models, and involvement in a community. (See 'Stigmatization and minority stress' above and 'Potential protective factors' above.)

- Health care providers can support sexual minoritized youth by normalizing sexuality throughout childhood; early identification of gender or sexual diversity and associated psychosocial and health concerns (table 1 and table 2); helping parents support their child; helping the youth with decisions about disclosure (table 5); advocating for schools that provide safety for sexual minoritized youth; and providing educational and support resources to the sexual minoritized youth (table 6) and his or her family (table 4). (See 'Support and advocacy' above.)

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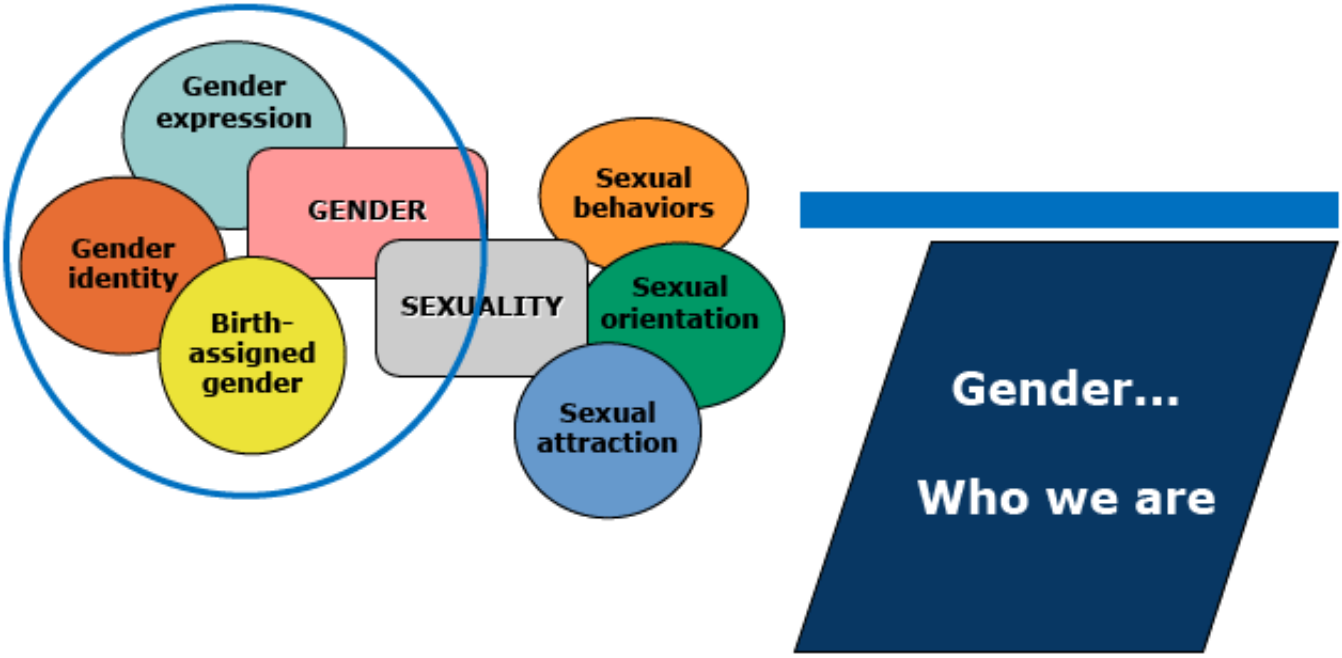
GRAPHICS

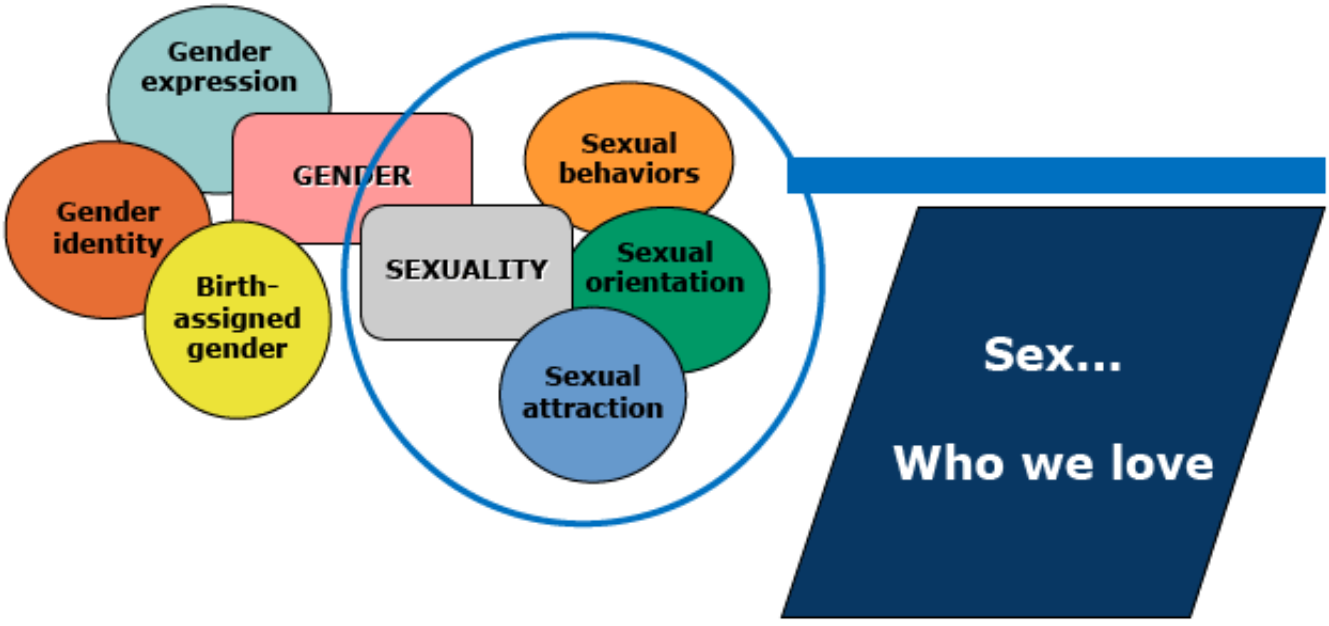
Paradigm of sexuality



Birth-assigned gender - Brain, hormones, body parts assigning male/female gender, usually at birth

Gender identity - Person's basic sense of being male, female, both, neither, or something else entirely – especially as experienced in self-awareness and behavior

Gender expression - Ways in which person acts, presents self, and communicates gender within a given culture



LGBTQQI - Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex

YMSM - Young Men who have Sex with Men

YWSW - Young Women who have Sex with Women

Bisexual, pansexual, asexual, queer

Courtesy of Michelle Forcier, MD, MPH and Johanna Olson-Kennedy, MD.

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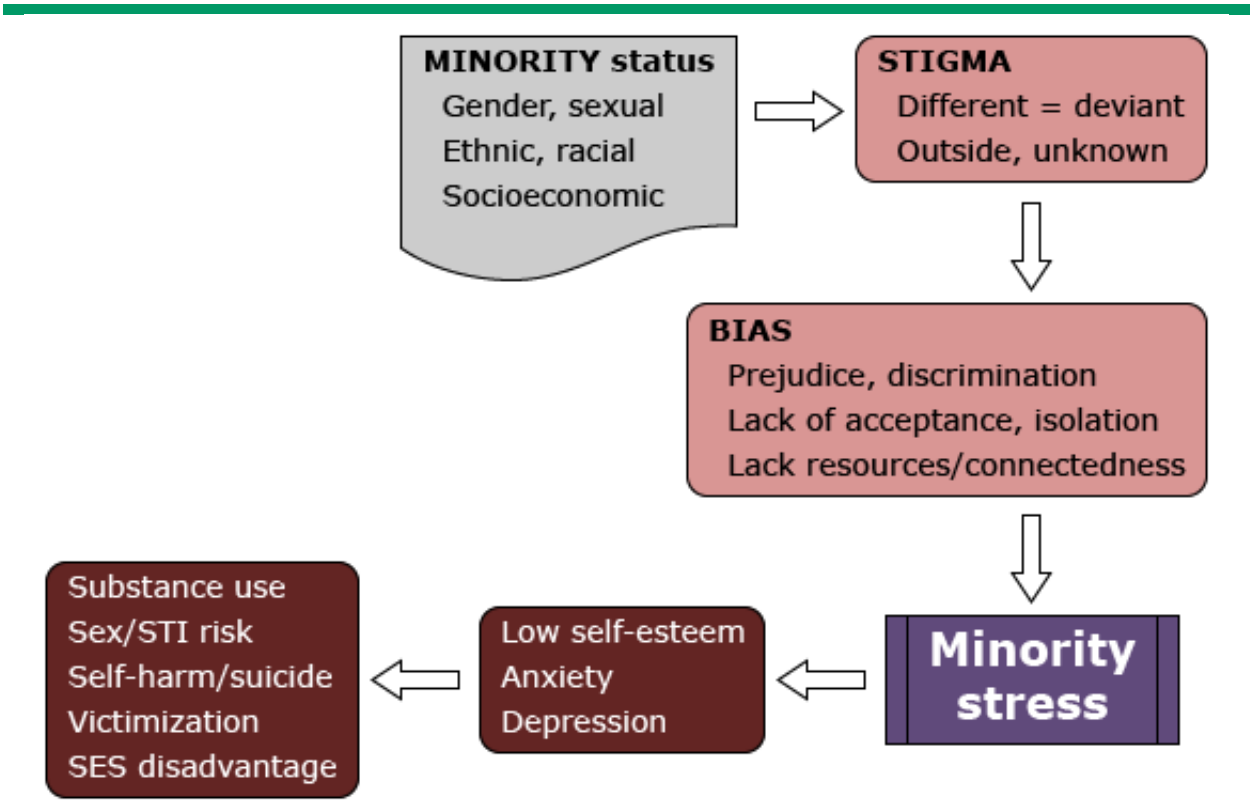
Minority stress theory



Sexual minoritized youth (eg, lesbian, gay, bisexual, transgender) may experience stigma related to their sexual orientation or gender diversity. This stigma can lead to prejudice, discrimination, and lack of acceptance in society at large or in one's relationships with peers and family members, resulting in "minority stress." Stigmatization and minority stress may increase vulnerability to psychologic distress (eg, anxiety, depression), which may contribute to adverse health and psychosocial outcomes (eg, suicide, substance use, socioeconomic disadvantage, victimization). Psychologic distress and adverse psychosocial outcomes are society-induced and not inherent to being a sexual minoritized individual.

SES: socioeconomic status.

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Graphic 95318 Version 5.0

Strategies for interviewing parents about their child's sexual attraction, identity, and behaviors

Sample questions regarding sexuality	Developmental goals
For parent(s) of prepubertal or peripubertal adolescents (age <14 years)	
▪ Do you have any questions or concerns about how your child expresses gender or sexuality? ▪ What sorts of play, interests, and friends does your child have? ▪ Does any of your child's play, activities, or interests concern you or your co-parent? ▪ Do you have any concerns about your child's friends, lack of friends, bullying, or other social issues? ▪ Do you need information regarding upcoming changes with puberty and adolescence? ▪ How do you plan to talk with your child about puberty? ▪ What were your experiences with puberty, adolescence, and sex? ▪ What sort of expectations and plan for communication have you established with your teen?	▪ Preparing parents to tasks of puberty ▪ Preparing parents to talk with children about upcoming puberty changes ▪ Prepare parents to have open, honest, supportive communication ▪ Give parents skillset to set limits, establish plans, and discuss consequences

Courtesy of Michelle Forcier, MD, MPH and Johanna Olson-Kennedy, MD.

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Strategies for interviewing prepubertal and peripubertal adolescents about sexual attraction, identity, and behaviors

Sample questions regarding sexuality	Developmental goals
For prepubertal children and peripubertal adolescents (age <10 years)	
▪ Do you have any questions or concerns about what being a boy or girl means? ▪ How do you feel – more like a boy, girl, or somewhere in between? ▪ Do you like your body? ▪ Do you think your body is healthy? Does your body fit you? ▪ What do you wish was different about your body? ▪ If you could change anything about your body, what would it be? ▪ Have you talked with your parent(s) or at school about puberty? ▪ What does puberty mean to you? ▪ Do you know what changes are ahead when you start puberty? ▪ What sort of plan do you have with your parent(s) for talking about teen issues?	▪ Prepare children to enter puberty ▪ Prepare children to have open, honest, supportive communication ▪ Give children permission to ask questions ▪ Give children a skillset to ask questions ▪ Give children an explicit plan about how to bring up sensitive topics with adults
For peripubertal and early adolescents (age 10 to 14 years)	
▪ What do you know about puberty? ▪ What sort of conversations have you had about being a teen with your parents, at school, or with friends? ▪ How do you feel about the changes in your body? Have your friends' bodies started to change? ▪ What changes are occurring with your friends regarding crushes, romantic feelings, dating, or sex? ▪ Do you have any crushes or romantic interests in your life? ▪ Is there anyone who is extra special and who you would like to get to know or date? ▪ Most kids masturbate. Do you get aroused, touch yourself, or wonder about having sex? ▪ Some kids start experimenting with sex early. Do you have any questions about what sex is? ▪ What are your friends doing in regards to sex? ▪ What have you done so far about sex? ▪ What and how do you and your parent(s) communicate about sex? ▪ What is your parent(s) position on being sexually active? ▪ Can you talk openly with your parent(s) about sex? ▪ Is there anything I can do to help you communicate with your parent about puberty and sex?	▪ Early education, preparation for puberty ▪ Early identification of gender dysphoria, same-sex attraction and behaviors ▪ Early support for sexual minoritized youth and early intervention for parents (eg, resources, referrals) ▪ Risk reduction and prevention of: anxiety, depression, suicidality, and other mood or behavioral concerns

Courtesy of Michelle Forcier, MD, MPH and Johanna Olson-Kennedy, MD.

Graphic 95294 Version 3.0

Strategies for interviewing middle and late adolescents about sexual attraction, identity, and behaviors

Sample questions regarding sexuality	Developmental goals
For middle adolescents (age 15 to 17 years)	
▪ Do you have any romantic interests in your life? ▪ Are you dating anyone? ▪ Is there anyone with whom you have a sexual relationship, including kissing, touching, or other stuff? Tell me about your partner. ▪ Are you sexually active or have you ever had sex*? ▪ What do you mean by "sex"? ▪ What sorts of sex have you had? ▪ What parts went where when you were having sex? ▪ Has sex been something you have wanted or something you felt emotionally or physically forced into doing? ▪ Have you ever paid for sex or been paid for sex? ▪ Who have you talked with about sex? ▪ What do your parents have to say about sex? ▪ What do your parents, family, and friends say about same-sex or gay people? ▪ Do you have any gay or bisexual people in your life that you can talk with? ▪ How do you feel about homosexuality or same-sex relationships?	▪ Safer exploration, experimentation ▪ Risk reduction and prevention of: sexually transmitted infections, unintended pregnancy, dating violence, bullying, substance use, mental health concerns, and suicidality ▪ Acknowledging and modeling support for diversity
For late adolescents (age 18 and older)	
▪ Are you sexually active or have you ever had sex*? ▪ Why or why not? ▪ What benefits or risks does being sexually active bring to a relationship? ▪ What sorts of things do you and your partner(s) do when you are sexually active? ▪ Do you kiss, touch each other's genitals, put your fingers in your partner's vagina or butt, put your penis in your partner's vagina or butt, receive a penis in your vagina or butt, give or receive oral sex? ▪ Has sex been something you have wanted or something you felt emotionally or physically forced into doing? ▪ Have you ever paid for sex or been paid for sex? ▪ Is sex pleasurable for you? ▪ Do you have any concerns about sex, orgasm? ▪ Any concerns about premature ejaculation or having a hard time getting aroused, wet, or hard? ▪ Do you do anything else that gives you and/or your partner sexual pleasure? Masturbation? Pornography? Drugs or alcohol with sex? Sex games or fantasy? Sadism or masochism? Fetishes or unusual ways to pleasure yourself or partner?	▪ Risk and harm reduction ▪ Explore sex for pleasure and pleasurable sex ▪ Explore sex's role in intimacy and mature relationship building ▪ Prepare for intimate partners, family planning

▪ (Remember to **leave long and open pauses** for patients to fill in the blanks or report other activities or interests)	

* For those who are sexually active, it is also important to ask about the number of partners, use of condoms or dental dams, and contraception.

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Resources for parents and family members of sexual minoritized youth

Advocates for Youth: LGBTQ Issues Info for Parents https://advocatesforyouth.org/resources-tools/?_sft_type=health-information&_sft_audience=for-parents
American Academy of Pediatrics Gay, lesbian, bisexual teens: Facts for teens and their parents www.healthychildren.org/English/ages-stages/teen/dating-sex/Pages/Gay-Lesbian-and-Bisexual-Teens-Facts-for-Teens-and-Their-Parents.aspx
American Academy of Child and Adolescent Psychiatry Facts for Families: Gay, Lesbian and Bisexual Adolescents https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Gay-Lesbian-and-Bisexual-Adolescents-063.aspx
American Psychological Association Understanding sexual orientation and gender identity www.apa.org/topics/sexuality/index.aspx
Centers for Disease Control and Prevention Electronic aggression: Technology and youth violence https://www.cdc.gov/violenceprevention/pdf/ea-tipsheet-a.pdf
Kids Health: Sexual Attraction and Orientation kidshealth.org/parent/emotions/feelings/sexual_orientation.html
Parents, Families, and Friends of Lesbians and Gays pflag.org/Family
Stopbullying.gov www.stopbullying.gov
Stop Bullying Now www.stopbullyingnow.com
Supportive Families, Healthy Children: Helping Families with Lesbian, Gay, Bisexual and Transgender Children familyproject.sfsu.edu/sites/sites7.sfsu.edu.familyproject/files/FAP_English%20Booklet_pst.pdf
The Trevor Project: Education and training for adults www.thetrevorproject.org/section/education-training-for-adults

LGBTQ: lesbian, gay, bisexual, transgender, questioning.

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Discussing disclosure with sexual minoritized youth

When?	Coming out can be a lifelong process. Everyone's timing is different. The person coming out should decide when is best.
	Consider coming out when you: ▪ Are comfortable with your sexual interests, identity, and orientation ▪ Want to share this with persons that you trust and are close to you ▪ Have had a chance to gather information or talk to others to learn from their coming out experiences ▪ Have a plan for support – where could you live, get money for food and clothes, go to school, and work if you are not accepted in your home and need to live elsewhere? ▪ Are ready to
Who?	You don't have to tell everyone at the same time. Parents and family may be a strong source of support but also may respond differently than you expect. Sometimes telling a close and trusted friend or professional (eg, teacher, coach, counselor) can be easier and safer the first time you tell someone about your sexuality.
	Choose a person or persons who you: ▪ Know well and expect to be respectful and supportive ▪ Trust, feel safe with, and know will keep your information confidential if you ask them to ▪ If you are thinking about telling a friend, choose carefully; some may have trouble keeping your information safe and confidential ▪ If you are thinking about disclosing to a school staff member, it is important to know whether or not your school's privacy and confidentiality policy requires staff to reveal that information to your parents ▪ Be sure to tell the person or persons you tell, who else may be told and who should **not** be told
How?	**Planning**
	Planning for your disclosure can help to make it a more positive and safe experience. Preparation may include: ▪ Talking to other sexual minoritized youth or sexual minoritized adults who have already come out to family and friends; listening and learning from others may provide useful strategies and help you feel confident about when and how to come out ▪ Participating in LGBTQ youth groups, support groups, or school groups that can offer advice on coming out ▪ Accessing internet resources that relate other youths' coming out experiences ▪ Creating a support network before you come out; professionals (eg, health care providers, mental health professionals, counselors) who work with children and teens may be able to help with this
	Process
	Disclosing in a letter
	Writing a letter gives you time to carefully say what you mean to say. Reading a letter in private gives the other person time to consider how they feel and how they might respond to you.
	Disclosing in person
	Some things to keep in mind if you decide to disclose in person: ▪ Try to choose a quiet and private space where you can talk with one or two people at a time. ▪ If you have concerns about your parents' reaction (or the reaction of whoever you are telling), try to choose a quiet but public place with other persons around and available to help if needed. ▪ Disclose when you and the other person are well rested, not dealing with other active stressors, and have time to continue talking. ▪ Focus on a few issues that are most important to you. Actively listen to what is important to the other person as well.

	▪ Plan how you might want to end the conversation and how you might plan to talk about it later. ▪ Avoid using alcohol or drugs; your mental and emotional state should be stable and secure when you have this important conversation. ▪ Try to avoid coming out because of pressure from others, being angry, or fighting.
Safety	**Be prepared for the possibility of a negative or rejecting reaction.**
	Safety first and foremost. Plan how to keep yourself physically safe at the time of disclosure and afterward. This may be difficult, but it is important to figure out ahead of time where you would go if the disclosure is difficult or threatening.
	Emotional safety is important, too. If you think you may be disclosing to a person who will be negative or rejecting, have your support network ready to help you process the negative reaction.
	Some people's first reaction may be more negative than you anticipate. The negative response may be based on the initial shock, surprise, or discomfort. They may need time to process the disclosure. People with negative initial reactions may still accept and support you but have a hard time processing their own feelings.
	Strong negative reactions may reflect personal biases or a background and culture that discriminate against sexual minorities. Issues of religion, morality, and culture have a large impact on how people view sexual diversity. However, there are many social and religious institutions that support civil and social rights of individuals regardless of sexuality or orientation.
	You get to decide if and when to walk away from people who are negative, unsupportive, or harmful.

LGBTQ: lesbian, gay, bisexual, transgender, questioning.

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Resources for sexual minoritized youth and their friends

Gay-Straight Alliance Network gsanetwork.org
Gay Lesbian Straight Education Network: Information for Students glsen.org/students
It Gets Better Project www.itgetsbetter.org
Sexuality Information and Education Council of the United States www.siecus.org
Stopbullying.gov www.stopbullying.gov
Stop Bullying Now www.stopbullyingnow.com
The Trevor Project: Help and Suicide Prevention www.thetrevorproject.org
Trevor Space: News and Networking www.trevorspace.org

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Health-related national organizations/coalitions for sexual minoritized persons

American Psychiatric Association - LGBT Sexual Orientation www.psychiatry.org/mental-health/people/lgbt-sexual-orientation
Gay and Lesbian Medical Association www.glma.org
National Association of Lesbian and Gay Addiction Professionals www.nalgap.org
National Coalition for LGBT Health http://healthlgbt.org/
National LGBT Cancer Network www.cancer-network.org
National LGBT Health Education Center www.lgbthealtheducation.org
National LGBT Tobacco Control Network www.lgbttobacco.org
Society for Adolescent Health and Medicine Position Statement on LGBT Adolescent Health and Well-being www.adolescenthealth.org/Advocacy/Position-Papers-Statements.aspx

LGBT: lesbian, gay, bisexual, transgender.

Courtesy of Michelle Forcier, MD, MPH and Johanna Olson-Kennedy, MD.

Graphic 95289 Version 8.0

Contributor Disclosures

Michelle Forcier, MD, MPH Consultant/Advisory Boards: Planned Parenthood. Other Financial Interest: Springer [Gender book royalties]. **Johanna Olson-Kennedy, MD** Consultant/Advisory Boards: Novartis [Transgender adolescents and young adults]. Consultant/Advisory Boards (Spouse/partner): Novartis [Transgender adolescents and young adults]. **Diane Blake, MD** Nothing to disclose **Mary M Torchia, MD** Nothing to disclose

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